

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

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## RESULTS OF NEEDS ASSESSMENT AND ACTION PLAN

ŁÓDŹ, POLAND

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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?

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### **Introduction to Part 1**

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

A key product of the project is the [HE2020 Toolkit](#) providing step-by-step guidance in designing evidence based action plans: (i) conducting a needs assessment, (ii) a capacity

assessment, (iii) selecting entry points, (iv) carrying an impact assessment. Following the Toolkit structure this template helps regions document the data and information collected during the course of the process of assessing and addressing socioeconomic health inequalities.

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

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

The full HE2020Toolkit is available at this link:

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

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

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

## Phase 1 Carrying out the NEEDS ASSESSMENT

Assessing the magnitude and determinants of socioeconomic health inequalities

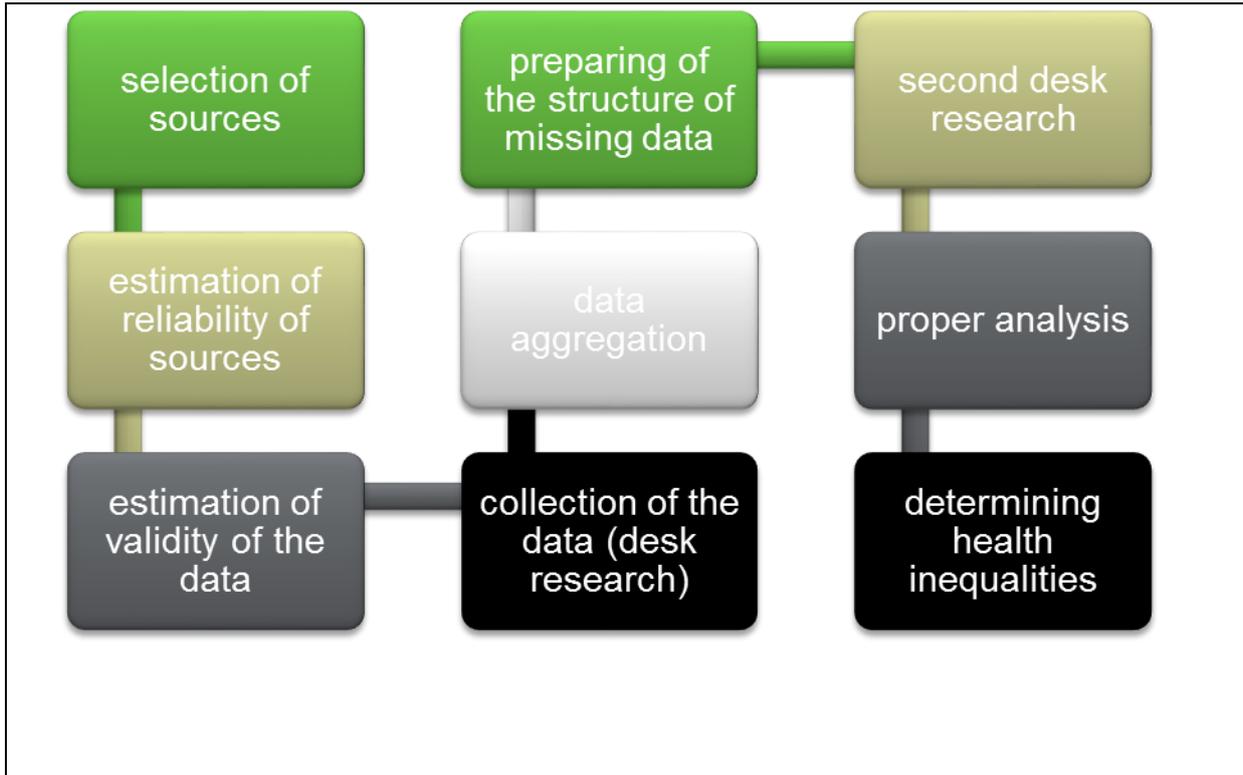
### 1.1 Introduction

*The process of collecting the data was divided into several stages. On the first one, the selection of sources, based on the accessibility criteria, was conducted. Then, the reliability of sources was estimated. On the third stage the validity of data was estimated. On the next stage the process of the data collection has started. The data were collected by desk research and meta analyses of reports and research announcements. Part of the data were easily accessible from The Central Statistical Office of Poland, The Centre of Information Systems for Health Care, other data had to be asked for from The National Health Fund, Voivodship Centre for Public Health and other offices and institutions. Last steps included the data aggregation (when needed) and preparing the structure of missing data. Then the second phase of the desk research started, which aim was to collect the missing information. In this phase we analysed less reliable sources. after that we started the proper analysis which resulted in determining main areas of health inequalities in our region (Picture 1). We managed to collect high quality data (in terms of validity and reliability) almost in all required areas. Unfortunately, the structure of variables usually takes into account only age and sex and we don't possess the data combined with education, income or SES. Thus, the use of the given tool was impossible and our analyses of inequalities in health are based only on criteria of age and sex. To improve the quality of the report the comparative study was conducted to find how our region presents in relation to the whole country and other regions (voivodeships).*

*During collecting the data, we encountered two main obstacles:*

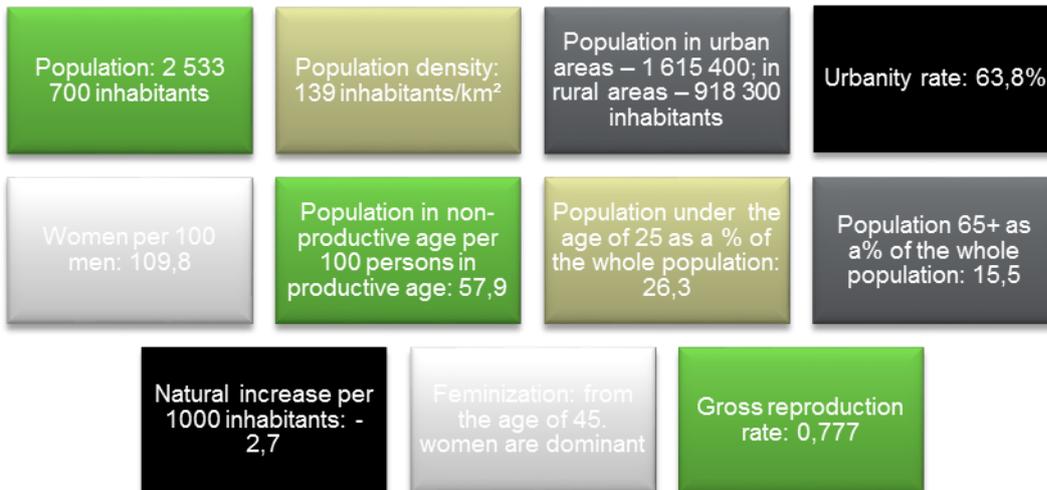
- inaccessibility of valuable data (problem of the personal data protection, lack of willingness in cooperation);*
- lack of the data combined with certain criteria (eg. SES);*

*We haven't conducted any additional surveys (lack of time and money).*



## 1.2 Regional profile

Picture 2. Main regional data



Population of the region systematically decreases from 2005. Population density is average comparing to other Polish regions. Slightly more people live in urban than in rural areas. We can observe an alarming tendency: per 100 men there is 109,8 women and at the same time women are dominant in age group from the of 45 (see Table 1), so we say about feminization. Another negative tendency is decreasing number of population under the age of 25 with accompanying increase in the population of 65+. Lodzkie has, in addition, the

lowest natural increase and gross reproduction rate in the whole country (-2,7 per 1000 inhabitants and 0,777, respectively) (see Picture 2).

**Table 1. Population of Lodzkie by gender and age in 2011**

	total	0-2	3-6	7-12	13-15	16-18	19-24	25-34	35-44	45-54	55-64	65+
	2 533 700	75 600	96 300	133 600	75 500	86 900	199 400	399 700	342 700	346 700	384 700	392 600
males	1 207 900	38 800	49 500	68 700	38 800	44 400	101 800	204 200	172 800	168 800	177 500	142 500
females	1 325 800*	36 700	46 800	64 900	36 700	42 500	97 600	195 600	169 900	177 800*	207 200*	250 100*

\*females>males

Migration of the population is not so huge in comparison to other regions, but if we consider previously described vital statistics and indicators the situation seems to be rather non optimistic (see Table 2).

**Table 2. Migration of population for permanent residence in 2011**

total	INTERNAL						INTERNATIONAL				
	inflow		outflow		net migration		immigration	emigration	net migration		
	to urban	to rural	total	from urban	from rural	total				urban	rural
22 693	10 937	11 756	24 537	15 541	89 96	- 1844	- 4604	27 60	504	551	-47

Considering socioeconomic indicators, it has to be underlined that feminization has its impact in the area of marital status (see Table 3) – there is more women than men living alone, widowed, divorced and separated. Especially in last 3 situations it can have its negative impact on the financial situation of women. As far as education level is concerned we possess only general data concerning different levels of education but without such variables as gender or age (see Table and 4).

**Table 3. Population aged 15+ by marital status**

	total	singles	married	cohabitant	widowed	divorced	separated
	2 183 100	554 300	1 170 800	52 200	247 000	111 600	14 000
males	1 027 700	314 600	586 600	26 700	36 300	41 300	5 900
females	1 155 500	239 800	584 200	25 500	210 700	70 300	8 000

**Table 4. Population by education level**

	total	higher	post-secondary and secondary	basic vocational	lower secondary	completed primary	incomplete primary and without school education	unknown education level
	2 234 100	360 800	740 000	450 500	104 500	478 300	34 400	65 600
in %	100	16,2	33,1	20,2	4,7	21,4	1,5	2,9

**Picture 3. Economic situation of the region**



Gross domestic product per capita in zloty was average in comparison to the whole country and other regions. Lodzkie has one of the highest unemployment rates in the country and it increases (long-term unemployment rate is 6,4%). 18,5% of the whole unemployed population are persons up to the age of 25 and 26% are persons aged 50+. Activity rate for men is 59,6 while for women only 44,8. Employment rates for men and women are 51,8 and 38,9, respectively. In 2011 we had the highest number of people terminated from the company reasons. We can observe a big dynamic on the job market – many new job offers appear but many companies are closed at the same time, the impact of which are one of the highest rates of employment and termination in the whole country. There are many people receiving benefits from the non-agriculture social security system (6th highest score for family pensions and 8th highest score for pensions resulting from an inability to work comparing to other voivodeships). At-risk of poverty rate after social transfers (on the basis of EU-SILC) is 6th highest score for all the regions). Average monthly per capita expenditures in households on health are one of the highest in the country (see Picture 3). It is important to notice, that, according to the WHO regional report published by the Polish Ministry of Health good situation on the job market and better education determine good health, while worse professional situation influences deteriorating one`s health .

*Main economic drivers of the region:*

- *Natural resources – lignite coal (Bełchatów, the biggest mine in Europe)*
- *Lodz Industry Area (former textile industry)*
- *Lodz Special Economic Area*
- *Bełchatów – energy, mining*
- *Piotrków Trybunalski – logistics, precise industry*
- *Łódź - one of the biggest academic centres in Poland; the site of the biggest call centres.*

*Łódź is a city with a multicultural history and excellent localization (central Poland, 1,5 hour to Warsaw, 3 hours to Poznan, 4 hours to Gdansk). The city has a local airport and rich cultural offer. Within the city one can find about 30 higher education institutions (including medical, art, music and film schools). Main general indicators that would have impact on health inequalities are:*

- *feminization of population*
- *ageing of population*
- *unemployment*
- *migration*

### **1.3 Socioeconomic inequalities in health**

#### ***Mortality and life-expectancy***

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

*Lodzkie has the highest mortality rate for all regions of Poland (deaths per 1000 population – 12,1). In almost all age groups mortality rates are higher for males than for females (exceptions are age groups 5-9 and 10-14). General data retrieved from the WHO report published by the Polish Ministry of Health show that, on the voivodeship level, mortality rate correlates with the level of education – the higher the level of education, the lower mortality rate.*

*In 2010 the leading causes of deaths in Lodzkie were: neoplasms, symptoms and ill-defined conditions, injuries and poisonings by external cause, diseases of the digestive system (the highest scores in the country), diseases of the circulatory system (2<sup>nd</sup> highest score in the country) and diseases of the nervous system and sense organs (3<sup>rd</sup> highest score).*

*Life expectancy in 2011 for males was 70,4 and for females 79,5 – these are the lowest values for all the regions.*

*Mortality and life expectancy are strongly related with the quality of life (job, incomes, living and working conditions, education, etc.). Women live longer than men, but their quality of life is rather low – they usually have to join professional and household duties, but they are less paid. Due to pregnancy and motherhood leaves their job positions are worse than men, they also stay shorter on the job market and their social benefits after the retirement are lower. They more frequent become widows than men and have to cope with everyday problems alone.*

### **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.]*

*Disability can occur in-born or gained, so it is hard to talk about inequalities based on such criteria as age. Analyses showed that disabilities that raise with age are mental disorder, sensory disorders (vision, hearing, voice) and mobility disorder. The criterion of gender revealed that men suffer more frequent from epilepsy, pervasive developmental disorder, respiratory and circulatory system disorder than women, while women suffer more frequent from mental, mobility and genitourinary system disorders. The variable of education level can't be easily used as a determinant of disabilities because the relation disability-education is two-dimensional (level of education determines profession which can lead to certain disabilities but suffering from a certain disability can be a serious obstacle in achieving proper education).*

*Longitudinal health problems revealed inequalities in relation to age and sex. 22,5% of young citizens (aged 15-29) suffers from which problems which is the 5th highest score in the country. Women suffer more frequent than men and health significantly decreases with age. Women suffer more frequent than men from the following chronic diseases: allergy, diabetes, coronary without stroke, other heart disease, high blood pressure, atherosclerosis, brain stroke, spine/dyscopathy, osteoporosis, rheumatism, other joint diseases, cholelithiasis, cataract, glaucoma, thyroid diseases, migrena/headaches, neurosis/depression. One can see there are some diseases effecting from biological differences between females and males, but quite surprising are coronary diseases with stroke that affect women and men similarly.*

*Rate of people evaluating their health as very good and good in 2004 was 55,1 and it was the worst result comparing to all the regions. 40,6% of all the men and 47,4% of women described their health as worse than good.*

*Alarming data concern also infectious diseases – we observed one of the highest incidence of tuberculosis, viral hepatitis type B and veneral diseases. Among malignant neoplasms the highest score had breast cancer, the second highest was eye, brain and other parts of central nervous system neoplasm.*

## **1.4 Socioeconomic inequalities in health determinants**

### **Health behaviours**

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

*Tobacco use, high blood pressure, high cholesterol and glucose levels, obesity, lack of activity are among leading indicators of non-communicable diseases. Their important feature is that they can be modified positively influencing the population's health.*

### Smoking

Smoking population of Lodzkie consists of 42% of men and 21% of women, placing the region among areas with the lowest rates, which seems to be an optimistic information. Worrying fact is that among active smokers in age groups 15-29 and 70+ are two times more men than women. Heavy smokers (20 cigarettes and more) are mainly men between 30 and 69. Alarming fact is that among occasional smokers the biggest group are young men (15-29). Early smoking experiences usually leads to regular smoking. National data depict that smoking cigarettes strongly correlates with the level of education (51% of smoking men and 33% of smoking women had the lowest level of education, while smokers with higher education were 21% and 16%, respectively).

### Physical activity

Correct physical activity relates to 29% of females and 35% of males and these are rather poor results comparing to the rest of the country. Unfortunately, we don't have any detailed data that would show relation between lack of activity and age or level of education that would cast some light on the potential causes of such.

### Alcohol

Men drink alcohol slightly more frequent than women in all age groups apart from 70+ that can result from the huge mortality of men in that group and overrepresentation of women. The most often men drink alcohol 1-3 times a month and women 1-5 times a year. The biggest number of men drinks alcohol between 30 and 49. Statistical everyday drinker belongs to the same age category. the most disturbing fact is that younger and younger persons of both sexes reach for alcohol.

### Drugs

Another health related problem is use of drugs. They become more and more popular among pupils. They usually use marijuana and hashish. In 2009 Lodzkie was among top 5 regions with the highest number of deaths caused by overuse of drugs.

Data concerning cholesterol, blood pressure and BMI levels were retrieved from WOBASZ and because of the small sample of surveyed people they can be less reliable.

### BMI

Body Mass Index is an important risk factor. According to the collected data women have more proper BMI than men (52% versus 38%) but obesity concerns both sexes almost equally, while huge obesity was only a female problem (2% of females have been diagnosed with it). Additional survey conducted in Lodz showed that the high level of education correlated with the lower risk of excessive body mass.

### High blood pressure

24% of women and 30% of men suffered from high blood pressure and these were the lowest scores for the whole Polish population. This can be surprising result comparing to the high rates of cardiovascular diseases (with and without stroke).

High levels of blood pressure, glucose and cholesterol strongly correlate with the level of education.

### Physical activity

Poles belong to lazy nations. Physical activity is still unpopular and unwillingness to do exercises raises with age. Usually people spend their free time passively (watching tv, reading). 35% of the whole population doesn't practice any physical activity that would last minimum 30 minutes. Practicing physical activity correlates with age (under 35), place of living (small towns), sex (males) and level of education (higher). Alarming fact is that lack of activity starts at an early age – only 1/5 of the surveyed population of Lodzkie aged 6-14 participated in physical education lessons and correction activities.

*To sum up, factors described above strongly correlate with the level of education on the national level which can be a predictive that this correlation can be observed on the regional level as well. Indicators like high blood pressure, BMI or lack of activity are related to one's lifestyle and can be modified, thus, they should become crucial elements of regional health policy. As education is the key factor influencing not only knowledge but behaviours as well, this should be the area of planned strategy. Health promotion on early stages of education, rewarding of pro-health behaviours in the place of work and health education of people with low education should be the main directions of the regional health policy to reduce social inequalities in health in that area.*

### **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.]*

#### Living conditions

*According to the WHO report indicators of living conditions in households show the strongest correlation with health indicators. Very strong correlation was observed between the rate of households with bathrooms in cities and standardized rate of deaths. Another strong correlation is the one with life expectancy. Better sanitary conditions result in better health. Lodzkie has one of the lowest rates of dwellings with central heating, bathroom, gas-line system and lavatory. A remarkable fact is that citizens live rather in old buildings (many of them were constructed before 1945 – 18,9% or between 1945-70 – 27,7%). This may result in problems with dampness, coldness, fungus and mould and lead to respiratory system diseases, allergy.*

*Areas of old buildings, tenement houses in Lodz are called “the poverty districts” due to the fact that most of inhabitants are poor people, with low level of education, low SES. People whose living conditions worsen are moved from higher quality flats to old tenement houses (very often without basic facilities) for economic reasons. Poor social condition results in increase of pathological behaviours (crimes, sexual abuse, domestic violence, alcohol and drug abuse) and can be the cause of deterioration of health. People with Low SES living in those areas don't have enough knowledge, time and money to protect their health properly (overcrowded flats, lack of facilities, lack of money for balanced diet, physical activity and health prevention).*

#### Working conditions

*Only 7% of the surveyed persons work in hazardous health conditions. The main hazardous factor is noise. People working in plants are exposed to chemical and physical carcinogens and mutagens and women are group that is exposed more to their influence than men, which can result in worse health condition (see section Health during life).*

*Working conditions don't only mean factors mentioned above. Very important are psychological conditions. As it was mentioned above job market in Lodzkie characterizes huge dynamics. Our region has one of the highest unemployment rate; people who already have job declare uncertainty*

*of their professional future (short-term employment contracts, working without contracts). This may lead to dissatisfaction, professional burn-out and depression and thus, can worsen health conditions.*

### **Access and use of health services**

*[Describe inequalities in access to and use of health care and preventive services such as general practitioners, medical specialists, hospitals, dental care, screening, vaccination programs, and maternal and prenatal care. Consider both the geographical access as well as the financial barriers.]*

*Geographical access to health services is not sufficient criterion. On one hand people living in big cities (like Lodz) have much easier access to various specialists as well as GP`s, which can result in seeking for the best doctor and influence competitiveness on the health service market. People from smaller towns and villages are deprived of such choice. But, on the other hand, many non-public but contracted with the National Health Fund health care facilities work outside big cities giving opportunity to seek for the GP as well as specialist advice faster than in metropolitan area due to smaller number of inhabitants. More and more often people from Lodz seek for the medical advice in the closest small cities around Lodz (Konstantynow, Zgierz).*

*On the regional level the number of doctors per 1000 inhabitants in 2004 was 2,39 and was higher than an average for Poland. The rate of dentists per 1000 inhabitants was 0,42 and was one of the highest in the country. The number of beds per 10000 inhabitants and the number of inhabitants per one bed was among the lowest rates in the country. But at the same time our region has the highest rate of consultations provided in ambulatory health care per 1 patient. Among main reasons of resignation from the visit at GP were lack of money and long waiting lists and at the dentist – lack of money and time. Long waiting lists are main obstacle in visiting specialists (eg. endocrinologists, orthopedists, neurologists) and some of them are unavailable in smaller cities at all.*

*Lodzkie implemented several screening programs. The most popular is breast cancer screening. Other preventive checkups (cervical cancer screening, ultrasonography) are done due to doctor`s advice or care of one`s health.*

## 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.]*

*GDP per capita in 2010 – 92,1 (the 6<sup>th</sup> highest for all regions). Labour productivity gives our region 12 position, that shows rather pessimistic view of the situation. Activity rate is 4<sup>th</sup> the lowest for all regions (51,8%) and it is slightly higher for males (59,6%) than for females (44,8%).*

*Average number of days of absence due to one`s sickness was almost 14 days and gives the region the first position. This is rather pessimistic picture of productivity and points out on the high costs of health services.*

*In occupational diseases in 2008 per 100 000 of employed the region situates on the second lowest position, which is good as it means that our citizens suffer from such health problems less often than inhabitants of other regions.*

### **Direct costs related indicators**

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

*High costs of social security benefits resulting from pathology on the job market (illegal sick leaves, hiring people with legal confirmation of disability).*

*As analyses revealed health care expenditures are average.*

## 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?)*

*Capacity audit in Lodzkie region was made between September 2013 and April 2014. We have collected 5 short reports from members of Regional Action Group: National Health Fund, Department of Health (City of Lodz), Department of Health Policy (Regional Government), Department of Regional Policy (Regional Development) and Medical University of Lodz.*

## 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.]*

## 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.]*

*Firstly analysis covers Organizational Development, which has pretty well developer approach towards health inequalities. By this, we mean proper structure and assets of different stakeholders. Organizations may play significant role in reducing health inequalities. None of crucial barriers were identified.*

## 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.]*

*Resources are one of the key elements of starting, developing and sustain the long-term impact within the process of reducing health inequalities. In Lodzkie even if there is no dedicated budget line for reducing health inequalities, financial resources are dedicated to certain socio-economic intervention. The main challenge is to establish the mechanism that could help to measure the impact of the investment on real reduction of inequalities.*

## Workforce development

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

*A bit different outcomes were identified concerning workforce. Even if each institution covers proper individual development of the staff, it is very difficult to link the competences with real influence on health inequalities processes. This is the area that has to improve in order ensure strategic approach in building regional competence in terms of reducing health inequalities.*

## Leadership

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

*Leadership and Partnership are key dimension, that need to be improved in order to provide strategic and systematic reducing of health inequalities. Lack of leaders in the area makes it very difficult to exchange and communicate possible strategies and good practices. If the leaders are active at local level, the political issues are the main barriers to transfer their experience on regional level.*

### Partnerships

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

*Leadership and Partnership are key dimensions, that need to be improved in order to provide strategic and systematic reducing of health inequalities. Building partnerships at local level, e.g. social economy seems to quite common activity, contrary at regional level is identified by RAG members as one the main challenges. For example, the main step to improve the processes of reducing health inequalities is the access to proper socio-economic data. This process in not realized, the data is not presented and exchanged by different stakeholders. Performing real change is not possible due to the lack of cooperation and communication.*

## 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?]*

- 1/ Districts of poverty
- 2/ Lack of cooperation between local health institutions and foundations
- 3/ Feminization of disease
- 4/ Health problems in children
- 5/ Access to nurseries and kindergartens (not mentioned in the table)
- 6/ Unhealthy lifestyle
- 7/ Lack of activity

### 1.7 Choosing actions

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

- 1/ Research
- 2/ Coordination centre
- 3/ Coordinated actions (information campaigns, preventive / screening programmes)
- 4/ Active participation of population – health leaders among the youngest (improving school education) spreading knowledge and pro-health behaviours among their relatives.
- 5/ Engaging local stakeholders (institutions, associations, academic environment, students)

### 1.8 Translating actions into regional action plans

*In the case of Lodzkie, we decided to use straight forward method of direct translation of entry points as a names for umbrella and main initiatives. Then we decided to cascade the entry point/initiatives in order to merge them with existing and planned activities. This approach made the possibility to use the existing potential, projects and financial possibilities to support the action plan.*

## 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?]*

As our action plan aims rather to stress the necessity of reducing health inequalities in broader, strategic context, we don't expect that it is going to influence the policy itself. But the disadvantaged groups, which in e core interest of the plan, who are elderly people may contribute directly and short-term perspective due to the pilotage programmes and initiatives. We hope that those pilotages will enable us to build the capacity to influence the health policy in longer perspective.

### Scoping

*[Which health outcomes or determinants of health outcomes does this impact assessment focus on? How was it carried out (literature reviews, quantitative modelling, qualitative analysis- expert consultations, interviews, focus groups)? What evidence was used to show how the health equity impact was identified?]*

In the phase of scoping we have mainly used the quantitative analysis to develop the basic approach for entry points, then we had expert consultations and involvement of Regional action Group stakeholders in order to perform the list of expected actions and relevant impact assessment. Although the analysis of the impact was not very deep, as we had not so much experience in cross-sectoral approach (as well as the profile our organisation is more health oriented, then social one), we have made quite promising benchmarking in other regions. Basing on good practices from EIP-AHA we reach the final action plan.

**Impact assessment**

*[Quantify or describe potential, important health and health equity impacts.]*

**Decision making**

*[Provide recommendations to improve policy (evidence-based, practical, realistic and achievable measures that would reduce the negative and enhance the positive health equity impacts of the policy).]*

*Our aim was rather to underline the negative trends, like ageing society as a challenge for socio-economic activities and healthcare, as well as chronic diseases and child's health. We could not reach the relevant decision makers in order to influence a certain policy making processes or significant indicators performance at regional level. But somehow this task was fulfilled, because at least two topic incorporated to action plan, where used by regional authorities to build some actions in 2016 – ageing society interventions and integrated care.*

**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?)]*

This process needs to set up in later phase, we mainly concentrated on building the capacity around the entry points. We did not find relevant partners and stakeholders to move the process of evaluation. Also due to specific of our organisation our resources are not enough to delay with that issue at regional level.

**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

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### 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.)]*

(i) and (ii)

After deep analysis, we selected 7 areas, that are covering main challenges in health equity:

**1. Ageing society** – probably the main challenge to tackle for the city and the region.

**2. Feminization of society** – one of the highest rates in Poland.

**3. Lowest rates of life expectancy in the country** – especially among men, where we have a lost death between 40 and 50; life expectancy of men and women is 8 years lower than in the benchmarked regions and Poland.

4. Highest mortality rates in the country due to: cancer, injuries and poisoning by external factors and diseases of the digestive system

- 2nd in the country in terms of mortality from cardiovascular disease

- 3rd place in terms of number of deaths due to nervous system and sense **organs**

5. Some of the highest in the country in the incidence rates of tuberculosis

hepatitis B venereal diseases; of cancers predominate breast cancer and tumours of the eye, brain and other parts of central nervous system

**6. Enclaves of poverty** – challenge addressed especially to City of Lodz; this area was selected due to quite good research background and documentation of the problem from socioeconomic point of view.

**7. Poor health of children** – connected with point above

(iii) When entry points were selected, we can have collected ideas for actions and priorities from the RAG members (May/June 2015). Then we took time to evaluate and put priorities

for certain proposal and plan was developed and shared again with RAG members (July/August). After this gamification, we took expert to consolidate the action plan. The expert let us understand, how action plan can be linked with other initiatives and programmes and how to ensure its sustainability by linked it with structural funds. Finally, November was dedicated to finalizing the action plan and making specific description of tasks to those parts of the document, who were ready to be implement quickly, possibly in 2016.

(iv) We have made several synergies of our action. This is was made at few level: regional and local – Regional Development Strategy and RIS3, Lodz Development Strategy, Regional Depopulation Strategy and Sectoral Policy for SmartSpec; Regional Operational Programme  
national – Operational Programmes: Knowledge, Education, Development; Intelligent Development; Infrastructure and Environment; Digital Poland.  
We also linked the action plan with Europe 2020 Strategy, Horizon 2020 possibilities and Knowledge and Innovation Communities.

## 2.7 List of partner organisations

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

*National Health Fund,  
Department of Health (City of Lodz),  
Department of Health Policy (Regional Government),  
Department of Regional Policy (Regional Development)  
Medical University of Lodz*

## 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 supporting information regarding the socioeconomic background of our action plans were presented in the PART 1 of this report.*

2.9 Action Plan table

Actions	Output/ Deliverables	Responsible party	Others to involve to complete action	Timeline	Indicators	Financial resources
Priority area/Objective						
Lodz4Generations – (EIP-AHA reference site)	<ul style="list-style-type: none"> <li>• Living labs – smart buildings, innovative ICT solutions</li> <li>• <b>Social intervention – creating inclusive environment within revitalised urban quarters</b></li> <li>• Dedicated services for senior citizens</li> <li>• Silver economy – growing importance of older workers</li> </ul>	Medical University of Lodz	Nofer Institute of Occupational Medicine, ERICPOL, City of Lodz	2016 – 2017 (phase 1) 2017 – 2022 (phase 2)		Own resources, city and regional funding; Regional Operational Programme for Łódzkie Region Horizon 2020 and EIT funding

	<ul style="list-style-type: none"> <li>• White economy</li> </ul>					
Social education	<ul style="list-style-type: none"> <li>• Building the capacity between generations</li> <li>• Improving the social relations and „bottom-up” initiatives</li> <li>• Addressing demographic changes into professionalization of the services</li> </ul>					
Promoting the healthy lifestyle Promoting women’s health	Education activities, capacity building PR activities, VIP’s engagement	Łódzkie Region, City of Lodz	Educational sector, entrepreneurs	2016 - 2020		Regional Operational Programme for Łódzkie Region; City and regional funding
Regional oncology programme	Link to novel therapies and personalized care	Medical University of Lodz	Łódzkie region, entrepreneurs	2017- 2020		Regional Operational Programme for Łódzkie Region; National dedicated operational programme + state

						budget funding; Horizon 2020 and EIT funding
Capacity building in the rural areas	<p>Involving the municipalities adjacent to Łódź, particularly those with a rural profile. To prevent social exclusion of people 60+ living in rural and regional areas, our cooperation platform intends to implement services and programs dedicated to this target group, such as:</p> <ul style="list-style-type: none"> <li>• <b>farm houses which will offer care and activities for senior citizens</b></li> <li>• programs to increase access to specialist medical services (virtual doctors, e-</li> </ul>	Local foundation for development	Social and healthcare providers, non-governmental organisations	2017 – 2019		Regional Operational Programme for Łódzkie Region

	health)					
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Please add further rows as necessary.

## 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](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](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/checklist/)

[http://ec.europa.eu/regional\\_policy/en/atlas/](http://ec.europa.eu/regional_policy/en/atlas/)

[http://ec.europa.eu/health/health\\_structural\\_funds/used\\_for\\_health/index\\_en.htm](http://ec.europa.eu/health/health_structural_funds/used_for_health/index_en.htm)

<http://www.esifforhealth.eu/>

<http://fundsforhealth.eu/>

## PART 3 DEVELOPING THE ACTION PLAN: the process

### Introduction to Part 3

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

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

#### 3.1 General overview of the process

*[Please describe the overall process of developing the action plan throughout the HE2020 project. Please define the context.*

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

The area of health inequalities was considered to be analysis quite deeply before in the regions. The capacity in this field was very low, also the cooperation with the regions was weak, even though we had some other practices in the field of healthcare or social care, the approach of HE2020 project was a completely new experience for us.

We have faced the process of education needed both for experts, stakeholders to decision makers as well. This step was necessary in order to perform better understanding of that approach, acknowledging why health equity bring as a value to regional policies and how it can be effectively linked with structural funds. In this way our action plan was develop rather from expert, very much health-oriented approach.

#### 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?]*

Although not all required data was available, we tried to match the final outputs with existing data, available reports, publications etc. As the organisation is involved in many expert bodies, we could easily understand the role in project and guide other partners in the process of collecting needed information.

In our opinion the Action Plan is developed under a collected evidence based approach. Of course, because not all data was available, we had to use the data from national level, or estimate or benchmark some aspects in order to perform final output.

We were using other quantitative methods in order to achieve that goal.

### 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).]*

In order to allow for an intersectoral approach, and tackle health inequalities in the most effective way, the invitation to join the Regional Action Group was sent at the very beginning of the project lifetime to diverse local stakeholders. This invitation was accepted, and the relevant contact person was appointed from every one of the institutions listed below:

1. National Health Fund,
2. Department of Health (City of Lodz),
3. Department of Health Policy (Regional Government),
4. Department of Regional Policy (Regional Development)
5. Medical University of Lodz

Under the supervision of the Medical University of Lodz, these institutions started cohesive collaboration, which aimed to cover local situation with multifaceted activities, in order to assess the prevalence of health inequalities in both urban, and rural parts of Lodzkie voivodship, as well as design relevant Action Plan.

The only institution that did not answer the call for joining RAG, despite repeated attempts, and both indirect, and direct contacts, was Ministry of Health. During the course of the project, the Act for Public Health was designed, and finally proclaimed by the Polish Parliament, and the process of drafting health maps was started. Nevertheless, frequent changes of the head of Public health unit at Ministry of health, and recently, the change of the entire Government made involvement of Ministry of health in the works of RAG even more difficult.

### 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?]*

This part we understand as very difficult and disappointing. We did not get any feedback or support from Ministry of Health. On the regional level we also spend at least 2 years to attract regional government to understand the necessity of health equity and its value for 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? ]*

There is only one thing that has to be underlined in this points. We have tackled the situation of having huge agglomeration – city of Lodz and the region. This caused some challenges, as we had to develop separate actions for both areas. Naturally as Lodz offers much better and closer environment to build the capacity and resources for health equity, the action plan forces more on the city of Lodz.

### 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 major challenges encountered during the action learning process were twofold:

1. a number of data needed for detailed analysis of state of the art in health inequalities were either lacking, or were available only in an aggregated form at country level, making benchmarking of the local situation in Lodzkie less effective
2. only minor support to the RAG activities from regional authorities, and complete lack of involvement of Ministry of Health put obvious limitation over the performance of the project, as well as the future use of its output

### 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?]*

Despite initial lack of full involvement of the regional authorities in designing of the Action Plan, at the end of the project finally the things are going toward better. The head of the local authorities (Marshall of Lodzkie) has been invited to the final conference of the project and get personally interested in its outcomes. A briefing has been prepared for his office, with a plan to include the Action Plan in the nearest perspective of their activities.

Despite lack of direct support of the Action Plan uptake from the side of Ministry of Health, Medical University of Lodz is committed to adopting this vision very much. Therefore, following the line of the Action Plan, a plan for development of local pilot in coordinated healthcare has been designed, and provisionally agreed with regional authorities. Once executed, tested and validated, it will be further proposed to the Ministry of Health, serving as a good practice for other regions, and possibly, for the country level.

### 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 plan, 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.]*

Financial plan is going to be developed in 2016, because almost 90% of resources dedicated for health equity are frozen up to now.

### 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?]*

*I think that we had few, main achievements:*

- 1. data was collected in the way we never did before; the information was gathered and also the way it was done, will help us better understand the socioeconomic background of healthcare;*
- 2. we started to talk to our stakeholders in the way, that we can do something together, that will enable us not to compete, but to bring the common value to the region*
- 3. finally, we use the methodology to plan and deliver certain actions in the region and for the stakeholders aims to become flagships, long-term development initiatives.*

### 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?]*

In 2013 we had a request from Lubelskie region to discuss possible collaboration between the regions in the field of health inequalities. But from that time, even is some request from our side were sent, we had no response.

We will try to cascade that approach towards on the areas in the action plan – integrated care – were we are planning to collaborate with Pomorskie regions. We hope to use the methodology of HE2020 project in the cooperation project.

### 3.11 Annex – Information on the Regional Action Group

Official name of the group: Regionalna Grupa Działania

List of member organisations of the Regional Action Group

1. *National Health Fund,*
2. *Department of Health (City of Lodz),*
3. *Department of Health Policy (Regional Government),*
4. *Department of Regional Policy (Regional Development)*
5. *Medical University of Lodz*

*[Any other information concerning the work of the RAG (e.g. working method, who is coordinating the group, responsibilities etc.)]*