World Health Organization

REGIONAL OFFICE FOR **Europe**

Positioning health equity and the social determinants of health on the regional development agenda

Investment for health and development in Slovenia

Studies on social and economic determinants of population health, No. 6

Chris Brown and Tatjana Buzeti

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ABSTRACT

The WHO European Office for Investment for Health and Development, Venice, Italy, of the WHO Regional Office for Europe carries out national case studies to support the advancement of policy-relevant knowledge on tackling the social determinants of health and health inequity in the WHO European Region. This report describes how linking the policy domains of health equity and regional development paved the way for intersectoral collaboration on these issues at the national and local levels in Slovenia.

KEYWORDS

Health status disparities
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Social determinants of health
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FOREWORD BY THE MINISTER OF HEALTH

I am pleased to introduce the Slovene experience in developing policy initiatives to tackle socially determined health inequity within the regional development agenda. The findings included in this report result from a case study conducted by the WHO Regional Office for Europe from the late 1990s through the first decade of this century. The report is intended as a reference source for policy-makers and programme planners, and strives to present learning points that can also be used in other policy domains.

It is my hope that, in these times of economic crisis, the report will provide a forum for discussion on the many forces that affect social equity and stimulate action towards the development of appropriate measures to deal with it.

In its broadest sense, poverty is a form of social inequity involving material and social deprivation related to social marginalization and limited access to education and health-related and cultural commodities. Thus, it affects both the human capital and economic potential.

The Government of the Republic of Slovenia wishes to provide its citizens, to the greatest extent possible, with universal and fair access to sustainable health care and preventive services. However, systematic differences in mortality and morbidity do exist between the different socioeconomic groups and between the regions of the country.

The Pomurska region has the most unfavourable health indicators of all regions of Slovenia. To address this situation, the Ministry of Health initiated and supported the investment for health and development programme – MURA – and, later, the development of a regional strategy and action plan to tackle health inequities in the Pomurska region. The strategy serves as the basis for developing programmes and interventions on reducing socially determined health inequity in the Pomurska region through health-promotion initiatives involving sectors, such as those for agriculture, tourism, employment, environment, cultural heritage and education. The effects of Programme MURA in the form of lifestyle changes among the population of the region are well documented.

The strategy and action plan target the socioeconomically disadvantaged groups of the Pomurska region, whose physical, social and mental health is more likely to benefit from health-promotion approaches that are adapted to their specific living conditions and needs and, thus, more effective.

Since inequity can, to a great degree, be attributed to structural determinants, i.e. the sociocultural and historic context of a given society, the report does not aspire to propose a general model for tackling the issue. Nevertheless, important lessons can be learnt from it.

The fundamental learning point derived from this case study is the importance of recognizing the value of local community support. Partnerships between actors at the national and community levels in Slovenia were crucial in pushing forward the agenda for investment for health and development. Moreover, we found that it is essential to have advocates at all levels of government, from local to national, to support common goals and help overcome barriers. In our experience, an intersectoral approach, involving a network of institutions and pooled resources, is particularly important in times of economic recession. We also realized that the lead does not necessarily need to come from the health sector; other sectors too can define health objectives and achieve set goals.

Currently, the Ministry of Health is endeavouring to ensure that the need to reduce inequity at the national level be addressed as a priority issue, bearing in mind that to do so will require well-coordinated

action in various policy areas. This includes the development of social policies, health-promotion strategies, and other concerted intersectoral initiatives targeting the most disadvantaged groups. The newly developed national policies on food and nutrition and on alcohol exemplify the positive results of intersectoral initiatives to reduce health inequity in Slovenia.

This case study was a formidable task and I believe its findings will provide an incentive to further address this important issue. We are indebted to many for the success of this initiative, especially the staff involved from the Institute of Public Health Murska Sobota, the Centre for Health and Development Murska Sobota, and WHO, as well as the political leaders of Slovenia, all of whom contributed with their invaluable expertise and enthusiasm.

Tomaž Gantar
Minister of Health

FOREWORD BY THE WHO REGIONAL DIRECTOR FOR EUROPE

Where we live and work has a major influence on our health. The impact of public policies on and investments in health, housing, education, employment and the environment significantly shape the opportunities available to the individual and whole communities at the local level to participate in the social and economic areas of life. Thus, even before we are born, these factors play a role in determining the opportunities and risks associated with our health and continue to do so throughout the life course.

At the same time, there is increasing recognition of the importance of health to performance at school and during higher education. Good health also contributes to positive outcomes of the labour market and is a core ingredient of individual, family and community well-being and resilience. Where health levels are low, many development indicators also tend to be low.

The bidirectional relationship between good health and positive development is well documented in the European and global evidence. Ensuring mutual benefits for health and development requires a joint policy approach involving all sectors and levels of government. This has been the focus of the health-in-all-policies approach for many years. However, connecting social, economic and health policies remains a challenge to public-sector performance, particularly for the health community. We must learn from the past and rethink our approach to intergovernmental partnership and to engaging stakeholders from the public, third and private sectors of society, as partners for change. The goal must be to design policies, introduce services and make investments, which are beneficial to health and conducive to positive development. Evolving health governance across sectors and society is one of the key aims of the new European policy for health, Health 2020.

New models of public health leadership are required if we are to reduce social inequities in health. Given the complexity of the task and the increasing involvement of a wide range of stakeholders in shaping decisions that affect health, our leadership roles are very diverse. At any given time we are partners in, and supporters and advocates of, policies and investments to improve health in our societies. It is not simply a case of providing information about the importance of collaborating to produce results but of developing new skills and know how for working in partnership.

This reorientation of our approaches to health policy-making is taking place at a time when roles and responsibilities are increasingly being decentralized to the subnational levels of government, which has the likely advantage that policy implementation would be more attuned to local priorities and the needs of the beneficiaries. To ensure the realization of such advantages, we need to harmonize the policy instruments used in planning and implementation at the national and local levels. Backed up by clear accountability mechanisms, these instruments should enable subnational involvement in shaping and influencing national priorities and investment flows.

There are important lessons to be learnt from the Slovene case regarding the implementation of these new forms of partnership working and intersectoral governance. The innovative approach being taken by Slovenia in tackling the social determinants of health can be adapted for use in

other countries at both the national and subnational levels. Thus, I regard this publication as a valuable tool for inspiring others on ways of making health an important whole-of-government goal and of delivering public health in the 21st century.

Zsuzsanna Jakab
WHO Regional Director for Europe

EXECUTIVE SUMMARY AND KEY LEARNING POINTS

EXECUTIVE SUMMARY AND KEY LEARNING POINTS

In Slovenia, considerable progress has been made since the late 1990s in the development of policy approaches to reducing health inequity, one aspect of which has been to link this issue to regional development. It is important to recognize, in the political context, that Slovenia gained independence as recently as 1991. However, the impetus for tackling health inequity can be traced back to several specific factors. Firstly, in 1996, at the request of the Slovenian Ministry of Health, WHO conducted an investment-for-health appraisal *(1)*, which paved the way for the establishment, in, 2001, of Programme MURA, a pilot programme on health equity in the Pomurska region. Secondly, Slovenia's entry into the European Union (EU) in 2004 brought with it several political imperatives, one of which was to promote balanced regional development. Thus, the story of policy action in Slovenia has always involved links between national and regional dimensions.

Kingdon's model of effective policy development, around which this report is built, identifies three streams of activity: the problem stream, the policy stream and the political stream *(2)*. One problem area identified at the outset of the study was that of regional imbalance. In the early years of policy action, around 2000–2004, the focus of tackling health inequity in Slovenia was on reducing the gap between the poorer-performing regions and the national average. The decision to address the determinants behind this health gap was influenced by officials of the Ministry of Health who had participated in international events where the evidence linking health outcomes to social and economic conditions had been debated.

Throughout all stages of development since 2000, the Ministry of Health has demonstrated its commitment to tackling inequity and its understanding of the need for intersectoral action to address it. The Ministry recognized that, in order to increase a sense of ownership of the problem in the other sectors, responsibility for the problem and the power to take action should be shared. Thus, in this dynamic process, the health sector sought to achieve consensus with other sectors on joint short- and long-term goals. The same attitude was observed in other sectors that supported and even pushed health-related issues as priorities in national and local policy processes.

It was evident that support at the political level was essential but it took more than five years to progress from the first WHO investment-for-health appraisal in 1996 *(1)* to the implementation of Programme MURA in the Pomurska region that started in 2001. In spite of a lack of evidence at the time to show how the investment-for-health approach could contribute to reducing health inequity, there was a clear interest on the part of both the political and the professional leaders in taking the risk of adopting this innovative approach. In making the argument to the policy-makers, international evidence clearly illustrating the direct impact of socioeconomic conditions and investments in this field on health was essential. The extent of the political support provided was reflected in the Government's initial investment of the financial and human resources necessary to launch the pilot programme.

One of the initial intentions of the Slovenian approach in the Pomurska region was to disseminate the experience gained there to the other regions of the country but economic challenges resulting from the global recession and loss of political champions prevented this from happening to any significant degree. However, as one of the national goals was to reduce the difference in levels of health inequity between the eastern and western parts of the country and among various population groups, the Ministry of Health was able to keep health equity on the 2004–2008 agenda. The close collaboration of the regional stakeholders in lobbying strongly for the implementation of the investment-for-health approach through their parliamentary and planning roles was helpful to this end as illustrated, for example, by the health-equity targets in *Slovenia's development strategy* adopted in 2005 *(2)*.

Key learning points

The stimulus provided by several external factors was helpful in starting the process of developing policy on health equity, particularly the WHO investment-for-health appraisal process used by the policy entrepreneurs[1] and the political imperatives created through the accession of the country to EU. In addition, by using international evidence and examples from other European countries, policy entrepreneurs and key interest groups (for example, mayors and nongovernmental organizations (NGOs)) were able to illustrate how health levels had influenced the development of equity policy in these countries and to advocate taking them into consideration in deciding policy and investment in Slovenia.

Linking health equity with regional development paved the way for intersectoral collaboration at both the national and the regional/local levels. A conscious decision was made to increase intersectoral policy and investment, targeting the social and economic conditions of vulnerable groups and the general population in poorer regions. This encouraged the release of cross-sector resources for implementation.

The nature and availability of relevant data influenced the choice of priority issues and strategic direction. The choice to focus on reducing the health gap by targeting the most vulnerable regions and groups was influenced by the political imperative to promote balanced regional development created by EU accession, as well as by the fact that, at that time, only data on geographic (regional) inequity in health were available.

Political commitment to developing policy on health equity at both the national and the local levels is essential if action is to be taken. In Slovenia, the persistent efforts of the key players in the health and regional development sectors were crucial to putting the issue of health inequity and the determinants of health on the political agenda and maintaining it there. Framing the problem as one of relevance across government helped keep it in focus.

Once Kingdon's three activity streams *(3)* have coalesced, allowing the formulation of policy action, leadership becomes a critical component in moving forward on the agenda. The Secretary of State, Ministry of Health, played a pivotal role in pushing concerns about the need to place health, social and economic development – as interdependent issues – higher on the policy agenda. This involved establishing policy alliances with the sectors responsible for economic and regional development, as well as developing a supportive, dedicated communication strategy.

Policy scanning and assessment tools are valuable in helping to identify policy options and determine the course of action. The use of scanning tools revealed the potential of addressing the problem of health inequity by aligning it with the political drive for more balanced growth and development, which was high on the Government's agenda at both the national and the regional levels. Using assessment tools allowed the development of scenarios for testing ways of orientating ongoing structural reforms to redress regional imbalances in key social determinants, such as educational opportunity, employment and income security.

The achievement of progress through a cross-cutting, whole-of-government approach depends to a significant extent on the existence of effective partnership mechanisms that encourage in-

[1] Kingdon uses the term, "policy entrepreneurs" to describe leaders in government, academia or other sectors who are willing to invest resources in changing policy by defining the problems and connecting them to political agendas *(3)*.

tersectoral action. An example of such mechanisms was the agreement between the Ministry of Health and the Regional Development Sector of the Ministry of the Economy, supported by the local mayors, to pilot the approach in the Pomurska region, the least developed of the twelve statistical regions of Slovenia and, at the same time, to take intersectoral action to develop structural policy at the national level.

Clearly defined roles, goals and expectations of the national and local government structures and agencies are the core of an effective implementation strategy. Although relations between the players at the national and local levels were constructive and supportive, the anticipated expansion of the Pomurska region experience did not occur.

Policy development and implementation need a patient, determined and pragmatic approach. To achieve success in tackling health inequity across government, it is important to apply these "softer" attributes and not to rely solely on scientific or theoretical constructs.

1. INTRODUCTION

1. INTRODUCTION

1.1 National policy–learning case studies on reducing social inequity in health

In line with the recommendations contained in the report of the WHO Global Commission on Social Determinants of Health (CSDH), *Closing the gap in a generation (4)*, and the commitments made by global health leaders in endorsing World Health Assembly resolution WHA62.14 on reducing inequity in health through action on the social determinants *(5)*, the WHO European Office for Investment for Health and Development, Venice, Italy, of the WHO Regional Office for Europe is working with national authorities and scientific experts to support the advancement of policy-relevant knowledge on tackling socially determined health inequity in the WHO European Region. One aspect of this work involves conducting national case studies on action taken to address the social determinants of health and health inequity in the countries concerned and producing reports on the findings.

The aim of the case studies is to synthesize relevant learning from the experiences of the countries in developing and implementing policy to tackle socially determined health inequity. The reports analyse the roles and functions of the key stakeholders and the tools, methods and intelligence used at the different stages of the policy process, including: (i) agenda-setting; (ii) the generation and testing of policy options; (iii) implementation; and (iv) monitoring and evaluation.

So far, case studies have been carried out in England, Norway, Scotland, Slovakia and Slovenia. This report describes the Slovene experience.

1.2 The Slovene example

The Slovene story describes experience gained in setting and implementing a policy agenda to address the social determinants of health within regional development. The process began in the late 1990s and continued throughout the following decade, a period during which the country was experiencing significant social and economic change. The initial policy focus was on tackling regional health inequity by leveraging action on the social determinants of health in regional development plans. In this connection, a pilot programme (MURA) was established in the Pomurska region with the aim of integrating health with regional development and developing policy on health equity for implementation at the national level. This proved to be challenging.

The process, seen from the perspectives of both the public-health sector and intersectoral collaboration, started with a balanced regional development objective within national development policy, namely, *Slovenia in the new decade: The strategy for the economic development of Slovenia (2001) (38)*. The approaches and mechanisms used to shape agendas, generate policy options and frame implementation priorities and systems are examined in parts 2–4.

1.3 Frameworks used in analysing the Slovene policy-making experience

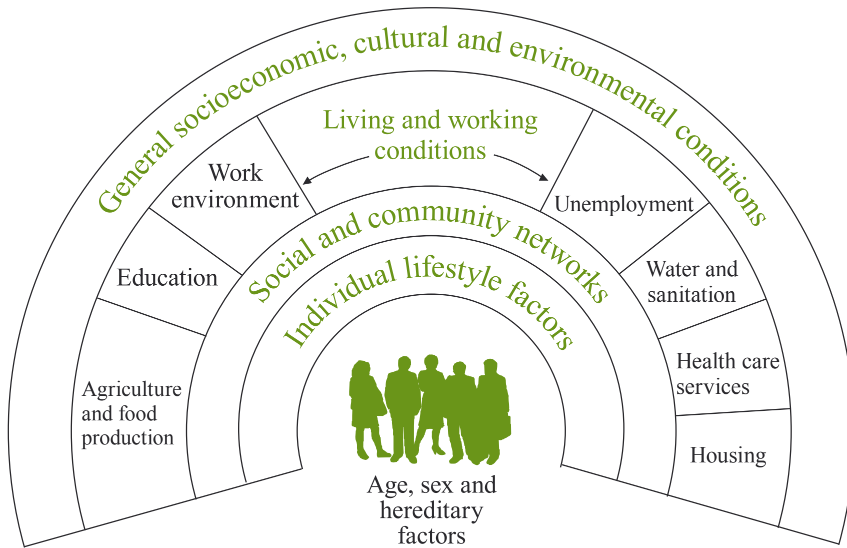
The content of this report was informed by the work of several policy scientists, including Dahlgren and Whitehead's rainbow model of the main determinants of health *(6)*, Kingdon's multiple-stream model of policy-making *(3)* and Graham's models for tackling health inequity *(7)*.

1.3.1 Dahlgren and Whitehead's rainbow model of the main determinants of health

Social conditions are dependent on the structural drivers of political and economic change and, together, have a decisive influence on individual and population health. The rainbow model *(6)*

conceptualizes the main determinants of population health and demonstrates the connections between health and socioeconomic, environmental and cultural conditions (Fig. 1).

Fig.1. The rainbow model of the main determinants of health

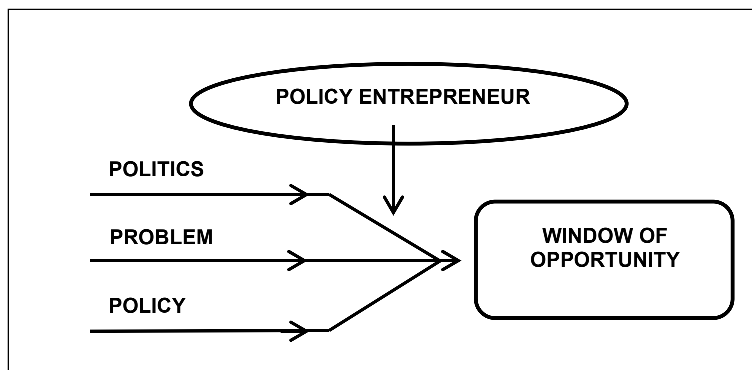


Source: Dahlgren and Whitehead *(6)*.

1.3.2 Kingdon's multiple streams model

As one of the analytical frameworks, this model is used to illustrate the key features of the Slovene policy-making process, specifically the flow and timing of policy action taken along three streams: the problem stream, the policy stream and the political stream (Fig. 2). These streams are largely independent throughout the policy-making process. Each has its own dynamic and pace, though the actors involved can overlap. It is when the three streams converge, linking a compelling problem to a plausible, politically feasible solution, that a policy window opens *(3)*.

Fig. 2. Model of policy-making



Source: Adapted from Kingdon *(3)*.

A political opportunity may occur as a result of an ideological shift or change in administration, or when a compelling problem captures the attention of the policy-makers. Kingdon uses the term, “policy entrepreneurs” to describe leaders in government, academia or other sectors who are willing to invest resources in changing policy by defining the problems and connecting them to political agendas *(3)*. Some of these, such as persons representing institutions or networks, or individuals working within public policy-making, move among the different communities of practitioners involved in the policy development and implementation processes. Policy entrepreneurs are particularly important in the contexts of cross-sector and whole-of-government approaches, one of their key functions being to facilitate the exchange and cross-fertilization of ideas and interests within and across the health and other sectors and among the stakeholders. They also facilitate connections between the health and other sectors on the priorities and goals of the latter in the areas of health and equity, acting as “translators” in communication among those involved. They do this in a number of formal and informal ways, such as policy scanning and mapping or informal discussions. In addition to these visible participants are those working in the areas of research and academia, as well as public servants and interest groups, otherwise referred to as “hidden participants”.

1.3.3 Hilary Graham’s models for tackling health inequity

According to Hilary Graham, e.g. in *Unequal lives* (2007) *(8)*, there are three main approaches to framing action to tackle inequity: (i) that focusing on health disadvantages; (ii) that seeking to address health gaps; and (iii) that aiming to act across health gradients. These approaches can be used independently or in combination but each has potential limitations. The disadvantages approach targets specific groups without considering the status of health and equity in the rest of the population; the gap approach does not take into account that the absolutes of a health gap may improve at both ends resulting in no real narrowing of the gap; and using the gradient model raises the challenge of implementing coherent, progressive universal policies. All three approaches can be observed across Europe in both national and local-level policies and action, as well as in the policy frameworks and goals of pan-European institutions, such as the EU and WHO.

More recently, the findings of the Marmot review *(9)* showed that, for any of these approaches to have a real impact, action taken needs to be taken on a scale and with the intensity necessary to produce sustainable changes in the magnitude and trends of health inequity.

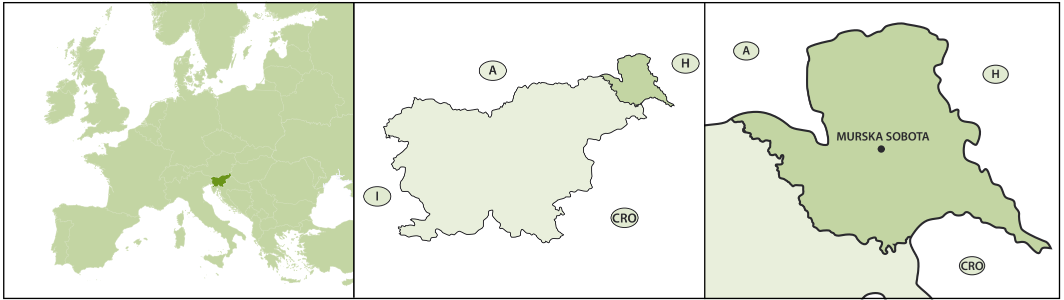
1.4 Methodology

This case study drew on policy documents related both to the Pomurska region (Fig. 3) and to Slovenia as a whole, as well as on a series of semi-structured interviews with representatives of the key stakeholders and organizations involved in developing and implementing the investment-for-health concept and regional development policy both in and outside the country.

1.5 The Slovene context

Slovenia is a small country located in central Europe with a population of approximately 2 million, just over half of whom live in urban centres. The Pomurska region, the capital of which is Murska Sobota, lies in the north-east of the country (Fig. 3).

Fig. 3. Location of Slovenia and Pomurska region



Note: A = Austria; CRO = Croatia; H = Hungary; I = Italy.
Source: Regional Development Agency MURA Ltd, Murska Sobota, Slovenia.

Despite efforts made for decades to ensure the equitable development of all regions of the country, obvious disparities in their social and economic development resulted in health inequity. With the independence of Slovenia in 1991, and the economic decline in the transition period of the early 1990s, it became apparent that the health gap could increase considerably. Thus, there was an imminent need to better understand the reasons for the inequities causing the gap if new approaches to addressing it in a fast-changing society were to be developed.

Slovenia joined the EU in 2004.

1.5.1 Government

Slovenia has a democratic parliamentary system with a proportional representation of 88 constituencies. Administratively, the country is divided into 12 statistical regions (Fig.4) and 210 self-governing municipalities. Slovenia does not have a regional-government structure as such. Each statistical region, however, has a council comprising the mayors of the municipalities in the region. Each regional council of mayors establishes development programmes for its region and decides the allocation of the region's development funds. Line ministries and their regional offices are responsible for the implementation of national policies and programmes in the regions.

Fig. 4. Statistical regions of Slovenia

Source: Surveying and Mapping Authority of the Republic of Slovenia; Institute of Macroeconomic Analysis and Development, Ljubljana, Slovenia.

Joining EU was a high political priority between 1991 and 2004 and, during this period, national legislation was largely synchronized with EU legislation. National development strategies and regional development programmes were (and still are) adopted and/or amended periodically in connection with EU's financial programming periods.

During the period covered by this case study, the political landscape in Slovenia changed considerably. In 2001, a centre–left government was elected that was particularly open to the notion that economic growth should encompass social development. Its priorities – sustainability, competitiveness and accession to EU – were enshrined in the *National development programme, 2000–2006 (10)*, which paved the way to the recognition of health as an essential component of sustainable development. From 2004 to 2008, the centre–right government at the time was strongly committed to increasing Slovenia's economic competitiveness. In 2008, a new centre–left government was elected, which was more strongly oriented towards social welfare.

1.6 Health and health inequity in Slovenia

Unlike other countries in central and eastern Europe that underwent similar transitions in their governing, economic and social systems in the early 1990s, Slovenia saw the health of its population improve after its independence. Between 2002 and 2005, life expectancy rose from 76.73 years (males 72.67; females 80.66) to 77.58 years (males 74.04; females 80.93) and this positive trend is expected to continue. It is closer to the EU15[2] average than to that of EU10[3], although it is still below the average for all 27 EU countries. Although premature death is still excessive, mortality rates for both men and women under 65 years of age have been decreasing steadily since the 1990s, while those for newborns are among the lowest in Europe. This overall improvement has been attributed, among other things, to Slovenia's system of financing health care, which has been relatively stable for a significant period of time *(11)*, and to increased investment in life-long education, maintenance of a well-established social-security system and strong social networks, particularly among the rural inhabitants who account for more than half of the population.

However, despite these improvements, not only does health inequity persist but it is also increasing, especially in relation to differences in health status within the regions and population groups. The regions in western and central Slovenia are better off than those in the east and north-east of the country, where differences in life expectancy of up to four years can be seen. Looking at mortality rates across specific regions, such differences become even more apparent: mortality rates are lowest (761 deaths per 100 000) in Ljubljana (situated in Osrednjeslovenska, the richest region) and highest (999 deaths per 100 000) in Murska Sobota (capital of the Pomurska region, one of the poorer regions of the country). Suicide rates differ across regions with a ratio of 1:3 when compared to the national level. Similar differences are observed with respect to alcohol-related liver diseases. Looking at the causes reveals that they relate largely to social and economic circumstances, which are outside the direct control of the Ministry of Health. Suicide is most common among the marginalized members of society, semi-skilled workers, the unemployed and those addicted to alcohol *(12)*.

The financial and economic crisis that began in 2008 led to a sharp increase in unemployment, especially among those with lower levels of education, youths and the elderly and, geographically, in the east of the country. This has the clear potential of affecting the overall health situation in the long term and has increased the pressure on the national health insurance scheme to provide more

[2] EU15 refers to the 15 countries belonging to EU before 2004.

[3] EU10 refers to the 10 countries that joined EU in 2004.

services, especially outpatient care and community services. According to the Employment Service of Slovenia, the rate of unemployment in the Pomurska region was 18.1% in January 2001, dropping to 10.9% in September 2008 and increasing to 21.1% in January 2010 *(13)*.

1.7 Health inequity and its social determinants at regional level

Between 1992 and 2008, Slovenia enjoyed continuous economic growth but, although the agenda for preserving this was combined with measures to improve social cohesion and environmental sustainability, unequal economic and social development prevailed. In 2006, the gross domestic product (GDP) per capita in the Pomurska region was only two thirds of the national GPD of €15 446, while the GDP per capita in the Osrednjeslovenska region was nearly one and a half times the national figure *(14)*.

In 1999–2003, life expectancy at birth in the Pomurska region (eastern Slovenia) was 69.2 years for men and 78.5 for women, while in the Goriška region (western Slovenia), it was 73.6 and 81.4 years for men and women, respectively *(15)*.

The proportion of the population at risk of poverty[4] fell from 12.9% in 2001 to 11.7 % in 2005. Nonetheless, during the same period, the proportion of the population entitled to financial social assistance rose from 2.1% to 4.7% in the country as a whole and from 4.5% to 8.8% in the Pomurska region *(15)*.

The statistics indicate that, overall, the level of health inequity in Slovenia is lower than in many other countries. For example, in 2004, the Gini coefficient for Slovenia was 23.8%, one of the lowest in EU. Income inequality was confirmed by the quintile share ratio, which indicated that the income of 20% of the richest people in Slovenia was 3.4 times as much as that of 20% of the poorest people in the country *(16)*.

When using the slope index[5], significant differences in health indicators (life expectancy, mortality from certain conditions, levels of morbidity) can be observed between population groups and between geographical regions in Slovenia.

There has for some time been a strong awareness in Slovenia that tackling inequity related to the social determinants of health is an important policy priority. Indeed, there are programmes and activities in place aimed at achieving policy goals to enhance equity, for example, by increasing inclusion in the labour market, education and life-long learning, support in the early years of life and access to services, to name a few.

1.8 Health and welfare systems in Slovenia

Since gaining independence, Slovenia has undergone substantial changes in the organization and financing of its health-care system. The health reforms of 1992 included a fundamental shift in

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[4] Poverty is often measured as "relative poverty" that is defined as having a disposable income below the at-risk-of-poverty threshold, which is set at 60% of the national median disposable income (after social redistribution) *(17)*.

[5] In contrast to range measures, which compare the experiences of the top and bottom socioeconomic groups, the slope index of inequality measures the socioeconomic dimension of inequality in health, i.e. it allows the health status or the frequency of health problems of each social group, relative to its position on the social scale, to be traced *(18)*.

ownership related to health care, as well as changes in the financial resources for and methods of administering it, which subsequently influenced the performance of the health system. Slovenia has a Bismarckian[6] type of social health insurance based on a single insurer, the National Health Insurance Fund, which is administered by the Health Insurance Institute of Slovenia, an autonomous public body.

Health insurance is mandatory in Slovenia and around 98.5% of the population is covered. Contributions are income-related although the State also provides health-insurance coverage for non-earners, such as children and non-working spouses. Since 1992, a voluntary health-insurance system has been in place to cover co-payment for compulsory health insurance. Co-payments can be substantial. Since 2000, overall out-of-pocket expenditure has increased by 72.4% or around 9.8% per year, which is also an indication of the increased privatization of the health-care services in Slovenia. Financing the health-care scheme is one of the greatest challenges of the Slovene health-care system; decreasing fertility rates and the rapidly increasing elderly population enhance the financial pressure on the health-care services. Additional factors that contribute to the rising health-care costs are the focus on curative care (to which slightly more than 50% of the health expenditure can be attributed) and an increase in the need for long-term nursing care *(12)*.

Structurally, the overall responsibility for the health of the population lies with the Ministry of Health whose public health role has been strengthened in recent years. Each of the nine health regions has a hospital and an institute of public health, which is responsible for communicable diseases, health statistics, health research, environmental health and health promotion. In 2005, the share of total health expenditure in GDP was 8.5%; the average for EU27 was 6.8%. Public health expenditure accounted for 72.9% of the total health expenditure (6.2% of GDP), while the share for private expenditure was 27.1% (2.3% of GDP) *(19)*.

1.9 Social protection

Slovenia ranks among the European countries with the lowest risk of poverty. This is mainly due to the Government's view that one of the most appropriate ways of preventing poverty is to ensure employment for those capable of working. The Ministry of Labour, Family and Social Affairs invests extensively in an active employment policy to secure an inclusive labour market for all (age) groups, especially people with disabilities, elderly women and the long-term unemployed. Increasing access to an inclusive labour market, social assistance and social services (including health-care services) is perceived as a major way of closing the gap between the most vulnerable and the financially secure.

[6] With his "Imperial Decree" of 17 November 1881, Emperor Kaiser Wilhelm I officially launched the development of an insurance system for people working in Germany based on the initiative of Imperial Chancellor Otto von Bismarck. Henceforth the state was to take responsibility for securing the livelihoods of its citizens, based on the following principles:
- financing pensions through contributions paid into the system over time by those insured;
- supervision of and participation in social insurance by the state;
- principle of self-government: employers and insured have full co-determination rights in the system through an assembly of elected representatives;
- participation of the employer in contributions paid into social insurance.

In 1883, Bismarck introduced health insurance, in 1884 accident insurance and from 1889 onward employees could for the first time insure themselves against the consequences of old age and invalidity (20).
The system of social insurance was based on the principles of solidarity, equity, fair financing and universal access.

In parallel with social-assistance programmes targeting specific vulnerable groups and the inclusive labour-market policies and productivity measures specifically aimed at people with disabilities, elderly women and the long-term unemployed, there are social-inclusion policies that prioritize equal access to the social services *(21,22)*. These are structured around three priorities: (i) to provide adequate support to vulnerable groups; (ii) to raise the potential of an inclusive labour market to fight poverty and social exclusion; and (iii) to provide access to social services.

The social-inclusion policies can be linked to four systems defined (by the Government) as important: (i) the labour market (to improve flexibility and promote employment while emphasizing quality of work); (ii) the social transfer system (to motivate people to work and to promote social equity); (iii) the pension system (to increase incentives for active engagement and ensure the long-term sustainability of the system); and (iv) the health-care system (to ensure rising costs do not undermine the standard of public health care). In addition, social assistance includes child and family benefits from early childhood to post-school/university age, which are relative to family-income levels. Public education in Slovenia is free of charge, i.e. without direct cost to those receiving it. Thus, education is accessible to all social groups. A good child-care system has resulted in Slovenia's having one of the highest rates of women in employment, which contributes greatly to gender equity.

2. THE AGENDA-SETTING PHASE UP TO 2003

2. THE AGENDA-SETTING PHASE UP TO 2003

A key stimulus for policy action to address health inequity was recognition by the Government and society in general of the differences in development standards among regions in Slovenia. In an effort to understand the reasons for this situation, an investigation was made of the way in which awareness of the relationship between health and social and economic development was raised. The processes, mechanisms and stakeholders involved in framing the problem as a compelling issue that needed to be placed higher on the political and policy agendas were also examined.

2.1 Setting the stage

The concept of, and policy discourse on, health inequity were new to Slovenia at the end of the 1990s. Although health inequity existed during the era of the former Yugoslavia, it was not addressed. During the late 1990s and the early 2000s, balanced regional development became a government priority, investment in which provided opportunities for the poorest parts of the country to improve their social, economic and health outcomes. At the same time, data began to emerge illustrating the growing differences in development conditions among the regions brought about by the political transition. These data, together with the requirement attached to EU funding that national policies be harmonized with EU treaties and agreements, gave impetus to addressing these issues. However, it took several years before policy-makers began to talk explicitly about health inequity and develop specific strategies and initiatives to address it systematically.

Several critical factors – the WHO investment-for-health appraisal undertaken at the request of the Ministry of Health in 1996 *(1)*, accession to EU, international influence, internal evidence, and government reform – served to increase the focus on health inequity at the national level, particularly the role of social and economic determinants, and to create more receptivity to addressing the problem as part of the regional development agenda.

2.1.1 Investment-for-health appraisal

The WHO Verona Initiative on developing partnerships at the local level *(23)*, which started in the mid-1990s, gathered emerging scientific evidence on links between health and social and economic development in Europe and globally, and highlighted the need for a new approach to strengthening governance for health gain as part of a broader development agenda. This approach became known as "investment for health and development".

The findings of the WHO investment-for-health appraisal in 1996 *(1)*, highlighted the importance of the non-health sectors, including those dealing with education, transport and tourism, as partners in the effort to increase investment for health by addressing the key social and economic determinants of health. This created an opportunity to couple the issues of regional development, which had high priority in the policy stream at the time, with the compelling problem of health inequity at the regional level.

2.1.2 EU accession

During the EU-accession process, the need to balance regional development was emphasized and funds were provided to this end. The Slovene Government was required to follow EU guidelines, which explicitly stated that economic, environmental and social development must be considered jointly in developing regional policy. The relatively flexible approach of the Slovene public-administration system towards introducing new ways of working played a key role in adapting to EU legislation. In addition, the target to reduce the development gap, especially economic development, created an opportunity to discuss the social and economic determinants relating to health and quality of life.

2.1.3 International influence

Although, there had been awareness about health inequity at the international level for some time, during the period covered by the assessment there was a marked increase in understanding and recognition of the connection between health and wealth and the fact that health can be affected by social factors. This was significant in creating greater awareness of the social determinants of health as a policy driver at the national level in Slovenia. Other important contributors were:

- the evidence provided by the WHO Commission on Macroeconomics and Health in 2001 that a country can be helped out of chronic poverty by improving its population health *(24,25)*;
- the development of the EU Health in All Policies (HiAP) approach in 2004–2005 *(26)*;
- the development of relations with the United Nations, WHO and other international organizations regarding the concepts of sustainable development *(27)*, social cohesion *(28)*, HIAP *(26)* and investment for health *(29)*;
- the work of the WHO Commission on Social Determinants of Health resulting in the report, *Closing the gap in a generation: health equity through action on the social determinants of health (4)*.

Thus, a mass of important evidence legitimized the connection between the social determinants of health and health inequity in the eyes of the key policy-makers and government officials. The incentive of EU accession and the related focus on harmonizing social, economic and other Slovenian policies with those of EU further increased receptivity of the issue. All of these elements were floating in the policy and political streams at the same time, which enabled the key stakeholders to frame the issue at an early stage.

2.1.4 Internal evidence and governance reform

The coupling of factors across streams mentioned in the previous section coincided with a series of internal developments relevant to making the case on addressing the social determinants of health and health inequity in the country:

A national survey on lifestyle and health conducted by the Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) Programme in Slovenia in 2002–2003 *(30,31)* highlighted the link between socioeconomic status and health outcomes in the country. This contributed to strengthening the role of local government, whose leaders recognized the opportunity offered by the concept of investment for health and development to enable their communities to link social, economic and health issues within one framework. Since communication among the stakeholders at the local level of government tends to be direct, informal and ongoing, the development of intersectoral partnerships was considered feasible. In addition, the inclusion of the Directorate of Public Health in the Ministry of Health strengthened the role of the health sector in the areas of public health and health promotion and increased its authority to create alliances with other sectors to promote and secure population health. These processes were largely facilitated by policy entrepreneurs operating at both the national and the local levels in various policy areas who saw the opportunity of a new and innovative approach to improving people's lives and the local economy.

All these developments helped soften the system and create a political environment conducive to including the issue of the social determinants of health in regional and national policy. However, at this stage, it was still one of many proposals circulating in the policy stream and, though promising, not mature enough to open a policy window.

2.2 Raising awareness: linking health with social and economic development

In 2006, the Ministry of Health, led by the State Secretary for Public Health, initiated a systematic campaign to inform all levels of society – politicians, professionals and the general public – about the interdependence of population health and socioeconomic development. The campaign built on the internationally recognized concept of investment for health established through the WHO Verona Initiative *(23)*, using national data and local examples. The findings of the WHO investment-for-health appraisal carried out in Slovenia in 1996 were incorporated in a national report presented the same year to the Ministry of Health and Parliament. The report presented the current strengths and weaknesses of the policy areas that were prioritized for improving health and highlighted entry points and mechanisms for increasing action in the short and medium terms. One of the recommendations in the report was to identify a pilot site for testing and refining the investment-for-health approach in Slovenia *(1)*.

The experiences of other countries also influenced the policy process, particularly the approaches being developed towards intersectoral action in the north-west of England (the Investment for Health North West Initiative (32))[7] and Finland (the North Karelia Project *(33)*). Policy dialogues, workshops and meetings were organized during which guest speakers presented the experiences of their countries to representatives of line ministries, businesses and civil society at the national and regional levels. A concerted effort was made to engage the support of the media, which provided coverage of the process. This systematic campaign was an important contributor to opening the discussion on the social determinants of health at all levels of government and not only within the health sector.

Furthermore, exposure to different models of governance for improving health strategies at the European and national levels, through brokered intercountry exchanges and peer learning, influenced the thinking of the senior policy-makers in Slovenia. They used this new found knowledge in their formal and informal briefings of political figureheads in the Ministry of Health who, in turn, were able to couple health improvement with policy issues linked to broader government priorities. In this way, they were able to create a dialogue with other ministries on how health was both an asset to, and a product of, social and economic policies. Adopting a regional approach to socially determined health inequity helped prioritize the issue on the political agenda.

[7] The Investment for Health North West Initiative *(32)* was born from involvement in the Verona Initiative *(23)* as a test site for the Verona Benchmark *(34)*.

Key learning

- The focus on balanced regional development, a requirement for EU accession, and the flexibility of the EU guidelines and public administration, made it possible to raise the issue of addressing the social determinants of health (using the investment-for-health approach) on the political agenda.
- Evidence emerging from the WHO Verona Initiative *(23)* and other European countries was useful in illustrating how creating a link between health and social and economic development could be a mutually reinforcing investment. It raised awareness about the potential benefits of considering health from an economic perspective and legitimized the issue of the social determinants among policy-makers and political stakeholders.
- To raise the issue of socially determined inequity on the policy agenda required a systematic, multifaceted communication campaign at different levels of government throughout the country. To strengthen interest and form alliances, it was critical that its key messages were both evidence-based and tailored to the different audiences for which they were intended. This enabled those actively promoting the issue, particularly the need to level up health in the poorer regions, to gain valuable insight into both the supporting and the countervailing forces, such as competing or contradictory policy issues. Equally significant for success at this stage was to enlist the key stakeholders that had access to important decision-making processes across the different sectors of government and society. Formal and informal mechanisms and networks also played an important role.

3. BALANCING REGIONAL DEVELOPMENT

3. BALANCING REGIONAL DEVELOPMENT

The decision to prioritize action to deal with the gap in development at the regional level was largely related to the criteria for EU accession, which emphasized balanced regional development, and the structural reform taking place in the regions to meet these criteria. The accession process offered the opportunity of linking issues related to economic growth and development to the social determinants of health with the aim of bringing about firm structural changes to benefit health.

3.1 The national perspective

Initially, health inequity in Slovenia could not be defined as a problem in its own right as no data on health status, disaggregated by social and economic factors at the individual level, were available to support this. Data linking regional development and health were available in some regions where databases had been set up before 2000 to record the results of ecological studies on economic, social and environmental development and health status, but they were fragmented and there was no collaboration between the databases.

3.2 The Pomurska region

The available data clearly showed a connection between limited regional development and poor health. The results of the CINDI health monitor survey carried out in 2001 *(35)* correlated with national data in highlighting the Pomurska region as the area with the worst indicators for health and development in Slovenia.

The WHO investment-for-health appraisal carried out in 1996 *(1)* had also identified this region as disadvantaged. At that time, the agricultural and food industries in the Pomurska region were being restructured, the textile industry was facing difficulties and entrepreneurial activity was relatively low compared to other regions of the country. The issues of low educational attainment and high unemployment rates were already being discussed by regional policy-makers as priorities in their own right. However, these indicators were also of concern to the Ministry of Health because of their link to poor health outcomes, including noncommunicable diseases (NCD) and premature and avoidable mortality, the rates of which were higher for the Pomurska region than those for wealthier regions and the national average.

In contrast to these negative indicators, there were some areas of growth in the region, including the traditionally active health-tourism industry with four spas. This was adversely affected after Slovenia gained independence but was starting to recover and was seen as an area of opportunity to stimulate growth and local employment in Pomurska region. Creating new jobs and increasing the number of educational programmes were, therefore, two goals that were high on the policy agenda of the regional development sector and also important to health. Furthermore, both the health sector and the regional development sector could see the benefits attached to linking: local agricultural production with tourism and healthy nutrition; nature protection with agriculture, rural development and the promotion of healthy lifestyles; and education with employment, business development and innovation, and health in the workplace.

Key learning

- The quality and availability of data can influence policy dialogue.
- The extent to which a problem is addressed depends greatly on how it is framed. In Slovenia, the gap in health status between the Pomurska region and the other regions was defined at the national level as a problem resulting from differences in, and an uneven distribution of, social and economic conditions. This clearly linked the problem to existing national policy, the main aim of which was to address social and economic differences between regions.
- Connecting the problem across government agendas was particularly helpful. The way in which the issue of equity was presented ensured that it resonated well with the agendas of other sectors and the Government's imperative of fulfilling the conditions for EU accession.
- It was the confluence of several factors, along with the impact of the systematic awareness-raising campaign on investment for health and development, led by the Ministry of Health, which enabled the issues of regional differences in health and the social determinants to advance on the policy agenda and opened a new policy window in Slovenia.

4. POLICY FORMULATION

4. POLICY FORMULATION

In Slovenia, the formulation of policy on health equity was based on the concept of investing in health as part of a wider regional development strategy and can be traced to the Government's initial conceptualization of the problem.

The differences in health status and the social determinants related to it were initially defined as inequities in the regional structure, mostly affecting the health of the people in the least developed regions. Discussion on options for improving health in the poorer regions was based on this definition, as evidenced in national policy documents on health, such as the national health plan, *Health for all by 2004.* It also significantly influenced the national equity aims, which were broadly: "to narrow the health gap between the best-off and worse-off regions and to target the social determinants of health and lifestyles of the most vulnerable groups". The targets set at this stage were non-numerical in nature, which was partly due to the fact that the available data only allowed for a comparison of the regional averages *(36).*

The planning of action to address the social determinants as a part of regional development was influenced by a number of important factors and policy entrepreneurs, as described in sections 4.1–4.4.

4.1 Shifting the focus towards public health

In line with the political developments occurring in preparation for EU accession, changes were taking place within the public health sector.

- The public health system was strengthened by changes in the remit of the Ministry of Health.
- Where the focus had previously been solely on the organization and delivery of personal healthcare services, it was expanded to include public health.
- The stewardship function of the Ministry of Health gained in importance. In particular, the newly appointed State Secretary for Public Health was open to, and actively advocated, new concepts of health promotion. She participated in and supported EU and WHO initiatives relating to the socioeconomic determinants of health and investment for health.
- This shift in approach offered the potential for integrating health and economic development in one framework, a move which promised more success than would have been the case in attempting to tackle health issues separately.

To encourage the use of the HiAP approach, the Ministry of Health played a supportive rather than an executive role at various stages in the policy-formulation process. An example of this was its support of decisions that were more beneficial to non-health sectors, such as those to grant financial support to the Ministry of the Environment and Spatial Planning for building a water supply system in the Pomurska region, and to the Ministry of Higher Education, Science and Technology for developing higher education programmes in the region.

4.2 The role of the regional development sector

The regional development sector, under the Ministry of Economy, played a pivotal role at the national level in lending credibility to the issue of health equity as a cross-cutting matter of relevance to several government departments. It was the ideal partner for the Ministry of Health in tackling geographic inequity in health. From the outset, the Ministry of Health sought collaboration with the regional development sector in promoting the investment-for-health policy approach. This partnership meant that the issue of including health in regional development weighed more on the political agenda than would have been the case had the Ministry of Health acted alone.

Working in partnership, both sectors brought several key resources into the arena, including external experts, internationally renowned evidence and policy allies, all of which created an environment conducive to successful policy development. Joint policy-support teams were given the responsibility of working together on synthesizing evidence, assessing incentives, testing options and building stakeholder receptivity, using both informal and formal means.

4.3 The engagement of regional and local stakeholders

At the local level, the mayors of the municipalities in the Pomurska region constituted a key interest group. A strong lobby in regional decision-making, this stakeholder group was able to influence national policy priorities, in particular the National development programme (2001–2006) *(11)*. They acted through informal contacts brokered by those with knowledge of the regional and local governance mechanisms. In addition, a series of high-level investment-for-health master classes, which are part of the WHO Verona Initiative *(23)*, was held to present the issue of addressing the social determinants with the aim of improving health and testing ways of integrating health-related issues in regional development. The examples and experiences of regions and municipalities in other countries, such as England *(32)* and Finland *(33)*, were presented and discussed during these events, which brought together mayors, representatives of local agencies, government departments and the voluntary sector of the Pomurska region, and health officials from the other countries involved. This external input strengthened the debate on the investment-for-health approach and resulted in this strong lobby supporting a similar approach in the Pomurska region. A letter of commitment on investment for health and development in the Pomurska region was signed by representatives of the public, private and nongovernmental sectors in 2002, clearly illustrating this support.

4.4 The role of WHO

As a result of the joint work carried out by the Ministry of Health, the Ministry of Economy and the WHO European Office for Investment for Health and Development to identify priorities for action in the Pomurska region (sections 2.6 and 3.2), a regional partnership network coordinated by the Centre for Health and Development and the Institute of Public Health, Murska Sobota (Fig. 5) was established and the basic documents required for setting up a site to test the investment-for-health approach were produced. This pilot site became known as "Investment for health and development in Pomurska region – Programme MURA".

The involvement of WHO in this partnership gave international credibility to the development of the investment-for-health policy approach.

4.5 External sources of evidence and know-how

Analyses of external models of and approaches to dealing with socially determined health inequity contributed to the selection of policy goals and options in Slovenia. The Investment for Health North-West Initiative (England) *(32)* and the North Karelia Project (Finland) *(33)*, in particular, illustrated the effectiveness of linking action to address the social determinants of health through social and economic agendas, policies and investment processes, and of engaging and empowering the community. International experts were invited to policy meetings with key stakeholders during the processes of generating and testing the options, allowing local policy-makers and politicians to air their concerns about the practical aspects of implementation.

At around the same time as these intensive interactions on policy formulation were taking place in the Pomurska region, steps were being taken at the national level to reinforce the importance of addressing the uneven development of, and differences in, health status at the regional level. These

Fig. 5. Regional partnership network

Notes: CHD = Centre for Health and Development; IPH = Institute of Public Health, Murska Sobota.
Source: Buzeti and Mauček Zakotnik *(37)*.

included: (i) the adoption of the strategy for the economic development of Slovenia, 2001–2006 *(38)*, which was based on the concept of sustainable development and focused on strengthening human resources, competitiveness, the efficiency and cost-effectiveness of the state, and regional development; and (ii) the launching of the national health-care programme, *Health for all by 2004 (36)*, which included a commitment to reducing health inequity between the eastern and western parts of the country and focused strongly on a public health policy on, and approach to, health promotion that was to be coordinated through the national and regional public health institutes.

4.6 Establishing investment for health and development in the Pomurska region

A rapid and intense series of meetings took place in 2001 and 2002 to test and formulate policy related to investment for health and development. These were crucial in changing the perspective on regional development, which had previously been considered only from an economic standpoint. As a result, it was viewed increasingly as a part of the broader social and environmental agenda on sustainable development and provided the foundation for developing the investment-for-health approach in the Pomurska region.

For Programme MURA to succeed in establishing links between health and regional development, specifically in relation to testing the robustness of policy goals, it was necessary to have strong leadership in both sectors already at the policy formulation stage. The success of the programme was also dependent on intersectoral models of delivery. Other countries were using a range of approaches, often in combination, to ensure the alignment of policy objectives with systems of delivery. These included common targets across sectors of government and in contracts with service providers (as seen, for example in England), legislation committing governments and ministries of health to devel-

opment plans (Belgium, Finland and Norway), and interministerial task forces, intersectoral committees and planning groups (for example, Canada, Norway, Scotland and Spain). At the time of policy formulation in Slovenia, all of these measures and approaches were new to the country.

To win the support of all sectors, the Ministry of Health undertook a policy-scanning exercise in 2000. Coordinated by investment-for-health staff, the exercise involved examining the policies of the different government sectors and the plans of other regional stakeholders to identify common goals and interests relating to health and development, potential areas for collaboration, and/or competing interests that could block or undermine the investment-for-health approach.

The analysis revealed that there was a higher rate of unemployment and a lower level of educational attainment in the Pomurska region than in other regions. These issues were discussed at the regional level and attempts made to implement strategies to deal with them but it was not until the mid-2000s that they were viewed through a health lens. By this time, the connection between health and development had already been demonstrated by the health sector at both the national and the regional levels. At the same time, there was growing international recognition of the closing-the-gap concept of narrowing the differences in health status between social groups, which influenced thinking in Slovenia as regards regional differences in health levels and the further development of policy to address them.

As a result of this problem recognition, strong emphasis was placed on identifying joint solutions and resources at the local level. The major stakeholders agreed that existing policy options and frameworks, as well as available resources and assets, should be taken into consideration in estimating possible additional resources needed for selected action. This would also ensure that small-scale communities, enterprises, organizations and individuals were actively involved in the planning process and, eventually, in implementing the programme.

4.7 Identifying policy priorities

Two elements were involved in the policy-selection process: (i) identification of the sectors that were most receptive to incorporating and delivering the health agenda; and (ii) identification of health issues that the public would find acceptable to tackle. Only those areas where collaboration was considered plausible, and in connection with which there was a realistic prospect of achieving common goals, were selected.

4.8 Sectoral issues

The Ministry of Health and the Ministry of Economy seized the opportunity created by the structural reforms taking place within the tourist, agriculture and food industries to form alliances with the sectors responsible for these areas. Meetings held by regional and national stakeholders encouraged dialogue across sectors and between the regional and national levels of government. These resulted in the identification of joint interests in the areas of health and social and economic development and a much more coordinated approach to policy development. The health sector was able to demonstrate that improvements made in the areas of employment, education and health would simultaneously contribute to achieving at least some of the other sectors' goals, as well as to enhancing conditions for policy development.

4.9 Health issues

There were a number of health issues that could have been addressed by Programme MURA to improve the health status in the Pomurska region. These included mental health, alcoholism and sui-

cide, which were of public health concern but seen as taboo areas and, therefore, difficult to discuss in the public domain. Although a practical, realistic and focused approach was deemed essential, it would have been exceptionally challenging in the early 2000s to gain public support in building a coalition to address them. Focusing on diet and physical activity, on the other hand, was more acceptable to the public and offered the potential of addressing two of the region's biggest killers, respiratory and gastrointestinal illnesses. In addition, a CINDI health monitor survey focusing on physical activity and nutrition was carried out in 2001 *(39)* and the resulting data were analysed in the light of the high unemployment rates and the low levels of educational attainment in the region. The analysis has shown that the highest prevalence of unhealthy diet and unhealthy lifestyle in general was among the poor and those with a low level of education.

4.10 Aligning health issues across sectors

The ongoing structural changes in the sectors dealing with tourism and agriculture provided the Ministry of Health with an opportunity to highlight how these sectors could benefit, in terms of financial and human resources, from including health priorities and the social determinants of health in their approaches. A number of positive effects on identified risk groups in the region could also be achieved in the same way. Small-scale farmers were identified as a high – risk group among the rural population due to transition to the Common Agricultural Policy.[8] Another emerging risk group consisted of unskilled workers or those with a low level of education, many of whom had lost or were in danger of losing their jobs due to the restructuring of the industry.

The Ministry of Health's approach to improving health focused on the cultural and social factors that affect behaviour and the use of natural resources to create a structural environment conducive to healthier choices. Negotiations and decision-making with other sectors were heavily influenced by this approach.

The key intervention areas were presented to the Government in the *Report on development issues in Pomurska region (40)*. The Government agreed to the measures proposed, which included transition to the production of sustainable food and restructuring the agricultural sector in the Pomurska region. As a next step, the Ministry of Agriculture and the Ministry of Health underwent a planning process with a view to securing national-level funding. This included an assessment of the economic, health and environmental benefits of the afore-mentioned transition, as well as of the financial, human and technological investment required. An assessment of the impact of the agricultural transition on health proposed by the Ministry of Agriculture was also carried out after accession to EU. The results of these assessments formed the basis of the proposed public health interventions in the Pomurska region.

The overall focus of intervention was on exploring how best to use local resources (both human and physical) to increase the quality, accessibility and affordability of fresh, locally produced food and to create new business and income opportunities for socially vulnerable groups, such as small-scale farmers. The environmental resources existing in the region proved to provide additional health-promoting opportunities.

Small-scale farmers were found to be those with the highest risk of unemployment and, therefore, most vulnerable to health threats. The health sector proposed investigating the employment opportunities of this risk group and entered into discussion with other sectors on options of sustainable livelihoods. One of these was for small-scale farmers to produce fruit and vegetables, which

[8] Information available: http://ec.europa.eu/agriculture/cap-overview/2012_en.pdf, accessed 20 October 2013.

were mostly imported at the time, instead of relatively low-value corn and wheat, using food-supply chains that guaranteed short transportation of the products to the local market. An important aspect of this option was the opportunity it offered farmers to earn a secure income using their knowledge and skills. At the same time, it made it possible for the Pomurska region to retain these social and cultural assets.

Asset mapping was used to identify the human and other resources existing in the region that could be used to improve health, social and economic conditions. This resulted in the identification of important stakeholder groups that were familiar with the local conditions and cultural traditions and could strengthen social cohesion among, and the engagement of, vulnerable groups.

Physical and environmental resources available in the region were also assessed during the exercise. One of these, Goričko Nature Park, was found to have the potential to support new income opportunities for vulnerable and risk groups in the areas of organic farming and agri–eco tourism. In addition, it covers a third of the Pomurska region and is an opportune site for the development of recreational activities, such as walking and cycling trails, which would provide safe and free options for physical activity.

The Ministry of Health supported an ecotourism-related proposal made by the Programme MURA Council, which was based on steering health-sector activities towards increasing employment and income opportunities in the region.

Let's Live Healthily *(41)*, the health-promotion programme of the Ministry of Health, contributed to Programme MURA by raising awareness at the local level about the importance of an active lifestyle and healthy nutrition and by enhancing the knowledge and skills of the population in these areas.

4.11 Launch of Programme MURA

A letter of commitment to addressing the social determinants of health, signed by representatives of a broad range of sectors and the mayors of all municipalities in the region,[9] officially marked the launch of Programme MURA. The specific objectives of the Programme (Box 1), focus on the spectrum of factors that, according to Dahlgren and Whitehead's rainbow model, influence health *(6)*.

The objectives of Programme MURA clearly demonstrate how the process of generating and testing policy options (building on earlier agenda-setting and problem-defining activities) promoted an understanding across sectors of the way in which socioeconomic, cultural and environmental factors influence lifestyle, behaviour and health outcomes, and how their impact on different social groups is mediated by social and community networks (see Fig. 1, page 6).

The objectives also suggest a greater understanding of the concept of heath equity. There was a corresponding shift in approach from that of addressing the differences in development within a region in general to that of focusing on the link between the differences in health status and the distribution of social and economic determinants among different social groups in the same region.

[9] Signatories include: the President of Programme MURA Council; the Secretary of State; the Mayors of all 26 municipalities; parliamentarians of the Pomurska region; and representatives of the Chamber of Commerce, the Institute for Agriculture and Forestry, the Institute of Public Health, Murska Sobota, food and agricultural enterprises, health spa resorts and development agencies.

Box 1. Objectives of Programme MURA

1. To spread knowledge about the economic, social and behavioural determinants of health and quality of life.
2. To make people aware of and accountable for their own health and to equip them to do so through health-promotion programmes.
3. To improve the health indicators of the Pomurska region and the quality of life of the inhabitants.
4. To identify the natural, entrepreneurial and human resources of the Pomurska region.
5. To identify and remove the main obstacles to better health and socioeconomic development in the Pomurska region.
6. To improve the network of professional and university colleges in the Pomurska region.
7. To reduce the ecological burden in the Pomurska region.
8. To encourage economic and social development by promoting and supporting strategic partnerships and programmes in the Pomurska region.

Source: Buzeti and Maučec Zakotnik *(37)*.

Programme MURA was designed to include a range of interventions that address the structural aspects of education and agricultural policy at the national level and to investigate the social determinants of health relevant to the most vulnerable groups in the Pomurska region. These interventions involve various sectors, local communities, municipalities and businesses.

Key learning

- The establishment of key partnerships between the health sector (Ministry of Health) and the regional development sector (Ministry of Economy) at an early stage paved the way for extensive intersectoral collaboration. The efforts made by the health sector to understand the agendas and priorities of the other sectors were crucial in forming common perspectives and led to an alliance between the Ministry of Economy and the Ministry of Health to champion the issue at the regional level.
- By joining forces, the Ministry of Economy and the Ministry of Health were able to raise health equity to a higher level on the political agenda than would have been the case had the Ministry of Health attempted to do so alone.
- Work with key interest groups, such as mayors and NGOs, to advocate the investment-for-health approach was strengthened through an exchange of knowledge with international bodies and local stakeholders. This provided valuable know-how and practical evidence about the approach and possible policy options at a time when it was most needed.
- Cross-sector policy scanning was helpful in identifying common priorities and enabling a dialogue on feasible entry points for developing common policy to tackle the social determinants, which, in this case, were balanced regional development and health equity. The policy priorities needed to be based on realistic choices given the cultural inappropriateness of certain health topics and the structural reforms taking place.
- Selected policies and programmes needed to reflect predetermined criteria and a balance between technical and financial feasibility, public acceptability and action that could result in early wins.
- The most useful methods of appraising the options were asset-mapping and impact assessment. Multistakeholder assessments facilitated a common understanding of the potential and feasibility of the different interventions proposed and of the benefits of adopting the investment-for-health approach at the national level.
- Key policy entrepreneurs, in this case the State Secretary for Public Health and the State Secretary for Regional Development, were essential in softening up the system by using their political connections and negotiating skills in persistently pushing the investment-for-health approach and facilitating a coupling of the policy and political streams.
- Finding a common, intersectoral language that made it possible for the wide range of stakeholders to understand the complex issues involved, such as the social determinants of health, was critical for the successful generation and testing of policy options.

5. IMPLEMENTATION

5. IMPLEMENTATION

The formal launch of Programme MURA marked the start of a specific phase in the development of policy on health equity in Slovenia, a dynamic period, which positioned the north-east of the country as the health-and-development region: the implementation of the pilot programme could begin.

5.1 Strategic partnership and mechanisms used

A strategic partnership lay at the heart of Programme MURA. Built up through the stages of agenda-setting, problem definition and policy formulation, it facilitated closer relations between the stakeholders prior to implementation. Informal communication among them about their challenges and priorities helped create a supportive culture that encouraged successful formal meetings and joint planning activities. In addition, the administrative scale of the Pomurska region facilitated prompt and direct contact among the stakeholders.

A key approach to enabling and sustaining the implementation of the programme was to work through existing structures. Good use was made of formal partnerships and collaboration with agencies and working groups at the municipal and regional levels. This ensured the engagement of the local communities in the design, implementation and review of interventions, and contributed to the development of regional assets, which was one of the objectives of the approach.

5.2 A shared agenda

It was considered crucial to have a single term of reference relating to the strategic partnership behind Programme MURA developed jointly by all partners involved and providing an agreed framework for joint review and assessment. The targets, objectives and activities of this document had clear links with the planning mechanisms, goals and outputs of the following national policies and strategies:

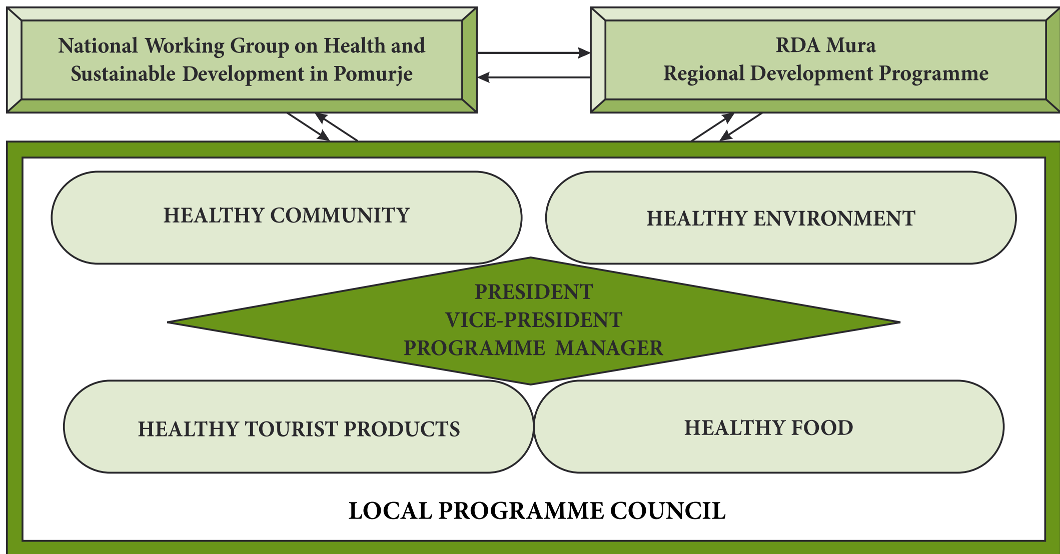
- *National programme on primary prevention of cardiovascular diseases (42);*
- *Resolution on the national programme of food and nutrition policy 2005–2010 (43);*
- *Food and nutrition action plan for Slovenia, 2005–2010 (44);*
- *National health enhancing physical activity programme, 2007–2012 (45);*
- *National development programme, 2001–2006 (10);*
- *National Strategic Reference Framework 2007–2013 (46);*
- *The strategy for the economic development of Slovenia, 2001–2006 (38);*
- *Strategy of Slovene tourism, 2002–2006 (47);*
- *Slovenia's development strategy (2006–2013) (2).*

The resulting synergy between Slovenia's national and regional policies on social and economic development and health equity ensured that the objectives of the Programme MURA were integrated in relevant structural policy documents at the regional and national levels, linking related investment plans and processes. This was to prove important in sustaining action through times of political and financial change and in the light of shifts in policy priorities both in the Pomurska region and nationally.

Dedicated national and regional coordination mechanisms facilitated collaboration among stakeholders across the various sectors, as well as a delineation of responsibilities relating to the work to be carried out (Fig. 6). For the most part, the institutional resources were already in place, although some additional programme-specific coordination mechanisms were created, such as the Intra-

governmental Working Group on Health and Sustainable Development in Pomurje at the national level, and the Programme MURA Council at the regional (local) level. Annex 1 lists the stakeholder partnerships involved in Programme MURA and their roles.

Fig. 6. Coordinating and communication mechanisms of Programme MURA



Note: RDA = Regional Development Agency

Source: Buzeti and Maučec Zakotnik (37).

A health-system representative (public health professional) was attached to each of the Programme MURA projects to provide technical input to the planning, delivery and review of the interventions. The same applied to the many governmental working groups responsible for the preparation of different policies and programmes, irrespective of which ministry was in charge of the work. This proved useful in averting decisions that might have had negative health-related consequences, as exemplified in Box 2.

Box 2. Example of a health representative's success in averting a decision with potentially negative health-related consequences

The Ministry was also very proactive in instituting joint discussions about policies of other sectors. For example, recognizing that a plan presented by the tourist sector (under the Ministry of Economy) to promote wine routes for tourism would undermine health messages about reducing alcohol intake, the health representative succeeded in persuading the tourist sector to review the plan and support investment in cycling and walking paths instead *(47)*.

5.3 Funding

Programme MURA activities were chosen and evaluated by the Intragovernmental Working Group on Health and Sustainable Development in Pomurska region rather than by the individual ministries responsible for implementing them. However, the coordinating roles played by the National Secretary for Regional Development, National Agency for Regional Development (in 2001–2004) and the

Government Office for Local Self-Government and Regional Development (from 2005) were crucial in the allocation of resources.

EU funds were allocated for structural and regional development, the overall goal being to improve quality of life and enhance regional competitiveness. They were earmarked for: improvement of education and social cohesion; tourism development; preservation of nature and environmental protection; agricultural restructure; and health promotion. However, while these funds were crucial for regional development, local NGOs had difficulty in accessing them, a situation that sometimes raised problems for the small, community-based projects within Programme MURA.

Policy-makers in Slovenia used the EU financing cycle as a means of bringing partners together and creating strategic direction within Slovenia's own planning frameworks. From a resourcing perspective, the Ministry of Health's financial support for Programme MURA was in place from the outset. Although harder to quantify, all the sectors involved contributed resources in the form of information, expertise, infrastructure and technology.

5.4 Programme governance

Programme MURA is underpinned by a legal framework that guides development-related policy throughout Slovenia. This framework takes the form of regional and national programmes, which include the reduction of health inequity at the regional level as a priority.

The implementation of Programme MURA was based mostly on projects with defined outputs and expected outcomes in connection with which the roles, responsibilities and expected results of the partners involved were clearly defined.

5.5 Supporting mechanisms

All staff involved in Programme MURA have been trained in the investment-for-health approach, as well as in monitoring and evaluation, policy development and health promotion (with a focus on local empowerment and rural areas). This has strengthened intersectoral communication, negotiation and project-management skills. The sheer number of people working on investment for health has raised awareness of the social determinants of health and created a critical mass of human resources across sectors and stakeholder groups both nationally and regionally.

5.6 Monitoring and evaluation

The monitoring and evaluation plan for Programme MURA comprised: (i) an assessment of the changes and the impact of the *Regional development programme 2002–2006 (48)* (ii) measurement of lifestyle changes; and (iii) evaluation of the programme projects. The evaluation was carried out by staff of Programme MURA and the Government Office for Local Self-Government and Regional Policy.

It was decided that, in evaluating the results of the regional development programme *(48)*, the focus should be on its efficacy and whether its objectives had been met. As the objectives of Programme MURA were incorporated in the regional development programme *(48)*, their impact would be evaluated at the same time.

Lifestyle changes were to be measured through the health monitoring survey carried out every 3–4 years through the CINDI Programme *(31)* whereby data is collected by region and classified according to socioeconomic status, thus enabling some analysis of inequity. The results of the annual data

collection instigated by the Ministry of Health and carried out by the regional institutes of public health to measure health inequity are also taken into consideration. The CINDI health monitoring survey conducted in 2001 *(35,39)* provided the baseline data for Programme MURA and the Let's Live Healthily programme *(41)*, while those carried out in 2004 and 2008 *(35)* allowed for a comparison of the changes that had occurred in relation to risk factors, such as unhealthy diet, low levels of physical activity and high levels of blood cholesterol and blood pressure. (These changes are discussed in Part 6.)

Each of the Programme MURA projects was to be evaluated individually. Because of the relatively short time frames of the projects (1–3 years), the results were limited in terms of health outcomes. However, the approach was to provide a valuable assessment of the process, capacity development, behavioural change and product and service development linked to: (a) the social and economic determinants of health priorities, such as education, employment opportunity and income security; and (b) health priorities, such as risk factors for cardiovascular diseases.

The Programme MURA project activities and their impact to date are outlined in Part 6.

Key learning

- Effective implementation of Programme MURA required:
  - an investment of time and energy, i.e., well-developed partnerships at the strategic and operational levels, such as the networks and relationships existing in the Pomurska region;
  - the establishment of a common agenda at both the national and the regional levels (to ensure a common understanding of Programme MURA's policy objectives and establish clear links with national policy);
  - secure funding, involving contributions across sectors through shared objectives and joint projects (i.e. not only health-sector funding);
  - the creation of effective planning and governance arrangements covering programme management, including coordination, funding and review mechanisms.

6. PROGRAMME MURA: INTERVENTIONS AND ACHIEVEMENTS

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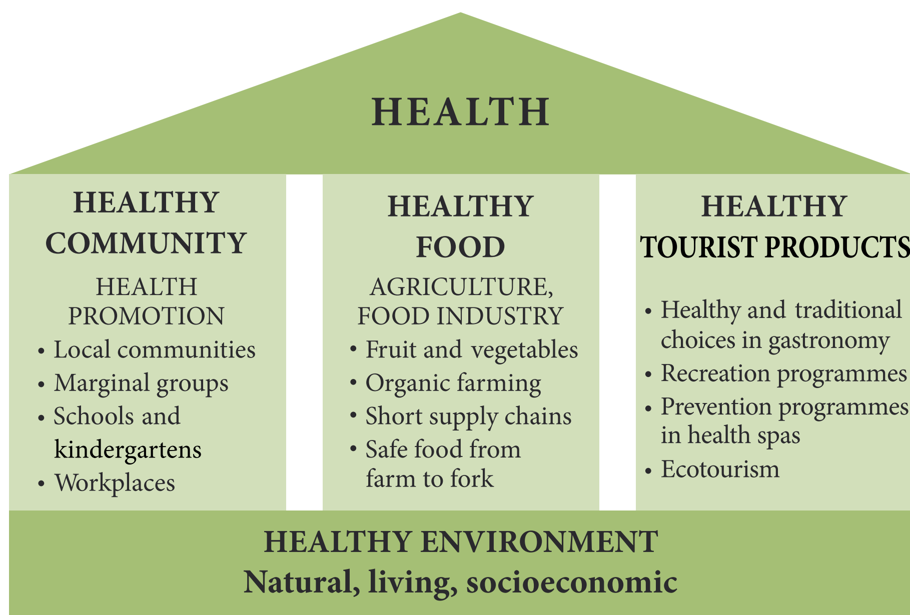
During the planning process, national and regional policy-makers in the health sector were looking to build on existing, promising initiatives rather than to implement new measures with uncertain outcomes. By the end of the process, the foundation and pillars of Programme MURA had been developed (Fig. 7).

Fig. 7. The foundation and pillars of Programme MURA



Source: Buzeti and Maučec Zakotnik (37).

Since tourism was perceived as a potential area of major development in the Pomurska region, one of the priorities was to focus on developing and promoting tourist products and services conducive to good health, such as healthy local cuisine and leisure-time activities (for example, cycling and walking). A second priority was to support the production of healthy food products (such as, fruit and vegetables, added-value foods), for example, by developing special quality standards and nutrition guidelines (on lower salt, sugar and fat content) and ensuring their distribution via short supply chains. This was related to the restructuring of the agricultural sector and the associated need to find alternative ways of keeping small-scale (primarily local) farmers in the market. Dealing with these priorities involved different interventions designed to address employment security in general and vulnerable groups (e.g. women, small-scale farmers, the unemployed) in particular.

The preservation of the natural environment and cultural heritage has mostly been linked to the development of new tourist products to secure long-term financial stability for selected sites. Programmes and interventions to this end have continuously been accompanied by health-promotion activities, such as the highly participatory Let's Live Healthily programme *(41)* that promotes healthy lifestyles in rural areas with the involvement of whole communities. Many of the programmes also aimed at strengthening social and community cohesion (e.g. by setting up community networks and

increasing cultural and recreational community events). This was done using existing assets (e.g. established networks, physical and social community infrastructure, tradition).

To support employability and economic sustainability, it was considered crucial to improve the education offered in the Pomurska region. Two programmes relating to the main priority development areas (tourism and agricultural restructure) were set up; these involved upgrading the Vocational School of Agricultural Management and Rural Development and the Vocational School of Catering and Tourism. The former school enrolled its first students in the academic year of 2005–2006. The programme to upgrade the latter, however, was not implemented due to the lack of regional financial support and a policy champion to promote it at the national level.

The project on learning for young adults (Projektno učenje mladih – PUM) targeting school dropouts, which was started in 1999 under the Ministry of Education and Sport, won the EU Committee of the Regions' European Regional Champions Award 2007. The Institute of Public Health and the Adult Education Centre of the Pomurska region collaborate in running it; "healthy lifestyles" was added to the curriculum in 2004 *(37)*. Partnerships in this project involve the private, voluntary and public sectors and participants range from sector experts to local volunteers. The following example illustrates how one of these networks contributed to implementing the objectives of Programme MURA (Box 3).

Box 3. Partnership networking for nordic walking

The network of local community tourist organizations and the Regional Tourism Association, which comprises more than 60 associations active at the community level, have been very efficient in implementing action to promote health and tourism simultaneously.

More than 30 guides and 70 nordic-walking promoters belong to the network, which is coordinated by the Centre for Nordic Walking for Pomurska Region and is a tangible result of investments in healthy lifestyle and tourism.

In addition to walking and cycling, the Centre for Health and Development, which also belongs to the network, promotes nordic walking as a tourism product. The Cancer Society of Pomurska initiated this form of physical activity as one suitable for all age groups; they started by training guides and then created the Centre for Nordic Walking.

Interest in nordic walking has increased in the Pomurska region where the number of tourist agencies that include this form of exercise among their activities has also increased. Several local communities, have introduced a regular, weekly nordic-walking day.

Working with the media, an important partner at the local level, helped Programme MURA to spread information about policy decisions both to the public and to the stakeholders at the regional and local levels. A detailed plan of work was drawn up to ensure mutually beneficial collaboration between the programme and the media, especially in terms of enlisting the support of civil society. For example, the local newspaper initially sponsored a column charting the programme's progress. News about the programme was often aligned with news on national issues. Media coverage was generally positive.

6.1 Policy development process: challenges and achievements

Policy-makers and programme planners recognized that the more complex the policy environment, the more difficult the implementation of intersectoral action. However, a number of mechanisms were in existence to enable Programme MURA to work across the sectors.

Finding incentives to engage the various sectors and, over time, bridge partnerships among them required the capacity and skills to be able to translate new evidence and policy developments within and outside of Slovenia for use in the context of the Pomurska region, and link them to the views and interests of the different stakeholders. For example, in restructuring the agricultural sector, it was necessary to invest in education. To this end, the Ministry of Education, encouraged by various academics and senior policy-makers,[10] upgraded the Secondary School of Agriculture in Rakičan to become the Vocational College for Food and Agricultural Sciences, which started a programme on agricultural management and sustainable development in 2005. The Mayor of Murska Sobota succeeded in securing the commitment of the other mayors in the region to fund this development.

In addition, the Regional Education and Research Centre was established in Murska Sobota in 2004 to support the development of new higher education programmes in the region and stimulate relevant research and development. However, engaging the support of other sectors was not always successful. When the need to establish a vocational college for tourism was identified, it was not possible to find an organization willing to lead the project or the political support to co-fund it.

The Slovenian experience demonstrates that policy development is a continual process. What began as a pilot project using the investment-for-health approach to address regional disparities in the Pomurska region, resulted in an overarching initiative to improve health by tackling its social determinants and promoting a healthy lifestyle. Programme MURA produced the *Health promotion strategy and action plan for tackling health inequalities in the Pomurje region (49)* (Annex 2); as a result, a chapter on health was included in the *Regional development programme for Pomurska Region, 2007–2013 (48)*. All partners in the region adopted the approach used by the programme, an approach that has influenced national policy development and contributed, for example, to an emerging national strategy for tackling health inequity.

An important element of the policy development process was the collaboration among the different sectors and stakeholders in formulating joint policies and plans. This collaboration was influenced by the coordination mechanisms in place, such as the Regional Development Council, which facilitated effective communication. Another important element was the way in which the policy was shaped from ground-level experience using the existing vertical and horizontal mechanisms, including intersectoral working groups at the national level with members from the local and regional levels.

As well as establishing policy priorities, maintaining them at the national and regional levels was essential to the continuity of interventions and their ability to have an impact. During the development of Programme MURA, the Slovene Government changed from centre–left, to centre–right and back to centre–left. Throughout these political changes, the focus of regional development continued to be on improving the social determinants of health through economic incentives and on keeping the issue a national priority. Two factors played a role. Firstly, despite government changes, the majority of ministry officials kept their positions. This meant that the experience and knowledge of the key policy entrepreneurs was not lost and that they could continue to build momentum for tackling regional health issues. Secondly, increased international awareness of the problem of health inequity and the attempts of Programme MURA to tackle this issue at the regional level ensured the continued support of the Ministry of Health. In 2006, Programme MURA won the WHO award for good practice in intersectoral investment for health, raising the profile of the programme at the international level. The publication, *Investment for health and development in Slovenia: Programme MURA* (2008) *(37)* contributed to spreading awareness about the programme.

[10] The key people involved were the Dean of the Agricultural Faculty at the University of Maribor, a senior policy advisor in the Ministry of Education and an expert in the Regional Institute for Agriculture and Forestry.

6.2 Changes in policy environment

Over the course of this case study, international interest in practical examples of intersectoral action for health increased as did international discourse on policy to tackle the social determinants of health inequity.

The sources of funding Programme MURA have changed over time. The Ministry of Health has provided continuous financial support, which has enabled the programme to share its experiences with other regions of the country. Direct regional funding for the programme was discontinued after 2006 but funding from EU cross-border grants for the period 2007–2013 became accessible for the further development of projects in the areas of health promotion and the determinants of health (for example, on hiking and biking, the development of new tourist products, preservation of nature, organic farming and active mobility). Relationships with European partners were also important; for example, the regional capacity to tackle health inequity was developed through a bilateral project with the Flemish Government and the Flemish Institute for Health Promotion and Disease Prevention, Brussels, Belgium.

6.2.1 Changes at the political level

Health policies on tackling inequity can often be vulnerable to government changes. In 2004, as a result of changes made by the newly elected government, structural funds were allocated mostly to projects dealing with the basic infrastructure, such as – in the Pomurska region – the water-supply system and roads. Prior to this, it had been a requirement that half of these resources went to social, economic and environmental development projects, such as Programme MURA. These funding changes had significant consequences for the Programme, which highlights the importance of sustained funding over a prolonged period of time. Since 2007, the Regional Council of Mayors has not matched the funding provided by the Ministry of Health for Programme MURA activities in 2004–2006.

6.2.2 The changing focus of policy measures

Over time, the focus of policy measures has shifted from large activities coordinated at the regional level to activities restricted more to the municipal level. This demonstrates the difficulty in sustaining commitment to intersectoral action in the face of competing political, social and economic issues. Until intersectoral action is embedded in the system, this is likely to continue to be the case.

During the course of Programme MURA, further evidence emerged of the gap in health levels between the different socioeconomic groups in the Pomurska region. Since 2005, the strategy has been to tackle the issue both interregionally and intraregionally. However, more recently, there has been a growing recognition of the need for a more comprehensive and systematic approach to tackling health inequity in Slovenia. This reflects national and international progress in analysing and understanding the nature and magnitude of the problem and how it varies within and between regions and population groups in a country, as well as from country to country.

Developing a national strategy for tackling health inequity was an important next step. The document prepared by the Institute of Public Health, Murska Sobota, in 2006 was, perhaps, too technical for the intended audience (politicians) since it was not adopted in full. This highlights the importance of using the appropriate language in framing an issue for debate. In addition, the process lacked intersectoral engagement and, therefore, did not involve the broader socioeconomic determinants, such as education, employment and income generation, which are crucial in tackling health inequity. It was, thus, difficult for the Ministry of Health to proceed with the debate.

6.3 Key achievements of Programme MURA

This section highlights some of the key achievements of Programme MURA in terms of influencing the regional and national policy agendas with regard to health inequity.

6.3.1 Regional level

Perhaps the most significant achievement has been the development of a clear understanding of the concepts of investment for health and health equity across the sectors in the Pomurska region. As a result, structural changes have been made in two areas related to socially determined health inequity, namely education and employment. This has lead to an increase in the capacity required for planning systematic action to tackle it.

There has been an increase in the number of health issues included on the political agenda at the regional level. For example, measures for tackling health inequity and social inclusion have been included in regional and municipal development plans, such as the *Regional development plan for Pomurska region, 2007–2013 (48)* in which health equity and social inclusion are explicitly mentioned in the strategy and budget.

An unintended but, nevertheless, beneficial side-effect at the local level came in the form of the health-promotion activities focusing on healthy lifestyles, which were carried out within the Let's Live Healthily programme *(41)*. These created an opportunity for renewed social cohesion both among marginalized groups and the general population. In cooperating with the municipal authorities in connection with these activities, it was also possible to address other health-related issues, such as alcohol and suicide.

6.3.2 National level

In 2004, the Ministry of Health, formally recognizing the importance of creating an understanding of the relationship between the social determinants of health and health inequity, began to fund projects to tackle these issues in the poorer parts of the country, including in the Pomurska region.

The *National development programme, 2007–2013 (50)* includes a target on increasing life expectancy from 74.1 years for men and 81.3 years for women, as recorded in 2005, to 74.6 years for men and 81.7 years for women by 2013. Thus, life expectancy – a traditional measure of health – was seen and is now used as a measure of development in Slovenia. It is also used in tackling health inequity within regions and population groups.

International recognition of Programme MURA as a model of integrated public health reinforced the value of the investment-for-health approach and embedded it in national policy development in Slovenia. The programme was innovative in advocating for balanced regional development and encouraging an intersectoral approach to tackling the social determinants of health, which led to the Government's extending it to other regions of the country.

Key learning

- Although there are many advantages to intersectoral policy development, its complexities present a challenge, particularly in connection with:
  - defining joint objectives;
  - measuring and monitoring outcomes;
  - achieving short-term (versus long-term) results; and
  - sharing accountability.
- One of the reasons for piloting the investment-for-health approach in the Pomurska region was to learn how these challenges could be overcome. The approach was to focus on a few priority areas – health promotion, agriculture and food production, and tourism – and to link these to employment, education and environmental issues. Due to the pressure of producing short-term results at all levels, a pragmatic approach was taken to tackling the lifestyle issues, such as nutrition and physical activity, in which civil society and other stakeholders were most interested and which they, therefore, would be more likely to support. Inevitably, this meant that other pressing public health problems, such as suicide, received much less attention.
- Embedding health equity as an important policy issue across government takes time and effort and, as an understanding of the lifstyle issues developed, that of tackling health inequity continued to gain a foothold on the policy agenda. Looking upon health as a measure of development in Slovenia contributed to softening the system during the agenda-setting and problem-defining stages.
- It is clear that national policy can benefit from using experiences gleaned from initiatives carried out at the subnational level, such as Programme MURA. Equally, such initiatives benefit from national support and commitment. A synergistic relationship between the two levels is essential to the success of each.

7. CONCLUSIONS AND FUTURE CHALLENGES

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7.1 Conclusions

The Canadian report, *Crossing sectors – experiences in intersectoral action, public policy and health* (2007) *(51)* concludes that intersectoral action is both dynamic and resource-intensive, and that it changes in nature throughout the phases of policy and programme development, implementation and evaluation. It suggests that the actors, skills and resources needed for intersectoral action vary considerably according to these phases. The experience of Programme MURA was that the principles of successful intersectoral implementation were similar to those that apply at the policy development stage, namely to:

- make use of existing structures rather than create new ones;
- facilitate shared ownership of projects with agreed aims and targets;
- use an agreed common language;
- ensure backing at the political and civil society levels;
- clearly define the mediating and coordinating roles (in this case played by Programme MURA);
- make balanced use of formal and informal communication channels.

Despite a changing political environment, it was possible to maintain policy priorities, including health equity, for the following reasons.

- The positions of the key stakeholders remained stable.
- Health inequity was gaining ground on the international agenda.
- There was an increase in international awareness of the initiatives taking place in Slovenia in the area of health equity.
- The issue of health inequity became integral to main policy discourse.
- Action to address the issue had a legitimate "home" in Programme MURA, with a clear track record, many stakeholders and formal documentation.
- There was synergy between the objectives and outputs of Programme MURA and those of major national policies and programmes, ensuring recognition of the programme's importance to delivery of the latter.

Engaging regional and municipal leaders as policy entrepreneurs in Programme MURA, which gave them a sense of ownership, was crucial to its implementation. The concept of investment for health and development was well positioned to channel investment towards a conceptually broad, programme-based approach to sustainable development rather than one comprising several unconnected projects. This was a key incentive at the time, backed not only by central government but also by EU policy. In addition, the concept was supported by the local authorities that had been seeking common goals and this enabled the development and implementation of Programme MURA.

Policy entrepreneurs at the regional and municipal levels included senior representatives of a wide range of partner organizations. They played a vital role in creating an environment in which they could engage in frank and open discussion about the goals and concerns of their own sectors and about possible areas for collaboration. The Coordinator of Programme MURA, in particular, was able to break down traditional barriers between the sectors by ensuring that every effort was made to fully understand their concerns and using a language intelligible to those working outside the realms of public health. This more informal approach was typical during the policy-development process in Slovenia.

Regional policy was implemented through established institutional frameworks with defined intersectoral objectives and responsibilities in the areas of economic, social and environmental development. These frameworks were relatively flexible and the regional partners were open to new initiatives and concepts, such as the investment-for-health approach. By engaging non-health sectors as partners in Programme MURA from the outset, the health sector was able to establish a sense of joint ownership among them, which was very important. Indeed, most of the partners did not see the programme as a threat but as an opportunity to advance their own agendas through a health lens. However, joint work towards a consensus on the priorities and actions necessary to attain the overall goal of improving the health and quality of life of the population of the Pomurska region was challenging. To facilitate collaboration, steps were taken in the health sector to increase negotiation skills and learn about the policies, priorities, initiatives and pressures of the other sectors.

Programme MURA played a central role in the development of a regional framework to address population health and in making it possible to evaluate the impact of various health policies. It has coordinated many community-based projects aimed at promoting healthy lifestyles and, in addressing the social determinants of health, has brought about structural changes related to regional development.

7.2 Future challenges

There are two key challenges for the future: (i) to convince the national policy environment of the need to develop national policy to address health inequity; and (ii) to sustain Programme MURA in less buoyant economic circumstances and a harsher political environment.

7.2.1 Policy to address health inequity at the national level

While the social determinants of health have been tackled successfully at the regional level through structural changes in the areas of employment and education, there is still a need to create a strong public health strategy or framework for tackling health inequity at the national level. The draft national strategy prepared by the Institute of Public Health Murska Sobota needs to be developed further and discussed both within the public health arena and with other sectors.

The initial strategy to encourage balanced regional development *(2,52)* has not been as successful as envisaged, although it has created a greater awareness of health inequity in general. In 2007, life expectancy in the poorer regions was 5 years less than in the richer regions; in 2001, the difference was only 3 years. This would suggest that economic growth per se does not reduce health inequity. Specific equity-oriented policies, actions and resources are required for this purpose.

The priority of the Ministry of Health in the period 2009–2012 was health reform aimed at securing better access to health services for all, regardless of social status and other differences. This involved preparing new legislation on health care and health insurance. It was considered critical to ensure that the reform would not increase inequity. Currently, there are no national health targets on health equity despite clear demand and repeated discussion on the issue. It is possible that these targets could be developed together with a public health strategy in line with the new health-care legislation. However, to do so would require much greater cohesion among the different regional centres for public health than has been the case to date.

7.2.2 Regional policy

Balanced regional development has been at the heart of regional policy in recent years. However, not all regions have included action to address the social determinants of health and health inequity

in their development plans. Programme MURA has advocated for balanced regional intersectoral collaboration and development and has been innovative in its approach to achieving it. However, in order to ensure the inclusion of health in all regional development plans, commitment is required at the national level. Furthermore, it is possible that – for political or economic reasons – the focus will shift from regional development, in which case it would be necessary to re-position discussions on the social determinants of health within the policy arena.

7.2.3 Capacity building

Training and capacity building for colaborative action within the health sector and between the health and other sectors at the national, regional and local levels are vital to ensuring a broad understanding of the importance of addressing health inequity and the social determinants of health. They are also essential to sustaining focus on these issues and as the first step towards mainstreaming health (in)equity. Although capacity building has taken place in an informal setting through regional collaboration, formal training in the investment-for-health approach is still needed. This could usefully be carried out at the level of the regional institutes for public health and regional development agencies in the first instance.

7.2.4 Global economy

As a result of the global financial crisis and slower economic growth in Slovenia after 2008, the positive social and economic trends are turning. This means that the lesser-developed regions with weaker development potential are more vulnerable and that the social determinants of health can be negatively affected. Consensus building, innovation, strong partnerships and joint agendas are even more important in these circumstances. The challenge is to argue the benefits that health-equity policies and investment for health would bring to the wider economy.

7.2.5 Sustainability of Programme MURA

So far, the programme has demonstrated that it can withstand changes in national government and funding mechanisms. This can be largely attributed to the strong support shown at the regional and municipal levels to addressing the social determinants of health and adopting the investment-for-health approach. The Pomurska region now has its own strategy and action plan *(49)* for addressing the health gap, which are integrated in the *Regional development programme 2007–2013 (48)*. The implementation of the strategy *(49)* depends very much on the national priorities and the allocation of structural funds at the regional level. The role of the policy entrepreneurs continues to be important. Although some of those originally involved have moved to other positions, others remain interested in taking the agenda forward. Thus, there is scope for optimism.

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ANNEXES

Annex 1. Programme MURA: overview of partners and coordinating mechanisms

Partners/coordinating mechanisms	Participants	Role/results	Decision-making powers
Interministerial working group comprising representatives of the Pomurska region, 2004–2006	Those involved in governmental project on health and sustainable development in the Pomurska region	Plays a political and strategic role in directing and accelerating development in the region	Members have decision-making power and leverage only over the resources of their own sector
Regional Programme Council Accepts new members based on their interests. Coordinated by manager of Programme MURA	Representatives of 25 regional organizations	Strategic and operational role Developed foundation and pillars of Programme MURA Has established four working groups	The Council decides the content and priorities of Programme MURA
Working group on the integration of health into the national development programme and other strategic government documents (Ministry of Health)	Representatives of various national and regional health institutions, 2004-2006	Analyses non-health-sector policies through a public health lens, proposes relevant changes and prepares the health content of the national development programme	No decision-making power
Institute of Public Health, Murska Sobota	–	Plays a key role in the development of Programme MURA Coordinates a wide regional-partnership network (see Fig. 5)	Directly responsible to the Ministry of Health. No decision-making power
Regional Development Agency Mura Ltd	–	Supports municipalities in intersectoral priority-setting, project and programme development, and investment planning for regional development	Responsible to the Regional Council of Mayors Serves as the regional counterpart to the national office for local self-governance and regional policy No decision-making power
Centre for Health and Development	–	Responsible for the promotion of policies, programmes and projects that will have a positive impact on the economic and social development of, and the health and quality of life in, the Pomurska region Coordinates and develops the implementation of interdisciplinary projects Coordinates the regional partnership network (with the Institute of Public Health, Murska Sobota)	Responsible directly to the Institute of Public Health, Murska Sobota and the Ministry of Health No decision-making power

Annex 1. contd

Partners/coordinating mechanisms	Participants	Role/results	Decision-making powers
Regional Programme Council for Regional Development Programme	Mayors and representatives of public agencies, private businesses and civil society	Responsible for the preparation of the regional development programme	Had decision-making power in 2000–2005, which was then ceded to the Regional Council of Mayors
Regional Council of Mayors	27 mayors	Responsible for the management of municipal assets and local public services (primary education, primary health care, certain social services, municipal infrastructure, etc.)	Decision-making power over the regional development programme, regional development priorities and the investment and allocation of regional development funds

Annex 2. Goals for reducing interregional and intraregional health inequities

Goal	Aims	Objectives	Targets
To reduce interregional and intraregional health inequity in Pomurska region	To raise awareness of health (in)equity at the community and individual levels	To increase the awareness and responsibility of regional stakeholders about health (in)equity in the region and about the importance of good health to regional development	
		To integrate health, as a value to other policies, in the regionally approved programmes of other sectors	To ensure adoption of the strategy on reduction of health inequity by regional stakeholders
			To enhance inclusion of health in the policies, programmes and activities of other sectors
		To increase the awareness of the local population about the importance of taking responsibility for own health and to motivate participation in local activities to this end	
		To support the evidence base on health inequity and health promotion	To develop of statistics on health inequity
			To gather information on the effectiveness of health promotion
	To increase community health-promotion capacity	To improve the health-support network of local institutions, NGOs and individuals	
		To enable community participation in decision-making processes	
		To encourage the use of existing community resources for well-being	
		To improve the capacity of professionals and lay-workers for health promotion	To enhance the capacity of public health professionals in the area of health promotion
			To improve the capacity of the health support network and lay workers in the area of health promotion
	To reduce interregional inequity through health-promotion activities	To encourage healthy lifestyles	To encourage healthy nutrition
			To increase the amount of daily moderate physical activity in the population
			To encourage drug-, tobacco- and alcohol-free behaviour among young people
			To encourage road safety
			To encourage environmentally supportive healthy and safe lifestyles
		To enhance social well-being the population and individual levels	To increase well-being in the community
			To increase social well-being in schools
		To enhance early detection of NCDs	To educate people to recognize early signs of disease and to seek advice
			To increase the use of early-disease-detection services

Annex 2. contd

Goal	Aims	Objectives	Targets
To reduce interregional and intraregional health inequity in Pomurska	To reduce intraregional health inequity by supporting vulnerable groups	To increase the early utilization of prenatal services by pregnant women in different risk groups (Roma, single mothers, women from socially deprived environments, etc.)	
		To encourage smoke-free pregnancy and a smoke-free environment for children	
		To encourage healthy nutrition in pregnancy and childhood	To encourage healthy nutrition in the home environment
			To increase the supply of healthy nutrition in schools and institutions
		To encourage self-esteem and healthy behaviour in school dropouts	
		Increase the skills of the unemployed	
		To encourage social contacts among, and the mobility and independence of, the elderly	To encourage the participation of the elderly in the community
			To improve the capacity of family members and friends to provide home care
			To promote safety in private environments
		To support measures to improve the health of individuals with special needs	To encourage healthy lifestyles in individuals with special needs
		To encourage healthy behaviour in minority and ethnic groups	To render health-promotion activities linguistically accessible to the Hungarian minority
			To mobilize the Roma community on health issues using the empowerment approach
			To identify the health needs of the Roma
			To increase the level of culturally appropriate health promotion for the Roma community
			To increase the use the preventive health-care services by the Roma
	To support measures towards a healthy environment	To encourage environment friendly behaviour	
		To encourage environmentally friendly policies at the local level	

Annex 3 . Summary of tools and mechanisms used in the policy process

Policy stage	Tools and mechanisms
Agenda-setting	Government receptivity to addressing health inequity Criteria for EU accession Regional policy framework Institutional, intersectoral framework for the implementation of regional policy: flexibility and openness to new ideas EU structural funds Skills, knowledge and commitment of policy champions International evidence demonstrating link between poor health outcomes and socioeconomic status Ministry of Health focus on public health and health promotion
Securing resources	Support at political level Increasing international interest in the investment-for-health approach Technical support of a credible international organization (WHO) Ministry of Health support Increasing international awareness about Programme MURA as a positive example of intersectoral collaboration Willingness of partners to contribute resources EU structural funds
Building partnerships	Willingness of other sectors to incorporate health in their agendas Open dialogue between sectors using a common language Understanding of the needs, pressures, objectives, initiatives and planning cycles of other sectors Communication, negotiation and advocacy skills of those involved Knowledge of people involved International evidence of “what works” in addressing the social determinants of health and health inequity Clearly define roles and responsibilities of partner organizations Transparency
Planning and implementation	Structures for sharing lessons learnt and good practice from project to programme level Vertical and horizontal sharing of ideas (within the health sector and across sectors) The media Capacity-building

Annex 4. Programme MURA: countervailing forces

Policy stage	Countervailing forces
Agenda-setting	Government focus on other priorities Pressure to produce short-term results and “quick wins” resulting in the neglect of other public health issues, such as suicide The over-technical nature of the draft national strategy for tackling health inequity (2006) Lack of understanding of other sectors’ priorities and decision-making processes
Securing resources	Decisions made at the regional level on the allocation of structural funds Transfer to basic infrastructure of funds previously allocated to development programmes The global financial situation The legislative requirement of pre-financing for most projects (resulting in the inability of small organizations and NGOs to participate)
Building partnerships	Agreement on measuring objectives Issues of accountability Individual interests
Planning and implementation	Short time-scale for project implementation (often only one year or less) Language issues (terminology differs from sector to sector) Lack of tradition for evaluation, reporting and monitoring at the intersectoral level Limited financial and human resources at the local level (especially in municipalities)

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