HE2020 CONSULTATION WORKSHOP REPORT

29 January 2015, Brussels

BACKGROUND

This one-day workshop hosted by the Brussels Office for Lodzkie region focused on challenges that EU regions face when they aim to tackle health inequalities through evidence-based action planning. In particular, overcoming these challenges means involving policy makers and decision makers in the process and working out how to practically link their work to regional development strategies. The policy implications were also considered by reviewing the findings and lessons learned by the project in its past two and a half years.

Invitees to this event were professionals, policy makers and researchers coming from various fields representing regional, national and European levels at the domain of tackling health inequalities. Participants representing regional governments, professional organizations, universities, and EU institutions shared their experiences with regards to evidence-based action planning. Regions identified immediate benefits they had from the project and that what obstacles remain in this process. Participants discussed how to maximise the impact of action planning at regional level, how to engage with decision makers in the planning process, and how to link this work to wider regional development activities. Financial resources to address regional priorities were also reviewed with special regard to Structural and Investments Funds.

SUMMARY OF THE PRESENTATIONS AND THE DISCUSSIONS

OPENING OF THE WORKSHOP

The Brussels Office of the Lodzkie region hosted the workshop. **Marcin Podgórski, office director** opened the workshop emphasising that

- One of their regional priorities is health acknowledging that health is a central recourse for growths;
- Supporting their regional stakeholders is of key importance who can promote well-being and health in general at different platforms;
- Health and health care are important drivers, which are supported by Structural Funds dedicated to Polish regions.

Jonathan Watson project director from Health ClusterNET in his opening speech raised some general questions in relation to tackling health inequalities as well as identified a few key issues that we have to take into account when working with regions, especially if we want to develop local strategies and action plans:

- *Dealing with health inequalities is not a new area*, we have more than 30 years of history in this field. The quality of evidence to inform action has markedly improved and yet health inequalities remains a constant problem;
- *We need to reflect on the learning of this past work*, and remember the meaningful, momentous stories with local people, local communities in relation to interventions, as these are still relevant today.
- We have learned that when we deal with our target groups, *our head is full of assumptions* about what these people need. So who sets the agenda? We talk with a few people from communities labelled as 'deprived' or from 'marginalised' social groups but do we really listen before prioritising and planning action? Let's continue to *ask people who have never been asked before about their own needs and priorities*!
- In our working culture *evidence has become more and more important*. It can lead to informed decisions but it can also act as an obstacle if common sense actions are delayed and/or opportunities not taken due to a lack of evidence. Actually 'lack of evidence' is used as a reason for not acting by public services under pressure to perform better under conditions of financial and political insecurity. In this context both staff and decision makers can become risk averse. We have to handle this by finding ways to overcome such obstacles.
- *Health inequalities had become a cross cutting issue*. This is a valuable development but it can overwhelm targeted communities and groups if we continue to work with multiple funding streams and initiatives (reflecting the organisation of traditional 'silo' approaches to governance by sector-specific departments and ministries at different levels) rather than working together to identify local needs and priorities and addressing these by pooling resources. We also have to keep in mind that even the most disadvantaged group is not homogeneous. There are cliques and some people remain more marginalized than others. We have to identify these groups, and accept that *our rigid assumptions as experts are constantly challenged by reality and everyday life*.
- The *HealthEquity-2020 project is developing tools and resources to assist evidence based planning and development of regional action plans to tackle health inequalities*. Within the project we encourage our EU10 collaborating regions to identify and address 2-3 key relevant priorities across the community by engaging the local stakeholders and key decision makers in parallel with the involvement of civic groups.

- It is difficult to fund our programmes, projects; we need to be realistic in that. *Carrying out option appraisal for funding opportunities is a crucial step in preparing viable, effective and sustainable projects.* How available budgets and other resources are best allocated to deliver necessary change needs to be strategic and not ad hoc.

THE HEALTHEQUITY-2020 PROJECT

Carole Maignan project manager from Health ClusterNET provided a more detailed overview about the HealthEquity-2020 project (See Presentation 1). The general objective of HEALTHEQUITY-2020 is to assist Member States/regions to develop evidence-based action plans on reducing health inequalities, which also informs use of structural funds (SF) in the current 2014-2020 cycle. Combining available evidence & learning with social innovation to inform knowledge exchange & capacity building can help achieve this. The specific objectives are to: develop and test a toolkit to support the process of evidence-based action planning in 10 participating regions; develop a website and database as a resource for use by participating regions; build capacity & competency in participating MS/regions that respects their different starting points; support participating regions to develop & adopt action plans on health inequalities that also informs their use of Structural Funds in the current period; maximise information exchange and sharing of good practice between member states and regions; ensure sustainability and longer-term benefits of the project. Overall, the project seeks to explore potential action areas & make the case (including economic evidence) for investments to reduce inequalities through actions within & beyond the health sector. The activity prioritizes MS & regions where premature mortality exceeds 20 per cent of the EU average.

Key challenges that regions face have been identified and reviewed:

- *Changes within the institutional/ political context* that can significantly influence the progress of work and achievements.
- *Securing political commitment for drafting and adopting an action plan* by getting the necessary support from key decision-making bodies, ESIF managing authorities, and intermediaries, also the Ministry of Health. How to raise awareness among policy makers about the importance of the issue? How to communicate the potential benefits to policy makers from this possible cooperation? Without commitment and support from the side of policy makers, decision makers in the regions, professional groups cannot be successful in realising their aims and objectives.
- *Community approach to health inequalities* – How to engage the community, all the necessary actors in this complex, long-term process?
- *A well-established network of stakeholders and institutions vs. small collaborations with stakeholders* - How to strengthen collaboration with local stakeholders? How to widen the partnership? How to engage the stakeholders of all relevant sectors?
- *Identifying possible investment options* (National and Regional OP, Horizon 2020).

Although the project has 1 more year to go, a few recommendations can be identified.

- *Develop knowledge and tools that support tackling health inequalities locally* is of key importance for the regions.
- Expertise *of professionals and support of the actors from the policy field is also vital* in this process.
- *Cooperation between regions has to be further strengthened* and support for collaborations should be continued by different initiatives (either national or international). We need to give the floor to exchanging experiences and learning in order to cascade knowledge into other regions.

In the discussion participants representing for example an Italian reference site of EIP-AHA gave also examples of working at regional level to tackle health inequalities. As a region they are open to collaborations, and to learn more about potential tools, like the ones that HE2020 is developing, in order to assist developing elderly-focused system level regional initiatives. When submitting SF proposals, local experts do have a picture of the opportunities for funding actions to address inequalities using ESIF; however they would also be very much interested in alternative ways of funding. In relation to building partnerships between regions in order to encourage communication and exchange of knowledge EuroHealthNet, one of the members of the HE2020 Advisory Board expressed its readiness to help by mobilising their contacts with European regional authorities.

THE ACTION LEARNING PROCESS - EVIDENCE-BASED PLANNING: TRANSLATING THEORY & LEARNING INTO MEANINGFUL ACTIONS IN ORDER TO TACKLE HEALTH INEQUALITIES

Marielle Beenackers, researcher at the Erasmus MC gave an overview about the toolkit that we are developing as part of the project (See Presentation 2 and background material). The toolkit is about assisting regions in drawing up evidence-based regional action plans to reduce health inequalities. The tools help the regions to review the current size and magnitude of socioeconomic inequalities in health in a region, and to identify the determinants of such socioeconomic inequalities in health. The toolkit has been

(i) Tested by the pilot regions throughout its development,

(ii) Introduced as part of an action learning workshop series. Most regions have completed phase 1 & 2 and have selected priorities and are now starting their action plans and considering the impact of these actions. At present regions are formulating review reports of the toolkit based on their experiences so far.

(iii) External review of the toolkit by interested parties has also been carried out (by EuroHealthNet, Assembly of European Regions, and Public Health England). The toolkit will be
(iv) Further improved based on feedbacks, and will be
(v) Published online in June 2015.

Neringa Tarvydienė, the representative of Klaipėda district in Lithuania provided an example of using the toolkit at local level (See Presentation 3). She summarized the strengths of the toolkit from their experience. She also presented how far they have got with the work within the project, i.e. the most important results of each phase of needs assessment. She also made the case for how their region can link this work to the national action plan on health inequalities.

Although the participating regions who were present expressed their strong interest in the toolkit, discussion also raised *the problems of using the toolkit, specifically the problem of collecting evidence and the difficulties of data gathering*. In this sense the project has various experiences among the collaborating regions. The projects' starting point is that the institutional background of participating partners is extremely varied. Some of the organisations work with HI only in an indirect way. Thus obviously those regions who had previous experience in carrying out data collection in the past on indicators related to HI, or had run projects on HI, have been more successful in using the toolkit, as they had past experience to build on. The regions that lacked the expertise or networks necessary for this needs assessment activity need(ed) more time to carry out the identified steps of each phase.

However, one of the main benefits of the toolkit that has been emphasised by collaborating partners is that i*t provides a rationale and framework for data collection*. Sometimes different types of data exists but in an unstructured form collected by different organisations, at different levels. The toolkit helps pull this data into a coherent structure, and moreover it also helps in with interpretation of the data.

It has also been raised *whether other regions that are not part of the project would use the toolkit*? Would they be interested and able to use it? Would they be able to cope with it being available only in the English language? Ensuring that other regions also use the tool is a big challenge for the project, as much as developing a relevant, useful, and flexible toolkit. DG SANTE can assist future dissemination activities, and also the regions themselves who know the toolkit already can become champions and guide other regions about its use. Future support (in forms of mentoring, consultation or trainings, workshops) as follow up activities from the project could be provided for regions that are interested in the toolkit. In some regions the tradition and practice of looking for information, looking for help e.g. in the form of toolkits is also present and HE2020 can build on this. Collaborating international organisations can also help in disseminating the toolkit available online, although we are aware that this passive way of information sharing is less successful compared to using more interactive ways of communication and dissemination.

It was also mentioned that if we develop local (regional or even municipal) level action plans, it would be crucial to have national strategies to tackle health inequalities to which the experts could make a reference to as was the case for Lithuania.

MAXIMISING IMPACT - MAKING THE BEST USE OF THE EVIDENCE-BASED ACTION PLANS - INCREASING THEIR IMPACT AT REGIONAL LEVEL

Peter Beznec, the representative of the Pomurje micro-region in Slovenia shared their local experiences on establishing a Regional Action Group (RAG). It helps involve all the local stakeholders in the planning process in order to tackle HI (policy makers, decision makers, professionals from various related sectors, both from governmental and non-governmental levels) (See Presentation 4). It has taken time to build effective relationships and processes (including work with the WHO Venice Office) that retains consistency despite political change. But, Pomurje can be considered an advanced (micro) region and so was asked to join the project as a pilot region. With already existing structures in place they provide a clear example of how to build and sustain regional collaborations using a step-by-step approach. Their Regional Action Group was set up well before the project and has an established track record. However, the work of the RAG has been further motivated by the participation of the region in the project. Earlier work results has been further reinforced by project activities e.g. learning about and testing the toolkit and becoming a model for other regions as far as intersectoral collaboration concerned in relation to tackling health inequalities at regional level.

Kristine Karsa, representing the Ministry of Health of Latvia provided an example on how to integrate an action plan on reducing HI with a wider development plan (See Presentation 5). The presentation gave a detailed picture about the structure of EU financing for health in Latvia 2014-2020, and within that the main principles for instruments to reduce health inequalities. It provided a timeline for using Structural Funds within the given period as well as showing in parallel the main development areas. The project has provided a good opportunity to focus on needs assessment and identify the most important problems. The most difficult point was how regional and national perspectives can be pulled together, and what regions are ready to accept. However, with regards to the Latvian example it has been emphasised that all of their work has to be interpreted in the context of Latvia, i.e. it is a small country with a population app. 2 million altogether, almost the size of a European macro region.

Oana Neagu, researcher of the Maastricht University has presented another key output of the HE2020 project called the Policy Matrix, which is going to be published in the second half of 2015 (See Presentation 6 and the related background material). The aim of the Policy Matrix is to assist local policy planning to match strategies at national/regional levels with EU policy priorities and the Common Strategic Framework for 2014-2020 in order to maximise opportunities to tackle health inequalities. It does this by seeking to merge priorities at European level with determinants of health inequalities. Ideally, the Policy Matrix can also help put health equity on the discussion table for policy makers and influence the drafting of operational plans or ensure that actions to tackle health inequalities are included within different project proposals. The Policy Matrix also draws upon a series of important observations that need to be taken into account when designing or choosing between

intervention options for health equity. It also makes the case for establishing policy synergies or using the *Health in all Policies principle* necessary for a more strategic and integrated approach to tackle health inequalities

In the following discussion the intersectoral working came into focus, specifically the *difficulties in cooperation between regions*. A group such as the RAG is a successful way to target regional stakeholders in a structured way. However, in order to be productive and able to maintain its work for the long run, we have to follow a few principles: (i) for the establishment of a RAG sometimes a top-down approach can be relevant, however, later on when we want to strengthen and/or widen this working relationship bottom-up approach will be more successful; (ii) setting common goals by taking into account the different perspectives, approaches, and aims for the benefit of all parties; (iii) planning for continuity by developing annual work plans and holding regular meetings following the working structure of the group; (iv) ensuring participation, i.e. making possible that representatives of the member organisations are actively present in the work of the group, which is the prerequisite for continuity; (v) involving decision makers as representatives in order to be effective and support that decisions made, recommendations formulated, action plans developed will be really put into action at the different fields, carried out by the member organisations. Though, obviously there are many obstacles to an initiative like this as there are more and less active actors. NGOs usually can easily be motivated, but e.g. the health care sector can sometimes be reluctant to participate in such collaboration due to other overwhelming and sometimes unchallenged commitments. Local characteristics, cultural context etc. can have an influence on the willingness to participate in such endeavours. The idea of intersectoral collaboration is not new, there is a wide literature on that, but time-to-time its necessity is justified again and again in every field, so we need to find the ways and techniques to make it work.

With regards to *the issue of integrating action plans into wider development plans* the most important message was not stopping with an action plan that identifies HI priorities but finding how to get those priorities integrated into a regional planning cycle and or a regional development plan based on local characteristics of the decision making processes. However, participants also raised the issue that what is the value of an integrated plan for health inequalities if key sectors working at different levels of government (e.g. social and health) are protective of their sector and organisational-specific agendas. These local Regional Action Groups are a good means to bring together the different sectors but cooperation between sectors needs to be driven from a senior level.

The *Policy Matrix* also generated a debate on differences between the newer and older EU member states. The conditions in Central and Eastern European countries are different, they have different starting points. The question is the same for all regions: where do you want to get to and how do you get there. The Policy Matrix shows options for thinking "outside the box" but we suggest regions need to think "outside the box" in their own context.

MONEY TO ADDRESS REGIONAL PRIORITIES – FUNDING SOURCES TO FINANCE REGIONAL INITIATIVES

This session looked at the question of funding from both a European and a regional perspective. This picture has been completed with presenting innovative or alternative approaches when thinking about getting funding for regional programmes. The question is always that if we have a plan with agreed priorities then how do we fund relevant actions? We now work in an environment driven largely by austerity-related measures with small consideration of the social consequences of such policies. Government funds will remain insufficient for many years and this will contribute to maintaining or worsening economic and social inequities. Relatedly, alternative sources of funds such as ESIF exist and especially the EU13 can benefit from these. However, there can be a tendency to see ESIF as a substitute for limited national funds. In this context, potential ESIF beneficiaries face considerable competition to access Structural Funds and then, if successful, to implement interventions that will be financially sustainable.

Andor Ürmös, policy analyst of EC DG Regio gave an overview of the role of European Structural and Investment Funds in tackling health inequalities with the focus on the European Regional Development Fund (See Presentation 7). In the presentation the audience was given information about the EU funds budget, the eligibility of regions to use the funds (3 categories: less developed regions, transition regions, more developed regions), budget allocations per Member State (2014-2020), programming tools in relation to demography and disability, relevant Ex-ante conditionalities (general and thematic like social inclusion, combating poverty and discrimination), as well as examples of poverty maps to be developed (EU is also focussing on micro regional level of poverty).

Mikolaj Gurdala, the representative of the Lozdkie region from Poland from the Medical University of Lodz presented their own regional experiences in getting ESIF funds for activities for tackling HIs (See presentation 8). Besides giving an overview about Operational Programmes and the relevant Thematic Objectives, a couple of points have been highlighted as challenges as far as the regional perspective is concerned for the new planning period (2014-2020). These are: (i) health infrastructure is a major point always during the negotiation process; (ii) mapping the health needs is also a crucial task in which the project helped a lot by introducing a toolkit and testing process in Lodzkie region; (iii) developing regional policy vs. bringing together regional stakeholders in health related issues; (iv) how to implement cross-sectoral approach: triangle of knowledge (fostering interaction between research, education and innovation), triple helix concept (building university-industry-government relationships - e.g. bring health policy issue closer to the future medical doctors), research driven education, community based services; (v) how to push for more on education (e.g. by taking in part in projects like HE2020, or contributing to regional activities like setting up the RAG in our regions, working on the action plan) and internationalization of learning.

Jonathan Watson project director gave notes to the session on a disinvest and reinvest approach (there was no formal ppt presentation prepared). The key points of this presentation were:

- The starting point for a new project or initiative has usually avoided serious consideration about what funds are available.
- The assumption has been: if we need money, we will find it. As yes, funding exists, but it is much more competitive to access it.
- A region, sector or organisation seeking funds to address a new priority should use as a starting point – a review of currently funded actions in order to determine if funding can be withdrawn from a current action e.g. because it is ineffective and then, reallocate those funds to a new priority (disinvest to reinvest).
- There are different means available to conduct this exercise. For example, Health Technology Assessment (HTA) or Programme Budgeting and Marginal Analysis (PBMA).
- HTA: very evidence-based, has got to cover legal, social, ethical and environmental issues as well as technological and financial issues. If we are considering how to maximise access to a new early diagnosis device and treatment in a community setting for older people, then early diagnosis methods are now available for this.
- An interesting alternative for action to tackle health inequalities (especially interventions focused on lifestyle and the social determinants of health) is PBMA - This is an appraisal of past resource allocation in specified programmes, with a view to tracking future resource allocation in those same programmes. Marginal analysis is the appraisal of the added benefits and added costs of a proposed investment (or the lost benefits and lower costs of a proposed disinvestment). PBMA involves an expert panel that can involve people from different sectors who are dealing with tackling health inequalities including civic groups.
- For example, the Welsh Government commissioned Public Health Wales to oversee a PDMA expert panel (n=12) to consider investment and disinvestment decisions for 25 current initiatives (but excluding pilots). The review identified a budget of 15.1m GBP spanning 10 Welsh Government priority areas and 6 life course stages. Due to lack of evidence the panel voted (electronically) for a total disinvestment for 7 of the 25 initiatives releasing 1.5m GBP and partial disinvestment from a further 3 initiatives releasing 7.3m GBP. None of the released funds were reallocated to any of the initiative sunder review. (Source: Tudor-Edwards et al (2014)) A national programme budgeting and marginal analysis (PBMA) of health improvement spending across Wales: disinvestment and reinvestment across the life course. *BMC Public Health* 2014 **14**:837 doi:10.1186/1471-2458-14-837.
- The essential question here is: Can we put money into something that is a priority by taking it away from things that we already do?

Fausto Felli, the president of Equity in Health Institute, Rome provided a very unique approach to the audience by placing social Impact investment into the focus (there was no formal ppt presentation prepared). The key points of this presentation were:

- **Social impact investing** is one form of socially responsible investing. According to the definition of the Global Impact Investing Network (GIIN): "Impact investments are investments made into companies, organizations, and funds with the intention to generate a measurable, beneficial social or environmental impact alongside a financial return". This type of investing is growing in the USA and is slowly emerging in the UK using social impact bonds (the current SIBs in the UK and especially Northern Ireland focus on employment).
- A **Social Impact Bond**, also known as a *Pay for Success Bond* or a *Social Benefit Bond*, is a contract with the public sector in which a commitment is made to pay for improved social outcomes that result in public sector savings. The term was originally coined by Geoff Mulgan, Chief Executive of the Young Foundation: Social Impact Bonds: Rethinking finance for social outcomes.
- An alternative vehicle is the **Social Investment Partnership** (SIIP). This is a partnership commitment between three parties designed to address a particular social issue. The Delivery Partner designs a service to address a need in the community, usually providing an early intervention and prevention service which supports people within their community to make more positive life style choices. The Investment Partner/s commit in principle to providing the working capital over an agreed period. The Delivery Partner agrees with the Outcome Partner the specific outcomes, which the Service will achieve. If these outcomes are achieved then the Outcome Partner repays the working capital with interest at a previously agreed rate. A Limited Company is set up purely to hold the funds and downstream these to the Delivery Partner providing the service. This mechanism allows retail levels of investment by ordinary members of the local community.
- A related initiative is looking at a **strategy for the civic economy** in Portugal. The goal of a recent meeting in Lisbon was to explore how the public sector can support new strategies to deliver social services, pegged to the announcement of a 150 million euro Social Innovation Fund (SIF) meant to kick start new forms of social investment in Portugal. This raised important questions about the intersection of public policy and social impact investment, and offers a concrete frame on which to explore the issue of how private investment can be directed to public purpose.
- **These alternative forms of investing, increasingly involving private institutional and local community investors offers an alternative route for funding actions to tackle the basic social determinants of health such as unemployment and income**.

PRESENTATIONS

You can download this report and presentations of the workshop by clicking here.

Programme

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HEALTH EQUITY-2020 PROJECT – CONSULTATION WORKSHOP 29 JANUARY 2015

1100 REGISTRATION AND COFFEE

1130-1200
WELCOME

Marcin Podgórski, Director, Regional Office of the Łódzkie Region in Brussels

Paola D'Acapito, Scientific Project Officer, EC, Consumers, Health, Agriculture and Food Executive Agency (Chafea), Health Unit

Jonathan Watson, HE2020 Project director, Executive director of Health ClusterNet, Managing Director and Co-Founder of INTEGRATE Think Tank

1200-1220
INTRODUCTION TO THE HEALTH EQUITY-2020 PROJECT
Results & achievements so far
Carole Maignan, HE2020 Project manager, Health ClusterNet, UK

Session 1
1220 - 1340
THE ACTION LEARNING PROCESS
Evidence-based planning: Putting theory & learning into meaningful actions in order to tackle health inequalities

Moderator:
Peter Beznec, Project manager, Centre for Health and Development, Murska Sobota, Slovenia, HE2020 Pilot region

Introductory remarks

Evidence-based planning – The HE2020 Toolkit
Mariëlle Beenackers, Senior researcher, Department of Public Health, Erasmus MC Rotterdam

Does the toolkit works as a local resource?
Neringa Tarvydienė, Director, Public Health Bureau, Klaipėda district, Lithuania, HE2020 Collaborating region

Discussion - Questions & Answers

1340 – 1430 LUNCH

Session 2
1430–1550
MAXIMISING IMPACT
Making the best use of the evidence-based action plans - Increasing their impact at regional level

Moderators:
Jonathan Watson, HE2020 Project director, Executive director of Health ClusterNet, Managing Director and Co-Founder of INTEGRATE Think Tank

Przemyslaw Kardas, Head of Department, First Department of Family Medicine, Medical University of Lodz, Lodzkie region, Poland, HE2020 Pilot region

Introductory remarks

What makes regional/local action groups work well or not? What gets policy makers/decision makers to engage in the planning process?
Peter Beznec, Project manager, Centre for Health and Development, Murska Sobota, Slovenia, HE2020 Pilot region

How are we looking to integrate our action plan with a wider development plan?
Kristine Karsa, Senior officer, EU Financing, Planning and Control Unit, Department of Budget and Investments, Ministry of Health, Latvia, HE2020 Collaborating region

Policy Matrix – Assisting local policy planning to match the strategic frameworks at national/ EU level
Oana Neagu, Researcher, Department of International Health, Maastricht University

Discussion - Questions & Answers

1550 – 1615 COFFEE BREAK

Session 3
1615 – 1745
MONEY TO ADDRESS REGIONAL PRIORITIES
Funding sources to finance regional initiatives

Moderator:
Jonathan Watson, HE2020 Project director, Executive director of Health ClusterNet, Managing Director and Co-Founder of INTEGRATE Think Tank

Introductory remarks

The role of European Structural and Investment Funds in tackling health inequalities
Andor Ürmös, Policy analyst, EC DG REGIO, Competence Center on Inclusive Growth

What do European Structural and Investment Funds really offer to regions? Funding sources locally
Mikołaj Gurdała, Director, Office for Research, Strategies and Development, Medical University of Lodz, Lodzkie Region, Poland, HE2020 Pilot region

Do we consider a disinvest to reinvest approach when wanting to resource a new priority action?
Jonathan Watson, HE2020 Project director, Executive director of Health ClusterNet, Managing Director and Co-Founder of INTEGRATE Think Tank

Alternative funding sources – Social Impact Investment
Fausto Felli, President**,** Equity in Health Institute, Rome, Chairman of the Executive Board and Co-Founder of INTEGRATE Think Tank

Discussion - Questions & Answers

1745
CONCLUSIONS AND NEXT STEPS

1800
CLOSE OF THE WORKSHOP

CONTACT DETAILS OF SPEAKERS

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Partnership: University of Maastricht, Department of International Health, The Netherlands (Action learning workshop series & Capacity building support); Health ClusterNET, UK (Project management, Dissemination & Evaluation); Erasmus MC, Department of Public Health, The Netherlands (Translational evidence & policy); Medical University of Lodz, Poland (Pilot actions); Centre for Health and Development Murska Sobota, Slovenia (Pilot actions).

Collaborating regions: Vysočina, Czech Republic; Northern Great Plain, Hungary; Trenčín, Slovakia; Klaipėda, Lithuania; Stara Zagora, Bulgaria; Covasna, Romania; Latvia; Estonia, Tallin.

Lead partner organisation: University of Maastricht, Department of International Health, The Netherlands

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