Co-funded by
the Health Programme
of the European Union

CHRODIS+
IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

16 Action Plans derived from Policy Dialogues

Report on learning from the 16 Policy Dialogues and Outcome Action Plans

Alison Maassen, EuroHealthNet

Lina Papartyte, EuroHealthNet

Dorota Sienkiewicz, EuroHealthNet

Iñaki Imaz Iglesia, Instituto de Salud Carlos III

Work Package 4

30 June 2020

This report is part of the joint action CHRODIS-PLUS which has received funding from the European Union's Health Programme (2014-2020)

chrodis.eu

Table of contents

The CHRODIS PLUS Joint Action

CHRODIS PLUS is a three-year initiative (2017-2020) funded by the European Commission and participating organisations. Altogether, 42 beneficiaries representing 20 European countries collaborate on implementing pilot projects and generating practical lessons in the field of chronic diseases.

The very core of the Action includes 21 pilot implementations and 16 policy dialogues:

- The pilot projects focus on the following areas: health promotion & primary prevention, an Integrated Multimorbidity Care Model, fostering the quality of care for people with chronic diseases, ICT-based patient empowerment and employment & chronic diseases.
- The policy dialogues (14 at the national level, and 2 at the EU level) raise awareness and recognition in decision-makers with respect to improved actions for combatting chronic diseases.

A heavy price for chronic diseases: Estimates are that chronic diseases cost EU economies €115 billion or 0.8% of GDP annually. Approximately 70% to 80% of healthcare budgets across the EU are spent on treating chronic diseases.

The EU and chronic diseases: Reducing the burden of chronic diseases such as diabetes, cardiovascular disease, cancer and mental disorders is a priority for EU Member States and at the EU Policy level, since they affect 8 out of 10 people aged over 65 in Europe.

A wealth of knowledge exists within EU Member States on effective and efficient ways to prevent and manage cardiovascular disease, strokes and type-2 diabetes. There is also great potential for reducing the burden of chronic disease by using this knowledge in a more effective manner.

The role of CHRODIS PLUS: CHRODIS PLUS, during its 36 months of operation, will contribute to the reduction of this burden by promoting the implementation of policies and practices that have been demonstrated to be successful. The development and sharing of these tested policies and projects across EU countries is the core idea driving this action.

The cornerstones of CHRODIS PLUS: This Joint Action raises awareness of the notion that in a health-promoting Europe - free of preventable chronic diseases, premature death and avoidable disability - initiatives on chronic diseases should build on the following four cornerstones:

- health promotion and primary prevention as a way to reduce the burden of chronic diseases;
- patient empowerment;
- tackling functional decline and a reduction in the quality of life as the main consequences of chronic diseases;
- making health systems sustainable and responsive to the ageing of our populations associated with the epidemiological transition.

Executive summary

In the Joint Action CHRODIS PLUS, we conducted fourteen national and two EU-level policy dialogues (PD). The aim of the dialogues was to identify policies or changes to existing policies and legislation that are capable of tackling major risk factors for chronic disease, strengthening health promotion and prevention programmes, and ensuring health systems are well-equipped and resourced to address the growing health challenges of chronic disease. In this report, we summarise the methodology and associated tools (a. questionnaire planning, b. reporting and action plan, c. evaluation) for organising national policy dialogues as well as highlight the lessons learnt from them. (Chapter 1)

Following an overview of all policy dialogues (Chapter 2 and Annex 8.1), we analyse the policy dialogues along several axes. Chapter 3 reviews themes and content from the national and EU-level policy dialogues and lessons learned. The topics covered by national and European PD organisers were highly diverse, ranging from water consumption and integrated care and management to tobacco inequalities and health impact assessments. Yet there were also many underlying similarities. 'Health in All Policies', health inequalities concerns, and capacity building, for instance, appeared in many policy dialogues. Along with diverse topics, national organisers also looked at different levels of governance and policy levers, from sub-national, 'bottom-up' approaches that engage local communities and end users (Malta, Ireland) to high-level regulatory changes affecting national action (Portugal, Spain, Iceland). Alignment with international initiatives was also observed in many national PDs though most referred to national programmes and laws. European regulation was predominantly cited in Spain, Malta and Portugal, referring to environmental, water and market regulations respectively.

In Chapter 4, we highlight learnings from the implementation and wider context of the national policy dialogues. The process of organising policy dialogues stimulated national organisers to identify and prioritise concrete policy actions which could be taken to address chronic disease, and gave them a mechanism which they could use to engage a diverse range of policy makers and set specific objectives and targets. As with the content, the context varied widely across countries. Some countries (e.g., Slovenia, Ireland) chose to focus on examining and revising existing policies while others selected topics (e.g., Lithuania, Hungary) at an earlier stage in the policy making process. This choice influenced the selection of policy makers and other stakeholders to participate in the dialogues, as well as the methods and materials used to prepare participants for the dialogue. Across the national action plans developed following the dialogues, some common approaches and activities were identified. These included establishing working groups, conducting pilot activities, or providing training. Two common barriers for follow-up actions included maintaining political and societal commitment towards policy dialogue objectives, as well as securing sufficient human and financial resources to continue the work.

Even though most CHRODIS PLUS policy dialogues took place before the emergence of COVID-19, the action plans have provided relevant guidance in the following categories: use of new technologies to provide knowledge and support for management and prevention of NCDs; provision of health system and community level services in safe ways for NCD patients; considerations regarding social, economic, environmental or behavioural determinants of NCDs. The importance of continuous improvement in capacities and knowledge was highlighted as a key component to produce effective outcomes in half of the PDs (Croatia, Greece, Italy, Lithuania, Poland, Spain and the two EU PDs on employment and funding). (Chapter 5)

The key learnings were gathered around a set of conclusions and recommendations (Chapter 6):

- The CHRODIS PLUS Policy Dialogue Methodology is useful and transferable to other policy research fields and policy dialogues can serve as a key step in the policy making process.
- Health promotion and disease prevention are central to policy efforts to reduce chronic disease.
- An inter-sectoral approach to health promotion and disease prevention is key to addressing chronic diseases.
- Adequate human and financial resources are necessary to accomplish objectives set out during the policy dialogues.
- Addressing socio-economic and environmental determinants of health through effective policies and practices becomes even more urgent in the aftermath of the COVID-19 pandemic.
- Health is an increasing priority at all levels which brings new opportunities but also a need for more communication and coordination across all sectors and all levels, particularly by policy makers.

Contributors and Acknowledgements

The preparation of this report was guided by EuroHealthNet, Brussels.

Additionally, we would like to highlight the invaluable contributions that have gone into preparing the Action Plans derived from the National Policy Dialogues that took place in Croatia, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Malta, Netherlands, Poland, Portugal, Slovakia, Slovenia and Spain. As well as for formulating and reporting the recommendations from the two European level Policy Dialogues (PD) that are discussed in this document.

Our sincere gratitude goes to the following authors from EuroHealthNet and Instituto de Salud Carlos III, who directly contributed to the preparation of this report: Alison Maassen, Lina Papartyte, Dorota Sienkiewicz from EuroHealthNet, who were the main writers of the report. Within this work, we are grateful for the knowledge and expertise provided by Clive Needle, Senior Policy Adviser at EuroHealthNet, to prepare the report.

We are particularly grateful to Scientific Coordinators of JA CHRODIS PLUS, Rokas Navickas and Laimis Dambrauskas, VULSK, as well as to the overall project coordinators Lorena Pinilla Navas, Teresa Corral Cantó and Mayte Moreno Casbas, Instituto de Salud Carlos III, for their dedication and diligence in reviewing this document and their continuous support throughout the project.

We would like to extend our thanks to Iñaki Imaz Iglesia from Instituto de Salud Carlos III, the WP4 leader, for his keen engagement and advice which helped us to successfully complete the task. We would also like to acknowledge with much appreciation the role of Elisa Poses i Ferrer, Agency for Health Quality and Assessment of Catalonia (AQUAS), the evaluation leader of the Joint Action, in developing policy dialogue evaluation questionnaires and analysing results. Furthermore, we are grateful to the organising institutions of national and European level Policy Dialogues: Croatian Institute of Public Health, and Croatian Ministry of Health; Aristotle University of Thessaloniki and Centre for Research and Technology Hellas in Thessaloniki, Greece; Semmelweis University in Hungary; the Health Promoting Community (HPC) team at the Ministry of Health in Iceland; Institute of Public Health in Ireland; Italian National Agency for Regional Healthcare Services and Ministry of Health in Italy; Vilnius University and Institute of Hygiene in Lithuania; Health Promotion and Disease Prevention Division at the Ministry for Health in Malta; National Institute

for Public Health and the Environment in the Netherlands; National Institute of Geriatrics, Rheumatology and Rehabilitation in Poland; Directorate-General of Health in Portugal; Ministry of Health in Slovakia; National Institute of Public Health of Slovenia; General Directorate of Public Health, Quality and Innovation, Ministry of Health and Carlos III Health Institute in Spain; EuroHealthNet, Belgium; Fondazione IRCCS Istituto Neurologico Carlo Besta, Italy; Finnish Institute for Health and Welfare (THL).

Lastly, the financial support from the European Commission is gratefully acknowledged and appreciated. In particular, we would like to thank Nicoline Tamsma from the European Commission DG Santé, as well as Marc Vandenbroeck from the Consumers, Health and Food Executive Agency (CHAFEA).

Abbreviations

AI	Artificial Intelligence
BI	Business Intelligence
DP	Disease Prevention
EIA	Environmental Impact Assessment
HIA	Health Impact Assessment
HiAP	Health in All Policies approach
HP	Health Promotion
IT	Information Technology
MoH	Ministry of Health
NCD	Non-communicable diseases
PD	Policy dialogue
SDG	Sustainable Development Goals
SWOT	Analysis of Strengths Weaknesses Opportunities Threats

1. Introduction

This chapter highlights:

- **the structure, objectives and the methodology of policy dialogues (PD);**
- **how national policy dialogues were organised;**
- **the main characteristics of European policy dialogues.**

As a response to the growing burden of chronic disease, the Joint Action (JA) CHRODIS-PLUS, a three-year initiative, was funded by the European Commission from 2017-2020. The goal of CHRODIS-PLUS is to support Member States through cross-national initiatives identified in the preceding CHRODIS Joint Action (2014–2017) to reduce the burden of chronic disease, while assuring health systems sustainability and responsiveness.

CHRODIS PLUS supports Member States in the implementation of new or innovative policies and practices for health promotion and prevention, management of chronic diseases and multimorbidity, as well as addressing social aspects such as employment. CHRODIS PLUS held fourteen national and two European level policy dialogues (PD) that committed to strengthen the development and adoption of European, national, regional and/or local health policies and strategies related to health promotion, prevention and innovative management of chronic diseases. The purpose was to use them as a vehicle to start, mature and/or advance the policy debate in the participating countries and result in tangible and relevant actions to improve national, regional, and or local policies and strategies related to chronic disease prevention and management. Initially, there were supposed to be fifteen national policy dialogues but after several unsuccessful attempts to choose the topic of the dialogue, Belgium withdrew from the task.

The national policy dialogues were a type of deliberative dialogue between key stakeholders designed to either:

a) start policy processes or
b) be embedded in and support on-going policy processes.

While European level policy dialogues aimed to find ways of improving the use of existing processes and mechanisms to address issues around chronic diseases.

Although it was not assumed that a single policy dialogue could change legislation or bring about new strategy in a vacuum, the overall expectation of the policy dialogues was to encourage effective and substantial collaborative action toward intended change and to aid the development of responsive, effective, sustainable and evidence-informed policy. The objectives of national policy dialogues varied across Member States and topics, including:

- Contributing to legislation intended to help prevent or reduce the burden of chronic diseases.
- Establishing governance mechanisms for institutional/cross-sectoral collaboration/consultation.
- Involving stakeholders from other sectors in a current issue/governance mechanism.
- Initiating a policy process related to prevention or management of chronic disease.
- Reaching consensus on tangible actions that will address the identified problem and assigning responsible actors.
- Increasing political will and engagement towards new or adapted policies.

Chronic diseases are a result of a combination of genetic, physiological, environmental and behavioural factors. Burdens of chronic disease cannot be solved solely by health departments, by ministries or even by whole governments alone. The complexity of chronic disease prevention and management requires the engagement of multiple actors across such sectors as social, environmental and health. Proposed policies and interventions to address chronic diseases can be analysed to try to avoid or mitigate unforeseen consequences and to engage all stakeholders meaningfully.

Efforts to reduce chronic disease are intimately tied to policy responses. Yet there is a broad lack of good practices in evidence-informed policy making for complex challenges such as prevention and treatment of chronic diseases. Broader coalitions of stakeholders reduce the fragmentation and 'silo' mentality that has often hampered intersectoral solutions. Given the complex nature of chronic disease prevention and management – across many sectors – a 'fit-for-purpose' policy solution will require increasing the meaningful quality participation and active engagement of a much wider variety of voices. It will also entail the use of innovative methods and tools as well as more of a focus on implementation and evaluation.

A policy dialogue is initiated to create an enabling space for discussion and facilitated debate on a previously and consensually defined topic related to existing or proposed policy. In a spirit of inclusive decision-making, engagement processes enable participation of a variety of actors and experiences from different organisations in accordance with the objectives of each specific dialogue. In addition, to deal with "wicked" problems – problems that include conflicts of goals/interests/stakes, important technical disputes, and multiple actors from several levels of government - stable and multi-sectoral coalitions are required. Building coalitions is notoriously difficult, and this difficulty is compounded within health systems as the complexity of problems and multitude of viewpoints make consensus difficult. Literature on coalitions points towards the need for careful discussion, deliberation, and debate around goals, targets and issues, an open and inclusive process, a recognition of varying levels of contribution and capacity, and transparent reporting and recording.

1.1 Methods

Fourteen National Policy Dialogues (PD) as well as two European Policy Dialogues were held during the Joint Action (2017-2020). The overview of countries where the policy dialogues took place as well as their topics are available in the overview below (Table 1). Summary reports from each national policy dialogue are also available in Annex 8.1. Initially, fifteen Policy Dialogues were planned, but one of the national policy dialogues was ultimately cancelled (Belgium) due to challenges in reaching a consensus on the dialogue topic between the two organising entities.

Table 1. Overview of national and European policy dialogues

Country	Date	Title
Croatia	December 2019	Multisectoral Approach to Reduce Burdens of Chronic NCDs
Greece	February 2018	Implementation of Integrated Care Services for Older and Chronic Patients
Hungary	February 2020	AI and BI Solutions in Medical Decision Support
Iceland	A series of meetings throughout 2018	How Health Promotion Programme Supports SDGs, especially SDG 3

Ireland	June 2018	Socio-Economic Inequalities in Tobacco Use
Italy	November 2019	Innovation Strategies for Chronicity
Lithuania	May 2019	Mental Health Literacy
Malta	September 2019	Promoting Water Consumption
Netherlands	January 2020	Promoting Walking and Cycling before, during and after Work
Poland	November 2018	Prevention of Cardiovascular and Respiratory Diseases in Older People
Portugal	January 2019	Advertisement of Food and Beverages to Children
Slovakia	October 2019	Control and Prevention of Cardiovascular and Metabolic Disorders
Slovenia	January 2020	Integrated Care in Tackling Chronic Diseases
Spain	June 2019	Health Impact Assessments
EU level	November 2019	Employment and Chronic Conditions
EU level	June 2020	Funding of health promotion and chronic disease prevention

National Policy Dialogues and the CHRODIS PLUS Policy Dialogue Methodology

A proposed procedure for the organisation of national policy dialogues was elaborated from the start of the process. This CHRODIS PLUS Policy Dialogue Methodology consists of a step-by-step process supported by key documentation. These documents were all outlined in a guide provided to national organisers.

The guide explained essential enabling requirements of the dialogues[i]. These could be outlined as:

a) Questionnaire planning (Annex 8.2)

A purpose-built questionnaire was completed by each organising partner (see Annex 8.2). There were five essential components for participants to consider:

- Clearly defining the objectives of the dialogue. This goes hand in hand with a clear vision of what outcomes and results would be expected.
- Conducting effective stakeholder and context analysis (as a part of collecting evidence-based background information) to select policy dialogue participants and main points for discussion. The participation was invitation-only and limited to build trust and ensure more frank and open flow of conversation.
- Identifying a moderator who would be able to provide effective facilitation. This was key to having meaningful and comprehensive discussions.
- Defining tangible and feasible actions or steps to achieve the expected results of the dialogue.
- Describing the potential added value of their actions to wider European efforts to prevent and/or manage chronic disease.

The national policy dialogues were conceptualised and planned based on the questionnaire. The topic, objectives and desired outcomes for each national dialogue were reviewed and refined in iterative and close collaboration with the project leaders. The topic was context-specific to the member state but there was some overlap across different countries.

It is important to highlight that the national policy dialogues were not intended as dissemination events. The main goal was to engage a small group of 'influencers' and senior change-agents in a practical and solution-oriented policy discussion. The numbers of non-essential attendees were limited in order to encourage exchange and trust and keep the discussions focused. So-called Chatham House Rules, which allow for disclosure of information without identifying the source of the information (e.g. identity and affiliation of the speaker), were followed in all dialogues to encourage frank and open discussion of complex and sometimes contentious issues. This applied to the associated reports and any communication and dissemination activities.

Following a stakeholder and context analysis, participants were selected and invited from sectors relevant to the topic at-hand and desired outcomes. They included 'influential' policymakers and key stakeholders to ensure the policy dialogue has the potential to make real practical changes to the lives of people. Due consideration was given to attracting senior officials. To help with the process and to emphasize the importance of the policy dialogue, official invitation letters were signed by the CHRODIS PLUS Coordinator. An appropriate venue was selected and the policy dialogue was conducted in the national language.

Exceptionally, in particular when it concerned an external – yet essential – participant setting out an EU background/relevance, an introductory session was conducted in English. Project leaders from CHRODIS PLUS also participated in each of the national policy dialogues, in order to represent CHRODIS PLUS and the broader sustainability objectives of the dialogues. Yet care was taken to not undermine the national ownership and trust through this 'international' intrusion. Rather, it aimed to add to the EU added value and credibility of the process.

Policy dialogue documents were sent to the confirmed participants at least two weeks prior the dialogue and included a detailed draft agenda and pre-prepared question list, as well as further background materials, as appropriate. The pre-prepared questions aimed to:

- introduce the identified issue;
- link from the broad themes to more specific topics;
- address the key/core issues which would be explored in the policy dialogue in order to elicit tangible and workable actions by the end of the meeting.

It was the responsibility of the national organiser to arrange for professional (external or internal) moderation, a rapporteur and to compile the minutes and complete the reporting documents. As needed, professional or informal translation services were also identified by the national organisers.

b) Reporting and Action Plan (Annex 8.3)

As indicated above, the policy dialogues were intended to be one key element in a broader policy making process. For this reason, it was essential that each national organiser followed the dialogue by preparing a report with the dialogue minutes (under Chatham House Rules) as well as an action plan outlining tangible and feasible next steps to address the identified problem. For each step, dialogue participants were assigned roles and suggested timelines were proposed (see Annex 8.3). Participants were also asked to demonstrate the potential EU added value of their actions to prevent and/or manage chronic diseases.

A pre-structured reporting template was provided to the national organisers in advance of the dialogue. This template complemented the national organisers and moderators in their preparations for the dialogue. All reporting templates were due back to the project leaders within one month following the completion of the dialogue. Reports and proposed action items were reviewed for clarity and feasibility.

c) Evaluation (Annex 8.4)

An evaluation questionnaire was designed and sent to participants of national policy dialogues at the end of the meeting (see Annex 8.4). The aim of the questionnaire was to assess the satisfaction of participants with the organization and outputs of the meeting, as well as compiling personal opinions about the main national barriers and facilitators to adopt the measures and recommendations discussed during the policy dialogue. The Agency for Health Quality and Assessment of Catalonia (AQUAS), the evaluation leader of the Joint Action, analysed the questionnaire results and shared a compiled report with project leaders and national organisers. The reports from each country had two main objectives:

- receive feedback about the meeting
- identify aspects that could be improved in future policy dialogues in order to generate the best discussions and outputs.

The analysis of the policy dialogues participants' satisfaction was not planned in the original set of surveys to conduct during the overall Joint Action, however, the analysis has been considered as an important and valuable tool for continuous improvement of policy dialogues and for being able to meet participant's needs and expectations. The evaluation process was an initiative between AQUAS and EuroHealthNet, and was not covered by the Grant Agreement.

While an exhaustive report of the evaluation findings was not developed, common themes were noted which came up across countries. The inclusion of key stakeholders, for instance, was crucial for the planning and implementation of new approaches. These key stakeholders included policy makers beyond the health space, such as those working in finance, marketing or education departments who were necessary for the implementation of new policy. The policy dialogues helped bridge a gap between implementation science, policy and strategic goals and the 'real world' challenges of putting change into practice. This helped to illustrate ways to make more evidence-informed policy and to highlight potential gaps in knowledge or current investment. Finally, they helped to re-establish or spark synergies between participating stakeholders and to identify the most critical barriers inhibiting the implementation of new practices. Across the evaluations, three key approaches were highlighted to break down barriers. They were: (1) knowledge that self-awareness of target population is not enough and that a multi-sectoral response and clear communications are required to spark change; (2) the necessity of forming stable working groups and 'policy partnerships' with actors involved in policy implementation; and (3) the creation of evaluation strategies to clearly monitor the effectiveness of implementation and share results with other policy makers, in order to make adjustments, as needed, and reinforce political commitment.

d) Roles

Three key roles were defined in the policy dialogue guidance. They included the national organiser, the moderator and the rapporteur. The work of the national organiser was key in each setting. Their primary responsibility was the overall design and execution of the dialogue, including selection of the topic, invitation of participants, and compiling the final report and action plan (in correspondence with the rapporteur). They also played an important role in managing the expectations of the participants by communicating the aims of the dialogue, providing background material and questions in advance of the discussion, and giving an introduction on the day of the dialogue to clarify the rules of the dialogue and reiterate its aims. The organiser

was present throughout the policy dialogue and liaised with the project leaders during the policy dialogue planning, execution and follow-up activities.

The moderator was identified by the national organisers. The moderator's role was to trigger, maintain and conclude the policy dialogue itself while directing the participants to agree on tangible actions. The role of the rapporteur was to accurately record and report the discussion of the policy dialogue. The rapporteur was tasked with clearly identifying the tangible actions that will address the identified problem. The use of Chatham House Rules, which allow for disclosure of information without identifying the source of the information (e.g., identity and affiliation of the speaker(s) and other participants), were to help establish an environment that allowed a full and frank discussion of the identified problem.

The following diagram provides a simplified illustration of the proposed CHRODIS PLUS policy dialogue process and associated documents (Figure 1). It should be noted that the optimal procedure includes a follow-up period during which the action plan is taken forward by policy dialogue participants. Given that the Joint Action budget did not foresee allocation of financial and human resources for follow-up meetings and processes, however, this step was not consistently applied throughout the dialogues.

Figure 1: The CHRODIS PLUS Policy Dialogue Methodology and associated documents

As further elaborated in this report, the CHRODIS PLUS Policy Dialogue Methodology provided a valuable framework to structure national policy dialogues while retaining sufficient flexibility to allow for a variety of topics and approaches. The documents in annex are the official versions which were reviewed and utilized by partners. Some small elements of the documents were adapted through iterative processes over the course of the project.

European Policy Dialogues

The organisation process and structure of the two European policy dialogues (PD) was more flexible which allowed organisers to freely choose how to structure the preparation of the dialogue and the way that the events were run. The topics for both policy dialogues were determined at the planning stages of the JA CHRODIS PLUS and came out either as a product of ongoing work of the CHRODIS PLUS project (e.g. EU level PD on employment) or an attempt to offer potential options for financial sustainability of CHRODIS PLUS outcomes (e.g. EU Level PD on funding health promotion).

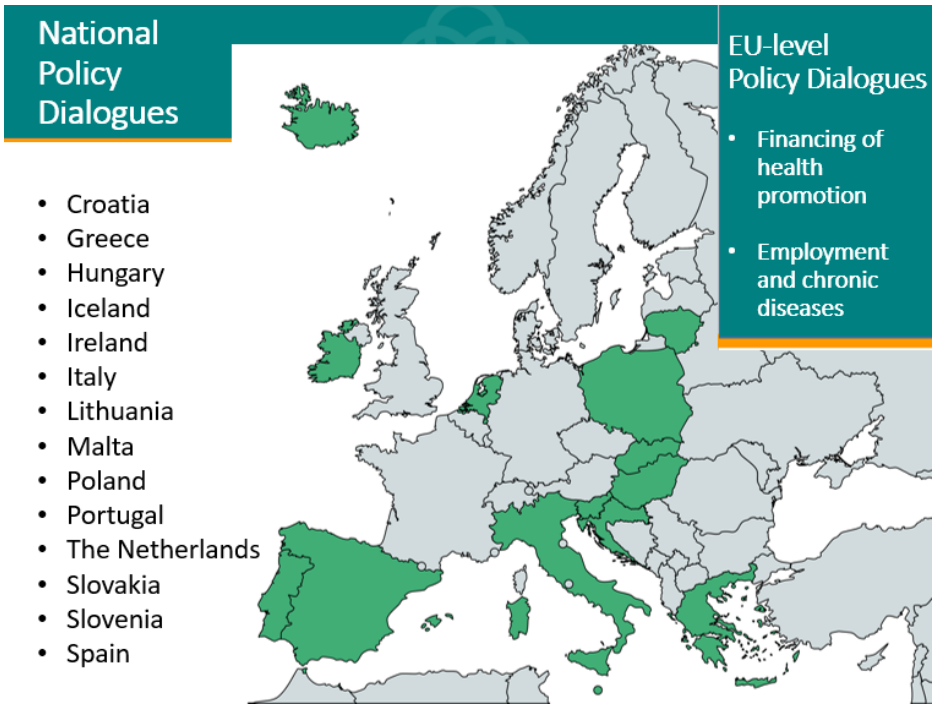
The first European policy dialogue aimed at bringing together EU stakeholders and presenting them CHRODIS Plus Workbox on Employment and Chronic conditions. The event took place in the European Parliament on November 12th 2020 and was organised like a parliamentary hearing where CHRODIS PLUS partners presented tools to analyse and improve workplace environments developed and piloted during the project, following which different stakeholders provided suggestions about how to encourage the use of those tools across Europe.

The second European policy dialogue took place electronically on June 26th looking at the sustainability of CHRODIS PLUS results in terms of financing health promotion and chronic disease prevention actions. The meeting aimed to raise awareness and encourage decision-makers to explore specific ways in which they can support the equitable financing of chronic disease prevention. The primary focus was how to foster more effective use of European Union funding mechanisms.

2. Overview of the Policy Dialogues

This chapter will provide a brief overview of subjects discussed during the national and European policy dialogues (PD) (Table 1, pg. 8). The comprehensive summary of all policy dialogues containing information about the organisers, list of participants, background information, objectives of the dialogue, main conclusions and the action points is available in the Annex 8.1. The information in this chapter and following chapters, including Annex 8.1, was developed based on the results of 'Questionnaire for the national organiser of the policy dialogue' (Annex 8.2) and Action plans (Annex 8.3) resulting from the policy dialogues[1].

Figure 2. A map showing where national policy dialogues took place



Croatia. The Croatian Institute of Public Health organised a policy dialogue on the importance of a multisectoral approach in reducing the burden of chronic non-communicable diseases. During the meeting, participants acknowledged that it is necessary to strengthen existing and initiate new cross-sectoral cooperation to achieve the implementation of the Action Plan for prevention and control of non-communicable diseases 2019-2025. At the end of the dialogue, stakeholders involved agreed to establish a multisectoral working group to monitor the implementation of the Action plan.

[1] To access Action Plans, please send a request to the Task leader, EuroHealthNet, at info@eurohealthnet.eu

Greece. Aristotle University of Thessaloniki and Centre for Research and Technology Hellas in Thessaloniki organised a policy dialogue to gather stakeholder commitment to improvement and optimization of integrated care, with special emphasis on elderly and chronic diseases patients. The ongoing primary care reform presented an opportunity to adopt integrated care services. The participants of the policy dialogue acknowledged that sustainable implementation needs to be supported by all relevant stakeholders.

Hungary. Semmelweis University organised a policy dialogue about how Artificial intelligence in national screening programs could significantly increase screening efficiency. The representatives from academia, public and private sector discussed technology assessment and related regulatory environment as well as how to ensure that products made with community resources are utilised.

Iceland. The Directorate of Health (DOHI) was responsible for organising a series of meetings with representatives of the prime minister's office and meetings with representatives of the Association of Local Authorities to ensure multi-sectoral collaboration in the implementation of the Health Promoting Community (HPC) programme aligning it with the Sustainable Development Goals (SDG). The SDG agenda opened a window of opportunity for HPC team to approach different ministries and other high level decision makers to work together towards common goals.

Ireland. The Institute of Public Health in Ireland organised a dialogue to identify and explore which elements of Tobacco Free Ireland are currently targeted to address socio-economic inequalities in tobacco use; exploring how European partnerships and initiatives could be leveraged in the future to support the reduction of inequalities in tobacco use in Ireland; and identifying which policy and programme actions should be sustained and what new actions should be considered to address inequalities in tobacco use in the future.

Italy. The Ministry of Health, together with the Italian National Agency for Regional Healthcare Services, organised a policy dialogue to share regional projects and plans to support chronic disease strategies, understand the capacity of regions in coordinated actions and explore how to boost the integration of services and coordination of different plans at regional and national level. Participants agreed to establish an inter-ministerial working group to review current chronic care models.

Lithuania. Vilnius University and the Institute of Hygiene organised a policy dialogue to gain insight on how to provide the needed supportive services for the divorced families (adults and children) or families going through a divorce. In terms of the ratio of marriages and divorces, there are currently 65 divorces per 100 marriages in Lithuania – one of the highest numbers in the European Union. Lithuania showed initiative to investigate the situation, to develop and implement a system of support for divorced families.

Malta. The Ministry of Health organised a policy dialogue to promote discussion of how water consumption can be increased through improving access to and availability of safe drinking water at the neighbourhood or locality level. Multiple stakeholders who took part in the dialogue examined each organisation/institution's potential contribution towards the main objective within a collaborative, intersectoral framework, and established next steps to address the issue.

Netherlands. The National Institute for Public Health and the Environment organised a policy dialogue about how to systematically promote cycling and walking before, during and after work. As a result, the National Alliance 'Werken in Beweging' (for exercise at work) will collaborate with stakeholders from policy and especially from practice to create a platform that could support employers promoting physical activity.

Poland. The National Institute of Geriatrics, Rheumatology and Rehabilitation organised a policy dialogue to assess the benefits of enriching Comprehensive Geriatric Assessment (CGA) to ensure better prevention of cardiovascular system and respiratory system diseases. Among other things, stakeholders decided to work towards increasing the availability of CGA for elderly patients (60+) through training and empowering a wider group of providers (e.g. nurses, physiotherapists) to perform the geriatric evaluation of patients.

Portugal. The Directorate-General of Health organised a policy dialogue to find ways to tackle the issue of advertising of unhealthy food and beverages to children at national level. After discussing the effectiveness of industry's self-regulation, participants decided that self-regulation was not enough and highlighted the need for stricter laws and improved health literacy among the population.

Slovakia. The Ministry of Health organised a policy dialogue to come up with a collaborative approach to prevention of cardiovascular and metabolic disorders. The conclusions of the dialogue will serve as a starting point for the creation of a new National Health Promotion and Healthy Lifestyle Programme for 2020-2026.

Slovenia. The National Institute of Public Health organised a policy dialogue to propose the integration of care model between primary and secondary level of healthcare for persons with complex multiple needs, with emphasis on patient participation. The participants committed to creating national streams and pathways of care for patients with chronic conditions.

Spain. The Ministry of Health (MoH) and Carlos III Health Institute organised a policy dialogue to reinforce collaboration between the MoH and the Ministry of Environment and Ecological transition (MET) to jointly address health and environment and to assess the possibility to include health indicators into Environmental Impact Assessment (EIA). During the meeting it was agreed to establish an Inter-Departmental Working Group between the two ministries that would start by defining criteria for Health Impact Assessment (HIA) within EIA that takes into account equity and social determinants of health.

EU level policy dialogue on employment and chronic conditions. The work led by the Fondazione IRCCS Istituto Neurologico Carlo Besta in Italy allowed CHRODIS PLUS partners to showcase tools that if employed would lead towards inclusion, integration and reintegration of people with chronic conditions in the workplace and improvement of workers' health and wellbeing. A number of stakeholders were invited to share insights on how EU policy can support the implementation of these instruments.

EU level policy dialogue on funding health promotion and chronic disease prevention. The primary focus of the policy dialogue was on understanding the ways in which revised European Union funding mechanisms may be used towards prevention of chronic diseases and to support the broader health system during this crisis period and its aftermath. The main outcome was a set of recommendations for action for EU and national policy and decision-makers to increase equitable and sustainable funding and financing of health promotion and chronic disease prevention.

3. Learnings from the themes and content of national and EU-level policy dialogues

This chapter highlights:

- **common aspects of policy dialogues;**
- **the health in all policies approach and alignment with international initiatives;**
- **how countries addressed equity within their discussions;**
- **relevance of sub-national dimensions;**
- **the importance of continuous improvement in capacities and knowledge.**

3.1 Common aspects within diversity

There was a wide variety of subjects chosen by national organisers and partners as shown in the Table 1 (p. 8). In a nutshell, policy dialogues (PDs) considered issues relating to chronic diseases based around the following:

- Water consumption;
- Marketing to children;
- Tobacco inequalities;
- Cycling in the context of work;
- Cancers and artificial intelligence;
- Mental health in family separations;
- Geriatric cardio-vascular diseases;
- Health Impact Assessments;
- Integrated care and management, including regional synergies;
- Artificial Intelligence in prevention programmes;
- EU-wide dialogue about employment and chronic diseases;
- EU-wide dialogue on sustainability of CHRODIS PLUS results through increased funding to health promotion and chronic disease prevention.

Considering the diversity of aspects that were worked out for the 14 Policy Dialogues and the two European PDs, it is noteworthy that there were also some common approaches shared by most countries. Despite choosing different themes, it is remarkable that all countries, including the European level dialogues, have agreed on actions related to Health Promotion (HP) and/or Disease Prevention (DP).

The presence of HP/DP in all of the action plans shows not only that the need of HP/DP persists but also that the HP/DP is perceived as a key tool to address the burden of NCDs. It also indicates that HP/DP is and should continue to be a key transformative element when a European country is willing to make significant changes in their NCD policies.

Regarding the targeted age groups in the PDs, there was no surprise that in the context of chronic diseases the attention was mostly placed on adults and elderly people. However, four countries focused on issues particularly affecting children and young people (Portugal, Lithuania, Malta, and Ireland). Addressing young

people was seen as an opportunity to generate longer-term impact on lifestyles. Increasing levels of health literacy among young people and families is a powerful tool which can help producing real changes in society.

Even though health care management of patients with NCDs was not the most popular topic, relevant commonalities were raised during six policy dialogues. Those countries shared a common vision about innovation in the management of NCDs must be done considering a cross-sectoral and integrated approach (Croatia, Greece, Italy, Poland, Slovakia and Slovenia).

Among the diverse approaches, it is remarkable that while all of the PDs included a bottom-up approach, some countries also recognized the importance of making regulatory changes as a key tool for progress in societies (Portugal, Spain, Ireland). The inter-sectoral collaboration was considered by all the PDs. This aspect is discussed in the following section.

This diversity in topics and approaches confirms the wide ranging and complex nature of addressing chronic (primarily non-communicable) diseases across Europe. However, few of the CHRODIS PLUS Policy Dialogues departed far from orthodox methods and subjects (Malta – obesity – water; Netherlands – physical activity via cycling; Portugal on nutrition – marketing to children and Spain on HIAs). In terms of how that affects effective outcomes we can only tell with implementation evaluation – strong results count more than interesting discussion. The following sections and Chapter 4 will show how some progress was made in terms of thinking about subjects, partners, pathways to solutions and outcomes.

3.2 Health in All Policies (HiAP) approach

All policy dialogues (PDs) share an inter-sectoral approach either as actual inclusion of participants in the dialogue or as potential participants in the future actions that were planned in the dialogue. An inter-sectoral approach was seen as a necessity but also as a facilitator by all of the dialogues' organizers. This approach not only helps address problems from a variety of angles, but also increases the overall sustainability and awareness of the Joint Action's activities. By involving whole-of-society and whole-of-government stakeholders, a more comprehensive and inclusive process of co-creation of solutions can be put in place, as well as aligning the expectations and responsibilities of each actor. The majority of national policy dialogues included the participation of actors from multiple ministries (e.g. health, social affairs, finance, transport), and many also included representation from academia (e.g., Greece,), the private sector (e.g., Hungary), and non-profits (e.g., the Netherlands). The following comment in the Portuguese report aptly describes the situation for many countries: "*a common understanding of the situation, needs and problem to solve among different stakeholders – including public authorities – will be the primary enhancing factor to achieve the goal.*"

To sum up, HiAP framed 10 out of the 16 Policy Dialogues (i.e. Croatia, Iceland, Italy, Malta, Netherlands, Portugal, Slovenia, Spain and the EU level PDs). The other 6 dialogues assumed an inter-sectoral approach. In Croatia the multi-sectoral approach was considered the mean to achieve a deeper adoption of the National Action Plan for Prevention and Control of NCDs 2019-2020. In Greece, Iceland, Italy, Slovakia, and Spain the dialogue established links among levels and/or sectors that although share the common objectives, mostly work in silos. The Maltese and the Dutch dialogues focused on specific and concrete actions (promoting water consumption and cycling, respectively) through an inter-sectoral collaboration. The dialogues in Portugal, Slovenia and Spain focused on trying to unravel existing blockages in the development of laws or programmes with the help of key stakeholders.

Wider stakeholder participation was also viewed as an essential factor to reach more ambitious objectives within existing programmes or plans (Ireland, Hungary, Poland, Iceland, EU level PD on funding). Different

stakeholder involvement also increased the legitimacy of actions foreseen during the meeting. The first European Policy Dialogue had its own specificities as it was shaped as a larger event at the European Parliament that gathered a range of European stakeholders to address the clear connection between CDs and employment. The event was an opportunity to present the CHRODIS Plus tools and encourage their application in the workplace settings.

3.3 Equity

Addressing inequality was among the objectives and action points in many of the dialogues. During the dialogue Croatia, participants were looking at how to reduce inequalities through a comprehensive approach of prevention and control of the NCDs. The stakeholders recognized the need to increase the population coverage through easing the access to individuals in high risk groups in the new National Action Plan for Prevention and Control of NCDs.

Other dialogues tackle inequalities working on sensitive issues like access to potable water in public spaces (Malta), mental health and social service support to families going through a divorce (Lithuania) or tobacco use (Ireland). The Irish policy dialogue focused on how to address inequalities within the tobacco control policies. It is well known that preventive campaigns and actions reach less the already more disadvantaged people. This dialogue explored how to effectively embed an equity approach in the strategies to reduce tobacco use.

The European policy dialogue on employment and chronic diseases looked at how to improve work access and participation of people with chronic diseases, offering tools to support employers in implementing health promotion and chronic disease prevention activities in the workplaces. The CHRODIS PLUS partners aim to reinforce decision makers' ability to create policies that improve access, reintegration, maintenance and stay at work of people with chronic diseases.

Investing resources in tackling inequalities is a sign of mature and developed societies. There are elements that indicate that the equity approach is being incorporated within the core of the national policies among the European countries.

3.4 Sub-national dimensions

Recognising that the EU Joint Actions require primary engagement of national governments and responsible authorities, it was not surprising that sub-national dimensions were not prioritised. With an exception of Italy, Iceland, Malta and Greece, a series of different authorities with competences in the subject area of the dialogue (i.e. health and social care) participated actively in the discussion. Moreover, their roles were acknowledged in the respective action plans with direct implications to the envisaged policy transformations.

In Italy, the need for coherent approaches to address chronic diseases prevention and care involving all governmental levels with responsibilities in health and social care. Both sectors actively participated in the dialogue. The local, regional and national institutions as well as NGOs (patient and professional associations among others) will play a role in the implementation of the Italian action plan. Iceland, under the supervision of Ministry of Health, integrated local communities in its national health promotion strategy, allowing them to design robust plans to reach the UN Sustainable Development Goals (SDG). The stakeholders in Malta, plan to engage with Water Services Corporation, the Planning Authority and Local Councils to promote water consumption through environmental change at community level. Finally, the Greek dialogue gathered stakeholders from different sectors (tourism, education, academia, patient associations, and municipalities) to find synergies in the implementation of integrated care services for the elderly and chronic patients.

A long-term uptake and eventual scale-up of good practices can hardly be achieved without a multi-level approach. Due to structural constraints of the policy dialogues, only around 12 participants were invited to join the roundtable discussions. It was always challenging to strike the right balance and guarantee the representation of all relevant stakeholders. Therefore, it is important to stress that a policy dialogue is not a one-off event but a series of meaningful interactions between different levels of public administration, as well as representation of public and private interests.

Furthermore, it must be taken into account that most of the policy dialogue organizers were small countries. Therefore, the sub-national dimension was less relevant for them than for the bigger countries (Spain, Italy and Poland). However, when addressing the issues of funding health promotion and disease prevention, EU level Policy Dialogue participants noted that it would be beneficial to build the capacity of local level organisations not only to monitor funding opportunities but also to develop skills to write proposals, allow time to engage with other local actors for bundling project for investment, and develop the overall capacity to absorb funds. Generally, the importance of a multi-level approach was recognized by all the countries in the discussion at EU level PD, but also is every single action plan derived from the national policy dialogues.

3.5 Alignment with international initiatives

The alignment with the predominant international framework was clear in all policy dialogues (PDs). The topics and objectives of all the PDs go in the direction to achieve the UN 2030 Agenda for Sustainable Development, particularly the Sustainable Development Goal (SDG) 3.4, which aims to reduce by one third the premature deaths through the prevention and treatment of CDs by 2030[ii].

Some of the PDs, used the SDGs to frame the problem and set their national objectives, this was the case for Iceland, Ireland, Greece, Portugal, Slovakia and Croatia. In Croatia, for example, the PD also intended to progress on the compliance of the SDG 3.5 (Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol). The Irish dialogue, apart from intending to advance the SDG 3.4, particularly targets the SDG 3.a, which is aimed to strengthen the implementation of the WHO Framework Convention on Tobacco Control. In addition, the Maltese PD can also contribute to achieving the SDG 6, aimed to ensure availability and sustainable management of water and sanitation for all.

Although the alignment with international initiatives was observed in many national PDs (e.g. Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025[iii]), most of the references used in the dialogues came from the national settings. Policy Dialogues where the European regulation was cited most were in Spain, Malta and Portugal, and they referred to environmental, water and market regulations respectively. Although it is expected that during the national PDs the national regulation was particularly relevant, a wider scope considering the European setting is advisable.

3.6 Information Technologies

Given the predominance of application of emerging digital or bio technologies in many aspects of health, the relatively small number of dialogues mentioned digital solutions to achieve their objectives. Hungary and Portugal were the notable exceptions, although some digital solutions addressing care and management of chronic diseases were mentioned in Greece, Italy and Slovenia. Other than that, digital solutions were neither systematically identified, explored, nor integrated in the national Action Plans.

In Hungary, participating stakeholders agreed that the use of artificial intelligence (AI) in national screening programs could significantly increase screening efficiency and early detection of cancer. They discussed what are the requirements for an AI based product or service to be used in medical practice and considered what needs to be done to ensure that products made with community resources are utilised. In Portugal, with the

aim to positively influence children and young people's consumption of healthy foods and beverages, health stakeholders decided to engage with 'digital influencers' for promoting healthier choices.

One of the reasons why digital technology was not included in many discussions could be that the PDs are not the best setting to discuss technological details. An agreement about new developments and actions in the field of Information Technologies (IT) would require a high level of specialised knowledge, which was not the choice of CHRODIS PLUS PDs organisers. On the other hand, the IT are already addressed by other European initiatives, such as the Joint Actions eHAction[iv] and Infact[v].

3.7 Training

The importance of continuous improvement in capacities and knowledge is widely recognized in the PDs. Training was highlighted as a key component to produce effective outcomes in half of the PDs (Croatia, Greece, Italy, Lithuania, Poland, Spain and the two EU PDs on employment and funding). In some instances, it was proposed as an action to increase the uptake of an existing policy or programme (Poland and Italy). In other instances, training was cited as a facilitator of inter-sectoral work (Croatia, Greece, Italy, Lithuania, Poland and Spain). The EU level PD on funding highlighted the need for administrative capacity to apply for and then later manage financial assistance.

The COVID-19 crisis has revealed the need of a constant and updated training in the public health setting. The increasing importance of the EU Skills Agenda for recovery and resilience of health systems, the competences and roles of associated professionals is a crucial element to produce transformative changes in prevention and management of chronic diseases. This can apply to health professionals, but also for the wider health workforce in public, private and civil society sectors.

It is noteworthy that significant EU funding can be identified to support training, re- and upskilling, and structural job creation schemes, including in areas considered health-promoting and socially-innovative, and supporting engagements with sub-national authorities with health responsibilities, for example through the European Structural and Investment Funds (ESIF). Specifically, provisions have been made available in the European Social Fund and the Cohesion Policy funds. The new EU funds under the next Multiannual Financial Framework 2021-2027, with notable enhancements to the European Social Fund+, the Cohesion policy and InvestEU's Social Investment window are promising for the next 7 years, certainly under the challenge of the post-pandemic recovery plans[vi]. Last but not least, the new much enlarged stand-alone EU Health Programme – EU4Health – will bring significant resources (especially in the first recovery phase) with a potential to support health promotion and disease prevention (re)training and workforce strengthening and creation as part of building health systems resilience and crisis preparedness[vii].

4. Learnings from the implementation and context of national policy dialogues

This chapter highlights:

- **the diverse situations, PD objectives and state of the policy-making processes related to PD objectives in participating countries;**
- **resources, stakeholder engagement and political commitment necessary to carry out policy dialogues;**
- **common follow-up activities highlighted in national policy dialogue action plans;**
- **participants' evaluation of policy dialogues.**

The questionnaires completed prior to the dialogue, the action plans and the narratives in the final policy dialogue (PD) reports contain rich information about circumstances in participating countries. These may be analysed and addressed in follow up actions nationally and at EU levels (which will be further synthesized in conclusions Chapter 6). The process of holding the policy dialogues already generated added value by stimulating national thinking and concrete actions about priorities and rationales to address chronic disease; by identifying existing knowledge, resources and potential partners; by setting concrete goals, targets and objectives; by engaging policy and decision makers, sometimes in new ways; and by raising awareness of needs, challenges and opportunities. The following highlight common features of the policy dialogue implementations and their proposed follow up actions.

4.1 Diverse situations

National policy dialogues were held in a variety of contexts. The CHRODIS PLUS policy dialogue format offers flexibility for countries to apply it to different topics, different stakeholders, and at different stages of the policymaking process.

The health and demographic situation across the European Union and its Member States, regions and communities varies significantly. This has been also made clear recently with the European Commission's new report on The impact of Demographic Change in Europe and an imminent Green paper on Ageing[viii]. It is no different when it comes to challenges specifically related to chronic diseases in CHRODIS PLUS partner countries who participated in the policy dialogues. This was reflected in the way that organising bodies presented their policy dialogue reports. While some participating countries provided a clear description of the context in which their policy dialogues took place, others remained quite general or focused more narrowly on their primary topic. For example, Croatia and Malta presented a detailed description of the broader current situation and rationale for their policy dialogues' choices of subject (multisectoral approach and promotion of water consumption respectively) and others focused directly on topical discussions, likely assuming the broader context is well-established and understood by the participants. Beyond different contextual situations – linked to unique historical and cultural factors, human, political and financial resources - partner countries have markedly diverse health systems, political willingness and available tools for addressing chronic diseases as a whole. Fortunately, the CHRODIS PLUS policy dialogue format offers considerable flexibility to be adapted for use in different contexts and at different stages of the policymaking process. In some countries, for instance (e.g., Ireland, Slovenia), the dialogue focused on examining and revising implementation of existing, well-detailed strategies and policy dimensions. In others (e.g., Lithuania

and Hungary), the dialogue began at a much earlier stage of policymaking processes by exploring potential approaches to newer or emerging situations, sometimes arising from beyond the public health sector (e.g., the social situation in Lithuania impacting on mental wellbeing, accelerating digital and technological transformations in the field of health-data collection and analytical capacity). The choices of topics and stages of policy making processes depended on situational judgment of national PD organisers. To make their decision, organisers took into consideration their national context and identified possible window of opportunities.

Looking at the long-term sustainability of CHRODIS PLUS outcomes, the variety of approaches to the policy dialogues may suggest that there is diversity in how states see and apply EU 'Joint Actions'. This may change as processes to coordinate Joint Actions are standardised (e.g., with the proposed introduction of the EC Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases). Lessons learnt from other Joint Actions over the years have shown that indeed there is considerable freedom and flexibility in translation of 'formal' requirements of a Joint Action's activity at EU level. One of key objectives of Joint Actions is transnationality and cross-border learning where countries exchange on how specific common challenges are dealt with. However, decision-making and implementation of concrete policy/political actions remain a big enabling or inhibiting factor.

4.2 Varying methods

The scope of each policy dialogue's objectives determined the methods used. In all contexts, ensuring sufficient human, financial and technical resources was a potential barrier to follow-up activities.

Given the diversity of contexts in which policy dialogues were held, there were varying methods chosen by organisers to determine relevant participants, frame the aim and objectives of each dialogue, and arrive at policy dialogues' final action plans. Some used tools such as barrier and facilitation studies, focus groups, clinical expert groups, SWOT analyses or case studies. Others provided a minimal background summary for participants on what to expect and how best to prepare for the discussions on the day, taking advantage of reflecting on issue or possible consultation with colleagues.

Resources were undoubtedly an issue for national organisers, whether financial, human or technical: the financial/human amounts allocated by the Joint Action budget did not foresee or allow for follow up meetings and processes on a grand scale but depended on inputs and capacities of organisers. With this in mind, therefore, one can expect large variations and likely inequalities in the way the dialogues were designed, performed and resulting action plans subsequently monitored. There was some evidence of varying commitments of participants, whether in extent of preparation, contribution to the dialogues, follow-up evaluations or commitments to action plans. In some cases, participants seem to have regarded the actual meeting as a stand-alone event of interest but not necessarily long-term importance for the broader policymaking process. This may reflect, as noted above, Member States' different perspectives towards Joint Actions and their embedment in national and transnational health policymaking processes. All in all, it results challenging to ensure continuity of the initiated processes during the policy dialogues because the dialogue is organised in the framework of the project but follow up actions would have to be integrated into existing programmes or processes. Otherwise, creating an external activity to the current workload, especially for the stakeholders outside of the health care sector, can result difficult to live up to the expectations set out during the meeting.

4.3 Stakeholder engagement

The stakeholders targeted in each policy dialogue closely aligned with the objectives of the dialogue, in that dialogues with a relatively broad scope engaged a wider variety of actors than dialogues with more specific objectives. This often correlated with the stage of the policymaking process around the topic (with issues at an earlier stage of development usually inviting a more diverse set of stakeholders).

Given the vastly different themes of the dialogues – as well as their stated objectives – one would expect to see significant diversity in the range and total numbers of stakeholders engaging in each policy dialogue (PD). In very tightly-directed dialogues, such as the Spanish or Portuguese dialogue which had specific laws and regulations in mind, a small group of stakeholders representing only the necessary actors (e.g. directly responsible ministries or agencies) were invited to participate. Others, with a wider framing of dialogue objectives (e.g., Hungary, Greece), engaged a more diverse and broad group of stakeholders, representing not only government but also academia and some civil society groups. Iceland had a particularly wide representation, across different government sectors (e.g., health, transport, environment, police) and national and international agencies (i.e., Icelandic Youth Association, National Queer Association, UNICEF). This was appropriate given the theme of the dialogues of linking national strategy explicitly to the UN Sustainable Development Goals. Others included more of a decentralised approach, notably in Italy, where the functioning of the health system is largely devolved to the regional level. In many settings, national associations (e.g., paediatricians, family doctors, patients) were an actor in the conversation. In the conclusions of many dialogues, local leaders and end users were highlighted as key stakeholders who could help implement policy dialogue action plans on the ground. This included in Malta, where local councils would help determine optimal placement of water fountains, as well as in Ireland, where greater engagement and co-design of smoking cessation supports could make the services more equitable. As already indicated in the section 3.4, roles of participating stakeholders were acknowledged in the respective action plans with direct implications to the envisaged policy transformations.

A few dialogues, including the Slovakian and Slovenian dialogues, brought together only participants from the health sector, sometimes including representatives from various departments of the Ministry of Health. This could demonstrate the importance of first aligning the approach within the health sector to specific challenges (e.g., integrated care, development of new national action plans) before engaging additional sectors and actors. Task 4.1 organiser EuroHealthNet participated in all dialogues in order to frame the dialogues within their wider European context. As indicated, the number of participants in each dialogue also differed considerably, largely along the lines of the objectives (e.g., the broader the objectives, the more participants in the dialogue).

4.4 Political and societal commitment of policy dialogue participants

Political and societal commitment can only be measured over the longer-term (beyond the scope of this report), but many dialogues attracted the participation of high-level policy- and decision-makers, as well as key representatives from civil society.

Apart from the engagement of stakeholders in the dialogue itself, there were also questions of how much political capital or commitment various stakeholders brought to the dialogues. This is difficult to estimate over the short-term, but it is worth noting that many dialogues attracted high-level participants, either to provide a keynote address at the start, or as active participants throughout the discussion. These included in Lithuania, Poland, Spain and Iceland (where the Prime Minister's office was directly engaged in the multi-dialogue process).

In other dialogues, such as in the Netherlands and Croatia, a large number of civil society actors (e.g., associations and federations) were engaged, which could provide an important 'push' factor to motivate continued political engagement with the topic at-hand. Exactly how such actors were identified in each country was not elaborated in the country questionnaires or action plans, though this could be an interesting area of further research. Furthermore, the long-term effects of such political and societal commitment remain to be seen, but further analysis and research could result in important longer-term learnings about this element of policy dialogue planning, implementation and overall impact.

The CHRODIS PLUS Governing Board members were not systematically present in their respective national Policy Dialogues, however, the Ministries of Health or representatives from the agencies nominated by the ministries were always taking part in the meetings. In terms of sustainability of results achieved during the policy dialogues, Governing Board members could oversee the activities of actors responsible to deliver on actions detailed in their respective national Action Plans. However, as detailed in the section 4.2, the Joint Action did not foresee neither resources nor asked policy dialogue organisers to explicitly commit to follow the plan designed during the dialogue.

4.5 Policy Dialogue Action Plans: Common approaches and proposed activities

Understanding that the national policy dialogues (PDs) are intended to be a single step or activity within a larger policy process, each dialogue concluded with the development and preparation of a national action plan. Some of these plans were more detailed than others, but there were some specific activities that stood out across multiple plans in spite of varied approaches to implementation and contexts. They are detailed below.

Working groups, monitoring and accountability

One of the most frequent outcomes from the dialogues has been plans for the establishment of working groups to take forward policy dialogue learnings and outcomes. For instance, some countries agreed to develop multidisciplinary teams able to address multi-risk factors of NCDs and an intersectoral committee to monitor and coordinate the activities (e.g. Croatia, Slovenia) or build health inequality dimension into the development of NCDs guidelines (e.g. Ireland). Some agreed to establish a standing inter-ministerial working group to review policy developments to concrete NCDs-related issues as well as identify and adopt metrics and tools for measuring and evaluating innovative approaches therein (e.g. Italy). Others wanted to look into employing cross-sector indicators that would also benefit, for example, environmental sustainability gains, such as plastic and CO2 emissions reduction (e.g. Malta). A very clear commitment to organisation of working groups was also seen in Portugal: one dedicated to following-up on ongoing legislative developments, and another on forward-looking issues related to identified gaps and challenges still to overcome (health literacy of the population). In Spain, it was agreed to create an inter-departmental working group, notably as a permanent structure within Ministry of Health, Consumer Affairs and Social Welfare, and Ministry of Ecological Transition.

A working group is particularly effective in bringing together individuals who can then break down complex tasks in parts and seek answers to specific questions needing clarification. They also offer an important channel to monitor and ensure accountability to the dialogue action plans. Many action plans indicated that their working groups would meet on a biannual basis, offering the opportunity to take stock of recent political and societal developments that may enable or inhibit progress on stated goals. Some of the working groups are specifically instructed to monitor progress, for instance in Croatia, Iceland and Italy. In Spain, the action

plan requires working group participants to establish specific criteria for health equity assessment within environmental impact assessment in order to jointly elaborate methodological guidelines and tools. Finally, in Portugal, one of its two working groups was fundamental in finalising a legislative proposal regarding advertisement of food and beverages to children. The other group will build on the work of the first, further promoting health and food literacy amongst the Portuguese population (via the National Health Literacy Commission).

Training

Another common item on action plans related to training. As indicated in Section 3.7 above, this was a common objective area, so it is appropriate that it would be included in several follow-up action plans. Specific examples include in Greece, where there would be both 'capacity building for health professionals,' as well as "training for management (e.g., private sector employers) regarding disease prevention and attention to people with NCDs." In Lithuania, training on the "Improvement of Mental Health Literacy" for educational, social and health care specialists working with families would help them support families who may be going through a divorce. In Poland, the action plan called for training and empowering a wider group of providers (beyond gerontologists) to perform geriatric evaluation of patients.

Pilot actions

The use of pilots is well-established to test policy initiatives and as such may be seen as useful components of action plans arising from policy dialogues; this item will consider where that mechanism has been contemplated, planned, begun or carried out in whole or part, bearing in mind the uniquely unhelpful intervention of the COVID-19 pandemic from early 2020.

The Netherlands begun carrying out a 'cycling as medicine' pilot project by a group of physicians and patients. In a similar vein, this particular policy dialogue identified further piloting activities to be explored: the Dutch Railways would research active commuting, productivity and sick leave; the Dutch city of Almere would design a physical activity-friendly city. Slovenia identified a pilot project for facilitation of integrated care as one of the actions included in their policy dialogue action plan. In Italy's Veneto Region, they will include the prescription of the physical activity/"health gyms" model in the upcoming review of the policy framework, with the goal to extend the model to the national population by 2021.

As for European level Policy Dialogue on employment and chronic diseases, a Training Tool for managers on workplace inclusion and work ability and a Toolkit for fostering employees' wellbeing, health and work participation, were already piloted in a number of Member States and are now available for use.

Impact assessments

The obvious initiative of Spain to specifically focus on how health and environmental impact assessments may be introduced regarding aspects of chronic disease prevention raises the wider question of how systematic impact assessments are applied in partner countries on policies impacting positively or negatively in this respect. This would be of particular interest given the equity priority of the CHRODIS PLUS Joint Action. Cases of Ireland and Hungary could also offer some additional insights. In both instances, specific attention was put to socio-economic vulnerabilities and the need to systematically assess the impact of the policy developments in the given fields (tobacco and artificial intelligence solutions, respectively).

4.6 Takeaways from outcome evaluations

Nearly all national policy dialogues (PDs) were complemented by an extra evaluation conducted by CHRODIS PLUS partner responsible for evaluation (outside of the grant agreement). The evaluation conducted in each of the policy dialogues not only gave an understanding of participants' views towards the policy dialogues, but also allows us to further 'validate' some of the learnings from the policy dialogue planning, implementation and follow up. As previously described, the evaluations help us see some of the most relevant common difficulties or desired scenarios among European countries when introducing new approaches to the prevention and management of chronic diseases. As indicated in Sections 4.3 and 4.4, the inclusion of key stakeholders seems to have a crucial role in the planning and implementation of new approaches. Stakeholders are not only limited to those directly involved during planning, but also to those that have a principal and secondary role when implementing the practice, particularly for ensuring its sustainability over time. Finance, marketing or environmental departments are examples of stakeholders whose participation in the policy dialogues was highly valued by attendees. These stakeholders seem to create further awareness of potential barriers to implementation related to access to resources, reaching vulnerable groups, ethical concerns and potential competitors to new approaches, sometimes not fully known by the developers and implementers of new health strategies. The creation of new synergies between those stakeholders, as well as establishing stable communications and coordination (e.g., working groups) between them seems to be one of the most accepted approaches to ensure successful design of policies oriented to contextual needs and sustainable implementation.

5. Potential COVID-19 implications and resilience factors

This chapter highlights:

- **using new technologies to provide support for management and prevention of NCDs;**
- **relation between healthcare and other sectors;**
- **the role of socio-economic, behavioural and environmental determinants of health in post-COVID circumstances**
- **funding opportunities for health promotion and how to seize them;**

The COVID-19 crisis has dramatically disclosed some weaknesses of healthcare systems. The need for preparedness and prevention against recurring or new threats is an opportunity to reinforce public health structures and processes. The experience of the CHRODIS PLUS PDs, although carried out before the COVID-19 crisis, addressed some issues with lessons applicable to this coming future.

An important article in *The Lancet online* on 8 May 2020 by Dr Hans Kluge, Director of WHO Europe, Dr Joao Breda, Director of the WHO European Office for the Prevention & Control of Noncommunicable Diseases and others, states that:

"Evidence from this and previous pandemics suggests that without proper management, chronic conditions can worsen due to stressful situations resulting from restrictions, insecure economic situations and changes in normal health behaviours…. This disruption… risks increasing morbidity, disability and avoidable mortality over time in NCD patients.[ix]*"*

Increased risks cited include:

- reduced physical activities,
- increased strains on mental health (anxieties and depression),
- increased consumption of unhealthy foods,
- increased harmful use of alcohol, possibly also tobacco,
- less availability of health supporting products and medicines,
- delays and restrictions to detection, testing and treatments of chronic diseases.

"The prevention and control of NCDs have a crucial role in the COVID-19 response and an adaptive response is required to account for the needs of people with NCDs. Prevention of NCDs is important since the true scale of at-risk groups is probably underestimated, given that many cases of hypertension and diabetes are undiagnosed. Communities and health systems need to be adaptive to both support and manage the increased risks of people with known NCDs and exercise sensitivity about the vulnerability of the large population with undiagnosed NCDs and those at increased risk of NCDs."

Therefore, although most of the Policy Dialogues took place before the emergence of COVID-19, their associated discussions and conclusions can offer relevant guidance in the following categories: use of new technologies to provide knowledge and support for management and prevention of NCDs (e.g., Portugal and digital marketing); provision of health system and community level services in safe ways for NCD patients (e.g., Malta and water consumption); considerations regarding social, economic, environmental or behavioural determinants of NCDs (e.g., Ireland and tobacco consumption in vulnerable populations).

5.1 Use of new technologies to provide knowledge and support for management and prevention of NCDs

Relatively few Policy Dialogues identified specific uses of new and emerging technologies and digital solutions to provide and exchange knowledge and support comprehensive prevention and management of NCDs. That choice could come as a surprise, given pace of developments and volume of emerging digital and biotechnologies in many aspects of healthcare delivery, including health promotion and disease prevention. As briefly outlined in section 3.6, policy dialogues in Hungary and Portugal were the two explicitly focusing on achieving chronic disease-related objectives via digitally-enabled solutions (cancer diagnosis and childhood obesity prevention), although some emerging technologies were also mentioned in Greece, Italy and Slovenia, addressing care and management of chronic diseases. In addition to considering other dialogues with components which lend themselves particularly to technological support in the new paradigm, including applications for prevention and promotion, especially in community contexts, digital solutions were not systematically identified, explored, nor integrated in the national Action Plans.

The CHRODIS PLUS PDs methodology was not intended to address digital solutions. An agreement about new developments and actions in the field of Information Technologies (IT) would require a high level of specialised knowledge and/or enabling political developments. In addition, IT aspects are already addressed by CHRODIS PLUS pilot actions on the implementation of mHealth tools for fostering quality care for patients with chronic diseases, and other European initiatives, such as the Joint Actions eHAction[x] and InfAct[xi], creation of the European Health Data Space. However, it has been noted that advances and uptake of digital tools have taken place at rapid and highly concentrated rates during the COVID-19 crisis and will be a major feature in European and national Recovery Programmes, including those governed within the EU Semester processes. All EU member States now have Country Specific Recommendations for health systems[xii]. Those structures are perhaps more fit for purpose to discuss advances on IT, including in chronic diseases

application. The relevance of the Portugal PD is highlighted by latest market evidence suggesting public switching to online purchasing and consumption; the Hungary PD exploration of AI and IT for screening and diagnosis will become a key feature in most States, the use of e-consultation being stepped up in Slovenia will feature universally.

5.2 Provision of health system and community level services in safe ways for NCD patients

The inter-connection between health and other sectors has been particularly key in the management of the COVID-19 crisis, for example with social care, regional and municipal authorities for housing, transport, food and water supplies, public safety and environments as well as public and private workplaces. This aspect has been well addressed in a significant amount of the PDs, where inter-sectoral collaboration was the main theme of dialogues for example Croatia, Iceland, Italy, Lithuania, Malta, Netherlands, Poland, Slovakia, Slovenia, Spain and in the EU PDs on employment and financial support.

The need for a smooth relation between healthcare and social services, as well as among the different levels of the health system, is being highlighted. Integrated care, which is a well-developed concept, was the main topic in a significant amount of the national PDs (Croatia, Greece, Italy, Poland, Slovakia and Slovenia). Those dialogues made progress in finding common interests and synergies among different health sectors and services. The creation of inter-sectoral working groups, the achievement of agreements for further common activities were examples of cross-sectoral collaboration and further integration of health services in a coordinated way.

Populations are now more aware about the importance of having a quickly reactive but also effective health system. This is likely to lead to numerous changes in terms of implementing and managing services for more vulnerable people, for example in diabetes or respiratory conditions. But for aspects such as self-care and designated responsibilities of individuals, communities and stakeholders there are likely to be similarly far-reaching shifts. The Greece PD on liaison with hospitality and tourism services, including for older people, is highly topical now. The Spain PD on use of health and environment impact assessments is a vital part of integrated preparedness and prevention for post COVID risk factors including air pollution, especially when equity is integrated. Those PDs with an equity focus such as in Slovenia will be highly relevant, given the evidence of diverse impacts of corona viruses on people across social gradients with underlying chronic conditions. In particular, the need for close collaboration between health and social services has been clearly demonstrated and is leading to major planning of new ways of addressing integrated chronic care across the life course, including in European and national recovery and investment programmes. The CHRODIS PLUS learning should contribute to this.

5.3 Considerations regarding behavioural determinants of NCDs

Behavioural determinants were considered throughout the CHRODIS PLUS national policy dialogues (PDs). From the first event, when Ireland focussed on tobacco control and inequalities, considerable expertise, background information gathering and productive discourse has been carried out throughout the PDs, which can prove valuable in the behavioural contexts of emergence from the pandemic. Indeed, respiratory factors and disparities have been among the major risk factors for corona viruses, with growing evidence of impacts of tobacco use as well as the environmental factors addressed in Spain's use of EIAs. Therefore, the learning from the Dublin and Madrid PDs can be transferred and used, as their evaluations suggested.

This early attention was borne out by the examples from Portugal and Malta. The former examined how behaviours are impacted and may be positively changed through attention to digital and emerging forms of

marketing of foods and beverages, particularly to children. This is going to be a major issue in the changed retail and market environments of the "new normal" and in contexts where educational provisions have been affected adversely - and may be changed significantly for the foreseeable future - with influences at home having more impacts. The Malta PD tackled the related subject of encouraging equitable access to and greater consumption of water ahead of sugary beverages, vital when both local communities, retail offerings and markets and being reshaped and behaviours changing with new demands emerging. They, together with the PDs which incorporated thinking towards achieving the SDGs such as Iceland, Croatia and Slovakia, are both highly relevant for new thinking around tackling obesity and its consequences, one of the most striking risk factors for corona virus incidence. Improving physical activity was a feature of most PDs. Similarly, the cardiovascular disease focus in Slovakia and Poland will be relevant, as is the attention to screening lung conditions in Hungary.

In addition to the community dimensions, the benefits of healthy activities and behaviours for workplaces were clearly advanced, most obviously in the national PD from the Netherlands plus the international tools of the employment PD. The Dutch initiatives build on well-known national strengths around cycling to link into physical activity programmes in liaison with employers and planning authorities, exactly the sort of integrated cross sectoral approaches which are being shown to be valuable post COVID-19, where commuting and public passenger transportation systems are being rethought in the face of new risks, yet increased car use would bring more harmful behaviours for individuals and communities. That benefit-driven approach with economic advantages as well as health, social and environmental gains is also demonstrated in the workbox discussed in the European context by the employment PD, where managers are engaged in wellbeing of employees and their peers.

It should also be mentioned that health and care systems are among the biggest employers in all countries and regions; therefore lessons learnt around training and improvements in those systems, from Greece, Italy, Slovenia and other PDs, should be important for addressing chronic diseases among many working people.

5.4 Considerations regarding social, economic or environmental determinants of NCDs

As mentioned in 5.3 above, the multiple benefits across determinants and risk factors for communicable as well as chronic non-communicable diseases has been a feature of the PD series. The focus on addressing upstream determinants as well as behaviours has been striking throughout, including in the choices of expert participants of the sessions and the use of evidence across sectors and from wide ranging sources. This applies in the post-COVID scenarios for the PDs held in the Netherlands and the European Parliament (looking at healthier and resilient employment practices); for those in Malta and Spain (on environmental determinants); in Greece and Poland (around conditions particularly applying to older generations); in Italy (on effective and resilient health and care management systems); or in those PDs which looked to take forward national public health planning measures (Slovakia, Slovenia, Croatia and others, plus the EU level funding PD). Health literacy has also been an important feature, exemplified in Malta, Lithuania, Ireland and Portugal.

But two examples of how elements of concern now prominent in the post COVID-19 circumstances have been particularly addressed concern particular social determinants with wider ramifications. The PD held in Lithuania may have been thought to have identified an outlier topic for the Joint Action: mental wellbeing in the circumstances of family divisions. For many people and families in the near unique isolating circumstances of necessary COVID-19 prevention measures – which may well recur in many EU states – loneliness, discord, even increased domestic violence[xiii], have been magnified realities with severe societal,

health and economic consequences. The learning about integrated approaches across sectors and services including justice, mental health and social systems, can be vital and transferable ahead.

Similarly, the (tobacco related) inequalities brought out in the Ireland PD process - and addressed in follow ups such as Equity Budgeting as shown in its evaluation - point to wider and universal chronic disease factors included across the CHRODIS PLUS work. But they now demand even greater prominence as shown by substantive further evidence on the impacts of social and health inequities on risks for communicable diseases such as COVID-19, ranging from economic deprivation to housing issues and excess risks from atmospheric pollution[xiv].

Therefore the importance of the diversity of CHRODIS PLUS Policy Dialogues has been demonstrated by the COVID-19 crisis: no single determinant has needed attention alone, but integrated and equitable approaches across determinants and systems is being shown to be crucial – and the PDs have delivered useful insights and potential solutions which taken together can make a valuable contribution to meeting the concerns raised by the WHO in the above article.

However, that can only be achieved if the means, tools and capacities are made available in the right way, which has major relevance for the Recovery programmes at EU and national levels[xv]. Those questions have been rightly raised throughout the Policy Dialogues and directly addressed in the final one, held in the COVID-19 context online facilitated by EuroHealthNet and CHRODIS PLUS organisers from Brussels, which section 5.5 will next report.

5.5 Other relevant factors considered in the policy dialogues

Investing in health and wellbeing is first and foremost a government responsibility, which requires priority setting and adequate public budgets. However, national budgets are limited and will be even more so after States and stakeholders have tackled the current COVID-19 pandemic. As a result, it is a general observation that we must think more broadly and innovatively about the tools at our disposal (both locally and at the European level) to finance health promoting services and disease prevention-oriented measures. This will also be the case in the CHRODIS PLUS context.

A number of national policy dialogues explicitly discussed the use of EU funding to help implement certain elements of dialogues or action plans. The most commonly cited EU funds were the European Social Fund and the EU Health Programme (Poland, Spain, Slovenia, Italy); however, some other interesting funding mechanisms were discussed. New EU long-term budget proposals under the next Multiannual Financial Framework 2021-2027 may offer several potential 'game changers' for addressing chronic diseases. These include opportunities under the European Green Deal and its Just Transition Mechanism (Just Transition Fund), Cohesion Policy Funds broadly covering the entire European Structural and Investment Funds, the new EU Research and Innovation fund ("HorizonEurope"*)*, and the "DigitalEurope" programme (which were discussed during dialogues in the Netherlands, Hungary, and at EU level (EU Workplaces)). Last but not least, the new "Next Generation EU" funds, including the amended EU Health Programme ("EU4Health") – which deal with post-COVID-19 recovery, the expanded EU investment programme ("InvestEU") and its social innovation window, and the Resilience and Recovery Facility (ex-Structural Reform Support Service) were all discussed at the EU level Policy Dialogue on funding health promotion and disease prevention that took place in June 2020.

Even though there are many funding possibilities out there, it is widely agreed that navigating this information is complicated. Ministries of health are usually engaged with the EU Health Programme, ESF and Horizon2020, but all other programmes and funds are not necessarily within immediate reach to them. The

European Commission acknowledges this complexity and as a response, DG SANTE is planning to launch a Joint Action that would help pool all information related to funding opportunities for health. The aim is also to increase the role and capacity of the national focal points (in health) and improve their cooperation across sectors. With facilitation of DG SANTE, the Steering Group on Prevention and Promotion could also seek more direct communication with other Directorate Generals of the European Commission to improve the relevant information flow.

There is a lot of demand for clear and targeted information on funding programmes from the source (e.g., the European Commission), which would facilitate the inter-ministerial communication at national level. It could also help improve information sharing to other institutions at national, regional and/or local levels. Considering the planned enhancements for beneficiaries to 'blend' various funds under the new MFF, it should become easier practically and administratively to design programmes and projects that tackle chronic diseases from a multi-angle perspective. This will particularly benefit the multi-sector collaborative activities identified in some policy dialogues and action plans (e.g., Croatia, Slovakia).

Being informed about existing funding opportunities is not enough. Prospective beneficiaries must have the knowledge and capacity to learn of eligible opportunities for funding, to apply for funding, and then to absorb the funds and successfully manage associated projects. Building this capacity and awareness amongst beneficiaries at all levels of government should be one of the main priorities for future actions in the field. The EU level Policy dialogue participants agreed that many local organisations do not have the capacity nor mechanisms in place to engage in European initiatives, starting from monitoring funding opportunities, nor to proactively look for other local actors for bundling projects for funding/investment. This is despite the fact that community-level ownership of the end product is key to maximise the sustainability of funded programmes/services.

European financial instruments (e.g., InvestEU) are demand- and market-driven. This is also considered a barrier in the health and social sector, where many actors and institutions primarily have experience with grants, not loans. There is a need not only to provide relevant information about these opportunities, and to build capacity to request and manage financing, but also to build a more proactive attitude towards new types of financing and approaching potential investors. For example, the Department of Health in Ireland approached the European Investment Bank to request investment for Primary Care Centres. As a result, 14 new centres have been built across Ireland since 2016, following the agreement of a €70 million, 25-year loan from the EIB[2]. All in all, working purposefully with other sectors we can address the growing needs for health promotion and chronic disease prevention.

[2] European Commission (2016), 14 new primary health care centres to be built across Ireland, supported by the Investment Plan for Europe https://ec.europa.eu/commission/presscorner/detail/en/IP_16_1903

6. Conclusions and Recommendations

This section will sum up the key learnings that were gathered throughout the preparation, organisation and implementation of fourteen national and two European policy dialogues (PDs) on chronic disease. Each learning is followed by a recommendation for either the organisation of policy dialogues or the issues to be picked up by the policy makers and addressed at national and/or European level. Recommendations from the policy dialogues feed into the Consensus Statement concerning the EU added value of cross-country collaboration in the field of health promotion and prevention and management of chronic diseases and the sustainability of the results from JA-CHRODIS and CHRODIS PLUS beyond 2020.

The CHRODIS PLUS Policy Dialogue Methodology is useful and transferable to other policy research fields and policy dialogues can serve as a key step in the policy making process

The process of holding the policy dialogues generated added value by stimulating national thinking and concrete actions about priorities and rationales to address chronic diseases. As a part of this exercise, national and EU-level organisers were required to consider the various challenges and opportunities faced in chronic disease prevention and care, and to rank priorities in order to select a topic for the dialogue. This has been accomplished through a) Questionnaire planning, b) reporting and Action Plan, c) Evaluation. Through this effort, engaged stakeholders, including policy makers, raised awareness of needs, challenges and opportunities, as well as set concrete goals and objectives for a wide variety of subjects (shown in the Table 1 on p. 8). CHRODIS PLUS PD methodology proved effective to address a wide range of topics in different settings, therefore, it could be applied to addressing multiple policy issues in different countries.

In addition, the CHRODIS PLUS experience reinforced the use of policy dialogues as an effective medium for launching or advancing policy discussions in participating countries. These discussions are critical to the broader policy making process. Thus, policy dialogues held at the beginning or key junctures in policy making can provide useful opportunities for ‘taking stock’ of progress or ‘unpacking’ complex issues and aligning stakeholder interests.

Recommendation: To maximise the benefit of engaging multiple stakeholders, use a verified framework, such as the CHRODIS PLUS Policy Dialogue Methodology, to prepare, run, report and evaluate policy dialogues. Carefully evaluate the optimal moment in the policy making process to employ the policy dialogue approach.

Health promotion and disease prevention are central to policy efforts to reduce chronic disease

Despite choosing different themes, all countries, including the European-level dialogues, agreed on actions related to health promotion and/or disease prevention. This demonstrates the key importance – from an outcomes, financing and health equity policy perspective – of preventing chronic disease, rather than focusing solely on treatment and curative care services. This suggests that health promotion and disease prevention should receive significantly more attention from health planners when setting priorities, allocating budgets and designing activities. Policy makers must keep this in mind as they are planning for the design and implementation of health services and broader public health policy.

Recommendation: Re-orient health services towards health promotion and disease prevention. It may require not only rethinking current policy approaches, but also a rebalancing of health system budgets to ensure that enough resources are allocated for prevention.

An inter-sectoral approach to health promotion and disease prevention is key to addressing chronic diseases

As noted above, prevention of chronic diseases was a key point across all policy dialogues. Given that many of the determinants of chronic disease lay outside of the health sector (e.g., environment, education, socio-economic status), all dialogues acknowledged the importance of bringing together and engaging stakeholders – particularly policy makers – from outside of the health sector. This commonly included actors in sectors such as finance, transport, education and social affairs. While the individual policy dialogues only brought together an average of 12 participants, meaning that not everyone was able to be represented in initial dialogues, most action plans laid out specific activities or areas of further work that would bring in other stakeholders from across different policy areas in future actions. As learned from CHRODIS PLUS work on transfer and implementation of good practices on health promotion, the long-term uptake and eventual scale-up of good practices in health promotion and disease prevention can hardly be achieved without a multi-level and multisectoral approach.

Recommendation: Collaborate horizontally and vertically to tackle chronic diseases. Invest in bringing together policy makers and other relevant stakeholders across a range of sectors to allow for more holistic and efficient health promotion and chronic disease prevention programmes.

Adequate human and financial resources are necessary to accomplish objectives set out during the policy dialogues

Even though policy dialogues were framed to be only one part of the policy making process, the financial and human resources allocated by the Joint Action budget did not foresee for follow up meetings and processes. As a result, it is challenging to ensure continuity of any initiated processes during the policy dialogues or to ensure continued political commitment to the dialogue's objectives. For sustainability purposes, all conceived actions should be integrated into existing programmes or processes. Otherwise, creating external activities to the current workload, especially for the stakeholders outside of the health care sector, can result difficult to live up to the expectations set out during the meeting. The long-term effects of such policy dialogues remain to be seen. Further analysis and follow up actions could result in important longer-term learnings about policy dialogue planning, implementation and overall impact.

Political capital and commitment were seen as key to achieving many of the follow-up actions indicated by the policy dialogues. Understanding how priorities and political landscapes adapt to the context, it is also important that dialogue participants envision ways to gain and maintain political commitments from the necessary policy- and decision-makers. Political capital often follows financial capital, reinforcing the importance of planning for adequate resources to meet established objectives.

Recommendation: Ensure adequate human and financial resources to accomplish objectives set out during the policy dialogues – and work to gain and maintain political commitment.

Addressing socio-economic and environmental determinants of health through effective policies and practices becomes even more urgent in the aftermath of the COVID-19 pandemic

The topics and objectives of all the policy dialogues are aligned with the UN 2030 Agenda for Sustainable Development, particularly with the Sustainable Development Goal (SDG) 3.4, which aims to reduce by one third the premature deaths through the prevention and treatment of chronic diseases by 2030. In the context of chronic diseases, the policy dialogue organisers decided to focus mostly on adults and elderly people. However, five countries saw an opportunity to generate longer-term impact on socio-economic and

behavioural determinants focusing on children and young people (Portugal, Lithuania, Malta, Iceland and Ireland). They aimed to address inequalities working on sensitive issues like access to potable water in public spaces (Malta), mental health and social service support to families going through a divorce (Lithuania), food and beverage marketing (Portugal) or tobacco use (Ireland).

In the context of COVID-19 pandemic, the relevance of the Portugal policy dialogue is highlighted by latest market evidence suggesting public switching to online purchasing and consumption; the Greek dialogue on liaison with hospitality and tourism services, including for older people, is also highly topical now. The dialogue in Spain on use of health and environment impact assessments is a vital part of integrated preparedness and prevention for post COVID-19 risk factors including air pollution, especially when equity is integrated. Those dialogues with an equity focus such as in Slovenia will be highly relevant, given the evidence of diverse impacts of corona viruses on people across social gradients with underlying chronic conditions. The Hungarian dialogue's exploration of AI and IT for screening and diagnosis will become a key feature in most States. The CHRODIS PLUS Workbox on Employment and Chronic Conditions which focuses on workplace inclusion, integration and reintegration of people with chronic conditions will become even more relevant in the aftermath of the global pandemic.

Recommendation: Monitor and take action to reduce health inequities by addressing social determinants of health through effective policies and practices, underpinned by research. Strengthen co-creation to foster inclusion and implementation of health and other policies. Make sure to assess impact of policies and other interventions on health and equity of the population.

Health is an increasing priority at all levels which brings new opportunities but also a need for more communication and coordination across all sectors and all levels, particularly by policy makers

Investing in health and wellbeing is first and foremost a government responsibility, which requires priority setting and adequate public budgets. However, EU level funding mechanisms can support governments in their journey to build more resilient health systems. There are many European programmes that offer investment in health but unfortunately the information is dispersed. Ministries of Health and other national or regional bodies are calling on the European Commission to provide as clear information as possible, which would facilitate the inter-ministerial as well as vertical communication within member states. Participants of the EU level dialogue on funding agreed that strong working relationships and communication channels between ministries (e.g., health, justice, finance, social affairs, environment) are also key to improving the flow of information about different, potentially-relevant funding opportunities. The Steering Group on Prevention and Promotion could provide critical insights on taking this recommendation forward, helping to facilitate further communication from EU to national to regional/local level and also facilitating engagement with other ministries to improve synergies in investing in and implementing health-promoting services. Related to the above, it is also critical that strengthening national focal points (in health) and improving their cooperation across sectors (e.g., bundling of projects) would improve the ability of local and regional organisations to participate in EU funding and projects.

Recommendation: Actors at all levels of governance (European, national, regional and local and including the Steering Group on Prevention and Promotion) should consider additional structured mechanisms for discussing and setting priorities, as well as for sharing crucial information about opportunities (e.g., funding) to act on these priorities.

7. References

[i] POLICY DIALOGUES: CHRODIS PLUS Guide (2018). URL: http://chrodis.eu/wp-content/uploads/2018/06/guide-for-national-policy-dialogues-chrodis.pdf

[ii] UN Sustainable Development Goals 2030. URL: https://www.un.org/sustainabledevelopment/sustainable-development-goals/

[iii] Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025. URL: https://www.euro.who.int/en/health-topics/noncommunicable-diseases/pages/policy/publications/action-plan-for-the-prevention-and-control-of-noncommunicable-diseases-in-the-who-european-region-20162025

[iv] Joint Action supporting the e-Health Network. URL: http://ehaction.eu

[v] Joint Action on Health Information. URL: https://www.inf-act.eu

[vi] EU long-term budget 2021-2027: Commission Proposal May 2020, URL: https://ec.europa.eu/info/strategy/eu-budget/eu-long-term-budget/2021-2027_en

[vii] EU4Health – a vision for a safer and healthier European Union 2021-2027. URL: https://ec.europa.eu/health/funding/eu4health_en

[viii] European Commission (2020), Report on the Impact of Demographic Change. URL: https://ec.europa.eu/info/strategy/priorities-2019-2024/new-push-european-democracy/impact-demographic-change-europe_en

[ix] Hans Henri P. Kluge et al, Prevention and control of non-communicable diseases in the COVID-19 response published online in the Lancet May 8, 2020

[x]Joint Action supporting eHealth Network, URL: http://ehaction.eu/

[xi] Joint Action on health information, URL: https://www.inf-act.eu/

[xii] European Semester: All Member States should strengthen resilience of their health systems, European Commission, Press Release of 20 May 2020

[xiii] EIGE (2020), COVID-19 and gender-based equality, URL: https://eige.europa.eu/covid-19-and-gender-equality/gender-based-violence

[xiv] Courtney L. McNamara et al. The socioeconomic distribution of non-communicable diseases in Europe: findings from the European Social Survey (2014) special module on the social determinants of health, European Journal of Public Health, Volume 27, Issue suppl_1, 1 February 2017, Pages 22–26

[xv] COMMISSION STAFF WORKING DOCUMENT Identifying Europe's recovery needs (2020), URL: https://ec.europa.eu/info/sites/info/files/economy-finance/assessment_of_economic_and_investment_needs.pdf

8. Annexes

8.1 Summary Reports from the Policy Dialogues

MEMBER STATE	Related information	
Croatia	**EVENT DATE**	17 December 2019
	SUBJECT	The importance of a multisectoral approach in reducing the burden of chronic non-communicable diseases
	ORGANISERS	Organiser: Croatian Institute of Public Health, Ministry of Health Moderator: Ivana Brkić Biloš, Head of the Division for Epidemiology and Prevention of Chronic Noncommunicable Diseases Rapporteur: Verica Kralj, Head of the Department for Cardiovascular Diseases
	PARTICIPANTS	**Keynote speakers.** Krunoslav Capak, Director of the Croatian Institute of Public Health; Dunja Skoko Poljak, Ministry of Health, Head of the Public Health Sector, Head of the Working Group for the Development and Monitoring of the Action Plan for the Prevention and Control of Chronic NCDs; Frank Lehmann, EuroHealthNet, Senior Advisor at the Federal Centre for Health Promotion and Health Education, Germany, on behalf of the Ministry of Health. **Participants.** Marija Bubaš, Assistant director of Occupational Health, Division for Occupational Health; Ivica Belina, President of the Coalition of Associations in Health; Miroslav Venus, President of the Croatian Epidemiological Society; Biserka Bergan Marković, President of Association of Teachers in General Practice/Family Medicine; Jelena Rakić Matić, Croatian Family Physicians Coordination; Dragan Soldo, President of the Croatian Society of Family Doctors; Maja Vajagić, Croatian Health Insurance Fund; Olgica Martinis, Education and Teacher Training Agency; Tea Peko, Ministry of Finance; Bojan Jelaković, Croatian Society for Hypertension; Zvonimir Marinović, Customs Administration, assistant director, Ministry of finance; Andrea Gross Bošković, Food Safety Centre; Mirta Pokrščanski Landeka, Head of Division, Ministry of Economy, Entrepreneurship and Crafts.
	BACKGROUND	According to mortality and morbidity indicators, chronic non-communicable diseases are most common diseases in Croatia. According to the WHO, 50% of the disease burden in Croatia, measured by the DALY (disability adjusted life years), is caused

		by three leading risk factors: malnutrition, high blood pressure and smoking, followed by increased body mass index, harmful alcohol consumption and insufficient physical activity. In response to the epidemiological situation, among other strategic documents adopted and implemented, Croatia is in a final adoption phase of Action Plan for prevention and control of non-communicable diseases 2019-2025. The National Public Health Institute acknowledges that it is necessary to strengthen existing and initiate new cross-sectoral cooperation to achieve the implementation of the Action Plan.
	OBJECTIVES	To explore with a group of national experts and stakeholders how to improve activities to reduce the burden of chronic diseases through intersectoral cooperation in order to reach the Sustainable Development Goal 3.4. (30% reduction in premature mortality from chronic non-communicable diseases). More specifically, the organisers aimed to achieve a consensus regarding the implementation of the Action Plan in all sectors of society. This would include identifying roles for different sectors in the prevention and reduction of the burden of NCDs and define how better co-operation between departments/sectors can be established.
	CONCLUSIONS AND MAIN ACTION POINTS	All organisations have agreed to participate in the future working group - national intersectoral committee to monitor and coordinate the implementation of the Action Plan. They have also agreed on the need to intensify cooperation and activities in the field of NCDs prevention. To overcome perceived barriers, capacities need to be strengthened in all sectors. Main Action Points: • To establish a multisectoral working group to monitor the implementation of the Action plan.
Greece	**EVENT DATE**	23 February 2018
	SUBJECT	Implementation of Integrated Care Services for Older and Chronic Patients
	ORGANISERS	Organiser: Aristotle University of Thessaloniki and Centre for Research and Technology Hellas in Thessaloniki Moderator: Prof. Apostolos Hatzitolios, Director of the 1st Propaedeutic Department of Internal Medicine of Aristotle University of Thessaloniki, AHEPA University Hospital and Dr Theodore Vontetsianos, MD, President of Greek Network EIP on AHA Rapporteur: N/A

	PARTICIPANTS	**Keynote speakers**: Esteban de Manuel Keenoy Director of the Research Centre of Chronicity at Kronikgune and Dr. Andrew Barnfield, EuroHealthNet. **Participants:** Christos Savopoulos, Medical School of AUTH; Vassiliki Kokkinidou Vice chair of the Board of the AHEPA University Hospital; Ifigenia Kamtsidou, Chair of the Board at the National School of Public Administration; Pantelis Aggelidis, University of Western Macedonia; George Tsoutsas, President of Greek Diabetes Patients Association; D. Theofanidis, Assistant Professor of Nursing; Dr. S. Fotiadis, representative of Public Power Corporation S.A.-Hellas; Mr. Simiakos, representative of the hoteliers of Northern Greece; Gerakina Bisbina, Vice chair of the Board of the Region of Central Macedonia; I. Kanellos, elected member of the Committee of the Municipality of Kastoria; Dr I. Chatzigeorgiou, Member of the Association of Doctors of the Cyclades Islands of Aegean Sea; Maria Stratigaki, Vice Mayor of the Municipality of Athens in charge of Social Policies.
	BACKGROUND	Apart from fragmented efforts by some academic and public institutions, there is no specific policy that exists in Greece focusing on the comprehensiveness, continuity and coordination of for chronic patients. In addition, management of the fiscal crisis in 2009 was based on public spending cuts that did not allow for cost-effective strategies in management of chronic diseases, the major consumer of the health and social budget. Chronic patients' care is currently both inefficient and unsatisfactory, as well as contributing to the overcrowding of hospitals. The implementation of policies and practices to address the problem is needed urgently. The ongoing primary care reform presents a good opportunity to adopt integrated care services. The organisers of the policy dialogue acknowledge that sustainable implementation needs to be supported by all relevant stakeholders.
	OBJECTIVES	To exchange ideas and proposals of implementation strategies. The policy dialogue was an effort to gather commitment to improvement and optimization of integrated care, with special emphasis on elderly and chronic diseases patients.
	CONCLUSIONS AND MAIN ACTION POINTS	It was agreed to continue the communication between the participants with the aim to developing and coordinating cross-sectoral and multi-sectoral activities. Main Action Points: • Major primary care reforms led by the Ministry of Health; • Improved ICT enabling care for older and "less favoured" people in Northern Greece; • Incorporation of use of ICT in health and social care in technological academies; • Capacity building for health professionals by the National Centre for Public Administration and its Vocational Training Institute;

		• Training for management regarding disease prevention and attention to people with NCDs in hospitality sectors by the Northern Greece Hotels Association; • Mobilisation on chronic diseases by major national associations like the Greek National Insurance Company, the Panhellenic Medical Association and the Greece Centre of Disease Control and Prevention.
Hungary	**EVENT DATE**	18 February 2020
	SUBJECT	AI and BI Solutions in Medical Decision Support
	ORGANISERS	Organiser: Zoltan Albert Aszalos, Semmelweis University Moderator: Istvan Schiszler, Health Intelligence Ltd. Rapporteur: Eva Csecsodi, Semmelweis University
	PARTICIPANTS	**Keynote speakers**: Zoltan Onodi Szucs, University of Debrecen, former State Minister for Health; Miklos Szocska, Semmelweis University, former State Minister for Health; Dorota Sienkiewicz, EuroHealthNet. **Participants:** Miklos Szocska, former State Minister for Health, dean Semmelweis University; Zoltán Ónodi Szűcs, former State Minister for Health, Deputy chancellor of Debrecen University (Lung AI programme); Gergő Merész, Head of Technology Assessment Department, National Institute of Pharmacy and Nutrition; Magor Papp, Director, Health Promotion Centre, Semmelweis University; Endre Kontsek, biochemical engineer, multivariate /image data scientist; Márton Kis, healthcare innovation expert, Semmelweis University; Peter Pollner and Gergely Palla, Data Scientists, ELTE University; Péter Toth, Head of Strategy, National IT Service Company Ltd.
	BACKGROUND	AI based medical decision making is a quickly developing area around the globe including Europe. As more and more health-related data is collected, and due to the lack of medical capacity to analyse and interpret such data, AI is to play a stronger role in data interpretation and medical decision-making support.
	OBJECTIVES	Participants in the dialogue looked at two options for information technology: 1. Technology assessment and regulatory environment 2. Artificial intelligence and deep learning algorithms

		Participants discussed what are the requirements for an AI based product or service to be used in medical practice, for unqualified services that are not registered as a product and for certified decision support services. They considered what needs to be done to ensure that products made with community resources are utilised. The discussion touched upon what the national eHealth Network needs to do to accommodate such services and plans for improvements, noting opportunities and challenges.
	CONCLUSIONS AND MAIN ACTION POINTS	Participants agreed that the use of artificial intelligence in national screening programs could significantly increase screening efficiency and early detection of cancer. Many factors impede the widespread diffusion of the technology, which were identified during the discussion and addressed the necessary measures. Main Action Points: • Socio-economic analysis of AI assisted low dose lung screen programmes for citizens over 50, by the National Institute of Pharmacy and Nutrition; • Licensing of the associated algorithm by the National Healthcare Service; • Introducing low dose lung cancer screening as an AI service by the National Healthcare Service.
Iceland	**EVENT DATE**	At least eight policy dialogue meetings were held throughout 2018
	SUBJECT	Facilitating multi-sectoral collaboration by highlighting the synergy between the implementation of the Health Promoting Community programme and the Sustainable Development Goals.
	ORGANISERS	The Directorate of Health, the Health Promoting Community (HPC) team with full support of the Director of Health, led this work. Roles varied depending on the context each time
	PARTICIPANTS	Members of the steering groups are representatives of the Directorate of Health (including the Director of Health), Ministry of Health, Ministry of Social Affairs, Ministry of Education and Culture, Association of Local Authorities and the national Development Centre for the Primary Health Care. Members of consultation platform for the HPC and SDGs are representatives from the Ministry of Transport and Local Government, Ministry for the Environment and Natural Resources, Directorate of Education, Environment Agency, National Planning Agency, Icelandic Transport Authority, National Commissioner of the Icelandic Police, The Office of Ombudsman for Children, Icelandic Food and Veterinary Authority, Administration of Occupational Safety and Health, VIRK – Vocational Rehabilitation Fund, Organization of Disabled in Iceland, UN Association in Iceland, UNICEF, Youth Work Iceland, The

		Multicultural Centre, National Olympic and Sports Association of Iceland, Icelandic Youth Association, National Queer Association of Iceland and National Association for the elderly.
	BACKGROUND	The HPC program is run by the Directorate of Health in Iceland (DOHI). It has been in a developmental phase over the last few years. As part of its participation in C+ WP5, DOHI has among other things committed to the implementation of selected elements of the Dutch JOGG program to strengthen the HPC work at the local level (see the Pilot action plan for further information). But other, identified improvement area was the need to further establish cross-sectoral collaboration of key decision makers and other stakeholders at national level. That should among other things improve the quality and elevate the status of the HPC work. The HPC program is already embedded in national policy documents like the *Public health policy and action plan for health promoting community* (2016-2030), in which one of the policies main goals is that all municipalities should become Health promoting communities. At the same time all UN countries, including Iceland, have committed to the implementation the SDGs and need to report back their progress to the UN. The SDG agenda is therefore a great window of opportunity to approach ministries and other high level policy and decision makers in order to work together towards common goals.
	OBJECTIVES	Establish multi-sectoral collaboration of key stakeholders for the HPC program at the national level by identifying and highlighting the synergy between the implementation of the Health promoting community program and the UN Sustainable Development Goals.
	CONCLUSIONS AND MAIN ACTION POINTS	Aligning the Health promoting community work with the SDG agenda, offering support and solutions regarding implementation of the goals has over time, via numerous steps, resulted in involvement of the Prime minister's office in the HPC work. That involvement further helped to attract other, high level stakeholders to the table, elevating the status of the HPC program and most importantly, has contributed to its quality and overall sustainability. The HPC high level steering group was established in autumn ´18. The HPC and SDGs consultation platform was established at the same time. Main Action Points: • Frame the HPC program work line with the SDGs and in general main governmental issues. • Establish the national HPC high level steering group, prioritizing the involvement of the Prime minister's office and the Association of Local governments. • Establish the Consultation platform for HPC and the SDGs, prioritizing the participation wide range of national level stakeholders.

		• Develop monitoring of the SDGs at local level via the HPC on-line working area.
Ireland	**EVENT DATE**	12 June 2018
	SUBJECT	Socio-economic Inequalities in Tobacco Use
	ORGANISERS	Organiser: Dr Helen McAvoy, Director of Policy at the Institute of Public Health in Ireland, David Bergin, Public Health Development Officer at the Institute of Public Health in Ireland Moderator: Clive Needle, EuroHealthNet Rapporteur: David Bergin, Public Health Development Officer at the Institute of Public Health in Ireland
	PARTICIPANTS	The dialogue brought together participants from the Tobacco and Alcohol Control Unit – Department of Health; Health Service Executive; Irish Cancer Society; The Institute of Public Health in Ireland; and the Department of Public Expenditure and Reform (the department responsible for the development of efficient public spending including equality budgeting).
	BACKGROUND	The policy dialogue was chosen as 2018 is the mid-point of implementation of Ireland's Tobacco Free Ireland strategy. the 2018 State of Tobacco Control in Ireland report created important new insights into the issue of inequalities in smoking. Like many European countries, Ireland has gone through some economic instability over the past decade. The impact of these shifts in critical social determinants of tobacco use is poorly understood. National and international evidence shows that tobacco taxation can drive cessation in low socio-economic groups. However, opinions differ on the expected returns from further significant increases. The impact of major Irish legislative measures (such as the workplace smoking ban, removal of point of sale advertising and introduction of standardized packaging) on inequalities in smoking behaviours remain poorly understood. Stop smoking services and campaigns are increasingly seeking to engage with socially disadvantaged smokers but this is challenging. Partnerships are central to Ireland's approach – a Tobacco Free Partners group meets regularly to share knowledge and input into developments. Ireland's community and voluntary and advocacy sector have supported significant progress on the tobacco inequalities agenda.
	OBJECTIVES	The objectives of the dialogue included identifying and exploring which elements of Tobacco Free Ireland are currently targeted to address socio-economic inequalities in tobacco use; exploring how European partnerships and initiatives could be leveraged in the future to support the reduction of inequalities in tobacco use in Ireland; and identifying which policy and programme actions should be sustained and what new actions should be considered to address inequalities in tobacco use in the future.

	CONCLUSIONS AND MAIN ACTION POINTS	Following conclusions were reached by dialogue participants: • Approaches to addressing inequalities in tobacco use must be effective in targeting and addressing both prevention and smoking cessation; • Tobacco pricing is central to addressing inequalities in smoking – but not enough on its own; • Tobacco and social disadvantage is a cross-government agenda and integration in the operation of statutory services may be beneficial; • Challenging attitudes and norms around tobacco in disadvantaged communities is important but can be challenging; • Knowledge on what works for disadvantaged groups is evolving but incomplete – this creates difficulties in investment of resources; • Partnerships are critical to success in the health inequalities component of tobacco control policies and programmes; • Monitoring and accountability on health inequality dimensions is important; • Effective advocacy is critical to make progress on inequalities – but some of those most vulnerable to tobacco related harm are under-represented. Main Action Points: • Build tobacco into government considerations for equality budgeting. • Build health inequality dimension into the development of clinical smoking cessation guidelines based on best evidence. • Enhance efforts to target investment in tobacco control including resourcing for equity-focused smoking cessation and progressive tobacco taxation. • Greater engagement with disadvantaged groups in particular with people with mental health difficulties.
Italy	**EVENT DATE**	27 November 2019
	SUBJECT	Innovation and strategies for chronicity: building alliances to overcome barriers
	ORGANISERS	Organiser: Giovanni Nicoletti, Ministry of Health; Paolo Michelutti, Italian National Agency for Regional Healthcare Services Age.Na.S Moderator: Graziano Onder, Istituto Superiore di Sanità Rapporteur: Giovanni Nicoletti, Ministry of Health and Paolo Michelutti, Age.Na.S

	PARTICIPANTS	**Keynote speakers:** Silvio Brusaferro, Istituto Superiore di Sanità, Vania Putatti, EuroHealthNet **Participants:** Claudio d'Amario, Ministero della Salute; Giovanni Leonardi, Ministero della Salute; Maurizio Masullo, Ministero della Salute; Isabella Morandi, Age.Na.S., Fabrizia Lattanzio, INRCA; Franco Ripa, Regione Piemonte; Immacolata Cacciapuoti, Regione Emilia Romagna; Federica Michieletto, Regione Veneto; Stefano Genovese, Centro Cardiologico Monzino; Giorgio Casati, ASL Latina; Giuseppe Noto, ASL CN1; Manuela Pioppo, ASL Umbria 1; Elena Tremoli, Centro Cardiologico Monzino; Elisabetta Vittori, ASUR Marche; Silvia Boni, Age.Na.S.; Giselda Scalera, Ministero della Salute; Daniela Galeone, Ministero della Salute; Giuseppe Visconti, ASL Latina; Patrizio Sarto, ASUR Marche.
	BACKGROUND	Multiple actors at regional and national levels share competences in addressing the challenges of preventing and treating chronic diseases.
	OBJECTIVES	To present regional projects and plans to support chronic disease strategies, understand the capacity of regions in coordinated actions and explore how to boost the integration of services and coordination of different plans at regional and national level.
	CONCLUSIONS AND MAIN ACTION POINTS	Participants agreed on the need for more communication and information involving all national, regional and local stakeholders from the planning phase of the innovation. They also agreed on the need to identify and adopt logics and tools for measuring and evaluating innovations so that synergies can be created on solutions that ensure greater effectiveness throughout the country. Main Action Points: • Inclusion of the prescription of physical activity/"health gyms" model in the upcoming review of the policy framework of minimum support services "Livelli essenziali di assistenza" by Veneto Region and the Ministry of Health to extend the model to the national population by 2021. • Establish a standing inter-ministerial working group to review current chronic care models. • Designing core competences profile for health professionals involved in NCD settings by the Ministry of Health and other stakeholders.
Lithuania	**EVENT DATE**	6 May 2019
	SUBJECT	Mental health literacy and challenges of going through a divorce – the needs and opportunities for systematic interdisciplinary cooperation

	ORGANISERS	Organiser: Vilnius University and Institute of Hygiene Moderator: Prof. dr. Natalja Fatkulina, Vilnius University Rapporteur: Dr. Gintarė Petronytė, Institute of Hygiene
	PARTICIPANTS	**Keynote speakers:** Aurelijus Veryga, Minister of Health; Prof. dr. Sigita Lesinskienė, Vilnius University; Ingrida Zurlytė, World Health Organization, Country Office of Lithuania; Algirdas Utkus, Vilnius University; Lina Papartytė, EurohealthNet. **Participants**: Goda Bačienė, The Lithuanian Society of Child and Adolescent Psychiatrist; Algimanta Buckiūnienė and Vincentas Liuima, Institute of Hygiene; Aneta Buraitytė, Barbora Butkutė, Edita Laurinavičienė, Ignas Rubikas and Eglė Čaplikienė, Ministry of Social Security and Labour; Aurelija Čepulytė, National Mental Health Centre; Jonė Čėsnaitė, Vaiva Hendrixson, Jūratė Jūrevičienė, Vytautas Kasiulevičius, Algirdas Utkus, Vilnius University; Sigutė Norkienė, Aldona Rauckienė-Michaelson, Klaipėda University; Neringa Tarvydienė, Algirdas Raslan, National Health Board; Vaidotas Urbonas, Lithuanian Pediatrician Society; Audronė Vareikytė, Lithuanian Municipality Association.
	BACKGROUND	Divorce for parents and their children is a challenging process which causes a lot of stress in different phases of divorce and adaptation after divorce. In terms of the ratio of marriages and divorces, there are currently 65 divorces per 100 marriages in Lithuania – one of the highest numbers in the European Union. Lithuania shows initiative to investigate the situation, to develop and implement a system of systematic help for divorced families. The theme of marital divorce requires close cooperation between the ministries of justice, social security and labour, health care, education, science and sport, internal affairs, and also municipalities, public health bureaus, non-governmental organizations, various specialists in responding to the health and psychosocial needs of divorced (or going through a divorce) adults and children of different ages.
	OBJECTIVES	To gain insight on how to provide the needed supportive services for the divorced families (adults and children) or families going through a divorce.
	CONCLUSIONS AND MAIN ACTION POINTS	Interinstitutional cooperation as well as cooperation between different levels is needed. These are municipalities, the Ministries (Government) and non-governmental organizations with strong support from researchers' and universities. Further development of mental health services is needed. The development of family packages would offer families full assistance, e.g. by a psychiatrist and/or a psychologist, social worker and directed to other specialists if needed. Main Action Points: • Establish interinstitutional collaborative network between Ministry of Health Care, other ministries, municipalities, and non-governmental organisations to ensure the mental health literacy of the population.

		• Training programme "Improvement of Mental Health Literacy" for educational, social and health care specialists, who are working with children and families (teachers, doctors, nurses, social workers, public health specialists, psychologists).
Malta	**EVENT DATE**	3 September 2019
	SUBJECT	Promoting water consumption through environmental change: the way forward
	ORGANISERS	Organiser: Dr. Daniel Cauchi, Resident Specialist Public Health Medicine, Dr. Paula Vassallo, Director Health Promotion and Disease Prevention, Ministry for Health Moderator: Prof. Charmaine Gauci, Superintendent of Public Health, Ministry of Health Rapporteur: Dr. Daniel Cauchi, Resident Specialist Public Health Medicine, Ministry of Health
	PARTICIPANTS	**Keynote speakers**: Mr. Richard Bilocca, CEO, Water Service Corporation; Dr Andrew Barnfield, EuroHealthNet. **Participants**: Dr. Paula Vassallo (Director), Health Promotion and Disease Prevention Directorate; Dr. Mariella Borg Buontempo, Health Promotion and Disease Prevention Directorate; Dr. Karen Vincenti , Ministry for Health; Wendy-Jo Mifsud, Planning Authority (PA); Matthew Costa, Water Services Corporation (WSC); Jeanice Mallia, Water Service Corporation (WSC); Mariella Mangion , EU Affairs representative ; Joseph Caruana, Islands and Small States Institute (ISSI), University of Malta (UoM); Antoine Zammit – Local Government Division.
	BACKGROUND	Around 70% of Maltese adults and 40% of children are overweight or obese. Sugar sweetened beverages (SSBs) have been linked to overweight and obesity, the development of Type 2 diabetes as well as dental caries. Substituting water for SSBs and promoting water intake - such as through making free potable drinking water (e.g. through water fountains) prominently and widely accessible in public facilities - is a key strategy to prevent obesity and associated negative health consequences. Substantial work is already being carried out to improve access to drinking water in Maltese schools, but no measures are being implemented at the neighbourhood and locality level. The installation of water fountains in public open spaces (e.g. playgrounds), communal spaces such as sports grounds, village squares etc., and public buildings (e.g. local council and government offices), would increase access to free, safe drinking water and encourage substitution for SSBs.

	OBJECTIVES	To promote discussion of how water consumption can be increased through improving access to and availability of safe drinking water at the neighbourhood or locality level. To examine each organization/institution's potential contribution towards the main objective within a collaborative, intersectoral framework, and establish next steps to address the issue.
	CONCLUSIONS AND MAIN ACTION POINTS	Participants agreed to set up a working group to promote water consumption in Malta and increase availability/accessibility of potable water in public places through the installation of water dispensers. It would be necessary to liaise with stakeholders across sectors and take a collaborative approach. Main Action Points: • Promote increased water consumption in Malta by facilitating accessibility to potable water dispensers in different localities, using key indicators such as water consumption, plastic bottles saved, CO_2 saved through reductions in transportation traffic (i.e. less need for distribution of bottled water) and anonymised user data (e.g. level of use by people of different SE groups). • Engage with the Water Services Corporation, the Planning Authority and Local Councils to promote water consumption through environmental change at community level. • Ensure that vulnerable groups are not 'left behind' or disadvantaged in their access to water and adopt a social determinants of health approach to ensure equitable access to water dispensers. This could be achieved through a set up of local mechanisms with resident associations and local councils to obtain feedback from residents of localities where water dispensers will be installed.
Netherlands	**EVENT DATE**	22 January 2020
	SUBJECT	Identifying intersectoral strategies to promote walking and cycling before, during and after work in the Netherlands to prevent NCDs
	ORGANISERS	Organiser: Sandra van Oostrom and Lea den Broeder, National Institute for Public Health and the Environment Moderator: Nicoline Tamsma, European Commission and Lea den Broeder, National Institute for Public Health and the Environment Rapporteur: Sandra van Oostrom, National Institute for Public Health and the Environment
	PARTICIPANTS	**Keynote speakers:** Ingrid Stegeman, EuroHealthNet; Ernest van den Bemd, Dutch Cyclists' Association and Joost Christiaansen, Water Authority Rivierenland.

		Participants: Miranda Vroom and Annemarie Jansen, Ministry of Health, Welfare and Sports; Marsha Oosterbaan, Ministry of Infrastructure and Water Management; Ernest van den Bemd, Dutch Cyclists' Union; Jeannette van Zee, Netherlands Patients Federation; Frank Hart, Wandelnet (network of recreational walking); Maarten Kroezen, on behalf of NS (Dutch Railways) and Femke Hulshof, CEO Alliantie Werken in beweging (national alliance for exercise at work).
	BACKGROUND	Sufficient physical exercise reduces the risk for a number of important chronic diseases including type 2 diabetes, coronary heart disease, stroke, depression, breast and intestinal cancer. For older people physical exercise reduces the risk for fractures, physical impediments, cognitive decline and dementia. However, active commuting is not enough; physical exercise throughout the day is as important. Walking and biking are modes of exercise that are easily put to practice in daily life and may help change sitting behaviour. The Alliance 'Werken in Beweging', formed by the Dutch Cyclists' Association and Wandelnet (network of recreational walking) was set up in line with goals of the National Prevention Agreement, i.e. to encourage daily exercise among employees to prevent obesity. The Alliance aims to launch an online platform to inspire and inform employers about possibilities to promote walking and cycling to / during work and to offer this in the form of step-by-step plans, downloads, etc., as concretely and as easily as possible. The actual implementation of these programmes and activities at the workplace is thus the central aim of the project of the Alliance 'Werken in Beweging'.
	OBJECTIVES	The two action oriented sub-questions were: 1) How can the ministries engaged (Ministry of Health, Welfare and Sports, Ministry of Social Affairs, Ministry of Infrastructure and Water) effectively contribute to structural activities: coaching, organisations' sports day?; and 2) How can societal stakeholders contribute?
	CONCLUSIONS AND MAIN ACTION POINTS	The coordinating body Alliance 'Werken in Beweging' will bring the theme of this Policy Dialogue forward by collaborating with stakeholders from policy and practice in different sectors and policy fields such as social affairs, infrastructure, transport and health. Each participant in the Dialogue formulated an action point and will continue with their own actions, they included: • Promoting 'Cycling as medicine' by pilot group of physicians and patients; • The Ministry of Infrastructure and Water Management has a cycling mission: every employer in the Netherlands makes an effort for 10% more employees to cycle to work. • Almere city will design a physical activity-friendly city.

		• The Dutch Patients Association will incorporate practical guidance for stimulating physical activity among workers with a chronic disease into the 'central information point for chronic diseases & work'. • Waterschap Rivierenland is disseminating information about its role as cycling friendly employer to other national water authorities.
Poland	**EVENT DATE**	27 of November 2018
	SUBJECT	Prevention of cardiovascular system and respiratory system diseases and their consequences by modification of the Comprehensive Geriatric Assessment
	ORGANISERS	Organiser: National Institute of Geriatrics, Rheumatology and Rehabilitation Moderator: Anna Kozieł, Senior Health Specialist at the World Bank Rapporteur: Tomasz Targowski, Head of Department of Geriatrics and Ewa Kądalska, Domestic Consultant in Geriatric Nursing Didactics, at National Institute of Geriatrics, Rheumatology and Rehabilitation;
	PARTICIPANTS	**Keynote speakers:** Dorota Sienkiewicz, EuroHealthNet; Marek Tombarkiewicz, Director of the National Institute of Geriatrics, Rheumatology and Rehabilitation; Tomasz Kostka, Domestic Consultant in Geriatrics - Geriatric Comprehensive Assessment (CGA); Robert Olszewski, Head of Department of Gerontology, Public Health and Didactics, National Institute of Geriatrics, Rheumatology and Rehabilitation; Tomasz Targowski, Head of Department of Geriatrics, National Instituteof Geriatrics, Rheumatology and Rehabilitation. **Participants:** Sławomir Gadomski, Undersecretary of State, the Ministry of Health; Maciej Miłkowski, Undersecretary of State, the Ministry of Health; Roman Topór-Mądry, President of Agency Assessment of Medical Technologies and Tariffation; Dominik Dziurda, Director of Department of Health Care Services, Agency Assessment of Medical Technologies and Tariffation; Leszek Szalak, Deputy Director of Department of Public Health Services, National Health Found; Joanna Kilkowska, Deputy Director of Health Policy Department of the Ministry of Health; Marcin Rynkowski, Director of Department of International Cooperation of the Ministry of Health; Dariusz Poznański, Deputy Director of Department of Public Health the Ministry of Health; Małgorzata Michalska, Head of Policy Department, Department of Public Health of the Ministry of Health; Kamila Malinowska, Deputy Director of Department of Analysis and Strategy of the Ministry of Health; Katarzyna Przybylska, Department of European Funds and e-Health of the Ministry of Health; Grzegorz Juszczyk, Director of the National Institute of Public Health; Marek Tombarkiewicz, Director of the National Institute of Geriatrics, Rheumatology and Rehabilitation; Ewa Kądalska, Domestic Consultant in Geriatric Nursing Didactics, National Institute of Geriatrics, Rheumatology and Rehabilitation.

	BACKGROUND	Heart failure is a disease frequently diagnosed in Poland. In 2015, it was diagnosed in around 226 thousand people, but morbidity forecasts indicate that in 2025 the figure will be 258 100 (Rywik TM et al. 2011) Starting from the age of 60, the percentage of those suffering from heart failure doubles with each decade of life. (4, 5). The prevalence of HF in the group of people over 80 is estimated at 10%. The classic model of diagnostic procedure in HF is to assess clinical symptoms and, if present, to perform an echocardiographic examination. Assessment of plasma concentration of N-terminal prohormone of brain natriuretic peptide (NT-proBNP) can be used as an initial diagnostic test, but mainly in patients with an unclear onset of symptoms or if there is no access to echocardiographic examination. Access to echocardiographic examination is sometimes difficult, which may result in a delay in diagnosis and treatment, leading to lower effectiveness of the treatment. The NT-proBNP assessment is mainly performed in large hospitals, academic centres, but is not widely available or used in screening.
	OBJECTIVES	To present state of the art and Polish experience in Comprehensive Geriatric Assessment (CGA); To assess the benefits of enriching CGA; To assess the economic justification for inclusion of NT-proBNP and spirometry in CGA.
	CONCLUSIONS AND MAIN ACTION POINTS	During the meeting, the main areas of future activity were selected: • increasing the availability of CGA for elderly patients (60+) through training and empowering a wider group of providers (not only geriatricians): doctors, nurses, physiotherapists to perform the geriatric evaluation of patients, introduction of incentive mechanisms for conducting VES-13 and Total Geriatric Assessment in primary care facilities and non-geriatric hospital departments. • extending the list of current laboratory and specialist tests performed as part of the Total Geriatric Assessment by 2 obligatory tests: NT-proBNP and spirometry; and re-evaluation of the costs of the procedure. • reactivation of the Team of Experts in Geriatric Care at the Ministry of Health for updating and disseminating standards of geriatric care, proposing innovative solutions in geriatric care, implementing the integrated geriatric care model.
Portugal	**EVENT DATE**	30 January 2019
	SUBJECT	Advertisement of Food and Beverages to Children
	ORGANISERS	Organiser: Directorate-General of Health Moderator: Miguel Telo de Arriaga, Maria João Gregório and Sofia Mendes de Sousa, Directorate-General of Health Rapporteur: Joana Larangeira, Nicole Chaves and Rita Horgan, Directorate-General of Health

	PARTICIPANTS	**Keynote speakers:** Maria João Gregório Directorate-General of Health; Dorota Sienkiewicz, EuroHealthNet **Participants**: Gisela Serafim, Consumer Directorate-General; Cristina Rodrigues, People–Animals–Nature Political Party; Sara Martins, People–Animals–Nature Political Party; João Toledo, Ministry of Agriculture; Filipa Menezes, Portuguese Regulatory Authority for the Media; Rui Lima, Directorate-General of Education; Rosário Tereso, The Portuguese Association for Consumer Protection; Filipa Vasconcelos, Food Safety and Economic Authority; Telmo Carvalho, Portuguese Institute for the Ocean and Atmosphere.
	BACKGROUND	In Portugal 30,7% of children are overweight or obese. The eating habits of the Portuguese children and adolescents are concerning: 69% of children eat less than 400g of fruit and vegetables per day, 41% of the adolescents consume soft drinks daily and 43% of them drink more than one soda per day. Food advertising to children promotes products that are mainly high in sugar and fat. The evidence indicates that unhealthy food and beverage marketing increases dietary intake and preference for energy dense, low-nutrition foods and beverages. Thus, unhealthy foods and beverages marketing increases intake and influences dietary preferences in children during or shortly after exposure to advertisements.
	OBJECTIVES	The main objective of the policy dialogue was to find ways to tackle the issue of advertising of unhealthy food and beverages to children at national level. The specific objectives included understanding the perception of each participating entity regarding the current status of the matter; understanding what each participating entity has done to date to address the matter and how each participating entity could contribute to next steps to tackle the issue; to discuss the effectiveness of regulation versus self-regulation and the main barriers to regulation of food and beverage advertisements to children.
	CONCLUSIONS AND MAIN ACTION POINTS	Participants concluded that that self-regulation is not enough, highlighting the need for health literacy improvement among population. "Trendy" advertising of healthy foods and beverages, through young influencers, was considered a smart option. Main Action Points: • to create a working group to close the ongoing legislative proposal regarding advertisement of food and beverages to children. This proposed legislation would limit advertising of foods and beverages with a high content of sugar, fat or sodium in preschool, basic and secondary education establishments, in children's playgrounds and within a specific radius of those places, as well as in publications, programmes, or activities for minors.

		• To create a working group focused on the promotion of Health and Food Literacy amongst the Portuguese population. The objectives would be to define actions that would have two aims: (1) to improve health and food literacy of the population, enabling them to be more critical towards advertising and marketing of foods and beverages; and (2) to work together with digital influencers in order to raise awareness about this issue.
Slovakia	**EVENT DATE**	29 October 2019
	SUBJECT	Collaborative approach in Control and Prevention of cardiovascular and metabolic disorders
	ORGANISERS	Organiser: Ministry of Health Moderator: Zuzana Gulová Rapporteur: Zuzana Matloňová, Monika Hurná, Ministry of Health
	PARTICIPANTS	**Keynote speaker**: prof. Stanislav Špánik, State secretary; Andrew Barnfield, EuroHealthNet. **Participants**: doc. Liptáková Adriana, Representative of Section of Health; doc. Kállayová, Representative of Public Health Department; MUDr. Fábry' expert in diabetology for adults, Ministry of Health; MUDr. Hlivák, expert in Cardiology, Ministry of Health; MUDr. Šimková expert in GP, Ministry of Health; Mgr. Gondášová, Public Health expert, Ministry of Health.
	BACKGROUND	Cardiovascular diseases and cancer account for almost three-quarters of deaths in Slovakia. Heart diseases and stroke are the leading causes of death, followed by lung and colorectal cancers. Slovakia wishes to support health promotion across the broader health system, increase the use of clinical preventive services, provide services that extend care outside the clinical setting, implement interventions that reach the whole population.
	OBJECTIVES	To discuss with the experts on diabetology, cardiology, general medicine and public health how to collaboratively approach prevention of cardiovascular and metabolic disorders. More specifically, participants aimed to prepare the concept of the National Program of Health Promotion and Healthy Lifestyle and discuss the creation and implementation of standard diagnostic and therapeutic procedures in the field of diabetology for adults and children.
	CONCLUSIONS AND MAIN ACTION POINTS	The conclusions of the dialogue will serve as a starting point for the creation of a new National Health Promotion and Healthy Lifestyle Programme for 2020-2026, which the Ministry of Health should submit for the Government's meeting discussion and further approval. This process requires the highest political support, as well as appropriate investment in terms of stakeholder efforts, prioritization and financial resources.

Slovenia	**EVENT DATE**	30 January 2020
	SUBJECT	Integrated care in tackling chronic diseases
	ORGANISERS	Organiser: National Institute of Public Health of Slovenia (NIPH) Moderator: Jelka Zaletel, Branko Gabrovec, NIPH Rapporteur: Branko Gabrovec, Ivana Kršić, NIPH
	PARTICIPANTS	**Participants**: Klavdija Kobal Stravs, Ministry of Health; Boris Kramberger, Health Insurance Institute of Slovenia; Karmen Janša (HIIS); Milivoj Piletič, General hospital Novo mesto; Dušan Jukič, General hospital Novo mesto / Patient representative; Radivoje Pribaković Brinovec, NIPH; Danica Rotar Pavlič, Slovenian Medical Association, Slovenian Family Medicine Society; Anita Prelec, Nurses and Midwives Association of Slovenia; Mila Mršić, Primary healthcare centre Novo mesto; Sabina Klemenčič, Social care, Primary healthcare centre Novo mesto; Mojca Gabrijelčič, NIPH/EuroHealthNet; Denis Oprešnik, NIPH.
	BACKGROUND	The policy dialogue fits into broader perspective of Slovenian national health resolution 2016-2025. On the basis of JA CHRODIS recommendations and set of criteria, representatives of General hospital Novo mesto and Heath centre Novo mesto made a proposal for integration of care between primary and secondary level of healthcare for persons with multiple, complex needs, with particular emphasis on patient participation. Barriers and facilitators for integration of care were analysed with use of focus groups, in-depth interviews, case studies and SWOT analysis. Facilitators include e.g. the existence of professional guidelines, well-developed medical activity of primary and secondary level and the impression of good collaboration among health professionals. Barriers present many recognizable features of current healthcare, e.g. lack of systematic communication (patient as the main transmitter of information among different healthcare professionals), the current organization of care supports the fragmentation of care, which focuses on individual diseases. Case studies provided important qualitative data. Among other things, people with the highest risk of poor health outcomes are those suffering major socioeconomic deprivation. An integrated model of care, besides including social welfare, involves proactively linking health service and social work centres.
	OBJECTIVES	To propose the integration of care model, its implementation and sustainability. More specifically, this would include mapping of the key players including potential owners of the process, potential positions of power and potential sustainability drivers;

		as well as identification of smart steps forward to support policy process, proposed integrated care model implementation and sustainability in short, middle and long term.
	CONCLUSIONS AND MAIN ACTION POINTS	Invited Policy dialogue participants were a heterogenic group with a strong patient orientated professional commitment. Thorough and comprehensive debate contributed to five action plan proposals: • Identification of key chronic conditions**;** • Creation of national streams and pathways for chronic conditions; • Pilot project for facilitation of integrated care with method of bundle payment of healthcare services; • Upgrade of e-consultation, and • the commitment of members to hold ad hoc meetings regularly for next 2 years.
Spain	**EVENT DATE**	10 June 2019
	SUBJECT	Health Impact Assessment. Alternatives for an effective implementation of Article 35 of the Spanish Public Health Act 33/2011
	ORGANISERS	Organiser: General Directorate of Public Health, Quality and Innovation, Ministry of Health and Carlos III Health Institute Moderator: Antonio Sarría. Director of the National School of Health. Carlos III Health Institute Rapporteur: Jara Cubillo and Alberto Martin-Pérez, Health Promotion Department, Ministry of Health; Iñaki Imaz, Carlos III Health Institute
	PARTICIPANTS	**Keynote speakers**: Hugo Morán. Secretary of State of Environment, Ministry of Ecological Transition (MET); Faustino Blanco, General Secretary of Health and Consumer Affairs, Ministry of Health (MoH); Lina Papartyte, EuroHealthNet. **Participants**: Pilar Aparicio, General Director of Public Health, Quality and Innovation, MoH; Francisco Javier Cachón, General Director of Biodiversity and Environmental Quality, MET; Ismael Aznar, Head of Cabinet, Secretary of State of Environment, MET; Francisco Muñoz, Cabinet Advisor, Secretary of State of Environment, MET; Pilar Campos, Deputy Director of Health Promotion and Public Health Surveillance, MoH; Covadonga Caballo, Deputy Director of Environmental Health and Occupational Health, MoH; Julio Bruno, Head of Technical Cabinet, General Secretary of Health and Consumer Affairs, MoH; Eugenio Domínguez, Deputy Director of Environmental Assessment, MET; Maj Britt Larka, Deputy Director of Air Quality and Industrial Environment, MET; Yolanda Agra, Deputy Director of Quality and Innovation, MoH; Francisco Vargas, Margarita Palau, Santiago González, General Sub-directorate of Environmental Health and Occupational Health, MoH; María Terol,

		Claudia Ruiz-Huerta, General Sub-directorate of Health Promotion and Public Health Surveillance, MoH; Carmen Arias, General Sub-directorate of Quality and Innovation, MoH.
	BACKGROUND	According to the General Public Health Law (Law 33/2011), the Health Impact Assessment (HIA) consists of "a combination of procedures, methods and tools with which a standard, plan, program, or project can be analysed in relation to its potential effects on the health of the population and about their distribution". The HIA is included in article 35, which establishes that Public Administrations must submit to HIA the standards, plans, programs and projects that have a significant impact on health. However, since the publication of Law 33/2011, the MoH has not developed the article 35. Some Autonomous Communities (Basque Country, Catalonia, Andalusia and Valencian Community) decided to take the initiative and have normatively developed the application of the HIA in their territorial scope. The dilemma is whether the health authorities should have a greater participation (integration) in the Environmental Impact Assessment, or if they should develop the methodology and the application of the HIS in a parallel and independent way; or adopt a mixed and integrated approach.
	OBJECTIVES	To reinforce collaboration between the MoH and the MET to jointly address health and environment and to assess the possibility to include health indicators into Environmental Impact Assessment (EIA). They specifically hoped to achieve a clear commitment to intersectoral work addressing equity and social and environmental determinants of health, as well as the establishment of formal mechanisms for joint work between the two ministries.
	CONCLUSIONS AND MAIN ACTION POINTS	The action plan detailed an agreement to create an Inter-Departmental Working Group between the two Ministries to address the above-mentioned issues. This is a permanent working group with participants from both Ministries (Ministry of Health, Consumer Affairs and Social Welfare and Ministry for Ecological Transition). Main Action Points: • Establishment of criteria for HIA within EIA that takes into account equity and social determinants of health • Joint elaboration of methodological guidelines and "ad hoc" tools • Addressing involvement of Autonomous Communities and adequate channels and procedures for it • Definition of the HIA scope of application, particularly when there is no implicit link with the EIA • Joint evaluation of alternative solutions for the establishment of specific regulations to perform HIAs.
	EVENT DATE	12 November 2019

EU Level Policy Dialogue	**SUBJECT**	Employment and Chronic Conditions. Towards inclusion, integration and reintegration of people with chronic conditions in the workplace and improvement of workers' health and wellbeing: the CHRODIS PLUS Workbox
	ORGANISERS	Organiser: Matilde Leonardi, Fabiola Silvaggi, Michela Eigenmann, Fondazione IRCCS Istituto Neurologico Carlo Besta, Italy; Jaana Lindström, Eeva Rantala, Finnish Institute for Health and Welfare (THL); Iñaki Imaz Iglesia, Instituto de Salud Carlos III, Spain; Zoltan Aszalos, Semmelweis University Budapest, Hungary Moderator: Clive Needle, EuroHealthNet Rapporteur: Alison Maassen, EuroHealthNet; Michela Eigenmann, Fondazione IRCCS Istituto Neurologico Carlo Besta
	PARTICIPANTS	**Speakers:** Rokas Navickas, VULSK Lithuania, CHRODIS PLUS Scientific Coordinator; Matilde Leonardi, FINCB Italy; Jaana Lindström, Eeva Rantala, THL Finland; Katie Gallager, European Patients Forum; Raymond Vanholder, European Chronic Disease Alliance; Alberto Lapi, Accenture, Representative of Enterprises; Sarah Cospey, European Agency for Safety and Health at Work, EU-OSHA; Anna Ludwinek, European Foundation for Improvement of Living & Working Conditions, EUROFOUND; MEP Massimiliano Salini, Group of the European People's Party.
	BACKGROUND	The increasing prevalence of chronic conditions in Europe's working age population underlines the need for a European strategy towards inclusion, integration and reintegration of employees in the workplace as well as towards the development of actions to support workers' health and wellbeing. The JA CHRODIS PLUS Policy Dialogue on aimed to identify the practical steps for EU policy to support employment for people with chronic diseases and to address the impact of chronic diseases in the employment sector.
	OBJECTIVES	To bring together EU stakeholders around the benefits of the workplace inclusion, integration and reintegration of people with chronic conditions; To present the CHRODIS PLUS Workbox on Employment and Chronic Conditions which includes a Training Tool for managers on workplace inclusion and work ability and a Toolkit for fostering employees' wellbeing, health and work participation (which is freely available in different languages on the CHRODIS website)
	CONCLUSIONS AND MAIN ACTION POINTS	In terms of concrete suggestions on how EU policy can support the implementation of these instruments, several points were raised and suggested for future activities. • The first opportunity is through integrating workplace health in the 'state of health in the EU cycle'. (i.e. 'Health at a glance' report and country reports).

		• The second suggestion is that many aspects explored by the Training for managers in particular can be taken up in the EU Semester process, proposing recommendations along these lines for reform to Members States in the areas of health and employment for example. • A third avenue of action is through public awareness campaigns such as the anti-discrimination awareness campaign currently ran by the Disability unit within the European Commission which, as part of their campaign, is organising local events for national employers on reasonable accommodation. • The fourth possible suggestion is the promotion of the Workbox for employment and chronic conditions through activities with social partners. • The fifth suggestion is to try, each stakeholder through its means, to reach out to public external programs that offer support to small businesses. • The sixth suggestion concerns the EU that needs to keep enforcing effective compliance with health and safety risks in workplaces. Employers must assess risks, particularly to vulnerable workers, including those with CDs. It is not always known that there is this specific focus on vulnerable workers. • Last important role the EU can play is cooperation and joint policy to bring public health, OSHA and employment services together.
EU Level Policy Dialogue	**EVENT DATE**	26 June 2020
	SUBJECT	Funding of Health Promotion and Chronic Disease Prevention
	ORGANISERS	Organiser: EuroHealthNet Moderator: Caroline Costongs and Alison Maassen. EuroHealthNet Rapporteur: Lina Papartyte, EuroHealthNet
	PARTICIPANTS	**Keynote speakers**: Iñaki Imaz Iglesia, Instituto de Salud Carlos III, Spain; Alison Maassen, EuroHealthNet. **Participants**: Lina Jaruševičienė, Vice Minister, Ministry of Health, Lithuania, Gitana Ratkiene, Adviser, Department of Personal Health, Ministry of Health, Lithuania; Edita Laurinavičienė, Head of Department on EU Funds, Ministry of Health, Lithuania; Riitta Aejmelaeus, Budget Counselor, Ministry of Finance, Finland; Ana de Blas. Budget for health promotion and disease prevention management, Madrid Local Authority of Health, Spain; Małgorzata Majewska, Head of EU Support Coordination and Programming Department, Ministry of Health, Poland; Daniela Kallayova, Senior Expert of Public Health, Ministry of Health, Slovakia; Bart Ooijen, Head of Section, Youth, sport, research and innovation in healthcare and welfare, Permanent Representation to the EU, Netherlands; Filippo Munisteri, Team Leader, Social Investment, Directorate-General for Economic

		and Financial Affairs, European Commission; Jaroslaw Waligora, Policy Officer, Directorate-General for Health and Food Safety, European Commission; Petra Goran, Policy Analyst, Inclusive growth, Directorate-General for Regional and Urban Policy; Lorena Androutsou Directorate-General for Economic and Financial Affairs, European Commission.
	BACKGROUND	Given the links between COVID-19 risk factors and chronic illness, decision-makers should have renewed urgency to step up their actions in order to prevent the development of largely-preventable chronic conditions. At the same time, the physical distancing measures required to slow the spread of COVID-19 have had direct or indirect impacts on European citizens' stress levels, as they are exposed to economic uncertainty, have reduced opportunities to stay physically active, and may be in toxic home environments where they have less access to healthy foods, more exposure to violence or greater risk of substance abuse. Where will the funding for this response come from? At present, important changes to the EU's multi-annual financial framework (MFF) have been proposed as a part of the response to the COVID-19 crisis. The health programme, in particular, may receive a much higher budget than in previous periods. This is an important opportunity for decision-makers to explore specific ways in which they can support funding of health promotion and prevention of chronic diseases, which are both affecting and affected by COVID-19.
	OBJECTIVES	The primary focus of the policy dialogue was on understanding the ways in which revised European Union funding mechanisms may be structured and how they may be used towards prevention of chronic diseases and to support the broader health system during this crisis period and its aftermath. It also explored the specific capacity building needs decision-makers may have in accessing these funds. The main outcome of the policy dialogue was a list of steps for action for EU and national policy and decision-makers to increase equitable and sustainable funding and financing of health promotion and chronic disease prevention.
	CONCLUSIONS AND MAIN ACTION POINTS	The discussion focused on how ministries of health and other organisations working on health normally access information about EU-level initiatives, opportunities and funding. It was widely agreed that the information from the source (e.g. European Commission) must be as clear as possible, which would facilitate the inter-ministerial as well as vertical communication within member states. It was also agreed that strong working relationships and communication channels between ministries (e.g., health, justice, finance, social affairs, environment) are also key to improving the flow of information about different, potentially-relevant funding opportunities. Future actions in the field of funding and financing health promotion and chornic disease prevention should include further focus on capacity building of regional and local organisations to request financial assistance, absorb money and subsequently

		manage projects on the ground. Overall, it was found that smaller organisations on the ground are harder to reach by national fund managing authorities, therefore strengthening of national focal points (in health) and improving their cooperation across sectors was welcomed (e.g., bundling of projects). It has also been concluded that empowering local organisations to participate in European initiatives has added value at regional level. When regional authorities are more pressured to respond to immediate care needs, local units have more time to dedicate to health promotion and disease prevention.

Co-funded by
the Health Programme
of the European Union

8.2 Questionnaire for the national organiser of the policy dialogue

This questionnaire will guide the preparation of the policy dialogues at national level. It helps partners to identify the problem they want to address, map relevant policymakers and key stakeholders to be invited and start preparing the logistics of the meeting (including dates, venue, catering, etc). The responses will form part of the deliverable and facilitate the discussions around the possible follow-up actions. Clear and detailed responses are therefore important.

Topic / Problem Identification (Context Analysis)

It is essential to have a clearly identified problem that needs attention from national and/or regional policymakers and/or other key stakeholders. This topic should relate to the overall CHRODIS+ objectives on tackling chronic diseases. For policy dialogues on health promotion, we encourage partners to refer to the existing JA-CHRODIS Country Reviews and to bear in mind what may be the information needs of the policy dialogue when preparing the new Country Reviews for CHRODIS+. For an effective policy dialogue, the scope should be wide enough to leave room for meaningful discussion, yet specific not to get lost and to arrive at relevant next steps, i.e. actions.

QUESTIONS

Which topic will your policy dialogue address? Please explain the policy background.

Specify the problem the policy dialogue will address.

Please provide any (evidence-based) background material that may be shared with participants.

What will be the working title of the dialogue?

Stakeholder Analysis

Key to policy dialogues are policymakers; those with the **power** (knowledge and influence) as well as **interest** (relevant portfolio) to initiate change in a country and a certain topic. The best placed to achieve this are senior-level people at national and/or regional governments, such as in the ministries of health, welfare, social affairs or employment, depending on the country context.

To initiate actual change, discussion, negotiation and engagement of all relevant stakeholders will be necessary. This is where the concept '*health in all policies*' comes into practice as health influences but is also influenced by other (policy) sectors. It makes thus sense to think outside the health ministry and consider areas such as environment, infrastructure or education. We strongly advise you to have the ministry of finance, health insurers or other investors invited to the policy dialogue. To have a meaningful dialogue and arrive at solutions adequate for all, other voices (i.e. stakeholders) need to be heard as well, which is why we recommend inviting representatives of e.g. NGOs for the voice of civil society, academia

for expert input, the potential implementers of a certain policy and/or the private sector. We suggest to have 3-5 participants and potentially a keynote speaker to set the scene, in addition to the facilitator.

QUESTION

Which *policymakers* do you identify to be relevant? Please give their name, organisation and position.

Which *stakeholders* do you consider relevant for your dialogue? Please give their name, organisation and position.

EU added value

Since the policy dialogues are co-funded through a European Joint Action, it is essential to highlight the EU added value in them. Chafea has identified a variety of activities that can deliver EU added value, e.g. exchanging good practices, using EU policy instruments or benefitting from economies of scale. The national policy dialogues will contribute to the EU wide exchange as the action plans will show how next steps have been elaborated in one country and can be an inspiring source for other countries, even if the topic is different.

In addition, EuroHealthNet will encourage partners to look for EU tools that can be used as part of the policy dialogues. Examples are the European Structural and Investment Funds (ESIF), the EU Semester process (including the Country Reports, National Reform Programmes and Country Specific Recommendations), the Social Scoreboard of the European Pillar on Social Rights and/or the Country Health Profiles. Partners can consider using the CHRODIS Platform to find good practices, including policies, on chronic diseases.[xvi] Furthermore, European policy initiatives could be used as background, like the EU's reflection process on chronic diseases, the Steering Group on Promotion and Prevention or WHO Europe's Action Plan on NCDs.

QUESTION

How will you use EU tools and/or instruments in your policy dialogue? How will you address EU added value? Please explain creatively.

Consensus Statement

Task 4 of WP4 is the preparing of "*a consensus statement concerning EU added value of cross-country collaboration in the field of chronic diseases and the sustainability of JA-CHRODIS and CHRODIS+*", led by the Italian Ministry of Health and the Regional Ministry of Health of Andalusia. The statement should be endorsed by the Governing Board (GB) members and published at the end of the Joint Action. It will analyse the sustainability and integration of outcomes in national policies and therefore make use of the input and conclusions from the policy dialogues.

This document will only have value if it really represents the views of the Member States at the national level. We therefore believe that it should be built with a bottom-up approach, giving each Member State

the opportunity to contribute both by raising its expectations and by providing its own considerations and input on EU added value. Policy dialogues can offer the occasion to address these contributions.

QUESTION

Do you think your policy dialogue is the appropriate vehicle to provide content for discussion at European level?

If so, would you be able to include a slot for a discussion on such content in your policy dialogue?

What support do you expect from task leaders to prepare for this discussion?

Are you willing to give feedback on the outcome of this discussion?

Logistics

Language

It is advisable to conduct the policy dialogue in the partner's national language to achieve high(er) participation, engagement and ownership of results later.

QUESTION

In what language will the policy dialogue be held?

External Facilitator

Engaging an experienced facilitator to moderate the policy dialogues is desirable. A neutral person can mediate heated debates and bring a structured approach. This person would ideally speak the national language and be familiar with (as well as sympathetic to) the topic at hand. EuroHealthNet can offer this service in a number of languages (English, Dutch, French, Italian). This role could be taken on by an internal colleague; otherwise it may be an option to appoint an external expert for facilitation.

QUESTION

Who do you foresee as a facilitator(s)? Please give their names, organisation and position. Who would be a suitable alternative?

Timing

It is important to consider major national events, like elections or conferences, and choose a date, which is favourable in terms of the policy process at hand.

QUESTION

When do you foresee the policy dialogue to be held? Please note any important events that need to be taken into consideration.

Please indicate an alternative date as second option, for overall planning purposes.

Venue

Since the policy dialogues are envisaged to be upon invitation only, the number of participants should be manageable and thus the meeting room not too big. To foster a meaningful discussion, the room should not have a podium to avoid a division between participants, who should ideally sit around a table.

Due to budget constraints, costs for renting of a venue should be minimal, if at all. Preferably the dialogue would be held at the partner's premises. Another viable option to be explored are EU premises in the national capitals, which would also increase the EU's visibility.

QUESTION

Where do you plan to hold the policy dialogue? Please state the city and venue/premises.

Other Needs

Instant polling and audience participation systems, where participants use their mobile devices to individually answer questions and the (anonymised) responses immediately appear on a screen, visible to all, have proved successful in these types of events. An example of such a tool is Mentimeter. Partners should consider whether they would like to use these kinds of innovative systems or whether they have other ideas.

The question of web streaming was raised during the kick-off meeting. EuroHealthNet would advise against this option for publicity as it would hinder speech and ideas to be 'free-flowing' to some extent.

QUESTION

Will you require any other assistance in terms of systems, software, etc? If so, does your organisation or the venue have the necessary equipment?

Draft agenda

Policy dialogues should last between two and four hours; for example:

10 mins	Welcome/Tour de Table
15 mins	Keynote Speech (not mandatory)
3-5 mins	Opening Statements of each participant, reflecting the various views and perspectives concerning the defined problem and policy action
60-90 mins	Guided Discussion (including consensus building on actions/next steps)
30 mins	Optional slot on EU level declaration concerning chronic diseases

15 mins	Conclusions

QUESTION

Please think of a first draft agenda of how you would structure your policy dialogue.

Objectives

QUESTION

What would your country like to achieve with the policy dialogue? Please define the key objectives.

Outcomes

QUESTION

What would be your ideal outcomes (in terms of suggested actions)?

Contacts

QUESTION

Please enter the contact details of the person(s) in charge of the organisation and the content of the Policy Dialogue.

Are the contact person(s) above specified willing to collaborate with other WP4 activities providing any further information on the topic discussed during the Policy Dialogue and its findings?

8.3 CHRODIS PLUS Policy Dialogue Reporting Form

Policy Dialogue:
Country:
Date:
Completed by:

POLICY DIALOGUE "*title*"

The *country* Policy Dialogue was held on *xxx*. It took place in XXX (XXX) in the XXXX. The **topic** of this Policy Dialogue was "XXXX".

Main objective:

Specific objectives:

Members and roles:

- Organiser:
- Moderator:
- Keynote speaker(s):
- Rapporteur:
- Other Participants:

Duration:

Conclusions:

(They should be **aligned with the objectives**).

Narrative Minutes:
(Explain the points of discussion).

POLICY DIALOGUE ACTION PLAN

ACTION POINT (1)	
Title of the action	
Description	
Objectives	
Target population	
Who is responsible	
When	
What Resources	
Identified barriers	
Outcome indicators	

Annex

- Agenda and pre-circulated question list
- List of documents.

8.4 CHRODIS PLUS Policy Dialogue Evaluation Survey

CHRODIS PLUS Policy Dialogues Survey

Thank you for taking the time to provide your valuable feedback relating to the Policy Dialogue you recently attended in the context of CHRODIS Plus Joint Action (2017-2020), implementing good practices for chronic diseases.

To evaluate the effectiveness and relevance of the Policy Dialogues and consultations with experts, we kindly ask for your assistance in completing this feedback survey. Your insights and comments will help shape and strengthen future Policy Dialogues.

The survey was conducted using SurveyMonkey.

The survey should take less than 5 minutes to complete. Your responses to this survey will be kept confidential.

Please provide us with the following information about yourself:

1. You are: [Drop down menu of occupations]

2. In which country did you participate? [Drop down menu of countries]

3. How would you rate each of the following?

From 1-Poor to 5-Excellent

- Background information shared in preparation for the Policy Dialogue
- Sufficiency of evidence provided and discussed in the Policy Dialogue
- Relevance of the topics covered
- Achievement of goals as delineated in the agenda
- Moderation
- Definition and agreement of outcomes and action plan to move forward
- The location of the Policy Dialogue
- Technical conditions (material, etc) for the Policy Dialogue

4. What is, in your opinion, the most relevant topic or idea covered/shared during this Policy Dialogue for you and your country and why?

5. What do you see are the primary enhancing factors and/or barriers for the implementation and sustainability in your National Policies of the outcomes/proposals agreed in this Policy Dialogue?

Enhancing factors:

Barriers:

6: In your opinion, what do you think worked well and what could be improved from this meeting?

7. Overall, how would you rate this Policy Dialogue?

From 1-Very Poor, to 10-Excellent

8. Do you have any further comments or suggestions?

Thank you for taking the time to complete this survey. We truly value the information you have provided. Your responses will contribute to our analysis and help us to improve policy dialogues in the future.

[xvi] Other sources can be the JANPA toolbox, RARHA Good Practices Collection, VulnerABLE Case Studies Inventory, Mental Health Compass and SCIROCCO project.