Reducing Health Inequalities through Health Promotion and Structural Funds

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Preface

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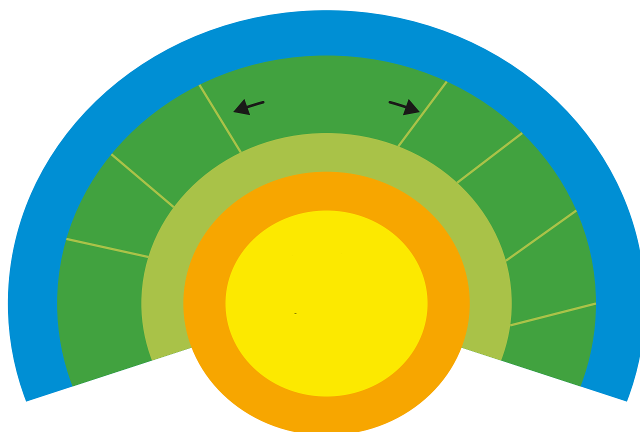
e ectively health promotion actions to reduce health inequalities and maintain and promote health. e rst part of this publication explains the underlying concepts and principles of health promotion on which e ective practice is based and how health inequalities can be tackled using such actions, in particular by accessing European Structural Funds. e second part of the publication highlights methods developed by the ACTION-FOR-HEALTH project, which form a bespoke training strategy that facilitates health promotion capacity building into practice.

Setting the scene: health and health inequalities in the EU

ere are established and growing inequalities in health both between, and within most European Member States, even though their populations are healthier than at any time in their history (e.g. Mackenbach et al, 2007). ese inequalities form a systematically-patterned 'gradient' between health and social circumstance across their entire populations which can a ect all individuals, with substantive evidence demonstrating that health

bec t3>es worse as you ove down the socio-ec t10(n)6(t3>)ic scale (Davies & Sherri , 2011, 2 Graha, 2001). e reasons for these health inequalities are c t3>plex and involve a wide range of factors which relate to the wider social deterinants of health including living c t10(n)]T



Other EU policies and nancial mecha

Health promotion: foundations and principles

Although not a new concept, health promotion received an impetus following the WHO Alma-Ata declaration (WHO, 1978). Over the last three decades, health promotion has received international attention and acclaim. e WHO has been the driving force in this process by establishing a vision, framework and agenda through a series of international conferences in an attempt to formulate new ways of understanding and promoting health with the rst conference in Canada producing the pivotal Ottawa Charter for Health Promotion (WHO, 1986; Figure 2).

e Ottawa Charter identi es three basic strategies for health promotion. ese are advocacy to create the essential conditions for health; enabling all people to achieve their full health potential; and mediating between the di erent interests in society in the pursuit of health. ese strategies are supported by ve priority action areas including: Build healthy public policy; create supportive environments for health; strengthen community action for health; develop personal skills, and; re-orient health services (Figure 2).

is cornerstone declaration and international conference for health promotion was subsequently followed by others which explored the major themes of the Ottawa Charter including for example, the Adelaide recommendations on healthy public policy (WHO, 1988); the Sundsvall Statement on creating supportive environments for health (WHO, 1991); the Jakarta Declaration on leading health promotion into the 21st Century (WHO, 1997); and the Bangkok Charter for Health Promotion (WHO, 2005; For a list of all key WHO milestones from the

Global Conference	Outcome
First International Conference on Health Promotion,	

Together, these conferences have contributed considerably to our collective understandings of health promotion, its strategies, and its practical application, as well as more fully accounting for issues of relevance to developing countries (WHO, 1998).

Statement on Health in All Policies (WHO, 2013) policy-makers at the local, regional, national and international levels have introduced a range of measures to improve the healthy life years of populations by addressing lifestyles (e.g. smoking, diet, physical activity etc.) and health-damaging aspects of the socio-ecological environment (e.g. hazards, environmental tobacco smoke, pollution and so on).

Whilst one of the main underpinning principles of health promotion is to involve the population as a whole rather than focusing, say, on more reductionist approaches to individual risk factors for particular diseases, linear causal pathways, and so on; health promotion also focuses explicitly on inequalities in health. Indeed the Ottawa Charter for Health Promotion (WHO, 1986) represented a-fundamental shift away from individuals to the social and wider determ(n)-9()8(u)1(p)8(e9(r)1(e)-19(s))13048Td (-)Tj 0.078 19(s e).l-7(t)-37(y221)

be analysed more appropriately in terms of social and political processes rather than relying on traditional epidemiological frameworks of ‘evidence’.

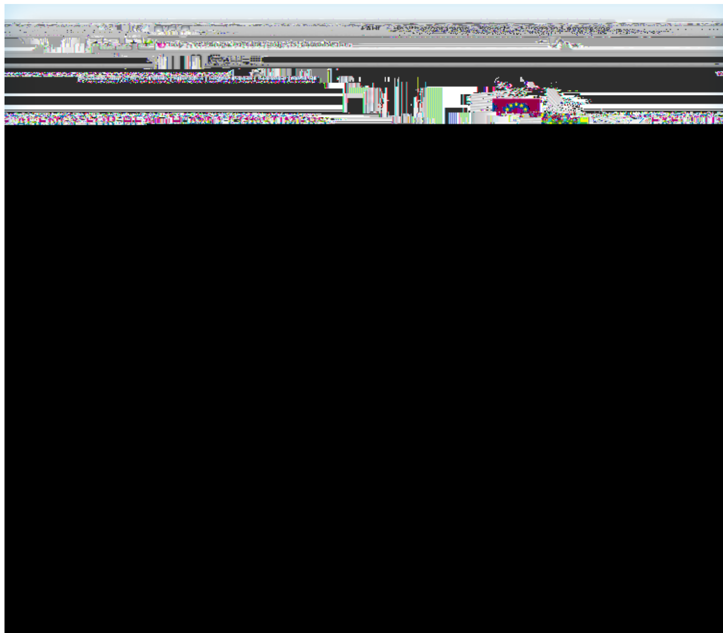
Whilst lots of attention has been paid to de

		In broader determinants	In individual risk factors
Tackling health inequalities	Reducing gradients	(1) Increase in level of determinants in all groups to match that in most advantaged group	(2) Reduction in prevalence in all groups to match that in most advantaged group
	Narrowing health gaps	(3) Faster rate of improvement in determinants in poorest group than comparator group	(4) Faster rate of reduction in risk factors in poorest group than comparator group
	Improving health of the poorest groups	(5) Improvement in determinants in poorest group	(6) Reduction in risk factors in poorest group

Determinants-oriented approaches to tackling health inequalities (Graham, 2009)

Further information on reducing health inequalities

It is beyond the scope of this publication to provide a comprehensive list of resources and information on reducing health inequalities. However, as noted previously, other useful sources include the searchable projects database of the EC Public Health Programme (see http://ec.europa.eu/eahc/projects/database.html) and the Seventh Framework Programme (FP7; Figure 3):



that would not happen without help from the cohesion policy. Types of projects funded include improving transport links, creation of networks of universities and research centres, shared management of natural resources, risk protection, and so on.

The different types of Structural Funds

e EU Cohesion Policy as a whole is thus designed to support measures that will boost economic growth in Member States thereby reducing the di erences in their respective levels of development (including health disparities). To meet these funding objectives, the Cohesion policy is nanced by three main funds (see Figure 4):

1. European Regional Development Fund
2. European Social Fund
3. Cohesion Fund

Objectives	Structural Funds and instruments		
Convergence	ERDF	ESF	Cohesion Fund
Regional Competitiveness and Employment	ERDF	ESF	
European Territorial Cooperation	ERDF		

Cohesion policy objectives and financial mechanisms

1. European Regional Development Fund (ERDF)

e ERDF (Budget: €201 billion) covers all three Cohesion Policy objectives (Figure 4) and supports major (often structural) projects addressing regional development, economic change, enhanced competitiveness (e.g. by direct aid to investments in companies, particularly, small and medium enterprises to create sustainable jobs) and territorial co-operation. All EU regions can access the ERDF.

2. European Social Fund (ESF)

e ESF (Budget: €76 billion) covers the convergence and regional competitiveness and employment objectives of Cohesion Policy (Figure 4). e ESF seeks to improve education, training, and employment in the EU and focuses on four key areas: 1) the adaptability of workers and enterprises (lifelong learning schemes, designing and spreading innovative working organisations); 2) access to employment for job seekers, the unemployed, women, and migrants; 3) social integration of disadvantaged people and combating discrimination in the job market, and; 4) strengthening human capital by reforming education systems and setting up a networks of teaching institutions. All EU regions can access the ESF.

3. Cohesion Fund (CF)

e Cohesion Fund (Budget: €70 billion) contributes to projects and activities in two main areas 1) Trans-European transport networks and 2) environment. e CF is specifically aimed at poorer EU regions or those with a Gross National Income of less than 90% of the EU average. e aim is to reduce Member States' economic shortfall and to stabilise their economy.

Why Structural and Cohesion Funds to reduce health inequalities?

It is beyond the scope of this publication to present in detail the case for why and how Structural Funds can be used to reduce health inequalities in the EU. However for an excellent and detailed perspective, see WHO (2010). In short, the Structural Funds (SF) and the Cohesion Fund (CF) are an investment policy allocated by the EU as part of its regional or Cohesion policy. e funds aim to reduce regional disparities in terms of income, wealth [our emphasis] and opportunities. In the Cohesion Policy funding framework for 2007–2013, a health priority was included with an estimated €11 billion allocated from the ERDF to support direct health system investments which includes approximately €6 billion for ageing and e-services priorities including e-health (WHO 2010). Moreover, the ESF is also used to support employment policies in regions categorised under both the Convergence and Regional Competitiveness and Employment objectives (see Figure 4). In this way, the ESF can provide funding for activities aiming to improve human capacity, to support healthy population and workforce, such as health promotion and disease prevention programmes, training of the health workforce, and health and safety at work measures. In other words, Structural Funds can be used to help Member States reduce health inequalities.

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Accessing Structural Funds

Accessing Structural Funds can be challenging and complicated and it's often best to work with someone or an organisation that already has experience in the process of applying and implementing a Structural Funds project. Moreover, it is important to note that projects funded by Structural Funds are co- nanced. at is, in addition to the European Commission's contribution, additional 'matched' funds are required. For the CF the EU contribution can be up to 85% but for the ESF and ERDF EU contribution ranges between 50-75%. For an overview of the 'who', 'how', 'when', 'which' and 'where' of applying for Structural Funds, see Table 5:

can apply for Structural Funds?	Generally, there are few restrictions meaning a wide range of organisations can apply and bene t from Structural Funds include public bodies, some private sector organisations (especially small businesses), universities, associations, NGOs and voluntary organisation If you are unsure, you can contact the appropriate managing authority in your country. see:

Preparing a project for structural funding

Although a rather simplistic representation, a project submitted to access structural funding typically comprises six key steps which approximate those for submitting any other kind of project for potential funding:

1. Identi cation of the idea and preliminary design
2. Preparation
3. Appraisal
4. Proposal approval and nancing
5. Implementation and monitoring
6. Evaluation.

Structural Funds 2014-2020

EU Cohesion Policy has been a considerable force for change during the current funding framework 2007-2013. To continue this work in the future and to strengthen the focus on European economic priorities, the EC (at the time of writing) is in the process of nalising the new Cohesion Policy for 2014-2020. e new framework is speci cally intended to reinforce the strategic dimension of the policy and to ensure that EU investment is targeted on Europe's long-term goals for growth and jobs (Europe 2020 strategy of smart, sustainable, inclusive growth). Other changes include a greater focus on results (e.g. the use of common indicators, reporting, monitoring, and evaluation, and so on), and a focus on maximising the impact of EU funding (e.g. more coherent use of funds, harmonising and simplifying funding rules etc.).

For the purposes of the ACTION-FOR-HEALTH project, the impact these changes may have for project partners is unclear.

However, it is likely that the foreseen project outcomes for ACTION-FOR-HEALTH (particularly the increased capacity of project partners and/or public health professionals in the areas of health inequalities, health promotion, and Structural Funds; and the preparation and testing of an action plan for tackling health inequalities) will remain relevant and valuable for the forthcoming 2014-2020 framework. Indeed, it is likely that the ACTION-FOR-HEALTH outcomes will provide important EU added value and considerable opportunities for accessing Structural Funds to reduce health inequalities in their respective regions and/or countries.

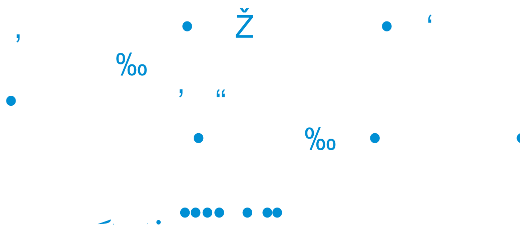
Further information on Structural Funds

e European Portal for Action on Health Inequalities was launched by the European Commission during 2011 (see www.health-inequalities.eu). Developed by EuroHealthNet, on behalf of the 'Equity Action' Programme (part of the Joint Action on Health Inequalities which is a collaboration between DGSANCO of the European Commission and National governments of 12 EU Member States), this portal aims to provide a source of information on health inequalities, social determinants of health, and Health in All Policies.

Of relevance to ACTION-FOR-HEALTH is that one of the work strands of this programme (coordinated by EuroHealthNet) has brought together a network of 29 regions to capture and share regional approaches to reduce health inequalities, and to strengthen understanding on how to in uence and use Structural Funds to address Regional health equity issues. e outcomes of this work are the basis for the content of a useful and up-to-date guidance tool on European Structural Funds (Figure 5).

Structural Funds guidance tool for health equity (http://fundsforhealth.eu)

Over the last three decades the concept of 'capacity building' has been introduced into the eld of health promotion as a (relatively new) focus on the requirements for successful implementation of health promotion programmes and/or interventions. Capacity building can be described broadly as any action that aims at developing resources, skills, and requirements that are needed in order to implement health promotion activities.



Capacity building to reduce health inequalities through Structural Funds needs to be nested in a broader capacity-building approach that ensures sustainable capacity is achieved at various levels including system, organisation, team and individual levels (WHO, 2010). Ideally, capacity building should aim at being sustainable in terms of producing fundamental and lasting changes, and needs to be viewed as an on-going process, multi-dimensional, and multi-sectorial, meaning that changes and interventions occur in di erent areas and across di erent sectors (Crisp *et al*, 2000).

Capacity building can be applied at various di erent levels including the national level and/eeally, c92 -1.4412 0 T45ieiei65e0 Tw Tem [(

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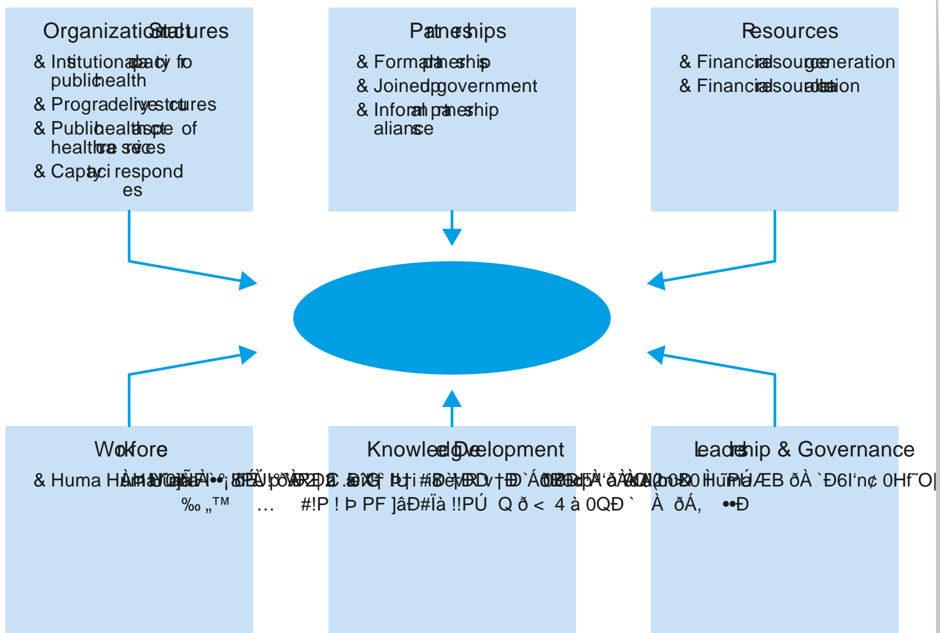
Different levels of capacity building

National level

At the national level and/or regional level, capacity building is particularly important for many of the EU new Member States, and to a large extent, usually concerns the development of infrastructure. is includes the development of “policies, surveillance systems, research and evaluation capability, a skilled workforce and programme delivery mechanisms” (Catford, 2005, p.2). In relation to tackling health inequalities, the development of policies is particularly important in order to stimulate the implementation and/or development of necessary and relevant structures and mechanisms (Stegeman et al., 2009).

Organisational level

Organisational capacity building concerns, amongst other things, the training of sta , the development of organisational policies, the provision of resources, and the institutionalisation of health promotion (Smith et al., 2006). “ e scope of organizational capacity building encompasses the range of policies and partnerships for health promotion that may be necessary to implement speci c programs [sic] or to identify and respond to new health needs as they arise” (Smith et al., 2006, p.342). An important part of building organisational capacity is, of course, organisational development, referring to processes that ensure that the policies, structures, procedures and practices of an organisation are in place, and that change is managed e ectively (Stegeman et al., 2009). Within the Reviewing Public Health Capacity in the EU project (see Aluttis et al., 2013), a useful overview of the capacity building concept as it relates to organisations was developed, di erentiating between organisational structures, partnerships, resources, won(n)16()b



Overview of public health capacities Aluttis et al., (2013)

Individual level

Finally, individual capacity building for health promotion concerns enabling and empowering individuals to take action for their health. Individual capacity building can happen within organisations or communities. A common strategy to build capacity for health promotion concerns the increase of knowledge and skills of individuals, which is why capacity building is often (wrongly) used synonymously with training and professional development (Potter & Brough, 2004). While training and professional development are of course key components of building individual capacity, other aspects of developing resources and creating suitable environments also need to be incorporated, including strategies such as the empowerment and enabling of staff, building of partnerships and networks, the creation of common visions, and so on.

Building capacity systematically

Capacity building is the objective of many development and interventional programmes including those designed to reduce health inequalities by addressing the social determinants of health. However, Potter & Brough (2004) argue that as a term, it too often becomes merely a euphemism referring to little more than training. e authors argue that when aiming to build capacity, it is important to approach it systematically which can help to identify sectoral shortcomings in speci c locations, improve project/programme design and monitoring, and lead to the more e ective use of resources.

To this end, Potter & Brough (2004) developed a pyramid of capacity building comprising nine separate but interdependent components that form a four-tier hierarchy of capacity building needs including: 1) structures, systems and roles, 2) sta and facilities, 3) skills, and 4) tools (Figure 7).

According to Potter & Brough (2004), to build capacity certain measures need to come before others to ensure that the foundations are put in place to enable the e ective implementation of further measures.

Important capacities on the rst stage include role capacity - concerning authority, responsibility, and decision making power; structural capacity - concerning decision-making forums and inter-sectoral discussions, and; systems capacity - which refers to the abilities and e ectiveness of the system, its communication, and ability to change.

On the second stage, support service capacity and facility capacity bect thom..16(t)-3

As noted in the Preface to this publication, the ACTION-FOR-HEALTH project and its underpinning principlu -h0un

of key learning and interactive sessions (e.g. covering health promotion, healthy literacy, health inequalities, Structural Funds etc.), practical demonstrations, and cultural and social visits (Table 6). e content of the summer school was designed speci cally to facilitate both partners' contributions in terms of their knowledge and expertise, as well as that of externally invited experts - resulting in a comprehensive and synergistic programme o ering a combination of theoretical perspectives and applied health promotion (e.g. through demonstrational workshops).

Topic areas for the development of knowledge and skills in ACTION-FOR-HEALTH

Distance learning tool

Although not yet available at the time of writing (November, 2013), a distance learning tool will be developed by the end of the project (June, 2014). Generated in part from the learning materials developed directly as a result of the Training Workshop and Summer School, this tool will be available for the public and will provide information on the core issues of ACTION-FOR-HEALTH. It will also enable partners and other stakeholders to revisit the most relevant topics in their own time (Table 6).

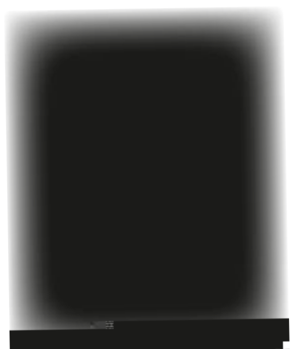
Final conference

Lastly, a nal project conference will be organised at the end of the project which will be open to invited experts, public health professionals, and the wider public. It will summarise the project, showcase achievements, and provide insights into the lessons learned and next steps. All documents from the conference will be available on the project website in due course (Table 6).

ACTION 2: Building partnerships

e second area of capacity building in ACTION-FOR-HEALTH, concerns the development of partnerships between the project partners, and perhaps more importantly, of project partners with stakeholders within the seven participating countries and regions. As part of the project, partners have been encouraged to strengthen existing partnerships and to make contact with di erent public health professionals, health promotion practitioners, and policy makers, in order to create a network of experts with which they can consult with. is was helpful for various activities within the project including the situation analysis and identi cation of promising practices (Action 1) which were conducted by project partners within WP4, and necessary for the creation of strategic action plans to reduce health inequalities (Action 3).

e third core area of ACTION-FOR-HEALTH, and the main result of the rst year of the project (2012-2013), is the creation of strategic action plans to reduce health inequalities. An action plan, in this context, is a strategic plan based on the situation analysis and needs assessment of a chosen region, with the general goal to reduce health inequalities. It consists of speci c aims and objectives that de ne how these aims can be achieved, activities that list a number of potential ways to act, and indicators by which success of the activities can be evaluated (Belovic et al., 2005). ereby, the action plans can provide a strategic framework and guidance for public health professionals on how to reduce health inequalities and which inequalities to focus on according to the particular region in question. Furthermore, the action plans that are developed during the project can then provide a basis on which to transfer and adapt to other regions thus potentially multiplying its bene ts.



Resource/Source	Availability*
Healthy schools toolkit – e health of a whole school community can be improved through taking some simple steps and health bene ts can support learning and working in schools. is toolkit has been developed by the Health Promotion Agency for Northern Ireland (UK) providing a focus for school sta to develop, implement and monitor a healthy school environment.	Download the pdf from the Health Promotion Agency for Northern Ireland's website: www.healthpromotionagency.org.uk/Work/hpschools/pdfs/HPA_Toolkit.pdf

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