

shaping health



Exchanging on social power in health

Learning from international experience on approaches to community power, participation and decision-making in health

Case Study: Pomurje Region, Slovenia



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July 2017

Produced within the Shaping Health programme led by the Training and Research Support Centre (TARSC).

With support from a grant awarded by Charities Aid Foundation of America from the Robert Wood Johnson Foundation Donor-Advised Fund



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Cite as: Beznec P, Maučec G, Nemeš S, Nemeš D (2017) 'Case study: Pomurje Region, Slovenia' in the Shaping Health programme on Learning from international experience on approaches to community power, participation and decision-making in health, Centre for Health and Development: Murska Sobota, TARSC: Harare, July 2017.

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This case study report is produced within the 'Shaping Health' research programme led by Training and Research Support Centre (TARSC), supported by a grant from the Robert Wood Johnson Foundation Global Ideas Fund at CAF America. The views expressed here do not necessarily reflect the views of TARSC, CAF America or the Robert Wood Johnson Foundation.

Cover photo: Youth activities © CHD 2013. The authors obtained permission for all the photos used in the report.

Acknowledgements: Thanks for country-level peer review by Tatjana Buzeti, MoH Slovenia. Thanks to Rene Loewenson, TARSC, for review and edit, and Sarah Simpson for external peer review. Thanks for copy edit by V Tyson.

Executive Summary

This case study in Pomurje Region, Slovenia, presents how active citizenship has promoted health as a potential contributor to development and vice versa, how to use development processes to promote health. The case study was implemented within the Shaping Health project led by Training and Research Support Centre (TARSC), with support from the Robert Wood Johnson Foundation Global Ideas Fund at CAF America.

Pomurje Region is one of twelve regions of Slovenia, situated in the northeast, it borders with Austria, Hungary and Croatia. Since the independence of Slovenia in 1991, it has been one of the least developed and most deprived regions in the country, with the lowest GDP and highest unemployment. It also has the worst health and lifestyle indicators in Slovenia.

This is why the Slovenian government, especially the Ministry of Health, the Regional Institute of Public Health and the regional development agency, with strong support of WHO, initiated a project to reduce health inequalities in Pomurje. This was implemented through different programmes, starting with Programme Mura in 2001. The programme used an 'investment in health approach'. A governmental Project Group for Health and Sustainable Development in Pomurje asked the Ministry of Health to propose establishment of an interministerial working group to co-ordinate the work of different ministries in the field of investment for health and development in the region. The intersectoral working group included representatives of involved ministries, especially health and economy, and a representative of Pomurje regional development agency. It analysed the situation in individual sectors, development possibilities and initiatives and proposed measures to improve and monitor action on health and development within Programme MURA. Backed by legal reforms for balanced regional development, and by political and WHO support, with the inclusion of health as one of the three regional priorities, Programme Council Mura and Centre for Health and Development (CHD) were established. A Regional Action Group (RAG) provided for wide participation of all groups. The assets, resources, capacities, interests in the region were used to identify and prioritise actions that had an impact on health and health equity. Taking this into account, agriculture, tourism, health and environment were prioritised.

The practices covered in the case study are about participatory intersectoral co-operation of regional stakeholders for investment in health and development through regional development programmes. From the beginning, the question was how to promote health as development potential and, vice versa, how to use development processes to promote health and wellbeing within the framework of regional development planning agenda. Our region is the first in Slovenia that is putting health on the regional development process agenda as a development opportunity.

Through cross-sectoral collaboration we established a Regional Action Group (RAG) for tackling health inequities and putting health on the development agenda from the already existing cross-sectoral Programme Council Mura. The RAG is an informal partnership. All members are equal, there is no higher authority and everybody has a voice on proposals, views and opinions. It has only one decision-making body, the assembly, consisting of all members each with one vote. It has four working groups that decide their own rules and process reflecting the four key action areas above. Each working group has a leader, a specialist or expert in the field of the working group, and a co-ordinator from the co-ordinating body, Centre for Health and Development (CHD) Murska Sobota. Elected by the assembly, the president of RAG holds a diplomatic and advocating function, not a decision-making function. All decisions are made in working groups within RAG or at the general meetings. It is an informal, open structure and everybody can come or leave the RAG if they wish.

The health system is part of this intersectoral regional stakeholders' group, the initiator of this practice and a knowledge provider. In some areas of work, it implements programmes and projects aimed at improving regional determinants of health and general wellbeing of the population. The four key action areas for health and development in Programme Mura include: creating new jobs; creating healthier environments for the population and healthy tourism, such

as by moving towards more non-motorised forms of mobility; promoting healthier lifestyles; and consuming healthier foods from local production. The CHD with relevant stakeholders develop the decisions and outputs from the working groups, and the RAG assembly writes them up into formal proposals. These proposals are presented to the Regional Development Agency and Regional Development Council (RDC), within the review and planning process these bodies apply to prepare and decide on the regional development plan and other directly funded projects. The proposals presented by the RAG have been integrated into these adopted programmes, with the acknowledgment of the RDC. Through CHD, the RAG has been officially designated as the expert body for setting priorities for improving health and social inclusion in the region.

The case study describes the actions undertaken in line with the RAG proposals. For example, the local farm community now supplies schools and kindergartens in the area with locally grown produce, incentivised by public procurement systems oriented towards preferring healthier choice, set at national level. 'Green procurement' in education (schools, kindergartens) and the health sector (hospitals, primary healthcare centres, rehabilitation centres) is practised in settings where a healthy diet is most needed. In a 'healthy tourist offer' programme, described below, local foods are sold in tourist sites, generating jobs in food processing and gastronomic sectors. The healthy tourist offer connects different local actors with the tourism industry, in partnership with the municipality, creating further jobs in local construction and maintenance industries. The infrastructure developed is used by tourists and by local inhabitants, improving opportunities for healthier lifestyles for all. The healthy tourist offer includes locally produced (healthy) foods that demonstrate culinary diversity, prepared and served as local specialties; cooking courses for tourist providers in hotels, tourist farms, restaurants, using healthy local seasonal produce; and working with civil society associations.

Various measures have also been implemented for healthy environments, ranging from building long-distance heating systems based on biomass to efficient energy use (insulation of buildings to reduce energy consumption), use of renewable resources of energy (biomass, sun, water, wind and geothermal energy) and social measures such as promotion of active mobility to reduce traffic from commuters or delivering children to schools and kindergartens and promote people's physical activity.

Formal evaluations, health monitoring surveys and key informants indicate that the work has led to job creation, recreational and healthcare infrastructure, access to rehabilitation for elderly people, increased consumption of fresh fruits and vegetables, reduced use of animal fats in cooking, and reduced smoking and consumption of unhealthy foods, such as fried foods, sweets, beverages, and salt, and an increase in recreation activities and exercise. KIs also saw institutional changes as positive outcomes, in terms of intersectoral co-ordination and participatory RAG processes.

Various features of the work may be usefully applied in other settings, including: establishment of an informal cross-sectoral and multi-stakeholder body to link social participation in health to social participation in local economic activities; linking the outcomes of this informal mechanism to formal decision-making structures; and using clear and measurable goals and evidence and a criteria of impact on health equity to support priority setting and collaboration. A [toolkit](#) for gathering and using evidence and [learning from its use in various processes](#) at local and [regional levels](#) is available. The RAG Mura approach was facilitated by social support for social cohesion; capacity building of all stakeholders in social determinants of health backed by evidence from assessments; support from institutions and policy actors at local, regional and national levels and from WHO; the sustained commitment of CHD to support the processes and the recognition of RAG proposals in the regional development plan in the regional development council.

Other regions in Slovenia have already adapted specific elements of Programme Mura, and the national level has a key role in supporting the transfer of tools, mechanisms and capacities for this. In the Health Equity 2020 and with WHO, we have committed ourselves to share the learning experiences and knowledge from this project more widely.

1. The case study site

Pomurje Region, the location of this case study, is situated in Slovenia, in Central Europe, a country that gained its sovereignty after the breakup of Yugoslavia in 1991. Pomurje Region is one of twelve regions of Slovenia and is situated in the northeast, bordering Austria, Hungary and Croatia.

Figure 1: Slovenia in Europe



Source:
<http://keywordsuggest.org/gallery/768089.html>
 (accessed 16 January 2017).

Figure 2: Slovenian statistical regions



Source:
https://upload.wikimedia.org/wikipedia/commons/3/35/Statistical_regions_of_Slovenia.PNG

The case study presents the experiences of participatory intersectoral co-operation of regional stakeholders for investment in health and development through regional development programmes. It explores participation within the context of WHO Investment for Health and Development and Health in All Policies' approaches at local and national levels. The health system is part of the intersectoral regional stakeholders group and is the initiator of this practice or co-operation and its knowledge provider. It is the implementer of different programmes and projects aimed at improving determinants of health of the region and general wellbeing of the population. It involves regional primary healthcare centres, the responsibility of municipalities, the regional hospital and regional unit of National Institute of Public Health (RNIPH). The case study presents how this programme developed through active citizenship and government involvement in public policy debates.



Mojca Breščak, co-ordinator of Regional Development Council Murska Sobota © CHD 2017

Pomurje was the first region in Slovenia to put health on the regional development agenda. The case study describes the cross-sectoral Regional Action Group (RAG) as a mechanism for participation in tackling health inequities and putting health on the development agenda. It was implemented within the Shaping Health project led by Training and Research Support Centre (TARSC) entitled 'Learning from international experience on approaches to community power, participation and decision-making in health' that includes five sites in the



Stanka Dešnik, director of Public institute Goričko Nature Park © CHD 2017

USA and case studies from twelve sites in twelve selected high-, middle- and low-income countries, with support from the Robert Wood Johnson Foundation Global Ideas Fund at CAF America.



Photos and videos of their comments left to right: (1) Viola Bertalanič, president of Pomurje Provincial Association of Pensioner's Associations and Amalija Šiftar, member of Slovene Federation of Pensioner's Associations; (2) Tatjana [Krajnc Nikolić, head of National Institute of Public Health, Unit Murska Sobota](#) and colleague; and (3) [Dejan Dravec, director of Public University – Lifelong Learning University Murska Sobota](#) and colleague, All photos: © CHD 2017

2. The context

The Republic of Slovenia extends over 20,273 square kilometres, located between the Alps, the Pannonia Plain, the Mediterranean Sea and the Balkans, and is bordered by Austria, Hungary, Italy and Croatia, as shown in *Figure 1*. In 2016, the country had 2,064,241 residents, 83.1% of whom are Slovenians (Statistical Office of the Republic of Slovenia, 2017). The country has 212 municipalities, of which 11 have the status of urban municipality, with no rural area. Ever since its independence in 1991, Slovenia has had a successful economy, especially in 1995-2008 when the annual economic growth reached 4%. By 2015 the gross domestic product was US\$29.1 per capita and three-quarters of the population were working, but there was also a 7.3% unemployment rate and 14.3% of the population lived below the poverty line (Statistical Office of the Republic of Slovenia, 2017).

Slovenia has a long tradition of regionalism and local self-government. In 2000 the country was divided into twelve 'statistical regions' (the term for administrative, territorial units used for statistics), grouped in two cohesion regions -- East Slovenia and West Slovenia. Regional development agencies co-ordinate stakeholders for planning activities. In the absence of regional governments, the municipalities have authorities that include: managing the municipality's assets, facilitating conditions for economic development, planning spatial development and managing local public services, including primary healthcare.

Pomurje's population in 2012 was 118,573 residents, or 5.8% of Slovenia's population, with 49% men and 51% women. The region has a lower population density than the Slovenian average, and includes a Hungarian minority and Roma ethnic community. The region's population below 14 years of age is 13.1%, of the total population, while those over 65 years are 17.5% of the total population (Beznec et al., 2015). Pomurje's regional capital is Murska Sobota, with 11,679 residents. The region's economy has traditionally been based on agriculture, but tourism has grown as an economic activity (Beznec et al., 2015, and see *Appendix 1*).

Unemployment in Pomurje has been high since the transition period in the 1990s. The global financial crisis hit the region harder than the average in Slovenia and there was negative GDP growth (Beznec et al., 2015). The education level in Pomurje is lower than in other regions in Slovenia and entrepreneurship is not well developed. According to a key informant from the regional development agency in 2017, young professionals trained in Ljubljana or Maribor universities are staying there to pursue their professional careers, as there are more opportunities for highly educated persons in western regions of Slovenia. Younger and older, experienced, skilled workers are leaving Pomurje for Austria and Germany, where they can find better wages

and work. This drain of skilled workers from Pomurje has further intensified a demographic change towards an aging population and higher mortality rate, suggesting that in the near future the region will be full of elderly people without community or families to support them, increasing the social and health problems and the inequities between other regions and the Pomurje population (Bez nec et al., 2015).

2.1 Social and health features

Health inequalities in Pomurje have been identified as products of all socioeconomic determinants of health, and not only of the performance of or access to the healthcare system (Buzeti et al., 2011). Lifestyle indicators vary between Pomurje and other regions (with improved or similar levels for some indicators and poorer levels for others). Health indicators are not improving at an adequate pace, and the region has amongst the widest variation between people with different socioeconomic status (Bez nec et al., 2015). Lifestyle, health behaviour and health outcomes are especially problematic for the Roma population. A universal approach to services is insufficient, and additional targeted measures are needed for those most disadvantaged and vulnerable. The Roma community, with the highest unemployment, mortality and morbidity rates, is one of these groups (Bez nec et al., 2015, and see *Appendix 1*).

A low birth rate, low fertility rate, low rate of population growth and ageing population in Slovenia also means that the elderly population has increased since the early 1990s by more than 50% (Albreht et al., 2009). Elderly people and recent retirees are a potential or actual vulnerable group, with inequities between elderly and the rest of population in the region (Group Fabrika, 2016; KI civil society, 2017). Elderly people are at risk of a slow decline into poverty and social exclusion, due to lack of social contacts, relatively small pensions, small or no family in the neighbourhoods to help them, high costs of maintaining their houses, raising the risk of their selling their property and moving to care institutions, especially for women. They have reduced mobility due to poor or relatively expensive public transport in rural areas, in a region that is largely rural with some smaller towns poorly connected to each other. Elderly people also face the risk of starting their retirement in bad health due to poor working conditions, lifestyles or social conditions that generate ill health.



Slovenia has a low birth rate....
© CHD 2013



... and an ageing population
© CHD 2016

In relation to housing quality, Pomurje has an increasing share of houses that are empty or with only one elderly person living in them. Connected to this is the problem of poverty and high use of energy due to old, energy inefficient houses. Low-income people are not able to improve the energy efficiency of their homes. Average useful floor space (m²) is 86.1 (slightly higher than Slovenia average of 80.0), while central heating levels at 74% and having a bathroom at 89% of households in Pomurje region are below Slovenia averages of 79% and 93%, respectively (Bez nec et al., 2015).

2.2 The organisation of the health and related systems

Slovenia has a well-developed healthcare system at national and municipal levels, governed and financed by central government and the Health Insurance Institute of Slovenia (HIIS). The regions have no governing authority over the healthcare system. The Ministry of Health holds responsibility for health stewardship, including health policy development, implementation and evaluation; design of health strategy; design and implementation of personal and non-personal services; financing, including capital investments in the hospital sector; and international relations in healthcare. The government owns all public hospitals, and healthcare is delivered by public institutions owned either by the municipalities or by the state, by private providers working under a concession contract, and private providers without a concession, who offer services either for out-of-pocket payment or for privately insured persons. The latter group is not common. Concessions are public contracts, ensuring inclusion in the network of publicly financed healthcare providers, agreed to for an indefinite period and with each party having the right to withdraw, with certain limitations and restrictions. The concession is necessary only for those services and for those practitioners wishing to be reimbursed for their services by compulsory health insurance and/or voluntary health insurance.

Healthcare delivery is organised at primary, secondary and tertiary levels. Primary healthcare is delivered through a network of primary healthcare centres (PHCCs) owned by the municipalities and private providers holding a concession. The healthcare system was inherited from that in Yugoslavia with some changes in a 1992 reform and is still considered by the population as a good system (Albreht et al., 2002). It has, however, recently faced an increasing number of problems due to lack of resources, demographic changes and political and professional disagreements on necessary and overdue reforms (Albreht et al., 2002, and see *Appendix 1*).

All sectors of government, including the health sector, are seen as not open to intersectoral co-operation. The reasons for this are not well researched. From our experience, the factors lie in the organisational and legal framework of public institutions that do not envisage or provide the legal framework for such co-operation, especially if officials have to work outside their disciplinary 'silo' on the topic for another sector. This leads to ministries facing difficulties co-ordinating intersectoral groups at national level. A few such groups are in practice at a formal level, and many exist rather as issue-based teams, taking up issues such as health inequalities. Most are formed or established by sectors outside the health sector and healthcare system.

The health sector has had limited success in reaching out to other sectors, even though collaboration with other sectors, such as environment, trade, industry, social care and treasury, is considered paramount. In contrast, health promotion is a broadly accepted concept, with numerous projects such as a 'Let's Live Healthily' health promotion programme yielding evidence of positive results (Krajnc-Nikolić et al., 2013; Buzeti and Zakotnik, 2008). Employers are becoming more aware of the importance of good health among employees, and the Health Insurance Institute of Slovenia has established public tenders for employers to tackle absenteeism and health at work (Beznec et al., 2015).



Promotion of healthy lifestyle: preparing healthy meals.© CHD 2012

2.3 Social participation in health

With its development policy grounded in the Lisbon Strategy, Slovenia has combined its economic growth agenda with measures to ensure social cohesion and environmental sustainability. The state works towards preventing social exclusion, particularly by influencing the

social position of the population in relation to taxation, employment and work, and through grants, housing policy, family policy, healthcare, education and other policy areas (Governmental Office for Development and European Cohesion Policy, 2015). In relation to the environment, the focuses are on the organisation of the economy, infrastructure, settlement, the carrying capacity of the environment and natural resources, and the integration of environmental issues with other sectoral policies (Government Office of the Republic of Slovenia of Climate Change, 2011).

Equity is one of the most important values for Slovenians. Since independence, Slovenia's economic development strategy has been based on sustainable management of resources and social cohesion, leading to it being one of the most equal societies in the world (World Bank, 2014). While population health has improved with economic development, the rate of improvement has varied for different social groups (Buzeti et al. 2011). The public role in health is, thus, important. People are sensitive to inequalities, especially those connected with access to healthcare and the quality of healthcare generally and at individual and family levels (Buzeti et al., 2011). The health and healthcare system are a common public topic in the media and in people's daily interactions with the system (Buzeti et al., 2011).

In relation to *formal* measures for social participation, the Constitution of the Republic of Slovenia (Official Gazette RS Nos. 33/91-I, 42/97, 66/2000, 24/03, 69/04, 68/06, and 47/13) provides that Slovenia is a democratic, legal and social state, reflecting the values and traditions of Slovenians. The legal framework enables government to adopt policies aimed at preserving universal healthcare and a comprehensive social protection system, taking care of all those who are not able to do so by themselves. The national health system integrates democratic processes in a top-down manner through elected representatives and referendums on issues that may require substantive changes. Decisions on health policy, planning and oversight, monitoring and evaluation are done in ministries supported by expert groups, taking into account input from regional council preferences and EU legislative recommendations. Decisions on interventions integrate local government and non-government input and public input.

No mechanisms are in place, however, that allow direct participation of the general public or different social groups in the national health system to respond to specific needs. Some non-government organisations (NGOs) are included in formal advisory bodies due to their work on the specific health issues or public health promotion campaigns covered by these bodies. Experts in different fields provide evidence and input to the health system and cross-sectoral approaches, raised earlier (Human rights ombudsman, 2008). According to key informants, people can make changes to the formal health system, but this involves highly time-consuming procedures calling for professional inputs and new laws. Citizens may, for example, participate directly in public debates held in the parliament on the healthcare plan, and regional-level committees of insured people have been established to provide an opportunity for the population to participate in planning and managing the health insurance system. Citizens may also participate indirectly through their representatives in parliament, in the Economic and Social Council of parliament, in the Health Insurance Institute of Slovenia assembly and council, in the councils of healthcare institutions and in health-related associations and NGOs. However, these forums face limitations as indirect forms of participation (Albrecht et al., 2002), and a key informant observed that politicians, as decision-makers, are disconnected from networks on the ground and have little interest in solutions that may not produce short- and mid-term results, a barrier that non-state actors and the public find difficult to surmount -- KI 2017.

The public can also express their demands and views on health and health policies through the media and social protests, people's initiatives and referendums. To change the Constitution, people must collect signatures of 30,000 voters, and to change a law, they have to collect signatures of 5,000 voters (Cerar et al., 2001). People can express their views and demands with the help of local politicians who work in the political groups in individual constituencies. Citizens have the right to establish petitions and other initiatives on general opinions that may influence policy or law.

Public concerns profiled in the media often raise a response from higher level officials. However, in the formal health system there is resistance to reform processes, even with constant reminders from European Commission to do so, and an insensitivity to public opinion outside political campaigning (Albreht et al., 2002). The system is controlled by the professional employees and appointed representatives from elected parties. The democratic mechanisms that give the general public an opportunity to influence decision-making, described above, are more consultative than forums giving meaningful power to make decisions (Albreht et al., 2002). This context of the lack of participation in the formal health system in Pomurje Region stands in contrast to the involvement of communities in the development programme in the region, described later in the case study.

At the local level, the public express their views mainly through locally elected representatives to municipalities, through patient agents and, as above, through website platforms and the media. Local and regional healthcare centres have councils with representatives of the public and non-governmental organisations, including representatives of: a founder (e.g. municipality) of a healthcare centre (who also appoints them); employees of a healthcare centre (who elect them by secret ballot) and insured persons and other users appointed by the HIIS. They all serve 4-year terms and may be re-appointed/re-elected. The members of council have direct influence on some decision-making processes as set by Article 28 of Health Services Act (Official Gazette RS, no 23/05 – official consolidated text, 15/08). One example is the government portal '[I suggest to the government](#)' where there is a significant debate on reducing waiting periods for specialist exams and healthcare centres.

Municipalities have a limited role in health financing, and representative input at this level is limited to the provision and maintenance of health infrastructure at the primary care level, like public pharmacies, health stations and healthcare centres (Albreht et al., 2009). The 2008 Patient Rights Act (Official Gazette of RS, no. [15/08](#)) gives individuals or users of healthcare services the right to basic information, professional help or other specific directions through representatives for patients' rights. These community agents give patients basic information, provide expert assistance and give concrete guidance mainly relating to the exercise of rights in the healthcare, health insurance and health services. Through an agent, patients or users can make suggestions, share opinions, criticism or recommendations on their services. The services are obliged to consider these inputs and answer the agent in time. A regional representative body appoints the agents on the basis of a public call for proposing candidates. Candidates are proposed by NGOs or associations working in the field of health or consumer protection, regional councils, HIIS and municipal councils. Their mandate lasts 5 years and they may be reappointed. The patient also has the right to appeal, in accordance with Patient Rights Act if they consider their rights to be violated. This law satisfies the multi-annual effort to improve protection and exercise of fundamental rights of patients (National Institute of Public Health, 2008).

Other processes in the region's health system that support social participation include:

- Community health literacy, directed by government, but often implemented through different issue-based NGOs in local communities, such as the [Pomurje Society against cancer](#) and the [Alliance of disabled societies Murska Sobota](#). These NGOs also raise awareness on issues and raise problems not recognised by the health system.
- Local assessment, identification and prioritisation of health/social determinants of health needs and priorities that trigger social policies and plans on a regional level. This involves public and NGO representatives in regional councils, including mayors and economic sectors. It is used to build public consent on which social determinants of health are to be prioritised based on evidence from assessments (Beznec et al., 2015). This is described further in *Section 4.1*.

3. Methods

The case study followed a framework and terms of reference provided by Training and Research Support Centre (TARSC). Ethical clearance was obtained from the Centre for Health and

Development and key informants interviewed gave informed consent. A document review was carried out and further evidence was gathered from interviews with seven key informants shown in *Appendix 4*. The report combines findings from the document review and interviews in describing, analysing and discussing the participation practices, processes and mechanisms; their contribution to the changes sought; the supporting and disabling factors affecting these outcomes and on what may be useful for wider application in other contexts, including in the USA.

4. Social participation in co-operation on health and development

The economic and health inequalities in Pomurje Region, noted earlier, led the Slovenian government to reduce health inequalities, especially through the Ministry of Health, Regional Institute of Public Health and regional development agencies, with support from WHO. This was implemented through different programmes, starting with Programme Mura in 2001, using an 'investment in health' approach that has, to date, implemented different programmes and actions aimed at supporting the region's economy and reducing health inequalities. For the most part, the institutional resources to deliver the interventions were already in place, but programme-specific co-ordination mechanisms needed to be created. Collaboration between the different stakeholders and design of joint work plans were made possible by setting up dedicated co-ordination mechanisms and functions at national and regional levels, described later.

At national level, a 2002 Government decision No 304-06/2002-1 mandated the Ministry of Health to establish an interministerial working group to co-ordinate the work of different ministries on Investment for Health and Development in the Pomurje Region. The working group was to have a political and strategic role in directing and accelerating development in the region. It was to analyse the situation in individual sectors, identify and assess development possibilities and initiatives, co-ordinate initiatives and measures of individual sectors, identify key development problems and propose measures for the removal of obstacles. In addition, it was to propose amendments for the improvement of development flows, propose financial measures, monitor and assess development indicators in the region and implement other strategic tasks to optimise the effects of Programme MURA. Among the members of the national programme group were representatives of all ministries and representatives from Pomurje Regional Development Agency Mura (RDA Mura). The working group was chaired by the state secretary for public health from the Ministry of Health and co-chaired by the state secretary for regional development from the Ministry of Economy (Buzeti and Zakotnik, 2008).

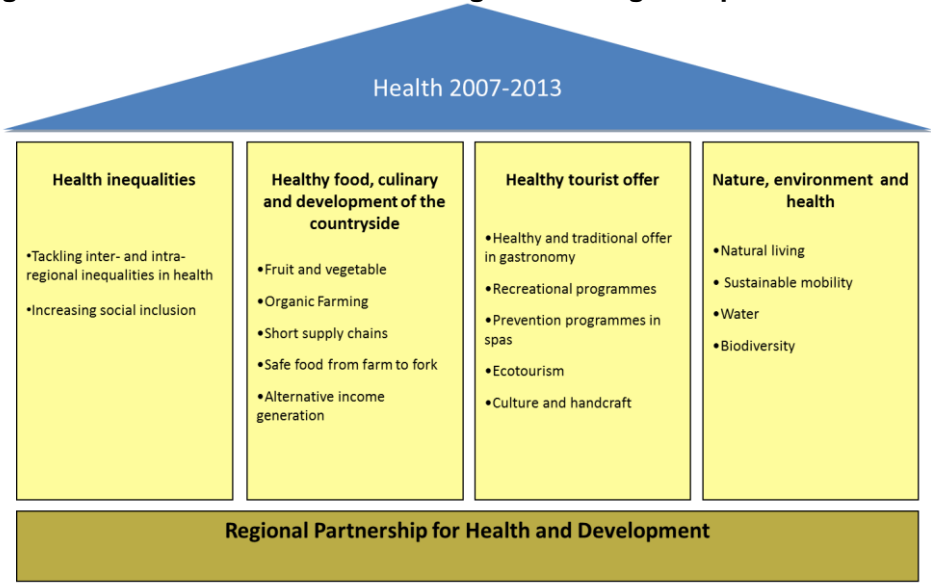
From the beginning, the question was how to promote health as a potential contributor to development and vice versa, how to use development processes to promote health and wellbeing within the framework of regional development planning agenda.

Health was thus put forward on the development agenda of the region. In 2004-2006, a new law on balanced regional development in Slovenia was identified as an entry point for this investment in health approach. With political and WHO support, health became one of the three regional priorities, beside business zones and the water system. A Programme Council Mura and Centre for Health and Development (CHD) were established. The programme council brought together members of the regional partnership network, including NGO and local community representatives. It identified actions based on the assets, resources, capacities, interests in the region, their potential impact on health and health equity and prioritised those that had the biggest potential to use health as driver for development, based on data and evidence provided by the members of the Programme Council Mura (Beznec et al., 2015).

Given the role of agriculture and tourism noted earlier, the mutual interests of agriculture, tourism and health were explored, and environment added at a later stage, to identify with the efforts of the different sectors in the region implemented through regional and rural development programmes in the three subregions of Pomurje. Regular co-operation and project partnerships between members were organised in a Regional Action Group (RAG), described in *Section 5*,

and other priorities emerged and were added at RAG meetings, with health in one form or another always factored into the development policies and strategies (See *Figure 3*).

Figure 3: The areas of work of the Regional Acting Group



Source: CHD 2007

4.1 Health issues addressed

It is well documented that the conditions in which people live and work have significant influence over their health, providing evidence that much of the responsibility for health lies outside the direct control of the health sector. Sectors including labour, agriculture, education, welfare, environment and tourism can have a major role in creating the conditions for health (Buzeti and Zakotnik, 2008). Participatory practices have thus been developed in ways that, to varying degrees of effectiveness, improve the conditions for health and wellbeing, with learning drawn from the most successful in terms of health outcomes and improved social capacities and from the mistakes made in the least successful.

For example, kindergarten teachers took part in implementing ‘The Travel Diary’ where, with the help of CHD, they test and run activities with children and their parents to help increase mobility on everyday short trips, improving the health of the residents. In this case, success was achieved when the participants continued to do so after implementation ended. Success in strengthened social participation for health and development was also identified in a community ecological garden, where CHD helped to establish the garden, partners in the project learned how to manage it and eventually a keeper was brought in to teach and support local community members on a more sustained basis how to grow and use vegetables, fruits and trees. Good practice was also seen to relate to bringing community evidence to decision-making, such as in the analysis through [surveys led by CHD of elderly people’s needs in Pomurje Region](#) (Group FABRIKA, 2016). (accessed 29 June 2017).

The identified areas for action were those with a potential to change social, economic and environmental determinants of health by creating new jobs, creating healthier environments for the population, such as by moving towards more non-motorised forms of mobility, by promoting healthier lifestyles, and growing and consuming healthier foods from local production.

These four major action areas are shown with their sub-areas in the box overleaf and *Figure 4* and explained further in this section and in *Appendix 2*.

Four key action areas for health and development in Project Mura

HEALTH, HEALTHY LIFESTYLE, involving:
Physical activity programmes, infrastructure, accessibility for vulnerable groups
Healthy diet in kindergartens, schools,
Healthy ageing
Social inclusion, social management
Mental health

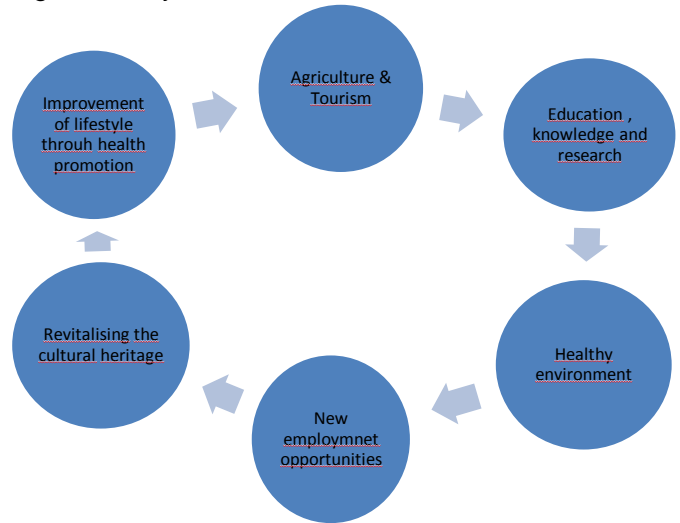
AGRICULTURE, involving:
Healthy food (organic food production)
Local food supply, short food supply chains
Social enterprises and co-ops for quality food production and processing
Fruit and vegetable production, diverse quality food

HEALTHY TOURISM, involving:
Hiking, biking, Nordic walking, active tourism (programmes, infrastructure)
Locally produced healthy food in local tourist offer
Sustainable tourism

ENVIRONMENT, involving:
Active mobility
Water resources
Renewable energy sources,
Efficient energy use

Source: Beznec et al., 2015

Figure 4: Key action areas



Source: CHD 2015

All of these areas are tackling wider determinants of health. Some, such as the work on palliative care, mental health and quality of life for vulnerable population groups, use targeted approaches for special groups in the population, such as Roma and disabled people, long-term unemployed and elderly people in remote rural areas. Some of the interventions are pilot projects that we believe have not been tried elsewhere in this form. Most, however, are actions that have evidence of effectiveness from other implementation research and evaluations in changing health determinants, such as job creation, improved recreational and healthcare infrastructure, or improving population health outcomes, such as by changing environments or lifestyles through promotion of physical activity, healthy ageing, workplace health promotion and access to rehabilitation for elderly people (Raphael, 2000; Warburton et al., 2006; Woodall et al., 2010; Health Improvement Analytical Team, 2014). They link participation in decision-making to participation in health and economic participation. They are described below and are explained further in *Appendix 2*.

Healthy tourism

We identified sustainable and environment -friendly forms of tourism that promote physical activity and consumption of local healthy foods, that enhance the awareness of local inhabitants and tourists about sustainable land use and environmental protection, and the importance of physical activity as a protective factor against non-communicable disease (NCD). We implemented a healthy tourist offer connecting different sectors of the local economy into a complex service for the tourism industry. Examples of these activities are shown in the photographs overleaf.

Given the need for infrastructure for these different activities, it has encouraged public and private investments in a healthy tourism infrastructure, creating additional jobs in local construction and

maintenance industries. This infrastructure is then used not only by tourists, but also by local inhabitants, improving opportunities for healthier lifestyles for all. The municipalities have thus seen value in partnering such projects and contributing necessary resources for the establishment of such infrastructure, as it is a wider public asset used by local residents and tourists.

Health promotion activities – Nordic walking



© CHD 2012

Health promotion activities – swimming



© CHD 2013

Health promotion activities –riding



© CHD 2013

Health promotion activities



© CHD 2014

Healthy tourism has also made a vital connection with local food production. The healthy tourist offer has generated a high demand for locally produced (healthy) foods that demonstrate a local culinary diversity, prepared and served as local specialties. Several projects included cooking courses for tourist providers such as hotels, tourists farms, restaurants, giving emphasis to healthy local seasonal produce and adding them to traditional tourist products of the region. Such demand has generated new, ‘green’ jobs, with higher value added, working with local entities such as the NGO for promotion of Prlekija ecological farmers – Vila Natura, EKO countryside, the Institute for Development of Ecological Farming and Countryside, Bioterme Mala Nedelja, SAVA TURIZEM – Sava Hotels & Resorts and the Association for the Promotion of Organic Farms of Prlekija. The resulting short food-supply chain avoids high costs of transport, decreases pollution generated by transport, promotes consumption of fresh and seasonal food and, if the food is produced in a sustainable way, mitigates the negative impact of extensive farming and food production on the environment and population health.

Agriculture and health

The risk factors for NCDs and major causes of different illnesses described earlier made the issue of food production and supply a strategic question for our work. The food that we buy in supermarkets and eat in Europe is cheap and available throughout the whole year, but comes with high externalised costs, paid by the whole community in form of environment pollution (unsustainable extensive food production, long-distance transport of food), negative impact on population’s health by chemical treatment of food for transport and processing for retail sale, as well as aggressive marketing of inappropriate food, especially to children, causing health problems associated to malnutrition (Bezruc et al., 2015).

Most of these costs can be avoided and local benefits accrued by establishing local, short food-supply chains, where possible. Creation of local markets for agricultural products produced in the area supports rural job creation, in a context where extensive farming is not an option because yields are too small for global markets. The local population is benefiting by having access to good quality fresh and healthy food options at an affordable price. This is a major priority given the concerns about food security, diet-related health problems in childhood and in the adult population and the associated costs to school performance and labour market productivity. The local farm community then supplies schools and kindergartens in the area with such produce, through public procurement systems oriented towards preferring healthier choice. These public procurement system preferences were set in Slovenia at national level (KI state, 2017) and the higher demand generated drives increased and cheaper local production. This has led to great interest in and support of the development from the local community, schools, kindergarten councils, city councils and municipalities (KIs community, 2017) Examples of the work are shown in the photos below.

The development of local food production has opened opportunities for supplying the public sector through green procurements with local food, especially in education (schools, kindergartens) and health sector (hospitals, primary healthcare centres, rehabilitation centres), where a healthy diet is most needed. This also connects with the healthy tourist offer programme, generating additional jobs in food processing and gastronomic sectors by selling locally produced food and specialties to tourist sites and to the local population. It



Food can be produced in a sustainable way. All photos © CHD 2010-2014

generates a consumption multiplier, where putting extra money in the local economy, usually from the public sector, the tourism sector and the local population, yields growth in the local economy and strengthens investment in jobs, incomes and wealth, all important determinants of health.

Environment

Our region is small and has no large cities producing major air pollution or traffic problems. Nevertheless, Murska Sobota is one of the seven cities with the highest levels of small particles (PM10) in the air, mainly because of individual wood heating in winter and traffic (Slovenian Environment Agency, 2016). Various measures have been implemented to control air pollution, ranging from building long-distance heating systems based on biomass, which is abundant in Slovenia, to efficient energy use (insulation of buildings to reduce energy consumption), use of renewable sources of energy (biomass, sun, water, wind and geothermal energy) and social measures such as promotion of active mobility to reduce traffic from commuters or delivering children to schools and kindergartens and promote peoples' physical activity. The CHD website provides [examples of how to promote active mobility in local communities](#), especially in kindergartens and schools.



Active mobility can reduce air pollution by reducing traffic © CHD 2011



Because of the wood heating in winter, Murska Sobota is one of seven cities in Slovenia that has the highest levels of small particles (PM10) in the air © CHD 2013

Water is also an important issue in Pomurje, with water supply problems during droughts and on higher grounds. This arises as the rivers run faster through Pomurje, not filling the underwater reservoirs sufficiently. Eco-remediations are applied to remedy this, to slow down the river and streams, so they can fill the reservoirs, together with flooded meadows and small lawns that support animals and plants. Chemicals from crop sprays are both poisonous to humans and are slowly reaching groundwater reservoirs with negative impact on health (Bez nec et al., 2015). To counteract this, we have promoted organic farming approaches for local production as environmentally sustainable and health promoting, further described in *Appendix 2*. When introduced, given the high level of extensive farming in the region, the proposals were accompanied with suspicion and opposition from local farmers. Over time, a growing market for such food in urban areas and tourism activities has encouraged more farmers to grow organic food (Štraus et al., 2011). Local communities have supported organic foods, particularly after organic products received subsidies for market places from a European agricultural fund for rural development drawing on the EU Common Agricultural Policy. With extra promotion, development projects began using organically produced products and public institutions procured organic foods for their programmes.

4.2 The interests and motivations for the practices

A major factor enabling the growth of support for and involvement in investments in health has been the RAG, described in the next section, as a means of building dialogue, a structured process, structured capacities for and review of cross-sectoral co-operation. An additional key factor was the substantial policy and technical support from the National Institute of Public Health, Ministry of Health, WHO Country Office and WHO Venice Office across the years on Programme Mura. They invested in understanding the capacities of the people and institutions in the region leading the work, including the concept of determinants of health.

For our region (and others in Slovenia), the possibility of regional development programming created the opportunity for autonomous decision-making involving stakeholder institutions and people concerned about the future of their own region and its inhabitants. This generates a mixture of a bottom-up approach (when assessing regions' assets and needs) and a top-down approach in terms of the framework and national priorities set by the government for the process, aligning the local programme in Pomurje for 2014--2020 with the development strategy of Slovenia. Regional programming enabled access to resources such as EU structural funding (Institute of Macroeconomic Analysis and Development, 2015). The establishment of a group of different stakeholders around health and development programming, described further in the next section, has helped to align specific sector goals with regional health goals through improvement of determinants of health. It has involved stakeholders in different projects and partnerships on a more sustained basis and reinforced their motivation.

Participants of RAG with Erio Ziglio



© CHD 2013

Inaugural meeting of RAG



© CHD 2012

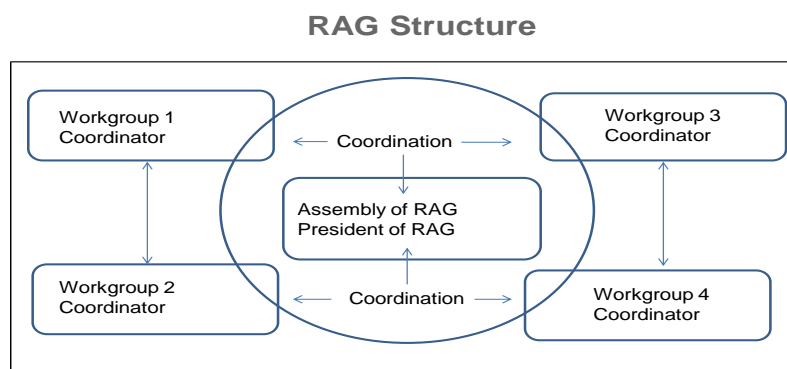
5. Processes and mechanisms for participation

The cross-sectoral and stakeholder collaboration described in the previous section was coordinated by establishing a [Regional action group Mura](#) for tackling health inequities and putting health on the development agenda, building on an existing cross-sectoral Programme Council Mura as described in *Section 3.1*. This earlier council involved stakeholders identified from stakeholder mapping by the regional public health institute, including NGOs that represent communities.

After several years of planning and implementing projects in the region, this council re-established itself in the form of a Regional Action Group (RAG), adding new sectors and social organisations to the existing ones, based on wider stakeholder mapping, such as associations of pensioners, people with disabilities, Roma community, NGO associations, long-term care organisations, local universities and media (See *Figure 5*). The full list of stakeholders in the RAG is shown in *Appendix 3*.

All stakeholders were invited to join the RAG, where they participate as a full member in every working group of the RAG they seek to join. People attending the meetings are usually from senior management of the institutions, companies, associations, NGOs, and they select the representatives in RAG by themselves in ways that align with their organisational processes, by management delegation, election in meetings and so on. There is no mandate letter necessary for representing the institution or association or for voting, but each RAG member signs a letter of intent to work within the RAG. This means that the structure is kept as informal as possible, to avoid problems raised earlier of legal and other barriers to co-operation.

Figure 5: RAG structure



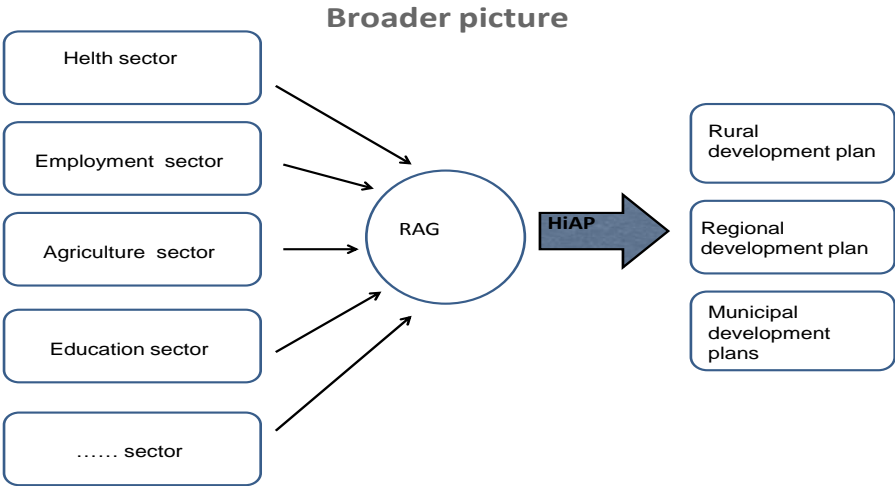
Source: Beznec et al., 2015

The RAG has only one decision-making body and this is the assembly. Each member has one vote. In the process of planning, working groups are set up and decide by themselves and by their own rules.

The role of co-ordinator to support the process is important. The Centre for Health and Development (CHD) plays this role and involves experienced staff who have skills in co-ordination of meetings, agendas, presentations and education of members, in producing minutes and the documents needed for the process. Horizontal co-ordination between members is one aspect, but there is also vertical co-ordination between local and higher levels of the system and of members. The co-ordinator needs to ensure both are implemented.

Members are organised into four working groups, each for one of the four key action areas. Each working group has a leader, a specialist or expert in the field of the working group and a co-ordinator from the co-ordinating body, together with its members. The processes applied review the evidence of the current situation and the potential areas for intervention. A [Health Equity 2020 toolkit](#) (undated) assists in the phases of work, described further in *Appendix 2*. The decisions and outputs from the working groups and the RAG assembly are developed into project proposals in meetings with the relevant stakeholders, documented by CHD Murska Sobota. The working group co-ordinator synthesises the output in a form required by the regional development programme planners and presents it to the Regional Development Agency and Regional Development Council. This process is summarised in *Figure 6* below.

Figure 6: Bringing areas of work to the development plan



Source: Beznec et al., 2015

Stakeholders have been motivated to participate in RAG Mura due to several factors. The first was an investment made in capacity building of regional stakeholders in the social determinants of health through a capacity audit and personal commitment to explain the concepts to every stakeholder needing it, using communication approaches that met their needs. For example, we listened to their agenda and goals and discussed common interests, rather than impose ‘health’ goals. We supported discussions with evidence on how their work and issues connect to health outcomes and population wellbeing. Second, with the support of national-level institutions, we built support for and involvement of the private sector, both enterprises and NGOs. We benefited from past investments in and positive values towards social cohesion. Finally, we benefited from having the sustained commitment and facilitation of an institution based in the region (CHD MS).

The capacity building process provided through the RAG has, for example, linked members of working groups with experts in key areas to provide information on concepts of social determinants of health and the role of each stakeholder in co-producing (ill) health. By applying

an equity lens to the main features of more complex theoretical concepts, such as investment for health and health in all policies, a framework provided for action on determinants of health. This capacity building is, in our view, changing participants' way of thinking, especially of their (non) involvement in health co-production, and has proven to be an effective way of sustaining the partnership over time in the RAG.

The processes, capacity building, meetings and dialogue have also raised awareness of institutions and people in the region that achieving better health means a lot more than a good healthcare system -- KIs community2017). Members of RAG are well aware of the problems in the region, and their potential to be part of the solution, even though they are not officially part of the health system. The processes, activities and progress have built a feeling of fulfilment and pride -- KIs community 2017) -- and the opportunity to be part of larger programmes in the region has sustained motivation and co-operation in the RAG on a voluntary basis, beyond the period of its direct funding by Programme Mura.

The work of the RAG is fed into more formal decision-making in the regional development council (RDC). This is the body of political representatives of the region (mayors), NGOs, private sector, minorities and development agencies. It is diverse and offers opportunities to involve general public or different groups of people with special interests. These representatives are elected among their own groups and all have the same voting rights and weight as other members. Plans are based on an analysis of the current situation using evidence from data and from different institutions in the region. The first stage is mainly evidence based. In follow-up, stakeholders are invited to present their views on the situation in the region, problems and issues and ideas on how to solve them. This input mixes technical evidence with the knowledge and experience of local people and institutions, and with learning from other regions and countries.

The RDC approves the regional development plan and certain directly funded projects. The projects presented by the RAG have been integrated in the Regional Development Programmes under different priorities, but mainly in the measures relating to:

- Measure 8: Strengthening of healthy and active lifestyle; and
- Measure 10: Access to integrated health and social services and intergenerational co-operation.

The work of our RAG has been acknowledged by the RDC, and the RAG through CHD MS has been officially designated as the expert body for priorities in regional development that concern improvement of health and social inclusion, further strengthening the participatory nature of this area of work. The action plans are also integrated in rural development plans for all three sub-regions of Pomurje.

One key informant from Regional Development Agency in charge of this process acknowledged the need for the RDC process to be as participatory and bottom-up as possible; the informant also expressed caution over creating a wish list with too many dispersed projects with low or no development impact or that may be difficult or impossible to achieve. The KI noted the challenge faced in dividing the limited resources available for implementation of the programme between different project proposals or different priorities, and the criteria for this: What is the best way to spend the resources? Which priority and what project will give us the best value for money, given that value is not measured only in financial terms, but also in improvement of people's wellbeing?

The RAG and its members may lack sufficient data or evidence to support a cost-benefit analysis of the multiple competing projects. As a result, indicators set in the operational programme for the national and regional levels are used to justify as priority projects those that are most likely to improve these indicators. This strengthens the possibility of their support in the RDC and the potential for them to be funded from other resources in the Regional Development Plan. Basing the proposals for closing health inequalities on the needs of the region and the capacities in the region to fulfil them and aligning priorities to the regional and national plans have encouraged European structural and investment funds to finance them.

Finally, the Ministry of Health of Slovenia and WHO Europe have played a further supporting role through exchange of knowledge and experiences with other countries and regions to share new developments and approaches in the areas we have prioritised. CHD Murska Sobota has become a WHO Collaborating Centre for intersectoral approaches to investment in health, and pilot actions, processes and methodologies of our work in the region are documented and shared with other countries and regions, and vice versa, we access developments and evidence from other parts of the world.

6. The positive features and challenges for social participation

6.1. Features facilitating participation

The RAG Mura has played a key role in promoting social participation in defining, advocating and implementing the economic, social and health-related processes described in this case study. As noted in the previous section, it is community led on a voluntary basis through commitment of its members. It provides a flexible space and processes (not set in law) for democratic participation for a range of stakeholders in identifying and recognising needs, prioritising actions and engaging with formal mechanisms for inclusion in formal plans and budgets. It uses internet and social media to share reports, conclusions, invitations to meetings and other information, such as [to draw decision-makers attention to good practice examples](#), and digital media (TV, web portals) to distribute ideas through TV shows and broadcasts.

Having a process that combines carefully researched data, official data and issues raised directly by local community actors has enabled the identified needs to be seen as 'real' needs, taken from the community. [The Health in the Municipality programme](#) explains in an accessible way the evidence from the National Institute of Public Health on health and health-related issues for each municipality in Slovenia. Having such data help to avoid sometimes chaotic debates on priorities and to support a more systematic priority setting process with input from all groups.

Government and political parties influence the decisions, mainly as recommendations, as noted in the earlier section. Inclusion of social groups that may be marginalised from such influence in the RAG, such as delegates of different Roma associations (Radio Romic, Roma Culture touristic society, Roma Kindergarten) and NGOs (RDA, Caritas, Romano Kher) has made it easier to take the needs of Roma population into consideration, as their representatives make input in the working group and RAG meetings or address their needs directly to CHD. The processes enable us to find possible solutions together (the right calls, the person or organisation that can help, other organisations that want to implement some solutions to similar problems, good practice examples in other regions, and so on). CHD acts as a technical actor able to support the preparation of plans and proposals and implementation of actions so this is less dependent on the individual capacities of the members.

This constant interaction has built trust and led to other areas of co-operation on health. For example, the issue of healthy dental awareness of Roma families was raised, especially with regard to young children. Traditional information and outreach approaches through leaflets or visit cards used by the health system did not work for this. CHD met in person with Roma community members to discuss the issue, for them to meet the dentist and familiarise with him and his team. We noticed that this reduced the fear of and barrier to first visits in Roma children and improved their uptake of dental services.

As noted earlier, health services have participated in rather than led this work. Two of the four primary healthcare centres in Pomurje Region are members of RAG and are represented by an employee, delegated by the management. The health system has its own measures for obtaining public views described earlier, more recently obliged by the law and a [Directive of Ministry of Health](#) (Ministry of Health, 2015). The community has a less direct role in decision-making in

council-led decisions on primary healthcare centres, where the local community has only one of many votes, limiting their influence on decision-making. The intersectoral co-operation in the RAG has thus provided a more flexible space to meet across different actors, to express different problems and solutions. The forum provides a space for experts employed in the primary healthcare centre to make input. So far we have no information on whether the primary health sector experts have proposed any significant changes in the system based on the discussions in the forum. There is a perceived change by all RAG members in their willingness to participate in the debate of needs of other sectors and openness for collaboration in the field of health and wellbeing.

6.2 The sustainability of the processes

Key informants in the case study indicated that they would like to further strengthen community participation in policy decision-making in the regional councils, following the example of the work of RAG, to give more profile to the social conditions affecting health and how policy makers can contribute to reducing health inequalities in the long term. Despite the participatory and inclusive processes in the RAG Mura to bring problems and solutions to the table, in most cases the biggest issue afterwards is financing these solutions, affected by the processes at this policy level.

At the same time our RAG has worked in its different forms and different types of funding (or no funding) without interruption for more than 12 years. The key factors sustaining the commitment and working processes, in our opinion and from the views of key informants, are:

- *The process of establishment of the RAG itself:* In establishing a regional partnership you have to go through different stages involving potential stakeholders. Building capacities for an investment for health approach and determinants of health had a positive effect on the thinking of representatives from different sectors, including the health sector;
- *The process for setting common goals* was important in building partnerships and a core action for building intersectoral co-operation. It also provides an opportunity to search for synergies and overlapping activities and to identify gaps in different services or programmes, including and beyond health and social care;
- *Planning for continuity:* Partnerships often come together in periods of intense development planning or when project tenders come out. To avoid such campaign types of collaboration, developing an initial long-term strategy with an action plan is a key input for sustainability;
- *Ensuring participation:* In the RAG, all members are equal, there is no higher authority and everybody gets to say their proposals, views and opinions. There is only one decision-making body and that is the assembly, one member - one vote;
- *Involving decision-makers:* In the end we would like to see our action plans implemented -- the glue holding the partnership together. The ability and flexibility to create partnerships and project proposals for different tenders on different times and from different funds give our group members a comparative advantage. We have our action plan pending, and when we see a tender or programme that can contribute to financing some parts of it, we produce the project proposal as a partnership in a relatively short time. This is why we involve decision-makers in the programming, so the decisions about what to do are already made and we are not subject to a time consuming decision-making processes in the short time where there is a window of opportunity to submit a proposal.

Some key informants emphasised the importance of the partnership being informal. In fact, becoming a member is a mixture of a formal and informal process, given the minimum commitment by the institutions of a letter of intent, but one that is not legally binding. Everybody is free to come or leave, and it is mutual interest and common goals that hold the partnership together, not legal documents.

6.2. Challenges and barriers

From our perspective and as raised by the key informants in the case study, various challenges in this work include:

- Issues relating to the processes used
 - Lack of data and systematic analysis of health inequities at the regional level;
 - Monitoring and evaluation of the action plan implementation;
- Issues relating to policy levels
 - Knowing when and how deeply to involve decision-makers in the process;
 - RAG is not a formal decision-making body and can only make proposals;
 - Lack of cohesion in the region between all stakeholders when dealing with national level – when negotiating terms with national level, region doesn't stand as one, but rather as a sum of partial interests, weakening the negotiating position of the region;
 - Centralisation of decision-making in the Slovenian government;
- Issues relating to sustainability, including
 - Sustaining the commitment of institutions in the RAG;
 - Financing the RAG in the long run, whether through systemic sources, membership fees or sponsors;
 - Whether in the long run a formal or informal structure of the RAG is more sustainable and whether it should become a part of the official regional development planning structure or stay independent.

These challenges persist today. Some of them, particularly around data, reporting and higher level decision-making, are deeper systemic challenges at national level, and beyond our influence. Others are more local, such as sustaining the commitment, especially in times of crisis, where the resources are scarce and members struggle even in their own daily activities. The question of whether to become a formal structure or maintain the (semi-) informal nature of the RAG and partnerships is one that we have yet to address. The informal structure has worked well to date, but this may not work in other settings or regions, and for us too may change as changes emerge in regional development planning and financing.

Notwithstanding these challenges, in our view and from the experience of this case study, there will always be an added value in investing and applying an intersectoral approach to improve health and reduce health inequalities. This study shows that doing so strengthens partnership and participation in health because it brings together interests and positive outcomes in economic, social, health and environmental terms, each reinforcing the other. It connects social participation in health with participation in the economy and other areas of life. We will find different ways of implementing and strengthening this approach and build the capacities that are the cornerstones of such partnerships, to enable them to remain flexible enough to adapt to change.

7. Outcomes

The full results of these participatory and intersectoral practices will only become clearer over longer time frames, as they consist of numerous small steps over the years (Krajnc-Nikolić et al., 2013). Evaluations to date show a significant improvement in health outcomes and wellbeing of the population in terms of jobs, creation of recreational infrastructure, healthcare infrastructure, improving access to rehabilitation for elderly or in changing health outcomes of the population by changing their behaviour/environment. Significant changes in how the local population, businesses and public institutions view healthier lifestyles and diets have opened opportunities for local industries, such as agriculture and tourism, to benefit from this change of mindset, to farm in a sustainable way, keep water drinkable and preserve natural resources for the future (Buzeti and Zakotnik, 2008). National CINDI Health Monitor Surveys carried out in 2001, 2004 and 2008 indicate positive changes in lifestyle in the region in terms of increased consumption of fresh fruits and vegetables, less use of animal fats and more olive oil in cooking, fewer fried foods, sweets, beverages consumed, less added salt, increased recreation activities, exercise and less smoking (Artnik et al., 2012).

Key informants also observed these positive impacts, pointing to improvements in general quality of life and lifestyles, with more hikers, cyclists, children who go to school on foot, new cycling and hiking lanes and regular physical activity now part of everyday life. One key informant from the National Institute of Public Health further observed that Programme Mura has raised awareness of these issues amongst decision-makers: *we have achieved that all population in rural areas and also in general region has become much more physically active than before the program 'Let us live healthily' started --KI 2017*. The same KI noted that such changes in exercise and diets could be achieved through co-ordinated work of public health experts and other stakeholders in the region. KIs from local pensioners' associations saw Project Mura as predecessor and the RAG as a success story of a participatory process that has contributed to sustainable positive shifts in the thinking and organisation of health in the local population, citing for example, 'Clubs 65' for these activities in some municipalities.

8. Insights and learning from the case study

8.1 Key insights and learning shared from the work

We are one of the first regions in Slovenia to put health on the regional development process agenda as a development opportunity. Through cross-sectoral collaboration we have established cross-sectoral Regional Action Group for tackling health inequities and putting health on the development agenda from the already existing cross-sectoral Programme Council Mura.

The RAG has influenced the approach to regional development planning. It has provided a successful cross-sectoral collaboration and participation of various stakeholders in a local milieu, including for health and healthcare, that bring many advantages. It has made it possible to engage the professional and lay public and civil society in shaping regional development programmes. Through the RAG we have programmed interventions that introduce positive changes in the way institutions, decision-makers and populations think about health. We joined different sectors to see areas of mutual interest and how to work together for people's better health.

The approach has yielded various benefits in terms of sustaining the commitment; building cross-sectoral communication at informal levels; allowing easy adaptation of priorities and intrasectoral advocacy for health as a development driver. It has had clear and measurable goals that have enabled these processes.

We have faced challenges: data on health inequities at regional level are not analysed systemically; and, we need to address the longer term financing of the RAG through what mix of systemic sources, membership fees, different sponsors, to ensure sustained action, monitoring and evaluation of work and sustained commitment of institutions in RAG. We are debating the level of involvement of decision-makers in the process -- when to involve them and how deeply. We are also exploring what is more sustainable in the long run, whether the RAG should be a formal or informal structure, and if it should be part of the official regional development planning structure or stay independent.

8.2 Practices, measures and tools that may be adapted

As a community-driven mechanism, the RAG has proved a useful practice for wider exchange, in open, horizontal structures involving organisations, societies and civic initiatives; as a cross-sectoral mechanism beyond the healthcare system and as a flexible structure. Our experience suggests that the wider the range of involvement the better, that it include 'champions' for development planning and implementation and that the role of a co-ordinator (CHD) that collects, evaluates and presents the results of working groups in its plans has been important.

The process for establishment of RAG may also prove more widely useful:

- Assessment of needs and capacities of the region to tackle health inequities;

- Defining a concept for reducing health inequities through social determinants of health and cross-sectoral co-operation;
- Mapping stakeholders and engaging identified stakeholders with an interest on common action to tackle problems, including regional and national authorities;
- Using this to established a Regional Action Group for investment in health and development;
- Linking the informal mechanism to the formal Regional Development Programme as an entry point.

To develop action plans, we recommend this [toolkit](#) (See *Appendix 2*), developed with partners in project Health Equity 2020 (Health Equity 2020, nd.). For learning from the process various sites have useful information, including

- <http://www.euregio3.eu/>
- <http://czr.si/files/investment-for-health-and-development-in-slovenia-programme-mura.pdf>
- <http://czr.si/files/positioning-health-equity-and-the-social-determinants-of-health-on-the-regional-development-agenda.pdf>

Being a small region has enabled us to be flexible and pilot or introduce new ways of tackling health inequities. The successful and sustainable establishment of RAG Mura and of its work was possible due to various factors:

- Investment in capacity building of regional stakeholders in social determinants of health and in new ways of communication with other sectors on how these determinants are connected to health outcomes and wellbeing of the population.
- Support for cross-sectoral co-operation at national level and internationally from WHO.
- The value placed on social cohesion at local level, the involvement of the private sector and civil society, and the role of past investment in social inclusion.
- The sustained commitment of CHD MS to put health in the development agenda and the reduction of health inequalities with cross-sectoral co-operation.
- The recognition of successful RAG projects as priority projects in the regional development plan in the regional development council.

Programme Mura was established as a pilot, and an important next step would be to share the lessons learnt as they apply to strengthening the policy-making/strategy-design context at national level with reference to better policy coherence between health and development goals. This is underway in an ad hoc way for certain development priorities, but could be mainstreamed for a more focused exploration of how the Investment for Health approach/ Health in All Policies orientation could be applied to address current development priorities. There are, for example, possibilities to use policy mapping to identify opportunities for joint/ intersectoral delivery of objectives, and use of integrated Health Impact Assessment methodologies to support this. While the health sector could take responsibility for convening this review, it is important that it be done by and with other sectors (for instance, involving those ministries that signed on to the original resolution and that have been involved in implementation). The commitment to making Health in All Policies a truly sustained approach in governance for health in Slovenia would underpin this activity (Buzeti and Zakotnik, 2008).

In the Europe-wide project Health Equity 2020, we have committed ourselves to share the learning experiences and knowledge with other regions. Partly, this has already happened by offering peer support to regions in the project (Covasna, Stara Zagora, Tallin and to some extent, Debrecen) and now through the Shaping Health project, more widely.

8.3 Areas of learning from other sites

From the exchange with other sites in this project we hope to gain learning and input on specific structures/mechanisms/strategies/arrangements to facilitate the participation of local communities in making health-related decisions, whether formal and institutionalised, informal, or a mixture of both. We are interested to learn how different levels of public, non-profit and private ownership in the health system affects the prospects for and forms of local participation; to understand the participatory budgeting process used to set health spending, where residents are directly and actively involved in health-funding decisions, and to learn more about the instruments and levers

for ensuring that the voices of local populations are heard in proposals – especially those that aim to reduce health inequalities within and between regions and the difficulties faced by vulnerable or disadvantaged groups. We are keen to hear experiences of local communities' participatory practices, what mechanisms have been used to link local decision-making to national processes, what participatory, transparent processes have been effective in empowering different groups and communities to participate in decisions; what impacts have been associated with them and how they have been assessed. We would hope to understand the conditions that enabled these practices to succeed.

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Appendices

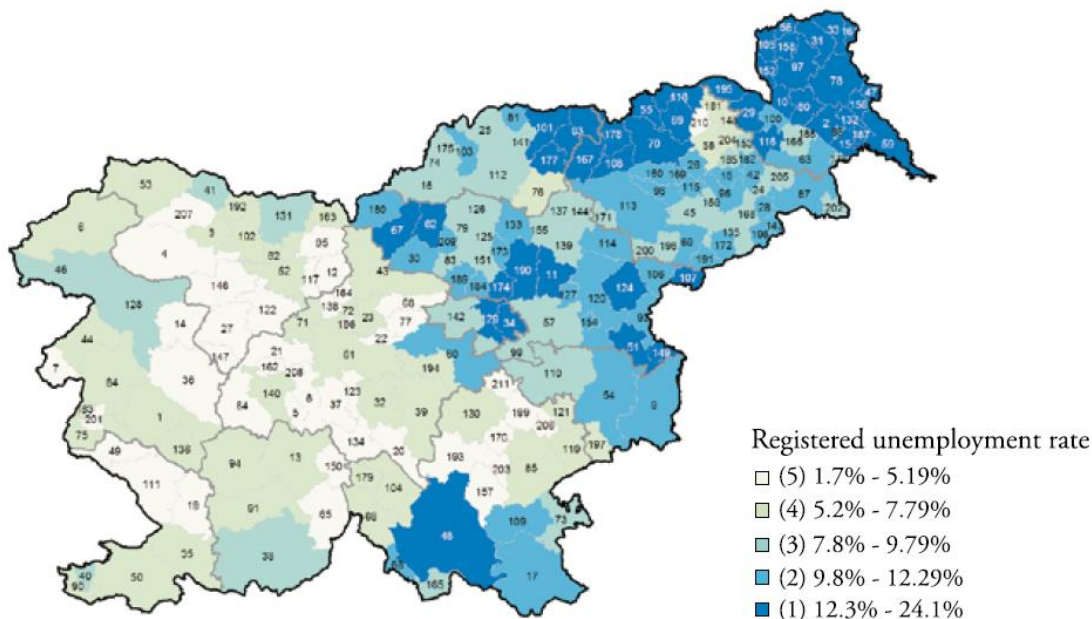
Appendix 1: Context for the case study

Pomurje region is one of the most deprived regions in Slovenia, with the highest unemployment rate (18%) in 2011 (Slovene average is 11,8%). The GDP per capita was 11 445 Euro in 2010, only 65,9% of the national average or 57,3% of EU-27 average. Education indexes show the same picture - 28,6% people have primary school or less (Slovenia's average is 20,8%), 55 % have secondary education and only 15% have tertiary education. 10,5% of the population is included in lifelong learning (Slovenia's average is 16%) (Beznec et al., 2015).

Life expectancy is lower than Slovenia average for men for 3 and women for 2 years. There is highest percentage of death from cardiovascular diseases (46,1%), highest premature mortality for men 32,4% in Slovenia (Slovenia average 29,4%). The birth rate in Slovenia is very low (2010 1,57), under EU-27 average, in Pomurje even one of the lowest in Slovenia (1,32) (Beznec et al., 2015). There is very limited data about health inequalities within the region and different life expectancy and mortality rates between different socioeconomic groups, but there is a clear social gradient in Slovenia between those with high education and those with low education. Mortality rates in municipalities with lower income from taxes (means less economic activity and higher unemployment) are higher than in those with higher income from taxes.

Although Pomurje was fairly industrialized during the 20th century, above all in textile, machinery (agricultural machines mainly), food and beverages production and tourism services, the region remains traditionally agricultural, having a large share of farmers earning a low income and above national average share of elderly people. One of the main reasons for high unemployment in Pomurje was the collapse of the textile industry in Europe in the nineties. The aftermath is still persistent since the region was not prepared on such structural unemployment, although it took several years from the beginning to the final closure of most textile factories. Because of the loss of markets in the former Yugoslavian republics and not being able to replace it adequately in the EU countries also the other traditional industries suffered a great deal. Luckily not as hard as the textile, but still significantly contributed to higher unemployment in the region, a very important determinant of health.

Figure A1: Distribution of Slovenian municipalities into quintiles relative to income tax base per capita and registered unemployment rate, 2004–2008

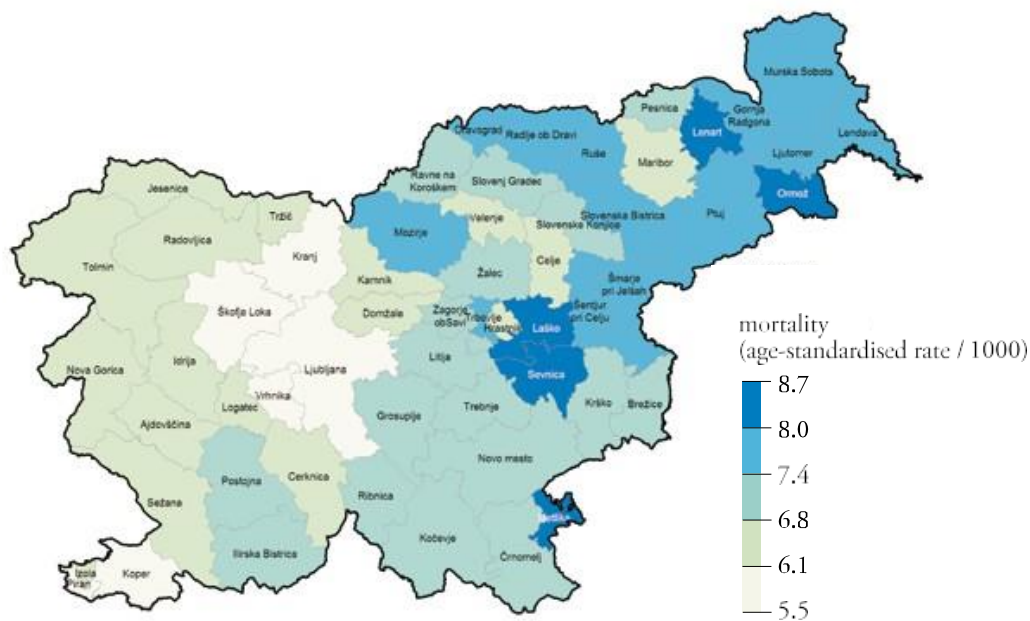


Source: Buzeti et al., 2011.

The eastern part of Slovenia has the most registered disabled people of third degree in Slovenia (9,5%), first and second degree are almost the same (first 4,7 and second 2,2) (Beznec et al., 2015). Pomurje region tackles health inequalities of disabled people through NGO's which deal with problems of one special population (for instance physically disabled recreationists), whereas there are no public institutions that would tackle inequalities of disabled people on regional or even policy level.

For most of the chronic diseases in eastern part of Slovenia the results show higher level of concern than for other parts of Slovenia. More than 46% of deaths are caused by CVDs. The most common reason for visiting primary healthcare institutions are respiratory diseases, muscular-skeleton system diseases and cardiovascular diseases (Beznec et al., 2015).

Figure A2: Mortality by Slovenian administrative units, 2005–2009



Source: Buzeti et al., 2011.

A CINDI Health Monitor survey (Artnik et al., 2012) shows that eastern part of Slovenia stated their self reported health as very good (8,8%), good (36,6), middle (42,8), bad (10,0), very bad (1,9) which presents the worst self-reported health among the three parts of Slovenia (east, central, west). Although, when answering the question “How do you take care of your health?” it is interesting that there are almost no differences between all three parts of Slovenia. The percentage of taking good care of health rises with age. The survey also shows that residents in rural communities also do not take as much care of their health, compared to residents in urban and suburban communities. Most of the people in CINDI survey answered that stress mostly contributes to bad health and high mortality (27%), physical work and bad nutrition are second in eastern part of Slovenia, whereas bad nutrition and bad living conditions are next in the Slovenia average. Access to health services is stated also as what mostly contributes to bad health more in eastern part of Slovenia than in other two parts (Buzeti et al., 2011).

In Pomurje we have more sick leaves (4,6) than Slovenian average (4,0), and if we compare other health indicators, we can conclude, that the costs of healthcare and social transfers are higher than Slovenian average. Unemployment is one of the biggest social security issues and costs, since the health insurance of those unemployed is covered by municipalities and state and they also can not contribute to health budget in the forms of contributions, deducted from wages from each employee's salary. At the same time, people that are long time unemployed are more likely to develop health condition, preventing them to re-enter labour market and are ending in vicious cycle towards poverty and social exclusion resulting in bad health and dependent on long

term care or dead. In Slovenia there is a high level of institutionalization of people in need of long term care, provided by state and municipalities.

The data in 2001, 2004 and 2008 (Artnik et al., 2012) shows a systematic increase of healthy life style in Pomurje region in general. Residents in general all lived healthier with better nutrition, more recreation and exercise and smoke less in this period (Beznec et al., 2015). All national prevention programs also took place in Pomurje region, co-ordinated on a national level and implemented mainly through primary healthcare centres and regional units of NIPH as well as hospitals and other organisations.

The present health system in Slovenia was established with the basic legislation that came in force in 1992 (Healthcare and Health Insurance Act, Health Services Act, Pharmacy Services Act, Medical Services Act). The main cornerstones of the reform introduced are: introduction of a social health insurance system; introduction of co-payments with an option for supplementary health insurance to cover them; independent position of the key groups of health professionals (physicians, dentists, pharmacists, in future also nurses and midwives); (re-)introduction of private practice in healthcare provision.

Healthcare delivery is organised classically on three levels: primary, secondary and tertiary. Primary healthcare is delivered through the network formed by primary healthcare centres (PHCCs) and private providers holding a concession. PHCCs are established and owned by the municipalities who also decide on the issuing of concessions. (Buzeti and Zakotnik, 2008). The organisational structure within the health system includes numerous actors, like various agencies under the Ministry of Health, such as the Health Inspectorate, it also includes public independent bodies, such as the Health Insurance Institute of Slovenia (HIIS), National Institute of (2008) of Republic of Slovenia which is publicly owned, and also hospitals and primary care centres. It includes also private providers of health services and various nongovernmental organizations (NGOs) and professional associations (Albrecht et al., 2009).

There are 18,9 physicians per 10 000 inhabitants in Pomurje region (Slovenia average is 25,7), 89,1 nurses with upper secondary and tertiary education (Slovenia average 84,5), 4,7 dentists (Slovenia average 6,4), 5,6 pharmacists (SA 6,1), 39,5 hospital beds (SA 47,6), more sick leave 4,6. Related to education, people with lower education visit the general practitioners or specialists more often as well as people with lower income. In terms of rural or urban the result are basically the same. Percentage of people who have never been to dentist in a year's time is highest in eastern Slovenia (10%), where there are mostly people with lower education, living in rural areas and elderly (age above 70). (Beznec et al., 2015).

The responsibility for public health lies with the National Institute of Public Health of the Republic of Slovenia, with regional units of National institutes of Public Health at regional level. These institutes address communicable diseases, health statistics and research, environmental health, health promotion and disease prevention. Implementation of national targets is co-ordinated through vertical co-operation between national and regional institutes, while the horizontal co-operation with other sectors is established on the regional as well as on the national level. In Pomurje, the Regional U-nit of National Institute of Public Health (it used to be autonomous until the merger of all regional institutes into National public health institute in 2013) is especially strong in health promotion and involvement of different stakeholders through community approach, especially in rural communities (Health in rural communities programme), resulting in positive changes in physical activities, infrastructure, social life and community capacity index level, according to the key informant from NIPH. It is not only implementation that takes place on the regional level; development of programmes, concepts and tools and research activities also represent a significant part of the work.

According to the World Health Organisation healthcare expenditure of the HIIS represented 67,1 % of total health expenditure and 92,9 % of public health expenditure in 2006 (WHO 2017). Expenditure on healthcare of HIIS in 2006 accounted for 67,1 % of total health expenditure and 92,2 % of public health expenditures (Albrecht et al.,2009). The health insurance system is

mandatory and provides universal coverage of the population (98,5 %). Contributions are related to earnings from employment. The Ministry of Health is responsible for financing health infrastructure for hospitals and other health services and programs at the national level, as well as covering health services of individuals without income, as it follows from the article authored by Albrecht et al. (2009).

The majority of the adult population, faced with the potential need to pay significant amounts in co-payments, takes out supplementary insurance, which covers expenses potentially incurred in co-payments. Since 2005, this insurance is regulated through a risk-equalising scheme, providing equal access for different population groups to the same packages of services.

The costs of bad health, health inequalities and inequalities in general are at the end not burdening only health system itself. It contributes also to the uncompetitive labour market in the Pomurje region. Sick, disabled, elderly, people with special needs are lost capital of the region, that needs to be activated, included into the labour market and we should strengthen their health and working capability with it. To achieve that, we need to invest in healthy society and environment, where living healthy is an easy and simple choice. We need to invest in disease prevention, promotion of healthy lifestyle and development of integrated services that will enable the deprived active inclusion in society and care for health. It is important, that all inhabitants take care of their health and live healthy and with that contribute to the image of a "healthy and active region" that will attract tourist, visitors and investors.

Appendix 2: Detail on the practices in the site

Healthy tourism practices

Natural and thermal resources in the Pomurje region continue to open up a variety of possibilities for the development of a high-quality opportunities for tourism. Important components of the tourist offer include cycling and hiking routes, wellness centres, a golf course, mini casinos, horseback riding, flights in gliders or light aeroplanes, local cuisine and a range of locally produced wines. 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 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 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 following example illustrates how one of these networks (Partnership networking for nordic walking) contributed to implementing the objectives of healthy tourism. 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 co-ordinated 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.

Agricultural practices

The second part of the implementation programme was oriented towards improving the demand for/procurement of healthy food products as well as the supply/production of these by local farmers. This is an investment for health in that it both increases the supply of high-quality

nutritional foods such as fresh fruits and vegetables, while also addressing employment and environment as determinants of health.

The Ministry of Agriculture, Food and Forestry co-operated with the Ministry of Health to assess the economic, health and ecological benefits of the transition to sustainable food production, and assess the need for financial, human and technological resources. The Ministry of Education and the Ministry of Health studied the existing curricula for the catering and tourism programme and upgraded them with contemporary guidelines in terms of healthy nutrition. The Ministry of Education, the Ministry of Health and the Ministry of Labour formed a coalition to secure healthy nutrition in preschools and schools for all children and adolescents. Guidelines and standards of healthy nutrition for public institutions including hospitals, preschools and schools, adolescents, old people's homes and health resorts are prepared by the Ministry of Health following the Food and Nutrition Action Plan for Slovenia 2005–2010, which delineate the national establishment of standards and norms for healthy nutrition in the organized nutrition systems, as well as the strengthened knowledge and skills and preparation of guidelines for professional staff for planning and preparing healthy nutrition for children and adolescents.

On the local level, to strengthen supply, in 2004, a consortium of fruit and vegetable producers was established through Programme Mura. It now includes 13 producers and supplies around 20 institutes. To further strengthen supply, Ecological Centre SVIT supporting organic farming practices was created by partnership of NGOs and private initiatives. The Centre provides training and resources to farmers for organic practices, and helps them develop and certify new (healthy) products with higher value added. An organic granary and mill was also established. To improve demand for healthy products from local producers, changes were advocated and adopted in the procurement practices of public institutions. The first institutions targeted were kindergartens and primary schools, which were encouraged to diversify providers and break down tender for food procurement by slots, considering green procurement guidelines (i.e., giving preference to small-scale providers within a 60-100 km radius), and selecting 2 to 3 providers by slot, thus giving more opportunity to small scale local producers. One-third (12 out of 38) of kindergartens and primary schools have made changes in this area in first two years of project.

In addition to modifying procurement practice, awareness-raising activities have been carried out to increase demand for healthy food. In more than half of all schools in the region, activities such as workshops and seminars promoting healthy nutrition in the school setting have been carried out, involving approximately 60 catering staff, 80 teachers, 300 parents, and 4 000 students.

For improving the demand and supply of healthy food products, co-operation between the Ministries of Health, Agriculture, Education, and Labour has resulted in:

- assessing the benefits of a transition to sustainable food production, and the resources required to support change (Health Impact Assessment)
- nutrition guidelines for children and adolescents
- menus and quality standards for children and adolescents
- improved healthy nutrition guidelines in catering curricula
- guidelines and standards for healthy nutrition in public institutions

To strengthen supply in the region of Pomurje, a consortium, of fruit and vegetable producers was established in 2004, and ecological centres supporting organic farming were created. The procurement practices of public institutions were amended to improve the demand for healthy products from local, and particularly small-scale, producers. Activities were supported by extensive awareness-raising programmes in the field of healthy nutrition. Increasing opportunities for higher education focused on the development of:

- higher education programme in Agricultural Management and Biotechnics
- higher education programme in Management of Tourism and related sciences
- Regional Research and Education Centre (RIS).

More work is required on the links between the outputs of Programme MURA and outcomes in terms of risk factors, morbidity, and mortality, but trends evidenced by current available data are

encouraging. Evaluation of activities has focused on assessing changes in risk factors, mainly unhealthy eating habits and a lack of physical activity. Results of the National CINDI Health Monitor Survey carried out in 2001 and 2004 indicate positive changes in lifestyle in the region (Artnik et al., 2012). People increased their consumption of fresh fruits and vegetables, used less animal fats and more olive oil in cooking, consumed fewer fried foods, sweet, beverages, and less added salt.

Practices concerning healthy environments

In terms of improving the environment, our efforts focused on supporting and advocating for the construction of a regional drinking water supply system, and the education of the general population on nature preservation and environmental protection. In protected nature areas, such as the Landscape Park Goričko, promotion of organic agriculture and ecotourism and the development of health-promoting products is underway.

The Pomurje region is facing environmental threats because of intensive agriculture and weak environmental protection measures. Priorities in this field include building a regional supply system for drinking water and establishing extended wastewater management systems. Rehabilitation measures of contaminated areas are also required. These activities should be accompanied by stronger public awareness and information-exchange activities for nature protection. Establishment of Landscape parks Goričko, Regional park Mura, Landscape Park Jeruzalem and Landscape park Negova as a part of larger biosphere reserve in Europe under European Nature 2000 net and habitat directives has been seen as essential. Currently only Landscape Park Goričko has all the necessary administrative and institutional establishments, while other natural valuable areas are under local community jurisdiction and responsibility in order to protect nature and the cultural landscape environment. Another tangible outcome of our work in this priority area is the establishment of so-called mobility centres in the regions to help relevant institutions to promote non-motorised transport and spatial planning. Last but not least, mobility capacity building and mobility awareness actions for public employees in cross-border area have been implemented.

All these processes and practices are documented and some of them publicised ([Programme Mura](#), [Health Equity 2020 report](#), [Positioning health equity and the social determinants of health on the regional development agenda](#)). With all this effort there have been significant changes in the way of thinking of local population, businesses and public institutions toward healthier lifestyle and healthier diet, that opened opportunities for local industries such as agriculture and tourism, to benefit from this change of mind-set. At the same time, we note that more and more of the land in our region is farmed in sustainable way which will hopefully keep our water drinkable and our natural resources intact in the future.

The HE2020 toolkit: a structured approach

To decide the most promising approach in a region to address socioeconomic health inequalities, priorities need to be set. The process of drawing up evidence based action plans to address socioeconomic health inequalities follows a structured approach in which four main phases can be identified. Phase 1 focuses on a needs assessment: what is the current situation in the region with respect to socioeconomic health inequalities (health outcomes and determinants) and what are the desired outcomes? The gap between these two is considered to be the needs with respect to socioeconomic health inequalities. These needs form the entry points for action to address socioeconomic health inequalities. Phase 2 focuses on the capacity audit and addresses capacities needed to address health inequalities such as organizational development, workforce development, resource allocation, partnerships and leadership. Phase 3 focuses on selecting entry points for action. With the information obtained in the needs assessment and the capacity audit, entry points for action can be identified. Actions can be selected that address these entry points or priority areas. Phase 4 focuses on impact assessment. An impact assessment of the selected actions can provide more information on the potential impact of each action and can therefore help in the process of deciding which action to take to address health inequalities. The final goal of these phases is to draw up evidence-based action plans that address socioeconomic health inequalities in the region. The Health Equity 2020 toolkit assists regions in these phases.

Appendix 3: The Regional Action Group

Figures A3 and A4: Members and Supporting Participants of RAG

1. NIJZ, OE MS – National Institute of Public Health - Unit Murska Sobota
2. Društvo za zdravo življenje Nova pot – Association for Healthy Living »Nova pot«
3. HOSPIC Murska Sobota
4. ZD LJUTOMER – Primary Health Centre Ljutomer
5. Društvo za pomoč osebam z motnjami v razvoju – Association for assistance to persons with intellectual development issues
6. ZZZS – Health Insurance Institute of Slovenia
7. SB MURSKA SOBOTA – General Hospital Murska Sobota
8. SAVA TURIZEM – SAVA Tourism, Sava Hotels & Resorts
9. ŽIVA V PARKU, ZDRAVSTVENE STORITVE – »ŽIVA V PARKU«, Health Services
10. ZRSŠ – National Education Institute of the Republic of Slovenia
11. LUMS – Public university – lifelong learning university Murska Sobota
12. Splošna knjižnica Ljutomer – Public Library Ljutomer
13. PIRA – Pomurje Educational and Development Agency
14. Hiša Sadeži družbe - Slovene Philanthropy
15. CDS MS – Centre for Social Work Murska Sobota
16. RIS RAKIČAN – Research and Educational Centre Rakičan
17. PIŠK MURSKA SOBOTA – Regional and Academic Library Murska Sobota
18. ZRSZ – Employment Service of Slovenia
19. MURSKI VAL – Local Radio »Murski val«
20. TA PÜTRA – Tourist Agency Pütra
21. MIKK MURSKA SOBOTA – Youth Information and Culture Club Murska Sobota
22. LRF POMURJE – Local Development Foundation for Pomurje region
23. LEA POMURJE – Local Energy Agency Pomurje
24. POMURSKI SEJEM – Pomurje Fair
25. ORANŽNA NIT – Centre for Education in Road Traffic Murska Sobota
26. ŠPANIK – Save Driving Centre Murska Sobota
27. DOSOR – Elderly Home Radenci
28. PU MS – Police Directorate Murska Sobota
29. PTZ – Pomurje Tourist Association
30. PGZ – Chamber of Commerce and Industry of Pomurje Region
31. RRA ZA POMURJE – Regional Development Agency for Pomurje Region
32. RA SINERGIJA – Regional Development Agency Sinergija
33. PORA - Development Agency Gornja Radgona
34. PRA – Regional Development Agency for Prlekija
35. RC MS – Development Centre Murska Sobota
36. TRS – Institute for sustainable development of local communities Ljutomer
37. JZKPG – Public institute Goričko nature park
38. EKOPODEŽELJE – EKO countryside – Institute for development of ecological farming and countryside
39. Društvo za biodinamično gospodarjenje Pomurja – Association for Biodynamic Agriculture of Pomurje
40. PEC – Pomurje Ecological Centre
41. KGZ – Chamber of Agriculture and Forestry Murska Sobota
42. Društvo za promocijo prleških ekoloških kmetij – Association for promotion of Prlekija ecological farms
43. EC SVIT POMURJE – Ecological Centre Svit Pomurje

SUPPORT PARTICIPANTS OF RAG:

1. NIJZ – National Institute of Public Health
2. MZ – Ministry of Health
3. Health resorts
4. Spas
5. Schools
6. Kindergartens
7. MIZKŠ – Ministry of Education, Science and Sport
8. MJU – Ministry of Public Administration
9. MDDSZ – Ministry of Labour, Family, Social Affairs and Equal Opportunities
10. CIPS – Vocational Information and Counselling Centre
11. CNVOS – Centre for Information Service, Co-operation and Development of NGOs
12. NGO – Non-governmental organisations
13. STO – Slovenian Tourist Board
14. TA – Tourist Agencies
15. TP – Tourist providers
16. TIC-i – Tourist Information Centres
17. MGRT – Ministry of Economic Development and Technology
18. Private Entrepreneur
19. OOOZ MS – Local Chamber of Craft and Small Business
20. Companies
21. Municipalities
22. Regional DA – Regional Development Agency
23. MKGP – Ministry of Agriculture, Forestry and Food
24. Local population
25. Natura 2000
26. Farmers
27. Organic farmers

Source: CHD 2017

Appendix 4: Key informants interviewed for the case study

1. Co-ordinator of Regional Development Council Murska Sobota
2. Director of Public institute Goričko Nature Park
3. President of Pomurje Provincial Association of Pensioner's Associations
4. Member of Slovene Federation of Pensioner's Associations
5. Head of National Institute of Public Health, Unit Murska Sobota
6. Director of Public University – Lifelong Learning University Murska Sobota
7. Director of SINERGIJA Development Agency

Changing socio-political and economic conditions and social inequalities in wellbeing within and across countries affect health in ways that call for strategic collective leadership and action.

Health services need to craft approaches that successfully prevent and care for complex co-morbidities and promote health in populations that are diverse, literate and socially connected. Participation in health and in decisions on services is increasingly viewed not simply as a means to better health, but claimed as a democratic right.

How are local health systems organising social participation and power to meet these opportunities and challenges?

There are many innovative, practical experiences and insights from those involved that we can learn from.

Shaping Health, an international project, is gathering and sharing evidence and learning on how community members are participating in decisions on and actions in local health systems across a range of high, middle and low income countries. It aims to build peer to peer dialogue and exchange on approaches and practices that can be adapted in the USA and in other countries.

This case study report is produced within the 'Shaping Health' research programme led by the Training and Research Support Centre (TARSC). The project is supported by a grant from the Robert Wood Johnson Foundation Global Ideas Fund at CAF America. The views expressed here do not necessarily reflect the views of TARSC, CAF America or the Robert Wood Johnson Foundation.



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CHD Murska Sobota
and TARSC, 2017