Community Action to Strengthen Health Equity in the Spanish Basque Country

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Foreword

This report is part of the project “Community participatory processes, focussed on equity in health, at the local level”, conducted by the Directorate of Employment, Labour and Social Affairs of the OECD. The report was produced in collaboration with the Department of Health of the Basque Country and funded by the European Union via the Technical Support Instrument. The project is implemented in co-operation with the Reform and Investment Task Force of the European Commission.

The main objective of this project is to support the Basque authorities in developing a strategy to establish mechanisms and processes that promote community action for public health and well-being, building on and creating synergies with existing initiatives. This report corresponds to Activities 3.1 and 3.2 of Output 3, and Activity 5.1 of Output 5 of the project, which began in November 2023 and was completed by January 2024. The report builds on the information collected during the fact-finding mission, follow-up online interviews and through several questionnaires completed by various stakeholders. The report presents the assessment of the work of the Department of Health of the Basque Country and the mapping of community action for health in the Basque Country. The assessment and the mapping of processes constitute key inputs for the development of recommendations for a strategy to strengthen community action processes and improve health and well-being in the Basque Country.

Authors acknowledge the support and active collaboration of the Directorate of Public Health and Addictions of the Department of Health of the Basque Country. The authors would also like to thank the many persons and institutions (Osakidetza, provincial and municipal authorities, other directorates of the Department of Health of the Basque Country, third sector and private entities and academic researchers) who contributed to this work through interviews, the provision of documentation, and the responses to questionnaires.

The action has received funding from the European Union via the Technical Support Instrument and is implemented by the OECD, in co-operation with the Reform and Investment Task Force of the European Commission.

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Acronyms and concepts

Acronyms frequently used in this report

AC	Autonomous Communities – There are 17 autonomous communities and 2 autonomous cities (Ceuta and Melilla) in Spain
SG REFORM	Reform and Investment Task Force of the European Commission
DHBC	Department of Health of the Basque Country (*Departamento de Salud del Gobierno Vasco*)
DPHA	Directorate of Public Health and Addictions (*Dirección de Salud Pública y Adicciones*)
OECD	Organisation for Economic Co-operation and Development

Concepts frequently used and terms that have a precise signification in the context of this report

Community may refer to a geographical area or to a community of people with common characteristics such as a shared interest or affinity (religion, sport, art, etc.) or a particular disease or diagnosis. The defined area can be as small as a neighbourhood, or it can be a city or a region, and with the increasing digitalisation of society, it can even refer to virtual communities linked by social networks.

Community action to improve health and well-being: In the context of this report, "community action" encompasses two concepts: i) Community participation, which is the involvement of a community in the analysis, design, implementation and evaluation of community processes that respond to their needs, establishing shared objectives and acting co-operatively; and ii) Community empowerment, which is the process by which individuals gain greater control over decisions and actions that affect their health. The definition of community action concept is discussed in detail in Chapter 1, Section 1.1.

Community health: Collective expression of the health of individuals and groups in a defined community, determined by the interaction between the characteristics of individuals, families, the social, cultural and environmental environment, as well as health services and the influence of social, political and global factors.

Public health: Public health is the science of preventing disease, promoting the health of people and their communities and prolonging life. This is achieved by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing and responding to infectious diseases. It is done through organisations, communities and individuals through informed choices of society and collective efforts.

Social determinants of health: The conditions in which people are born, grow up, live, work, age and socialise, in short, in which they spend their lives, and which have an impact on their health. Examples of social determinants of health are place of residence, level of education, social relations, type of work, level of income, access to services, economic and cultural and environmental policies.

Executive summary

Communities can play a vital role in addressing social determinants of health and reducing health inequalities, as they are uniquely positioned to identify and respond to the specific needs and challenges faced by their populations. Community-led initiatives often reach groups that are underserved by mainstream health systems, helping to reduce barriers to care and promote equity. When people are actively involved in shaping the policies and services that affect their lives, it fosters trust, empowerment, and more sustainable health improvements.

The Basque Government, through its Department of Health (DHBC), is developing a strategy to strengthen and better organise community action across the region. This report supports that effort by assessing the current landscape, identifying key challenges and providing recommendations for a strategy on community action for the Basque Country.

The OECD assessment shows that the Basque Country has a rich and vibrant activity on community action:

- Community action for health is an objective of the Directorate of Public Health and Addictions (DPHA) and the Health Plan Euskadi 2030. This Directorate, through the Health Promotion unit, has the mandate of working on the promotion of health in the Basque Country and is focussing on community action for health and well-being to facilitate achieving its mandate. The Health Promotion unit acts through three different channels: (i) by developing a framework to facilitate the implementation of community action; (ii) by elaborating guides, web pages and other documents to support the work of professionals involved in community action; and (iii) by financing specific projects for the community (e.g. grants on community action programmes).
- **There are many ongoing community action initiatives in the Basque Country, spread across the region and across stakeholders.** Initiatives often target young people and the elderly, but also women, individuals with substance use disorders and immigrants. They are dispersed widely across localities in the Basque Country, with a concentration around the three largest cities. Diverse stakeholders are involved in driving community action, ranging from the DPHA within the DHBC to healthcare services (Osakidetza), municipal governments and third sector organisations.
- **Most actors collaborate with each other through local or institutional networks for community action**. Almost 90% of respondents report to be part of at least one network for community action. Often, network members are government staff as well as Osakidetza's community nurses and other health professionals, while representatives of excluded groups rarely form part of local networks.

The assessment also identified a range of challenges:

- **There is no overarching structure to co-ordinate efforts in community action in the Basque Country**. At municipal level, initiatives for community action are numerous and address different needs; each initiative requires a leadership in line with its scope and with the resources available. There is no specific platform with such a purpose in the Directorate of Public Health and Addictions, although certain institutions within the Basque health system have crafted their own strategies for co-ordinating which could be used for community health initiatives. Strengthening horizontal and vertical co-ordination between actors could help to create a better environment for the development of community initiatives.

- Staff of the DPHA focussed on community action (mostly in the Health Promotion unit) are not present in the districts where field work occurs. Other professionals play an active role in community-based projects without an official mandate. To enhance focus on community action among staff in district units, it is advisable to explicitly include health promotion in their mandate.
- **Current staff in the DPHA often have professional backgrounds and skills not well suited to working with communities.** Due to the strong focus on health protection, recruitment has historically emphasised scientific disciplines such as public health technicians and epidemiologists, with no recruitment for social workers or staff trained to work with communities. If the DHBC intends to emphasise community action, it should consider specific training or recruit new hires with appropriate education background.
- **Public financial and human resources dedicated to community action activities are scarce.** Public health and addictions budget lines receive approximately 1.3% of the total DHBC budget, including staff and operational expenditures, with less than 10% of this amount dedicated to funding community health promotion projects through grants to municipalities and associations.
- Monitoring and evaluation efforts vary strongly across sectors, with serious commitment to continued monitoring and evaluation only observed in some third sector organisations. Other organisations either do not evaluate at all or do so only for selected initiatives. The main obstacles for regular monitoring and evaluation are both a general lack of personnel as well as a lack of trained personnel, combined with insufficient budget to finance such efforts.

The OECD has provided recommendations to elaborate a strategy with a long-term vision for community action and well-being. The development of the strategy is a multi-step process, essential for ensuring its long-term success and relevance and the process should include a thorough review by different stakeholders and multiple rounds of consultation to ensure engagement and support. OECD's recommendations for **the strategy are structured around three lines: (1) developing a governance structure to facilitate community action, (2) promoting community action at the local level, and (3) fostering awareness and policy evaluation.** These strategic lines intersect with several policy areas, including human resources planning and co-ordination of efforts across relevant sectors. The recommendations can be summarised as follows:

- Strategic Line 1:
  - Ensure sufficient personnel to promote community action at the local level, design and implement education and training programmes on community action, and diversify workforce profiles in the DHBC.
  - Strengthen co-ordination structures at the local level, include local communities in these co-ordination structures, and develop co-ordination between the institutions involved in community action.
- Strategic Line 2:
  - Strengthen the role of health promotion within the DHBC.
  - Implement a mechanism to ensure stronger emphasis on health promotion at the local level and encourage municipalities to develop programmes for health protection, promotion, and addiction prevention; develop a network of local entities to promote community action; build a knowledge-sharing database available to local communities; facilitate access to public spaces; and create new community-friendly public spaces.
- Strategic Line 3:
  - Develop a dissemination plan for the strategy and create a tool allowing the citizens to express their views on specific health matters.
  - Actively promote research on community action among Basque academic institutions.
  - Create a self-evaluation tool for local communities, design indicators to monitor and evaluate the impact of community action initiatives, and evaluate the implementation of the strategy.

1 Community action for health has gained momentum in the Basque Country

This chapter examines how community action is defined in the literature and in the Basque country. It also presents trends to highlight the health and socio-economic context in which community action is taking place.

Introduction

Health and well-being extend beyond the absence of illness to include psychological and emotional stability, as well as active participation in community life. Initiatives to improve health and well-being initiatives are often more effective and sustainable when developed in partnership with local communities and public authorities (Popay et al., 2023[1]). In recent decades, many OECD countries have increasingly embraced community action as a key approach to promoting health. In line with this trend, the Basque Government, and specifically the Department of Health of the Basque Country (DHBC, *Departamento de Salud del Gobierno Vasco*), is working to develop a dedicated strategy to promote and better organise community action across the region. This report supports the DHBC in its efforts by providing an assessment of the current state of community action to improve health and well-being in the Basque Country, by identifying the main challenges to be addressed and providing targeted recommendations for the strategy.

1.1. Community action is defined in many ways, but core principles remain consistent

Although the definition of community action varies across application fields, target populations and institutions, there is broad agreement across the literature on the concept that community action includes a community-centred approach, direct implication of the community in programmes and activities, and a multidisciplinary nature of the public policies to be implemented. Community may refer to a geographical area or to a community of people with common characteristics such as a shared interest or affinity (religion, sport, art, etc.) or a particular disease or diagnosis. The defined area can be as small as a neighbourhood, or it can be a city or a region, and with the increasing digitalisation of society, it can even refer to virtual communities linked by social networks. Other terms for community action present in the literature include community engagement, community empowerment, and collective control (Popay et al., 2023[1]). This report employs the term “community action” as a generic term and, in particular, focusses on community action for health and well-being.

1.1.1. Despite definitional differences, international frameworks highlight core elements of community action

The concept of community action was first mentioned by the World Health Organization (WHO) at the Alma Ata Conference in 1978 as an important part of primary healthcare. It gained further prominence in 1986 when it was included in the Ottawa Charter (WHO, 1986[2]). In 1998, the term community action was included in the WHO Health Promotion Glossary, where it is defined as collective efforts by communities directed towards increasing community control over the determinants of health and thereby improving health (WHO, 1998[3]). In 2017, through a framework development workshop on community action in combination with additional research on scientific and grey literature, the WHO elaborated a definition of community action (WHO, 2017[4]). In 2020, as part of the Universal Healthcare Coverage Goal of the UN Sustainable Development Goals and building on the 2017 community action framework (WHO, 2017[4]), the WHO published a guide on how to use community action to help achieve the health goals and targets of the SDGs (WHO, 2020[5]). Key principles identified by the WHO to be considered in any community action process include trust, accessibility (both geographic and social exclusion concerns), contextualisation (taking into account local language, culture, and context), as well as equity, transparency, and autonomy.

The National Institute for Health and Care Excellence (NICE) is a public body in the United Kingdom under the supervision of the Department of Health and Social Care that provides guidance and advice to improve health and social care, including on community action. NICE defines community action as approaches to

maximise the involvement of local communities to improve health and well-being and reduce health inequalities (NICE, 2016[6]). NICE requires that the minimum level of community involvement is participation in needs assessment; merely informing the community does not qualify as community action. Additionally, the NICE definition includes reducing health inequalities as a desired outcome of community action, alongside improving health and well-being. It emphasises the importance of ensuring the participation of those most at risk of poor health to guarantee a fair allocation of resources to the local community.

In the United States, the Center for Disease Control and Prevention (CDC) has long promoted the importance of community action. It established the Committee for Community Engagement in 1995 and published the booklet *Principles of Community Engagement* in 1997 – later updated in (Center for Disease Control and Prevention, 2011[7]) – which defines community engagement as the process of working collaboratively with and through groups of people who are affiliated by geographic proximity, special interests, or similar situations to address issues affecting the well-being of those people. The CDC considers a definition of community based on virtual links between people. The definition of the virtual perspective recognises that people increasingly rely on virtual communication to access information, meet people, and make decisions that affect their lives. A community in this perspective is a social group with a common interest that interacts virtually in an organised way. This approach recognises that individuals may identify with different communities than those in which others would place them.

The CDC also considers a definition of community based on virtual links between people. The definition of the virtual perspective recognises that people increasingly rely on virtual communication to access information, meet people, and make decisions that affect their lives. A community in this perspective is a social group with a common interest that interacts virtually in an organised way. This approach recognises that individuals may identify with different communities than those in which others would place them.

The CDC defines five levels of community involvement. From the lowest to the highest, they are:

1. **Outreach**, which consists of providing information to the community.
2. **Consult**, where feedback and information are sought from the community and entities share information.
3. **Involve**, which includes the community to a greater extent.
4. **Collaborate**, where partnerships with the community are formed on each aspect of the project from development to solutions.
5. **Shared Leadership**, where the final decision making is at community level and all entities have formed strong partnerships.

1.1.2. The Basque definition emphasises the social context of health

Based on the concepts explained above, and taking into account the Spanish and Basque contexts, the health authorities of the Basque Country have adopted its own definition of community health and community action. In the last decade, both the Spanish and Basque legislation have moved towards facilitating and enhancing community action, adopting an approach to public health based on social determinants of health from a community and multi-disciplinary perspective. The definitions of community action in the Basque Country are based on principles of equity, accessibility, transparency, and community autonomy.

Community health is the collective expression of the health of a defined community, determined by the interaction between the characteristics of individuals, families, the social, cultural, and environmental milieu, as well as health services and the influence of social, political, and global factors (Department of Health, 2024). While this concept comprises considerations for physical and emotional wellness, it is far broader and more inclusive. The definition follows from the Constitution of the WHO, which defines health

as: a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity (WHO, 1998[3]).

Community action is the promotion and facilitation of co-operative social relationships among individuals within a specific area or living space. One of the cornerstones of health promotion, it enables individuals to gain control over their health to improve it. This process is not solely individual, however, but is intrinsically linked to community health and has a threefold transformative function: improving the living conditions of those who inhabit the shared space; strengthening social bonds and cohesion, including integrating excluded groups; and enhancing individual and collective capacities for action in processes aimed at improving health and well-being.

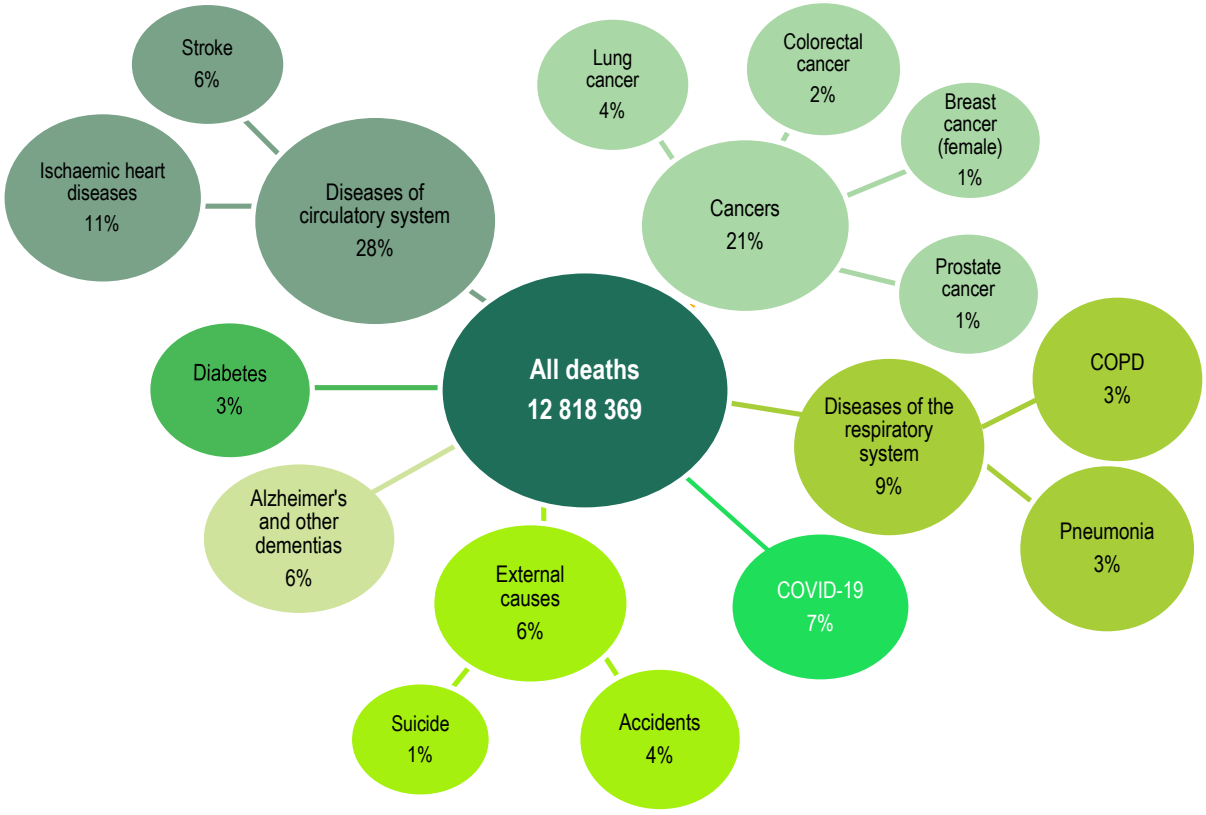
1.2. Trends in health status emphasise the importance of community action for health in the Basque country

Recent trends have transformed the health landscape in most OECD countries, including Spanish regions, and among them also the Basque Country. In the past decades, there has been a strong shift in importance from communicable to non-communicable diseases, which has a major impact on health outcomes and health systems (Gottfredson, 2021[8]). More than one-third of people aged 16 and over reported living with a longstanding illness or health problem on average across 24 OECD countries (2023[9]). Furthermore, heart attacks, strokes and other circulatory diseases caused more than one in four deaths, while around one in five deaths were related to cancer (see Figure 1.1). Population ageing largely explains the predominance of deaths from circulatory diseases – with deaths rising steadily from the age 50. Respiratory diseases were also a major cause of death, accounting for 9% of deaths across OECD countries and, more recently, diseases like Alzheimer's, which preliminary affect is more prominent among older individuals, have also become an important cause of death.

Excess weight, unhealthy diet, and insufficient physical activity are major risk factors for diseases such as cancer, cardiovascular conditions, and diabetes. In 2021, an average of 54% of adults across 32 OECD countries were overweight or obese, with 18% classified as obese. The OECD estimates that alcohol consumption above recommended levels – more than one drink per day for women and one and a half drinks per day for men – accounts for medical costs equal to about 2.4% of total health expenditure each year. Although tobacco consumption has declined significantly in recent decades – in the Basque Country, for instance, it dropped from 27% to 17% among men and from 20% to 14% among women between 2007 and 2023 – it remains a leading cause of numerous health issues, including cancer, stroke, circulatory disorders, and chronic respiratory conditions. Combined with the impact on labour force productivity, exceed alcohol consumption is estimated to reduce GDP by 1.6% annually in OECD countries over the next 30 years.

Figure 1.1. Main causes of mortality across OECD countries

In 2021 or nearest year



Source: OECD Health Statistics (2023[10]), https://www.oecd.org/en/data/datasets/oecd-health-statistics.html.

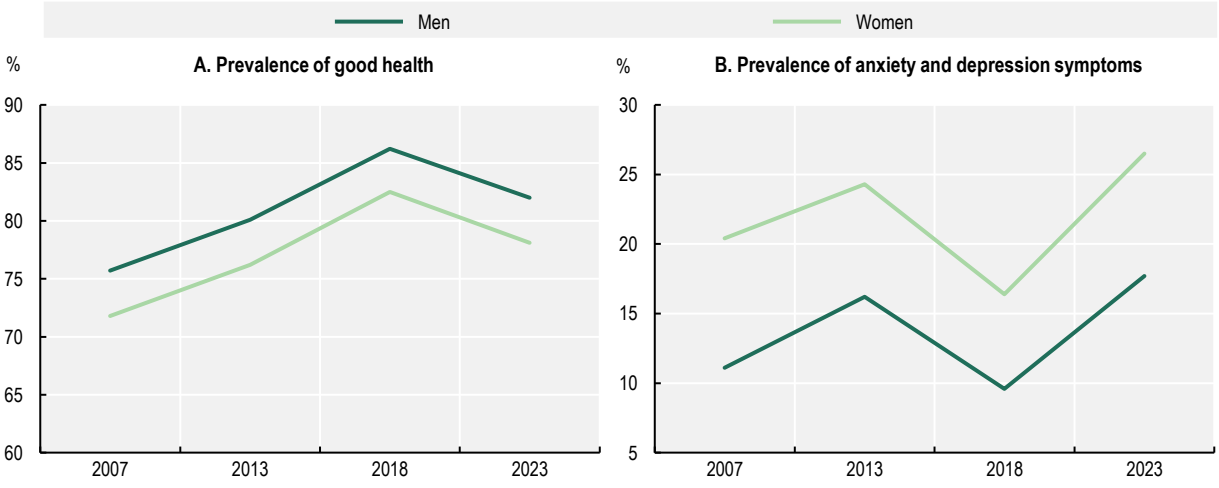
In the last decades, there has been an increased global awareness of the social determinants of health – the non-medical factors that influence health outcomes. These factors are related to the social (like access to education and decent housing), economic (like income and social protection), and environmental (like living in safe neighbourhoods) conditions in which people are born, live and age. According to the WHO,[1] social determinants may influence health more than healthcare quality or lifestyle choices, accounting for 30-55% of health outcomes. In parallel to the changing health landscape, socio-economic health inequalities have worsened over time, and this has been accentuated recently as COVID-19 has disproportionately affected poorer populations (Berchet, Bijlholt and Ando, 2023[11]). In most OECD countries, people with the lowest level of education are twice as likely to report their health as poor compared to those with post-secondary education. Similar patterns are observed in other health indicators, such as limitations in daily activities and the prevalence of multiple chronic conditions. This is partly explained by poorer health behaviours, such as smoking and obesity, which are more prevalent among less educated people, as well as poorer working and living conditions. For similar healthcare needs, people in the lowest income group are less likely to make a medical appointment than those in the highest income group. Preventive services such as cancer screening or dental care are also more frequently used by higher-income groups in most OECD countries.

The importance of new health challenges and the social determinants of health is also increasing in the Basque Country. The Basque Health Survey (2023[12]) reveals that, while the self-perception of good health has improved between 2007 and 2023, symptoms of anxiety and depression have increased, particularly among women (see Figure 1.2). Differences across socio-economic groups are also significant. For

example, Panel A of Figure 1.3 shows that anxiety and depression symptoms affect 25% of men belonging to the lowest socio-economic group, compared to 11% in the highest socio-economic group. Also, more than 46% of women in the lowest socio-economic group suffer from chronic diseases, compared to 39% of men in the same group and to 40% of women in the highest socio-economic group (Panel B).

Figure 1.2. Prevalence of good health, and anxiety and depression symptoms in the Basque Country

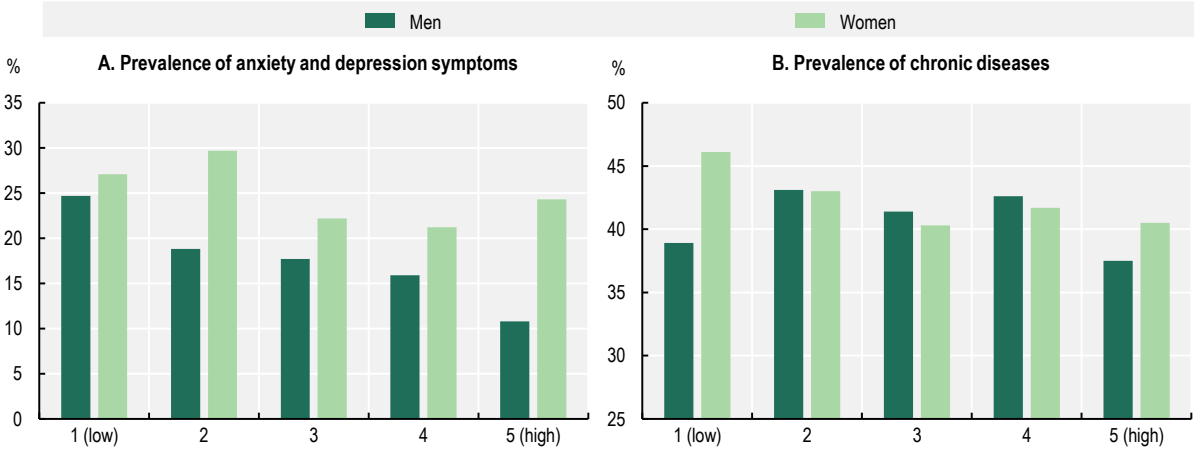
As percentage of population by sex, 2007-2023



Source: Encuesta de salud del País Vasco (2023[12]), https://www.euskadi.eus/introducion-escav23/web01-a3osa23/es/.

Figure 1.3. Prevalence of anxiety and depression symptoms, and chronic diseases in the Basque Country across socio-economic groups

As percentage of population by sex, 2023



Source: Encuesta de salud del País Vasco (2023[12]), https://www.euskadi.eus/introducion-escav23/web01-a3osa23/es/.

Health-in-all-policies is one of the ways to address new pressing health challenges. By integrating health perspective into decision making across various sectors – such as education, housing, and employment – this approach promotes a more holistic response to public health issues. It recognises that the social determinants of health, such as living conditions and income inequality, play a critical role in shaping health outcomes. Evidence in OECD countries shows that policies targeting social determinants reduce health disparities and improve overall population health (OECD, 2019[13]). For example, access to high-quality education and housing not only improves well-being but also reduces the long-term burden on health systems.

Community action is a key element of the broader health-in-all-policies strategy. It plays an important role in empowering individuals and communities to take control of their health. The Ottawa Charter for Health Promotion in 1986, which advocates for *Health for All by the year 2000*, recognises empowering people to take greater control over their health as a key element for building healthier societies. The conclusions of the 4th International Conference on Health Promotion in Jakarta (1997) reaffirms this approach, listing the strengthening of community action as one of strategies to achieve this goal. The WHO Commission on the Social Determinants of Health report (2008[14]) reinforces the importance of community action in empowering communities and building local capacity. The WHO Framework on Integrated People-Centred Health Services (2016[15]) further emphasised community action as one of its core strategies.

Evaluations of community action demonstrates its effectiveness in improving health behaviours and outcomes, particularly among disadvantaged populations. A meta-analysis by O'Mara-Eves et al. (2015[16]) finds that community action positively impacts a wide range of health outcomes. Furthermore, Cyril et al. (2015[17]) show that community action projects are especially beneficial for disadvantaged groups, contributing to a reduction in health inequalities. However, Milton et al. (2011[18]) find no direct evidence of community projects affecting health outcomes. Nonetheless, they show that these initiatives may have an indirect long-term effect on health outcomes, as they lead to improvements in housing, crime reduction, social capital, and community empowerment.

The body of evidence suggesting a positive impact on health has been rapidly growing. Using bibliometric analysis and big data techniques, Yuan et al. (2021[19]) conduct a comprehensive literature review on community action in public health. Results show that since 1980, the number of publications of community action in public health has been steadily increasing year-on-year. Between 1980 and 2003, the number of publications grew smoothly accounting for 9% of the total publications while the period between 2004 and 2020 is characterised by exponential growth, accounting for 91% of publications. Community action in public health has been one of the most influential and dynamic fields of health policy research. The study provides an interesting analysis of the keywords appearing with the strongest intensity in the publications. Among the top ten keywords are *empowerment*, *community participation*, *aid*, *association*, *health promotion* and *community-based participatory-research.* Based on the analysis results, the study provides recommendations to policymakers, practitioners, and researchers:

- Policy frameworks should be built for engagement to happen in a co-ordinated way.
- Novel formal or informal measures should be implemented to address critical issues around ownership, empowerment, education, mobilisation, and sustainability of health improvements.
- Evaluation schemes should not only emphasise the final effect, but also facilitate the process of dynamic control and adjustment by combining qualitative and quantitative methods.

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Notes

[1] See https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

2 The institutional setup for community health in the Basque Country is intricate

This chapter examines the institutional set-up supporting community health in Spain and the Basque Country, with particular attention to recent legislative developments and their implications for facilitating community-led health initiatives. It shows how the regulatory framework has been assigning more importance to community health action.

Introduction

The institutional framework plays a key role in enabling community action for health. A well-designed and accessible system can empower communities to take an active role in improving health and well-being. In contrast, complex, opaque, and fragmented institutional arrangements can discourage even the most committed communities from launching initiatives.

2.1. The division of competences in the area of health is complex in Spain

2.1.1. In Spain, health competences are shared across levels of government

Spain is a highly decentralised country, and many public services are provided at the regional level. According to the 1978 Constitution, Spain has a three-tier system with central, regional, and local governments. There are 17 self-governing Autonomous Communities (AC), 2 autonomous cities, 50 provinces, and 8 131 municipalities. The division of competences across different government levels is regulated by the Spanish Constitution. While some public services are exclusively provided by the central government, most, including health, are jointly managed by the central and regional governments. In contrast, certain public services, like social services, are exclusively managed at the regional and municipal levels (OECD, 2022[1]). As a general rule, all responsibilities not expressly attributed to the central government by the Constitution can be devolved to AC or regions. Additionally, the Statute of Autonomy for the Autonomous Community of the Basque Country provides a detailed list of areas where the Basque Country has exclusive competences. The 1985 Law Regulating the Local Administration further clarifies some of the competences of local authorities and establishes the possibility for competences to be devolved to the local level. Spain also has other bodies at the province or island level (*diputaciones, cabildos* and *consejos insulares*), or joining several municipalities (*mancomunidades)*, which might be relevant for community action initiatives organised in municipalities with a low number of inhabitants or in remote territories.

The division of competences in health matters across various levels of government is complex in Spain. The co-ordination of health policies between national and regional levels is organised through a permanent body: the Interterritorial Council of the National Health System (CISNS, by its acronym in Spanish). The Article 149.16 of the Spanish Constitution specifies that the central government has exclusive competences over external health, the basic rules governing the health systems (i.e. minimum floors and requisites for equal rights across the territory), healthcare co-ordination, and the regulation of pharmaceutical products, while Article 148.21 states that the AC are responsible for public health and hygiene. The General Health Law 14/1986, 25 April (*Ley General de Sanidad* or LGS) regulates the structure of the health system and further specifies the division of competences. Following this, the central government also holds competences related to inter-regional solidarity and high inspection. In turn, the AC are responsible for implementing and managing the health system and policies. They can also develop legislation and norms with respect to health according to the specific competences detailed in each of Autonomy Statutes. In this context, the CISNS's mission it to guarantee the co-ordination, co-operation, communication and information between the regional and the national health authorities. As a body for co-operation between the State and the AC, the CISNS is also entrusted with promoting the cohesion of the National Health System. The Spanish Minister of Health chairs the Interterritorial Council and each Autonomous Community's Health Minister (or Health Counsellor) is represented in the Council.

2.1.2. In the Basque Country, the division of health competences is similarly complex

Within the Basque Government, the DHBC is the health authority of the Basque Country, responsible for providing the stewardship, planning, organisation, administration, and evaluation of health plans and

programmes, as well as providing oversight and directing to the provision of health services, including those in the public health domain and healthcare. As part of this effort, Law 10/1983 established the Basque public healthcare service, Osakidetza. This structure has evolved over time to include the provision of all curative healthcare services to the resident population in the Basque Country. It includes a network of primary healthcare centres, secondary and tertiary hospital and specialised healthcare services, diagnostic and laboratory capacities, emergency care services, a mental health network, and ancillary services. Over 40.000 professionals from a wide range of disciplines are currently engaged in Osakidetza. In 1997 (through the Law 8/1997, the Basque Health Organisation Act), Osakidetza was transformed into an autonomous administrative body, attached to the Department of Health and Social Security (currently DHBC) of the Basque Country. Under its direction, supervision and guardianship Osakidetza carries out its attributed functions. The DHBC specifies Osakidetza's priorities, approves its budget and oversees its functions, which are primarily concentrated on the provision of healthcare to all residents of the Basque Country.

The Law 8/1997, the Basque Health Organisation Act (*Ley de Ordenación Sanitaria de Euskadi orLOSE*) abrogated the Law 10/1983 and reorganised the Basque health system. It defined the geographical organisation of the health system and provided a clearer, developed definition of the competences and organisation of Osakidetza, changing its legal nature. The law replaced the old autonomous body with a public body governed by private law and guaranteed its continuity and name (Basque Health Service-Osakidetza). The law also defined health prevention and health promotion concepts and regulated the intervention of local administrations. However, the organisation has evolved significantly since 1997 and many initiatives included in LOSE have been overruled long time ago.

Within the DHBC, the DPHA is the entity responsible for the provision of public health functions. These include health protection, health promotion, epidemiological surveillance, population-based health status monitoring, diseases and injuries prevention, and preparedness and response to health emergencies, as well as public health co-ordination and oversight. The DPHA has focussed on fostering community action through various programmes as an essential vehicle to conveying health promotion programmes and activities.

Several provisions impact the organisation of community action for health. The competences for action in areas other than health (urban planning, social services, environment, etc.) in the territory and which are related to addressing the social determinants of health lie primarily with the provincial governments and secondarily with the municipalities The Provincial Government Law (*Régimen Foral*) of the Basque Country gives fiscal autonomy to its three provinces of Araba, Bizkaia and Gipuzkoa. Each province may therefore deploy different arrangements to deliver its competences. Importantly, each province has the competence to maintain, establish and regulate their tax systems, including the ability to collect, manage and inspect all state taxes – that is, all the taxes established by the central government – except for import duties and the value added tax. Specialised social services are under the competence of provinces, while local governments have competences over the provision of primary social services and over the organisation citizen participation processes, including community action projects. While these competences in the area of social services, they have an impact the way social determinants of health are addressed. In fact, community action interventions organised by health and social services sometimes overlap and, in such cases, there is no clear definition about who has the leadership.

Public authorities are not the only actors in the service provision. Private profit and non-profit organisations play a crucial role in the implementation of concrete programmes and activities in social action, significantly impacting the social determinants of health. The Basque Country regulates the activities of these private actors through two texts: Law 6/2016 regulates the Third Sector of Social Action, and Decree 168/2023 regulates the social agreement system (*Régimen de concierto social*) and the partnerships in the Basque Social Services System (*convenios en el Sistema Vasco de Servicios Sociales*). The social agreements system is one formula available to public administration to organise social services provision included in

the Catalogue of Benefits and Services of the Basque Social Services System. Law 6/2016 also establishes a strong link between third sector organisations and the Basque Social Services System.

2.2. The regulatory framework has assigned more importance to community health over time

2.2.1. National legislation points to the importance of community action for health

Over the past 20 years, the legal and regulatory framework in Spain has been developing the concept of community action in health as well as the interventions to support its implementation. A number of national laws related to public health and the national health system provide guiding principles on community health.

The first of these is the 1986 General Health Law, which mentions the active participation of community members in improving the health conditions of their community. Although, this law does not specifically use the term “community action” in health (see Chapter 3), Articles 5 and 6 establish that the Public Health Services shall be organised to facilitate community action through the corresponding territorial corporations in the formulation and control of health policy. Additionally, the actions of Public Health Administrations should promote individual, family, and social interest through adequate health literacy.

Secondly, Law 16/2003 on the Cohesion and Quality of the National Health System clearly establishes in Article 12 that primary care is the basic and initial level of care guaranteeing comprehensive and continuous care throughout the patient’s life. This includes activities in prevention, health promotion, family care, and community care. Article 11 defines public health provisions as a combination of sciences, skills and attitudes aimed at maintaining and improving the health of all people through collective or social actions. Thus, this law assigns a primary role to the users of the health system in maintaining or improving community health collectively. Article 67 also defines the means through which users can participate in the national health system: the Consultative Committee (under the CISNS), the Open Health Forum, and the Virtual Forum, creating a space for all citizens to voice their opinions on health policy issues.[1]

Thirdly, Law 33/2011 on General Law on Public Health indicates in its preamble that health services, especially primary healthcare, should assume a more significant role in community health through preventive actions. Article 23 advocates for effective collaboration between public health and healthcare, while Article 26 establishes that public health services should adopt measures to make health centres “health promotion centres” following WHO guidelines, developing a health promotion plan in co-ordination with the competent public health authority of the autonomous community or city. Article 31established the need for a Public Health Strategy to ensure that health and health equity are considered in all public policies and to facilitate intersectoral action.

Beyond legislation, other important developments emphasised reducing health inequalities and the importance of community action. In 2008, the Commission to Reduce Social Inequalities in Health in Spain was set up. This commission identified the factors to address to reduce health inequalities. These factors include the distribution of power, wealth, and resources, living and employment conditions, health-promoting environments, and health services. Determinants of health include individual resources such as people’s skills and capabilities, community networks, participation in these networks and the social support received. The Public Health Strategy 2022 of the Ministry of Health introduces the term community health in several public health monitoring indicators. The strategy also indicates that community health should be promoted through advocacy, training, intersectoral work and participation. This efforts should be co-ordinated with the AC, local authorities, and associations, such as the Community Health Alliance, and through the production of reference documents like “Community action to gain health” (Ministerio de Sanidad de Espana, 2021[2]) and “Participate to gain health” (Ministerio de Sanidad de España, 2019[3]).

Over the past decades, Spain has progressively emphasised the role of public health in providing health services and explicitly included the idea of community action as part of it. In 2013, the Health Ministry published a Strategy for Health Promotion (*Estrategia de promoción de la salud y prevención en el SNS*) which includes health empowerment and participation and community action as one of its strategic directions. In November 2018, the plenary session of the CISNS agreed with the AC to develop a Strategic Framework for Primary and Community Care (MAPyC).[2] This framework was designed and approved in April 2019 through a participatory reflection process with the AC, scientific societies, professional associations, patient associations and citizens. The MAPyC defined six strategic lines to strengthen various aspects of primary care, with Strategy D explicitly mentioning community action in health, associating it with health promotion and disease prevention in primary care. Although, implementation was delayed by the COVID-19 pandemic, a Primary and Community Care Action Plan (PAAPyC) was developed in 2021 to strengthen the post COVID-19 recovery of primary and community care in the National Health System. Concrete actions include:

- The creation of the professional category of specialist nurses in Family and Community Nursing in primary care in all the AC, promoting the appointment of nurses with this speciality.
- The development of Community Health Strategies for primary care in all AC.
- The mandate to generate and facilitate structures and co-ordination mechanisms for community health, promotion and prevention between primary care, public health and other sectors and agents at different territorial levels: region, municipality, and neighbourhood.

In the guide *Community action to gain health* (Ministerio de Sanidad de Espana, 2021[2]), the Spanish Ministry of Health defines community action as the dynamisation of co-operative social relations among people in a given area, with three transformative functions: (i) improving the living conditions, (ii) strengthening social cohesion and inclusion of excluded, and (iii) enhancing capacities for individual and collective action to improve health and well-being. This approach highlights the need to intervene in various domains impacting community health status, such as social as social services, community life, education and urban planning. This complexity makes it challenging to clearly determine the necessary intersectoral and collaborative processes, their design, management and sustainability, and the level of government responsible for a given initiative. Compared to the definitions of community action used at the international level (see Chapter 1, Section 1.1), the definition the Spanish Ministry of Health's definition focusses on community health outcomes. In contrast, international definitions focus more on the implementation aspects of community action (albeit in abstract terms), while remaining imprecise about potential outcomes.

2.2.2. The Basque Country has adopted an approach to community action inspired by international definitions

In line with a global trend, the Basque Government has increasingly emphasised community health and the active participation of the community in health-related actions. The concept of community action was already mentioned in the Health Plan 2013-2020, which proposed "…to develop and boost community action in health through actions in the field of public health, with the participation and involvement of all stakeholders" (Departamento de Salud, Gobierno Vasco, 2013[4]). Since then, the DHBC and Osakidetza developed an integrated health plan for the institutions within the Basque health system aimed at adopting a proactive approach to public health based on three pillars: integrated governance, population focus, and community approach to health. This direction is confirmed and enhanced by the Health Plan Euskadi 2030, which specifies objective 6.5 to "promote social environments for citizen participation and community action in health at the local level, taking into account the diversity of populations and with a focus on equity" (Departamento de Salud, Gobierno Vasco, 2023[5]).

In 2015 the DHBC, in collaboration with Osakidetza, developed a conceptual framework to provide concrete tools for the Health Plan implementation. One of the tools, the DHPA designed in 2016 the guide

Methodologic guide to address health from a community perspective, an important conceptual milestone. The guide includes a glossary defining the key terms related to community action, such as "health actives", "community", "community approach based in health actives", and "health promotion" (Dirección de Salud Pública, Gobierno Vasco, 2016[6]). The definition of community action in health is as follows:

> *"Involving a community in the analysis, design, implementation and evaluation of community processes that meet their needs, set common goals and act cooperatively. It involves community organisation and collective awareness. Participation and community empowerment are closely related concepts."*

While this definition closely follows the WHO definition (see Chapter 1, Section 1.1), it makes a crucial distinction by defining a community as a group of people living and/or working in a defined geographical area. The WHO definition is more open, specifying that a community does not necessarily need to reside in the same geographical area.

The *Methodologic guide to address health from a community perspective* incorporates many elements from the WHO framework, but also from researchers working in this field in Spain (Marchioni, 2013[7]; Hernán, 2013[8]), and from the project *Asturias Actúa*[3] conducted by the Health Observatory of Asturias. Although the guide remains somehow abstract, it includes a step-by-step methodology for community members eager to engage in health-promoting actions and introduces a comprehensive five-stage approach to foster local health networks, assess and prioritise needs, and evaluate community health projects effectively.

In 2020, the DPHA and the Department of Governance of the Basque Country, in collaboration with iLab (*Espacio de Innovación en Participación de Euskadi*) and several other municipalities and institutions, published a second guide, titled *Guide for Participation Generating Well-being and Health* (iLab, 2020[9]). This guide builds on two main sources: the NICE report *Community engagement: Improving health and well-being and reducing inequalities in health* (NICE, 2016[10]) and its adaptation to the Spanish context published in 2018 (Cassetti V, 2018[11]). The *Guide for Participation Generating Well-being and Health* acknowledges that, although public administrations usually lead participatory processes, increasingly more initiatives are emerging from the communities. On this basis, the guide presents a set of evidence-based guidelines and recommendations for all actors involved in participatory processes, regardless of their nature or objective. These guidelines follow three fundamental principles: (i) guarantee diversity in the constitution of decision making groups; (ii) promote the autonomy and self-management capacity of communities; and (iii) foster empathetic and trusting relationships between different stakeholders. Rather than providing a definition of concepts like community or community action, the *Guide for Participation Generating Well-being and Health* is practically oriented for those wanting to set up projects and focusses on the conditions needed to implement successful participatory processes.

2.2.3. The 2023 law on Public Health of the Basque Country clearly adopts a community approach to public health

The Basque Parliament approved Law 13/2023 of Public Health of the Basque Country (*Salud Pública de Euskadi*), which adopts a public health approach based on social determinants of health from a community and multi-disciplinary perspective, incorporating health into all policies. This law creates the Basque Public Health System, which co-ordinates with the Basque Health System[4] to provide a network of benefits, services, equipment, and management and co-ordination tools aimed at preventing illness, injury, and disability, while protecting and promoting people's health. Additionally, Law 13/2023 lays the foundations for the prevention, early detection, monitoring and effective management of health emergencies, epidemics and pandemics. It also establishes the Basque Institute of Public Health to provide public health actions, benefits and services.

Law 13/2023 is organised around four broad themes:

- **Citizens and public health**. The law outlines the rights and responsibilities of citizens in relation to health, emphasising dignity, equality, access to information and protection of private information, effective community participation and health education. It also details the tools and procedures available for citizens to participate in public health matters, including the planning, development, monitoring and evaluation of public health plans, interventions and programmes.
- **Acting on health determinants and health in all policies**. The law mandates that all public health actors should adopt the principle of "health in all policies" and address health determinants in a comprehensive, intersectoral and sustainable manner.
- **The public health system in the Basque Country and its organisation**. The law clarifies the roles and responsibilities of various actors within public health system and co-ordination mechanisms between them Article 25 specifies that the Basque Government is responsible for planning and defining public health policies and strategies, while public and private health and non-health agents (notably Osakidetza), along with citizens, develop specific actions to implement them. Article 28 outlines the basic competencies for public health professionals. The Basque Health Plan (*Plan de Salud de Euskadi*) is the central regulation tool. with all regional, provincial (foral), and local (municipal) health plans, strategies and programmes aligning with it. The law establishes the Interinstitutional Commission on Public Health to share information and ensure the effective institutional co-operation avoid overlapping or duplication of competences between the different administrations. Articles 44-46 detail the co-ordination mechanisms between the Basque Public Health System and the Basque Healthcare Service.
- **The attribution of competences of various administrations**. The law defines the competences of the Basque Government (Article 33) and of municipalities and other local entities (Article 34), assigning a support role to provincial governments. The Basque Government oversees the strategic direction, and institutional organisation of public health, including the information systems. It is also responsible for approving health benefits, controlling and authorising public health establishments, and exercising inspection and sanctioning powers. Municipalities are responsible for monitoring compliance with health standards relating to the environment, food production and distribution, and animals on their territory. They also develop programmes and plans for health protection and promotion, including addiction prevention. The law stipulates that central, provincial and local administrations will apply the law according to relevant sectoral legislation (e.g. health, education, sport, etc.). However, these guidelines are very general, leaving the more precise definition to the sectoral regulation. As a result, the absence of a sectoral law on community action in health creates some ambiguity in these activities.
- **The Basque Institute of Public Health**. This autonomous institute is submitted to the supervision of the DHBC. Its purpose is to centralise all public health functions currently assigned to the DHBC (specified in the Article 53 of the law). Law 13/2023 details the institute's organisation, mission, and attribution of human and financial resources. Additionally, the law mandates the creation of a Public Health Information System to share, harmonise, and analyse key public health information and statistics across the Basque Country to improve policies.

Both the legal and regulatory framework and the institutional setup of the Basque Health System are the result of a historical evolution, which will continue to adapt to new health needs and societal changes. Understanding the current situation is crucial to guide and plan the development of policies to improve community health engagement. The next section explains how the DHBC is organised and its role in promoting community health in the Basque Country.

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Notes

[1] Although the means of participation defined in Article 67 of Law 16/2003 do not correspond to what is understood as community action in health in the literature, the article is interesting as it clearly shows the legislator's intention to give users an active role in defining health policies in Spain.

[2] The denomination of the specialty of primary care medical doctors (and same with nurses) in Spain is "primary and community care". This denomination was coined in the 80´s and responds to historical circumstances. Indeed, there is a clear and shared interest for the medical profession (doctors and nurses) adopting a community perspective, but this genuine interest does not imply that the locus of community action is exclusively primary care.

[3] For more information about Asturias Actúa check here: https://saludcomunitaria.wordpress.com/category/asturias-actua-en-salud/.

[4] The Basque Public Health System (*Sistema de Salud Pública de Euskadi*) is created by Law 13/2023 and refers to a large network of services, programmes and institutions that have an impact in public health, whereas the Basque Health System (*Sistema Sanitario de Euskadi*) was created by the Basque Health Organisation Act in 1997 and guarantees the provision of health services.

3 Community action for health within the Department of Health of the Basque Country is fragmented

This chapter explores the diverse roles and contributions of different units within the Department of Health and the Basque Government in general, illustrating a multifaceted approach to promoting community health. It provides information of the different programmes that are supported by the Department and the role of the district units in supporting community health.

Introduction

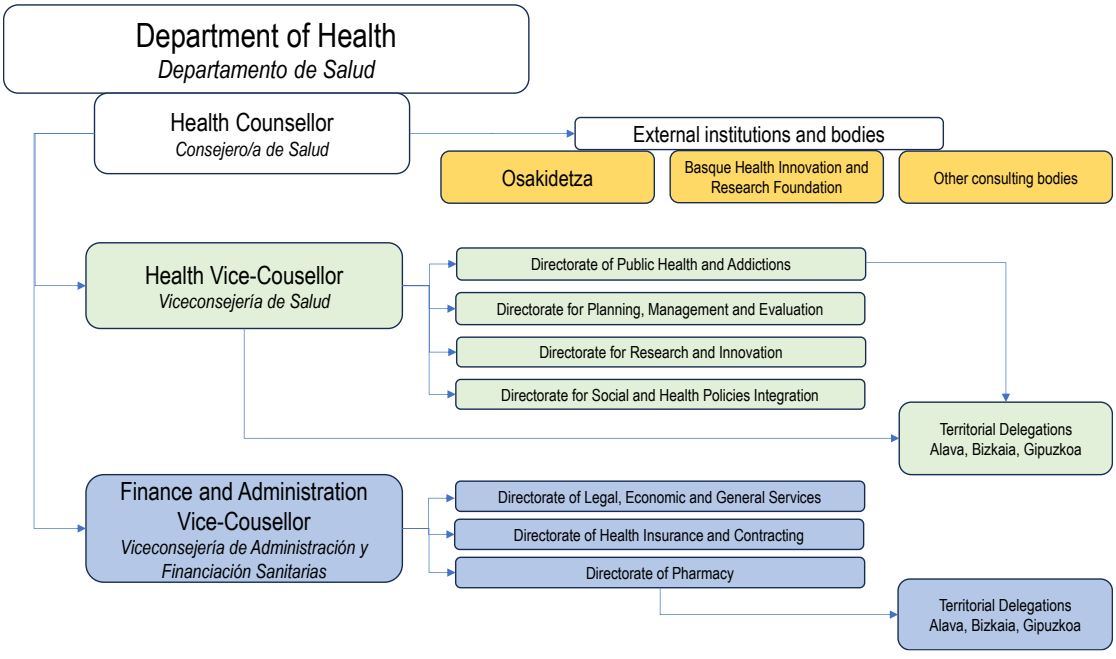
Community action for health within the DHBC demonstrates a commendable commitment to enhancing public health through various innovative initiatives. Despite the evident fragmentation, the department has made significant strides in fostering community action across multiple units.

3.1. The DHBC does not have a single focal point dedicated to community action for health

The activities of the DHBC cover a wide range of areas. The DHBC is headed by a Health Counsellor, whose mission is to direct, co-ordinate and control its subordinate bodies, establish strategic objectives and liaise with the Basque Government. Supporting the Health Counsellor are two Vice-counsellor's Offices (*Viceconsejerías*): the Health Vice-counsellor and the Finance and Administration Vice-counsellor. The Decree 116/2011 on Organic and Functional Structure of the Department of Health, defines the areas of competence and missions of the various Directorates and other administrative bodies attached to the DHBC (see Figure 4.1).[1] The Finance and Administration Vice-counsellor's Office, responsible for managing financial and human resources and contracting services with Osakidetza; consists of three directorates: Legal, Economic and General Services; Health Insurance and Contracting; and Pharmacy.

The Health Vice-counsellor's Office is primarily responsible for implementing the Basque Health Plan and maintaining adequate collaboration with other departments in the socio-health area. The office oversees four directorates: Public Health and Addictions; Health Planning, Management and Evaluation; Research and Innovation; and Social and Health Policies Integration. The Health Counsellor also co-ordinates with several affiliated bodies, including the healthcare service Osakidetza.[2] The DHBC has several offices throughout the Basque territory.

Figure 3.1. General organisational structure of the DHBC



Note: This is a simplified scheme, arrows indicate hierarchical dependency.
Source: Decree 116/2021, of 23 March, (2021[1]), https://www.legegunea.euskadi.eus/eli/es-pv/d/2021/03/23/116/dof/spa/html/webleg00-contfich/es/.

3.2. The main responsibility for promoting community action for health is within the DPHA

The Directorate for Public Health and Addictions (DPHA) plays a relevant role in the co-ordination, supervision, monitoring and evaluation of activities undertaken and in collaboration with other agents at a provincial and local levels (see Box 3.1). According to Article 9 of the Decree 116/2021, the duties of DPHA include:

- Drafting proposals for health objectives in the Basque Health Plan, developing strategies for their implementation, creating monitoring indicators, and drafting of evaluation reports.
- Developing health protection policies, particularly programmes related to food and environmental health, including the analysis of physical, chemical or biological risks. This also encompasses activities in health promotion, prevention, and protection, and responses to public health alerts and risks.
- Conducting epidemiological surveillance and analysis of health and its determinants, preventing diseases, promoting health initiatives, developing programmes for health information and education, and promoting actions to generating social, environmental and economic conditions conducive to public and individual health environments.
- Defining a comprehensive Basque policy on addictions and promoting interdepartmental and interinstitutional actions in this field. This includes supporting programmes aimed at preventing drug addiction with family, community, educational and work environments.
- Strengthening community action by actively involving communities in the design, implementation and evaluation of community processes that address their health needs. This aims to achieve greater control over health determinants and improve their quality of life.

While the work with community is primarily carried out by the Health Promotion unit, other units, such as Health Protection and Addictions, also play a role. At the local level, district units of DPHA (Comarcas) are engaged in designing and implementing community action projects. In addition to the DPHA, the Directorate for Integration of Social and Health Policy and the Pharmacy Directorate also play a role in fostering community action.

Box 3.1. Territorial organisation of the DPHA

The DPHA operates with a central office and additional units in each province's capital (sub-directorates of public health based in Vitoria-Gasteiz, Bilbao, and Donostia-San Sebastián) to co-ordinate actions at the provincial level. Additionally, there are nine district offices across the Basque territory. The district units of DPHA aim to provide public health services locally in close co-ordination with local agents. The Basque territory is divided into nine district units of DPHA: Araba (attached to Alava), Encartaciones/Margen Izquierda, Interior, Uribe-Kosta, Gernika-Lea Artibai (attached to Bizkaia), and Tolosa, Alto/Bajo Deba, Urola, and Bidasoa (attached to Gipuzkoa).

Decree 116/2011 establishes the Directorate for Public Health and Addictions, responsible for co-ordinating and supervising material, economic, and human resources assigned to public health and addictions, as well as managing processes related to health promotion functions. The Deputy Director of Public Health and Addictions performs the following functions:

- Implementing public health and addictions programmes and activities, including necessary health inspection and control actions.

- Formulating proposed objectives for the Health Plan, developing implementation strategies, monitoring indicators, and preparing evaluation reports.
- Co-ordinating the district units of DPHA.
- Resolving administrative-sanitary authorisations for the operation of activities, industries, and food establishments.
- Receiving applications and processing files related to Public Health and Addictions.

Note: The term district units of DPHA stands for *Comarcas de Salud Pública.* For historical and demographic reasons, the geographical organisation of the DHCB described here is not exactly the same as the geographical organisation of the Basque Health Service Osakidetza. In fact, there are some small differences in the geographical areas covered by Osakidetza's "health zones" and the DHBC's District Health Centres. It should be noted that geographical zones also exist for the pharmaceutical system.

3.2.1. The Health Promotion unit concentrates on developing concepts and securing funding for projects related to community action for health

Over the past decade, the Health Promotion unit has been actively engaged in promoting community action in co-operation with Osakidetza. The Health Promotion unit staff at both the central level and in the Subdirectorates (see Box 3.1) has undertaken various initiatives to foster community action for health. Key activities include the development of frameworks and guides for community action as well as the creation of an online platform to document community projects for health. The unit also directly sponsors projects through funding lines that fully or partially incorporate a focus on community action. In the past, the unit was also responsible for training on community action in the health districts.

Dissemination and outreach

The Health Promotion unit has taken steps to support community action by developing two guides aimed at enhancing community health through structured, participatory processes. Each guide reflects a comprehensive understanding of the complexities involved in public health promotion within diverse community settings.

The first guide, titled "Methodological guide for approaching health from a community perspective" (*Guía metodológica para el abordaje de la salud desde una perspectiva comunitaria*), was developed with support from Osakidetza in 2016. In 2020, the second guide, titled "Guide for Participation Generating Well-being and Health" (*Guía para una participación generadora de bienestar y salud*), was released. This guide focusses on integrating health perspectives into community action to strengthen well-being of local population. Developed through collaborations with the *Proyecto de Intervención Comunitaria Intercultural,* the Municipality of Hernani, and Innobasque-Basque Innovation Agency, it underscores the importance of diversity, autonomy, and relationships in community action.[3] Both guides are designed to provide guidance for staff within the DHBA, health centres and municipality to promote community action for health.

Additionally, the department has published guides supporting specific participatory projects, such as transforming school playgrounds (*Patios escolares*) and creating safer school pathways (*Eskolabidea*). These guides highlight stages from planning to evaluation, ensuring successful community action and health improvement.

To support the dissemination of community health actions, the Health Promotion unit has launched the Euskadi Aktiboa project – a platform that uses geolocation to highlight and enhance community health projects and organisations. Community initiatives can be included following registration and submission. With a user-friendly search feature, the platform facilitates the exploration of health initiatives by location, type, and status. As of 17 January 2024, the database boasts 337 active entries, highlighting the wealth of community action across the Basque Country's regions and various demographics.

Grants

The Health Promotion unit offers four types of grants and subsidies for organisations, individuals and programmes contributing to community action for health. Table 3.1 provides an overview of the four types of grants available in 2022.[4] Each type of grant has an allocated budget (e.g. EUR 250 000) used to fund projects that align with the grant's scope and meet eligibility criteria. Each grant has a maximum financing for a single project (e.g. EUR 5 000). Funding details include limits per project and entity, with payments structured around project milestones and regulatory, administrative and fiscal compliance.

The two top grants outlined in Table 3.1 prioritise community-driven health initiatives but can only fund a limited number of qualifying projects due to the constrained budget. The first grant, although open to all types of community action actors, predominantly targets local government units rather than non-governmental organisations. The two bottom grants have a broader scope and can include community health actions, particularly targeting non-profit social initiative organisations, and could be used more broadly for expanding community action.

Table 3.1. Grants offered by the Health Promotion unit supporting community action

Grants programme	Target	Objective/Description	Degree of community involvement	Annual budget
Development of Local Health Promotion Programmes *Ayudas para el desarrollo de proyectos participativos orientados a la promoción de la salud en el ámbito local*	Local entities	Enhance living conditions and health, encourage participatory projects, especially for vulnerable groups, covering up to 75% of costs.	Full	EUR 250 000
Development of Actions Aimed at Promoting Physical Activity among Students *Ayudas para el desarrollo de acciones orientadas a promocionar la actividad física entre el alumnado de la CAVC*	Parent associations	Support initiatives for increasing physical activity and reducing sedentary behaviour among students. May include developing school routes, transforming schoolyards, and family-based physical activities. Covered costs involve space conditioning, material, analysis, and event organisation.	Full	EUR 250 000 Capped at EUR 5 000 per project
Grants for non-profit associations aimed at improving the quality of life for groups of individuals with illnesses and their families *Ayudas dirigidas a asociaciones de iniciativa social sin ánimo de lucro que estén orientadas a la mejora de la calidad de vida de colectivos de personas enfermas del País Vasco y sus familias*	Individuals with a health condition and their families	Empower individuals with illnesses by funding projects that improve self-care, enhance health awareness, and reduce health disparities. Activities such as counselling, rehabilitation, psychological support, and awareness campaigns are eligible.	Partial, depends on the project	EUR 300 000 Capped at EUR 10 000 for associations, EUR 15 000 for federations
Grants for non-profit organisations for the prevention and control of HIV/AIDS, hepatitis C (HC) and sexually transmitted infections (STIs) *Ayudas dirigidas a entidades de iniciativa social sin ánimo de lucro para el desarrollo de programas de prevención y control del VIH/sida, hepatitis C (HC) e infecciones de trasmisión sexual (ITS) en el País Vasco*	Vulnerable or potentially at-risk individuals/groups	Support non-profit organisations in the engaged in prevention and control of HIV/AIDS, hepatitis C, and STIs, prioritizing initiatives for vulnerable populations.	Partial, depends on the project	EUR 300 000 Capped at EUR 25 000 per project

Note: Only includes grants with full or partial degree of community action, 2022.
Source: Government of the Basque Country (2024[2]).

Following a public call for applications, submissions are evaluated using a points-based system, which varies by grant category and criteria. For instance, the local health promotion grant evaluates applications based on technical project description (40 points), participatory level (40 points), and equity perspective (20 points), requiring a minimum of 50 total points to proceed, including at least 15 points for the project's technical description. Similarly, the grant for student physical activity promotion has unique criteria, emphasising the technical project description, educational and local community involvement, and attention to inequalities, with specific minimum scoring thresholds for consideration.

3.2.2. The Addictions unit relies extensively on community action for health

The Addictions unit addresses a wide range of addictions, ranging from substance abuse (e.g. alcohol and illegal drugs) to behavioural issues (e.g. gambling and social media addiction). The primary objectives of the unit include creating health-promoting environments aimed at reducing substance use and addictive behaviours; implementing initiatives targeting families, schools, workplaces, and broader communities; and supporting prevention and health promotion programmes, particularly by enhancing family and school competencies.

The Addiction unit provides grants to local entities and non-profit organisations to implement projects that contribute to community health actions, particularly focussing on schools and families.[5] Currently the unit offers three types of grants (see Table 3.2).The first two grants, which, together, account for the largest part of the DPHA's budget size, support a broader array of community action projects with relatively generous funding limits. One grant caters to local government bodies, while the other is designated for non-government organisations, thereby broadening the range of potential recipients for addiction prevention efforts. The third grant focusses on funding trained personnel for community-based initiatives, addressing concerns over insufficient human resources and expertise at the local level. The small number of rejected applications for these grants indicates that the available funding aligns closely with current demand.

Project budgets are capped according to the specific grant rules, and there are specific criteria for prioritising applications. The eligibility criteria for allocating grants, following the public application process, are similar to those used by the Health Promotion unit. For example, projects can score up to 100 points, with specific allocations such as a maximum of 12 points for the technical quality of the project plan and up to 11 points based on the number of directly or indirectly benefited individuals. These scores not only determine eligibility but also influence the funding amount designated for each project. Each type of grant has a predefined budget (approximately EUR 500 000) and requires some form of co-payment. Disbursements are milestone-based, contingent upon achieving project milestones and adhering to fiscal and administrative regulations.

Table 3.2. Grants offered by the Addictions unit supporting community action

Grants programme	Target	Objective/Description	Degree of community involvement	Annual budget
Development of community prevention programmes for addictions and the promotion of healthy behaviours *Ayudas para el desarrollo de programas de prevención comunitaria de las adicciones y de promoción de conductas saludables en este ámbito de actuación*	Local entities	Support local entities in the implementation of community-based addiction prevention, risk reduction, and health promotion programmes, covering up to 75% of the cost.	Partial, depends on the project	EUR 561 765, each project is capped at 10% of total budget
Prevention and reduction of risks and damages and the promotion of healthy behaviours *Ayudas para la realización de proyectos de prevención y reducción de riesgos y daños y de promoción de conductas saludables en este ámbito de actuación*	Non-profit organisations	Co-financing projects focussed on the prevention and reduction of addiction-related risks and damages, as well as the promotion of healthy behaviours	Partial, depends on the project	EUR 1 118 500, each project is capped at 6% of total budget
Creation and maintenance of technical staff *Ayudas para la creación y el mantenimiento de equipos técnicos*	Local entities with more than 8.000 citizens	Create and maintain technical teams for community prevention of addictions.	Indirect, financing staff that can be involved in the community action	EUR 1 174 135, capped depending on the job position

Note: Only includes grants with full or partial degree of community action, 2022.
Source: Government of the Basque Country (2024[2]), www.euskadi.eus/gobierno-vasco/tramites-servicios/.

3.2.3. District units of the DPHA are leading and implementing many programmes promoting community action

Most staff working in the district units of DPHA conduct health promotion activities (which are out of their scope of mandate, see Chapter 4, Section 4.2.1). They possess long-standing experience in leading and promoting multisectoral and multi-agent community action projects, co-ordinating with other institutional actors such as Osakidetza or municipalities. The implementation of such projects requires a wide range of skills such as communication or leadership, and specific knowledge of addressed issues. Examples of the projects in which district staff has a leading or important role are:

- "*Alimentación saludable en población mayor*": This project aimed to describe the nutritional situation of older adults in the Basque Country. The analysis, conducted in the Bidasoa and Uribe OSIs, involved professionals from Osakidetza (Bidasoa and Uribe), the Sub-directorate of Public Health of Gipuzkoa, Public Health Uribe-Kosta, the municipality of Irún, third sector representatives, research institutions, and representatives of older adults who participate in the design of the project (see Chapter 6 for further information).
- "*Apoyo a personas cuidadoras"* in the municipality of Irún: This initiative aimed to provide technical and psychological support to carers and prevent risks associated with caring activities in the home. The promoting group was led by professionals from Osakidetza (OSI Bidasoa) and the Irún district unit of DPHA including representatives from the Sub-Directorate of Public Health (Gipuzkoa), municipal social services of Irún, and other institutions (Municipality of Irún, 2024[3]).
- "Ttipi-ttapa" in municipality and district of Tolosa: The project, initiated by the DHBC, creates walking routes to boost community action and local stakeholder involvement. This initiative, leveraging local community participation, fosters social cohesion, intergenerational exchange, and inclusivity for those with diverse abilities. Organizing a route demands collaboration among three

institutions: a sports technician from the municipality to design and guide the walk, supported by public health technicians from the local unit of DPHA, and volunteers from a local school (Department of Health of Basque Country, 2024[4]).

- "Salud para tod@s" in Gordexola: The programme, led jointly by staff from Osakidetza and the local unit of DPHA, consists of a range of health-related educational classes open to the local population. Co-ordination with the local municipality ensures promotion and venue provision, while community associations contribute by suggesting the topics and helping with identifying instructors, ensuring the program's relevance and accessibility. A unique partnership with the local football club helps to achieve an unusually high male participation rate of 40%.[6]
- "Judimendi Neighbourhood Association" in Vitoria-Gasteiz: The association, located in a district of Vitoria-Gasteiz, benefits from the dedicated leadership of three women: a technician from the local unit of DPHA, a nurse from Osakidetza, and a volunteer from a local faith-based organisation. Their collaborative efforts, complemented by partnerships with municipal authorities, have broadened the association's reach into various fields, addressing diverse community needs and engaging multiple social groups. Most of the organised activities relies on the volunteer commitment of its members, with the technician from the local unit of DPHA and Osakidetza nurse (Judimendi Neighbourhood Association, 2024[5]).

3.2.4. Health Protection unit has also significantly promoted community action for health

While the primary focus of the Health Protection unit lies away from community action, some of its activities are closely linked to community health and can be considered under the broad definition of community action for health. This section outlines these activities.

The Health Protection unit has a wide-ranging mandate in food safety and nutrition, involving staff at central government and district levels. Health protection professionals are responsible for ensuring compliance with food industry standards and managing health risks associated with meat consumption, adhering to slaughterhouse standards. Additionally, they are involved in various aspects of environmental health, including water safety, air quality and chemical products. Recognising the close link between diet and health, the DHBC has promoted the development of healthy eating initiatives, which are under the responsibility of this unit. These initiatives aim to implement actions and objectives aligned with the Health Plan, adopting the *health in all* strategy as the overarching framework for action.

In 2017, the Health Protection Unit published a guide "Healthy Eating Initiatives in Euskadi" to support various health eating initiatives and identify clear, achievable lines of work in areas such as food production, distribution, management, consumption and healthy eating awareness (Department of Health of Basque Country, 2017[6]). The guide proposes objectives and actions to contribute to the collective effort to promote and establish healthier and more balanced eating habits. The Healthy Eating Initiative was launched with a three-year timeframe to achieve concrete objectives in 1000 days. These objectives include reducing sugar and salt consumption, increasing fruit and vegetable consumption among young people, and promoting multi-stakeholder collaboration. In addition, the guide outlines five strategic lines, the first of which focusses on creating an information and expert knowledge system. A project within this strategic line involves mapping of health and nutrition assets of the Basque Country and sharing this mapping through a geolocation platform aiming to make resources and initiatives promoting healthy eating visible to the entire population.

The Healthy Eating Initiative established governance mechanisms to co-ordinate and facilitate projects. A commission was formed to provide strategic guidance, bringing together the departments of health, education, economics (industry and agriculture areas), tourism, the Basque Institute of Labour Safety and Security (Osalan), and Osakidetza. This was complemented by a forum where private and public organisations and citizens could make proposals. One significant project under this initiative was the "360-degree update of school canteens", which aimed to rethink school menus to increase the

consumption of fruit, vegetables and fish while reducing fried foods. On the supply side, the initiative also targeted workplace canteens, promoted healthy options in vending machines, and collaborated with producers to reduce salt in products. To address the demand side, initial projects included sessions with young people and multidisciplinary teams to promote ownership of healthy eating, and training of health workers in nutrition. Additionally, campaigns using both traditional and social media were conducted to raise awareness and create a network of agents to promote healthy eating messages.

A more targeted strategy to prevent child obesity was published in 2019, encompassing actions in several areas, including the community (Departament of Health of Basque Country, n.d.[7]). The rationale behind this strategy is that the community plays a crucial role in promoting healthy lifestyles, and public authorities should promote healthy environments in towns and villages to encourage physical activity in a safe and accessible way. The strategy had a three-year target for increasing fruit and vegetable consumption, physical activity and the proportion of local authorities prioritising childhood obesity prevention. Specific co-operation with municipalities was a key aspect, aiming to prevent childhood obesity through actions such as the creation of a reference person (a health or sports technician) and establishing working groups at municipal or district level to discuss ways to improve physical activity. Additionally, the strategy promoted urban projects and safe mobility for children through cycle paths, access to sports, and other solutions. Finally, the strategy included specific actions such as co-operation with the media to develop communication strategies adapted to children and adolescents.

3.3. Community action for health has gained importance in other Directorates within the DHBC and Osakidetza

3.3.1. The Pharmacy Directorate could play a more important role in community action

The Directorate of Pharmacy actively collaborates with pharmacists and other relevant stakeholders in health prevention and promotion initiatives. Within the strategic vision of the DHBC, integrating pharmacists into the health system is a key objective. This integration is facilitated by a regulatory framework that ensures all pharmaceutical establishments and services, while privately owned, fall under the authorisation and oversight of the DHBC. Health promotion initiatives run by the Directorate of Pharmacy and sponsored by the DHBC follow a structured process. This process begins with organising a pilot programme in a limited geographical area, such as aa municipality, followed by a comprehensive evaluation of the pilot results, including cost-benefit analyses. Successful initiatives are then extended to other municipalities/districts.

Although many of the programmes sponsored by the Directorate of Pharmacy do not strictly fall under the category of community action, they significantly contribute to health promotion and disease prevention efforts. These initiatives highlight the scope for action in this field by the DHBC in collaboration with pharmacies. One notable initiative is the Methadone Maintenance Programme, conducted in collaboration with the Basque Pharmacists' College. Through this initiative, individuals suffering from drug addiction can benefit from supervised treatment with methadone, leveraging the proximity of pharmacies to citizens to improve access to vital treatment services. Pharmacies also play a crucial role in preventing HIV by providing quick tests to detect the virus.[7] Additionally, ongoing initiatives and pilot projects include monitoring diabetic medication, projects for asthma patients, integrating community pharmacies into Osakidetza, promoting the appropriate use of benzodiazepines, and initiatives to prevent suicides.

A notable funded initiative more closely related to community action is "Home Pharmacy" (*Farmacia a domicilio*). This initiative significantly contributes "Home Care Services" (*Servicios a domicilio*), targeting individuals with disability or in need of some degree of long-term care, enabling them to remain in their own homes. The Home Pharmacy initiative aims to provide access to medicines and ensure proper adherence to treatment. Pharmacies collaborate closely with professionals from social services (home

assistants) and/or family caregivers, addressing all aspects of medication procurement, storage, and administration. Other pharmacy initiatives involving elements of community action are detailed in Box 6.1.

3.3.2. The Directorate for Social and Health Policies Integration has all the governance tools to allocate more prominence to community action

The Directorate for Social and Health Policies Integration[8] focusses on people-centred care which requires co-ordinated action combining health and social care. According to Law 12/2008, of 5 December, on Social Services, "Socio-healthcare shall comprise the set of care aimed at people who, due to serious health problems or functional limitations and/or risk of social exclusion, require simultaneous, co-ordinated and stable health and social care, in accordance with the principle of continuity of care". Achieving integrated social and healthcare requires agreements between the Directorate of Social and Health Policies Integration and the provinces, as the latter hold the competences for specialised social services. The directorate promotes a co-ordinated approach, including co-financing from the DHBC. It finances a network of resources for people with long-term care needs, disability and mental health issues, often managed by NGOs, which include day care and sheltered housing facilities.

The current strategy of the Directorate for Social and Health Policies Integration incorporates concepts related to a community participatory approach, although it does not explicitly mention "community action". In June 2021, the Directorate for Social and Health Policies Integration published a strategy for social and healthcare in the Basque Country for 2021-2024. One area with potential for community action is social and health prevention, which includes plans for designing a Co-ordinated Framework for Social and Health Prevention and the Instrument for the Detection of Social and Health Risk. Those plans could potentially promote a community participatory action approach, though this is not explicitly stated in the strategy.

Another relevant area is socio-healthcare (*atención sociosanitaria*), which includes promoting, monitoring and raising awareness of the needs of individuals in vulnerable situations through relevant instruments and collaboration on actions that improve the quality of life for target socio-health groups, such as individuals with mental health and addiction issues, rare diseases, or those in end-of-life situations. While these activities could be conducted through a community action, the strategy does not clearly specify it as the preferred tool to achieve these objectives.

There is a stronger emphasis on community action in the area of mental health as demonstrated in the Mental Health Strategy 2023-2028, jointly undertaken by Directorate for Social and Health Policies Integration and Osakidetza. This strategy includes several "priority actions" that have links with community action. Notably, the priority action four focusses on community-based recovery care, while priority action six supports associations of families and individuals with mental health problems to create support groups (foreseen in 2026). Additionally, priority action eight emphasises citizen participation in the design, planning and evaluation of programmes by associations (foreseen in 2028). The promotion of a recovery approach and peer support is planned for 2026. Several associations of people with mental health issues and their families which receive support from the Directorate are already active in peer support, suicide prevention, and training to promote self-care, reduce stigma, and raise awareness.

3.3.3. Osakidetza has developed its own strategy for a community approach for health, allocating dedicated staff to this activity

Osakidetza has adopted a strategy for approaching health from a community perspective, initially focussing primarily on primary healthcare.[9] This strategy, resulted from the emphasis on community in Osakidetza's Strategic Plan (Osakidetza, 2023[8]). It addresses the social determinants of health and underscores the need for a multidisciplinary and intersectoral approach to tackle health inequalities and improve health outcomes. The strategy aims to promote community approaches for health, favour the creation of new initiatives, and co-ordinate existing ones. To this end, the Strategy identifies the community as a key

stakeholder and sees community action – defined as the effective involvement of communities in priority-setting, decision making and policymaking – as an effective way to support health priority-setting and strategy implementation. The strategy is structured around four key lines of action: (i) governance; (ii) mapping of initiatives; (iii) promoting a community approach at the three levels (individual, addressing the social determinants of health, group-based through activities to promote self-care and empowerment, and collective, through intersectoral approaches in the community); and (iv) dissemination. A line of action within the strategy focusses on promoting community action through several concrete initiatives:

- Establishing a "community notebook" at each primary healthcare centre to increase the visibility of community activities, designed with an intersectoral and multidisciplinary approach.
- Facilitating health promotion activities and promoting inter-sectoral relationships in health centres, encouraging collaborative work and community processes.
- Providing training and support for health centre professionals to join local networks.

In April 2023, Osakidetza established a new structure featuring "community nurses" dedicated to health promotion and community processes. Community nurses are assigned to Integrated Health Organisations (*Organización Sanitaria Integrada*, OSI), each covering several primary care units. Within each primary care unit, there is a community action reference person who acts as a liaison between the health centres and the community nurses, communicating the needs and suggestions of primary care centres. Community nurses, in consultation with the community liaison officer in the integrated care units, are currently mapping existing initiatives involving the community (and could therefore be considered community action interventions). They will also be responsible for advising primary care professionals on initiating health promotion activities and community processes. In the future, community nurses will create networks for multidisciplinary and intersectoral work within Osakidetza and with external community agents.

In April 2024, Osakidetza released two complementary documents: "Strategy for approaching health from a community perspective", providing theoretical basis for promoting a community approach in primary care units (Osakidetza, 2024[9]); and "A pathway to a citizen health empowerment strategy", designed as a reference space for all citizens to address their health and empowerment needs and expectations (Osakidetza, 2024[10]).

While the DPHA has a mandate for fostering health promotion, Osakidetza also includes health promotion as a part of its healthcare provision mandate. Health promotion is inherently multidimensional, requiring collaboration among multiple agents for effective deployment. It is evident that the various dimensions of health promotion need co-ordinated efforts, and a clearer definition of the mandates for each stakeholder is necessary. While the institutional structure developments mark significant progress, there is a need for a broader reconsideration of how Osakidetza's new strategy aligns with the DPHA's broader mandate. A more comprehensive strategy co-ordinating the contribution of various community action actors is essential for effective implementation.

3.4. Community initiatives outside the DHBC also support health and well-being

Community action for health extends beyond the DHBC. Various units across the government of the Basque Country play a role in promoting population health and well-being through community-based initiatives. This section highlights selected examples of such initiatives implemented outside the DHBC, illustrating the inherently interdisciplinary nature of community action. These examples stresses the importance of co-ordinated efforts across government directorates to ensure that all relevant stakeholders contribute to the development and implementation of a future strategy for community action for health and well-being.

The first example is the Esukadi Lagunkoia initiative. It was developed by the Matia Institute under the auspices of the Basque Country's Department of Equality, Justice, and Social Policies, and aims to explore

the potential of the older people to enhance community well-being and environment in the Basque municipalities, aligning with the WHO's Age-friendly Environments Programme (Euskadi lagunkoia, 2024[11]). Its goals include fostering elderly participation, encouraging community engagement, establishing a network of supportive initiatives, and adapting environments to improve life quality for all citizens. The initiative provides guides for forming promoter groups and assessing community assets, with additional resources for action planning and rural area adaptation underway. An important component, Farmacia Lagunkoia, partners with the Basque Pharmacist's Council to integrate pharmacies into the community support network, focussing on the older people's needs. This involves connecting pharmacies with municipal resources, social services, and health centres, with pilot studies underway to evaluate strategies for creating age-friendly pharmacy spaces.

Another example is Mugimen, a collaborative project designed to foster an active Basque society by integrating initiatives aimed at promoting physical activity and reducing sedentary lifestyles (Mugiment, 2024[12]). Launched by the DHBC, in collaboration with the Directorate for Physical Activity and Sports and the Directorate for Educational Innovation, the project engages a wide network including Provincial Councils, various municipalities within the community, and other organisations committed to advancing physical activity. This approach underscores a comprehensive effort to improve public health through enhanced engagement in physical activity across the region.

Urretzindorra is a project, supported by the Department of Equality, Justice, and Social Policies, aims at enhancing social inclusion and integration among immigrants and refugees through personalised mentorship. This approach facilitates their entry into local social networks by connecting newcoming families with small children to local elderly residents, who assume the role of "new grandparents". This intergenerational bonding not only aids in the social integration of immigrants but also helps in the fight with loneliness among older people, which has a direct impact on their mental health and well-being.

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Notes

[1] Unless stated otherwise, references to laws, regulations and institutions should be intended as references to the Basque legislation and institutions.

[2] As explained in Chapter 2, Section 2.1.2, Osakidetza is a public body governed by private law.

[3] Several other guides on the topic of community action exist. This section only mentions those where the DHBC has had a direct participation.

[4] The report provides the data up to 2022 due to the unavailability of full budget information for 2023.

[5] Institutional co-ordination following the in the Law on Comprehensive Care for Addictions and Drug Addictions is regulated through the Support and Assistance Body established in Decree 25/2018, of 18 February.

[6] Source: Interviews conducted during the fact-finding mission between 20 and 24 November 2024.

[7] On 26 November 2023, an HIV prevention programme was implemented in 60 pharmacies, facilitating the access to HIV testing for the entire population, and positioning neighbourhood pharmacies as a

valuable complement to the resources of Osakidetza. This has been evidenced by the programme's success in conducting 32 694 rapid HIV tests since its launch in 2009.

[8] The Spanish term "*atención sociosanitaria*" has not a straightforward translation in English. In this document, the *Departamento de Atención Sociosanitaria* is referred to as the *Directorate for Social and Health Policies Integration*, reflecting its role within the DHBC.

[9] The strategy is in line with the overall Primary Care Strategy and the sub-strategy of Empowering Citizens in Health and the Osakidetza 2023-2025 Strategic Plan, which aims to give people a more active role in their health and to develop healthy communities through active participation.

4 Community action accounts for a small share of the Department of Health of the Basque Country financial and human resources

This chapter examines the financial and human resource commitments of the DHBC towards community action initiatives, highlighting the modest share of resources dedicated to this area. It explores the specific budget lines and the legal and regulatory challenges associated with funding community projects. Additionally, the chapter delves into the human resource aspects, underscoring the scarcity of staff officially dedicated to community action and the skills gap that exists among the current workforce.

Introduction

Community action, despite its recognised importance for improving public health outcomes, currently represents a minor portion of the DHBC's financial and human resource allocation.

4.1. Budget lines financing the community projects are a very small fraction of the total budget for DHBC

4.1.1. The majority of DHBC's budget funds Osakidetza, and the second biggest allocation is to pharmacy budget line

The budget of the DHBC is sizeable, although below the OECD's average in terms of share of GDP. In 2022, the DHBC was allocated a budget of approximately EUR 4.3 billion, which is the largest allocation in the Basque Country's budget, accounting for about 5% of its GDP, and the [1] per capita expenditures are the highest among all the AC in Spain (Ministerio de Sanidad, 2022[1]). The DHBC funds a wide range of activities related to the health and well-being of the Basque population.

The largest share of the budget (81% in 2022) was allocated to the financing and contracting budget line,[2] which finance healthcare services (see Table 4.1). A significant part of this budget line (68%) was channelled to Osakidetza through the "*Contrato-Programa Osakidetza y Ostek SA"*. The remainder went to financing and contracting other providers. The last column of the table shows that more than 92% of the budget excluding the funding for Osakidetza is allocated to financing and contracting of other providers (about EUR 600 million) and to pharmacy (about EUR 530 million, mostly to pay medicines).

Table 4.1. Structure of the DHBC budget by programme, 2022

	Programme number	Budget (in EUR)	% of total budget	% of total exc. temporary and Osekidetza[3]
Total		**4 382 021 900**	100.0	
Total excl. Osakidetza and temporary budget lines		**1 219 375 201**		100.0
Temporary budget lines		190 610 000	4.3	
COVID-19 Measures	1 229	185 410 000	4.2	
Fund for innovation	5 414	5 200 000	0.1	
	Permanent budget lines	4 191 411 900	95.7	
Infrastructure and support	4 111	20 531 600	0.5	1.7
Financing and contracting, of which[1]	4 112	3 567 631 600	81.4	48.8
Contrato-Programa Osakidetza y Osatek SA[2]		2 972 036 699	67.8	
Public health	4 113	50 981 400	1.2	4.2
Research and planning	4 114	15 972 100	0.4	1.3
Pharmacy	4 115	531 410 200	12.1	43.6
Addictions	4 116	4 885 000	0.1	0.4

Note: The Public Health (4 113) and Addictions (4 116) budget lines are under the responsibility of the Directorate of Public Health and Addictions.
1. This budget line has one part under the responsibility of the Health Vice-counsellor's office (4112-10), which is the one that includes the "Contrato-Programa Osakidetza" and another part under the responsibility of the Directorate for Social and Health Policies Integration (4112-14), which includes the "Convenios de atención sociosanitaria", which may include some community action component.
2. This amount does not represent the totality of the Osakidetza budget but is, from far, the most important. Several other contracts between the DHBC and Osakidetza exist for a total budget of EUR 3.5M in 2022.
3. The percentage assigned to Financing and Contracting is calculated excluding the EUR 2.972 M of the "Contrato-Programa Osakidetza".
Source: Government of Basque Country (2022[2])

The second-largest budget allocation is directed to the pharmacy budget line, managed by the Directorate of Pharmacy, which accounts for nearly 12% of the total budget (see Table 4.1). While the majority of these funds (98%) are allocated to purchasing medication and related pharmacy services, a small portion supports community-oriented projects. For example, in 2022, EUR 120 000 was allocated to pharmaceutical socio-health initiatives, EUR 675 000 to the Matia Foundation[3] – an organisation that supports individuals through the ageing process to improve their well-being – and EUR 80 000 to a pharmacotherapy monitoring project[4] aimed, among other objectives, at increasing the healthcare contributions of community pharmacies.

The DPHA and the Directorate for Social and Health Policy Integration oversee the third and fourth largest budget allocations from the permanent budget lines. The public health budget lines account for almost EUR 51 million, while the addiction budget line is nearly EUR 5 million. This corresponds to 1.3% of the total budget and 4.6% of the budget excluding funds allocated to Osakidetza and temporary budget lines. The Directorate for Social and Health Policy Integration manages budget lines amounting to approximately EUR 35 million, which are part of the financing and contracting budget line. A significant portion of these budget lines is transferred to the provincial governments to support social programmes aimed at improving the health and well-being of their populations.

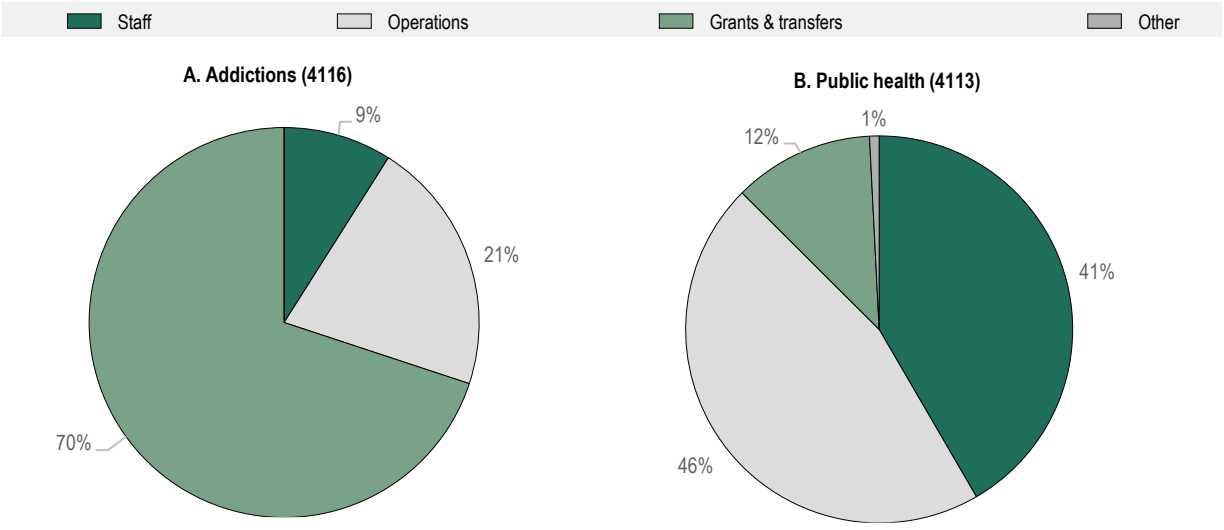
4.1.2. The DPHA has provided stable but small financing to community action over the past years

In absolute terms, the *public health* budget line provides a larger amount for community action than the *addictions* budget line. However, considered in relative terms, the amount dedicated to community action represents a small share of the public health budget line than for addictions. The expenditure structures of addictions (Panel A) and public health (Panel B) budget lines consist of four main categories: staff, operations, grants and transfers, and other.

In 2022, the majority of the public health budget lines was allocated to operations (46%), with staff costs representing 41%, and grants and transfers, which include community project funding, accounting for 12%. Conversely, the addictions budget line structure is different, with 70% allocated to grants and transfers, and only a significantly smaller proportion for staff and operational expenses. As a result, although the budget amount assigned to addictions was significantly smaller than for public health, it allocated a significant part of its funds to grants and transfers for organisations involved in community work (see Section 4.2.2 for details).

Figure 4.1. Expenditure structure of the addictions and public health budget lines

Share of the budget line, in 2022



Note: Staff only includes professionals working in central services. In the Public Health programme, the budget going to Staff includes both the Vice-counsellor's Office and the DPHA. The budget going to finance community projects comes Subventions & transfer expenditure line. Operations budget in the Public Health programme is mostly explained by vaccines purchase.
Source: Government of the Basque Country, (2022[2]), "General Budget of the Autonomous Community of the Basque Country ", https://www.euskadi.eus/contenidos/informacion/presupuestos_cae/es_def/adjuntos/pdfs/2022A/09_Osasuna_Salud.pdf.

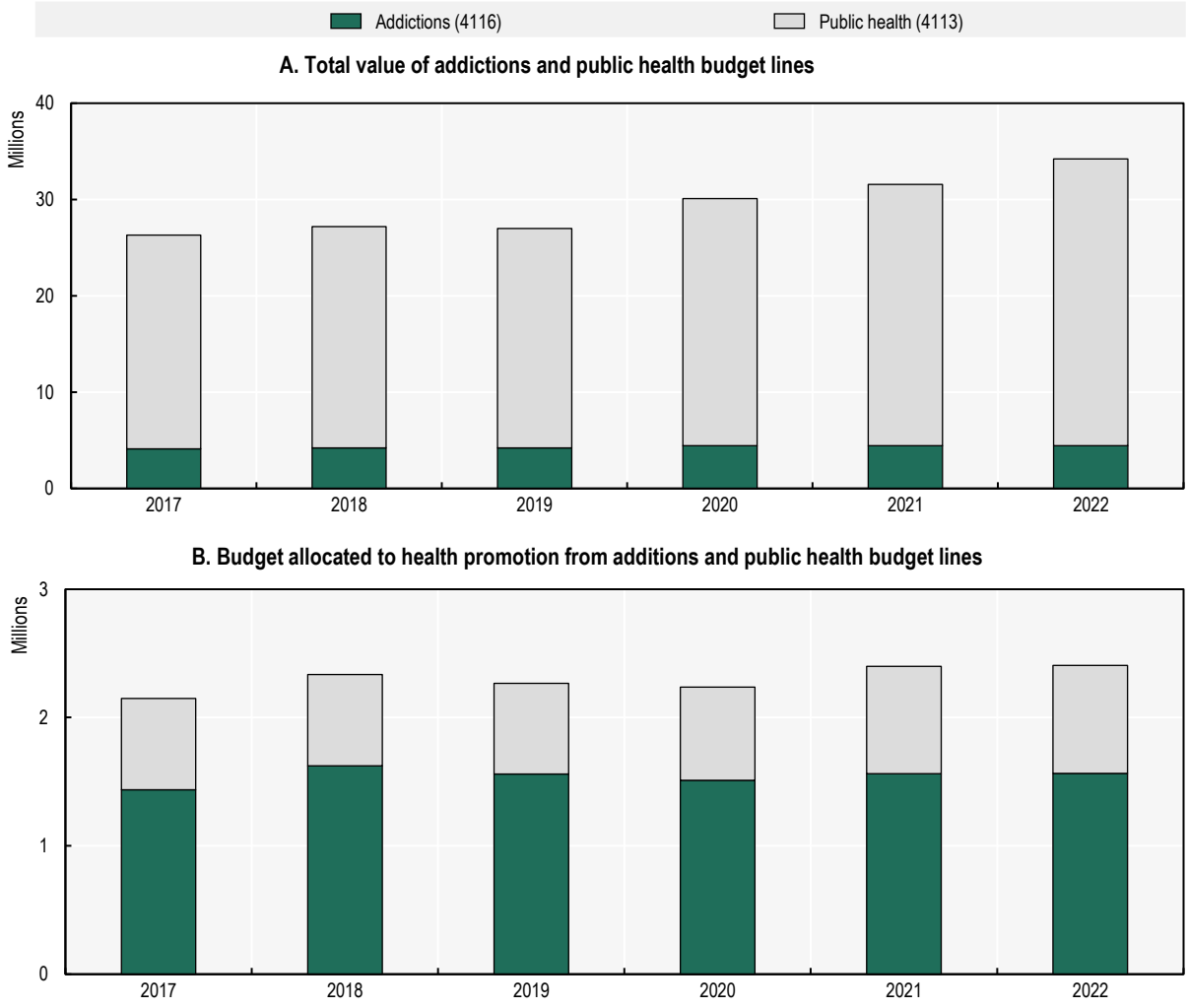
In absolute terms, the budget for health promotion from public health and addictions budget lines has remained stable between 2017 and 2022. The total budget allocated to these budget lines is slightly over EUR 30 million (excluding staff expenses), Panel A of Figure 4.2 shows that between 2017 and 2022, while the public health budget line increased its funding by 34% (partly due to vaccine procurement and distribution after 2020), the addictions budget line remained relatively stable. Within these two budget lines, the amount allocated to health promotion is less than 10% of the total budget line (approximately EUR 1.2 million in 2022). As shown in Panel B of Figure 4.2, the budget specifically for health promotion projects within the public health budget line stood at EUR 841 000 in 2022. Despite a slight increase in absolute terms, the part of the budget allocated to promotion has seen a slow but steady decline since 2017 (from 3.2% to 2.8%). The budget for health promotion within the addictions budget line has remained relative stable since 2017 (approximately EUR 1.5 million in 2022).

In relative terms, the budget for community action accounts for a very small fraction of the addictions and public health budget lines and saw a reduction in 2022 after stability in previous years. Excluding staff expenses, the budget for community action is estimated at less than EUR 700 000 per year, representing less than 0.02% of the total DHBC budget.[5]

Many of these projects require minimal budget beyond salaries of those who manage them. However, despite the low funding, community action projects can have a strong positive impact on the health outcomes of the communities. The financial resources allocated to health promotion are not fully synonymous with community action. According to the DHBC estimates,[6] in 2022, 45% of public health budget line was allocated support community action, down from 56% in 2017. The budget remained stable from 2017 to 2021 but experienced an 11% cut in 2022. Conversely, the addictions budget line, which lacks a dedicated funding for community action, allocated 15%-22% of its funding to community projects, increasing from about EUR 275 000 in 2017 to EUR 343 000 in 2021, before a 34% reduction brough it down to EUR 226 000 in 2022.

Figure 4.2. Addictions and public health budget lines in 2017-2022

In millions of EUR



Note: Number in parenthesis in the legend refer to specific budget lines as they appear in the Basque budget. The budget does not include costs of staff. There is a discrepancy between the published budget of the DHBC and data sent by the DHBC.
Source: Questionnaire filled out by the DHBC.

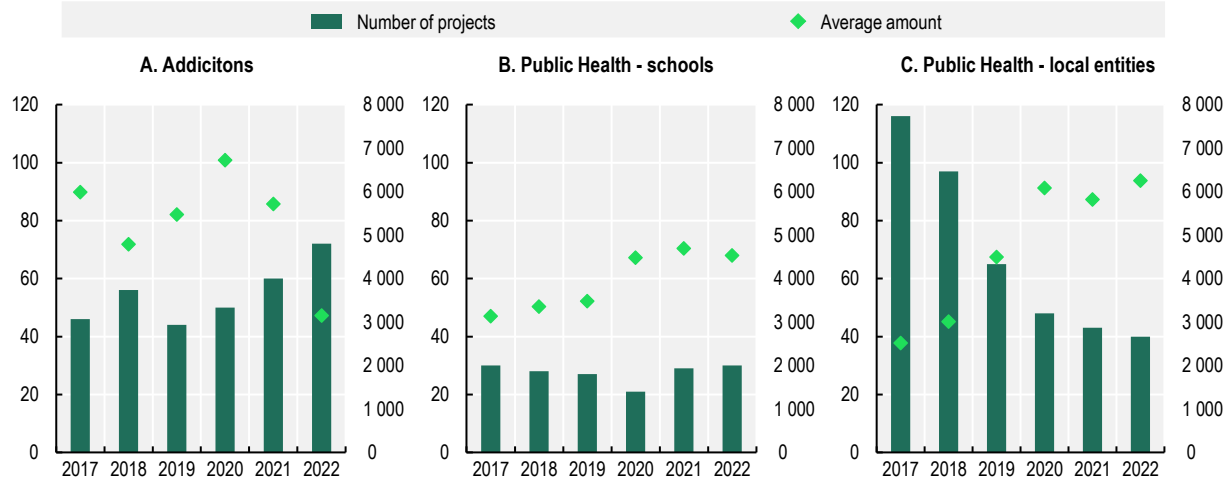
Trends in average funding per project and the overall number of projects have evolved in opposite directions between public health and addictions budget lines. Figure 4.3 illustrates the number of projects and the average funding per project between 2017 and 2022.[7] Each panel refers to projects financed by different grants:

- None of the grants financed by the addictions budget line are fully dedicated to community action (see Chapter 3, Table 3.2). However, many projects receiving either the "Development of community prevention programmes for addictions and the promotion of healthy behaviours" grant or the "Prevention and reduction of risks and damages and the promotion of healthy behaviours" grant have a strong community component. In 2022, these two grants had a combined budget of EUR 1.7 million, supporting a total of 127 projects. More than half of these projects involved community activities. They received, on average, EUR 3 145 per project, nearly four times less than the overall average funding per project. The addictions budget line has increased the number

of supported community action projects while decreasing the average funding per project (see Panel A of Figure 4.3).

- The health promotion component of the public health budget line primarily funds two grants for community action. The "Development of Actions Aimed at Promoting Physical Activity among Students" grant was allocated EUR 136 000 in 2022. Between 2017 and 2022, the number of supported projects fluctuated between 30 (2017) and 21 (2020). The trend shows an increase in the average funding per project from EUR 3 133 in 2017 to EUR 4 533 reflecting a shift towards funding fewer projects with higher individual budgets (Panel B).
- The second grant financed from the public health budget line, "Development of Local Health Promotion Programmes" grant, had a steady budget of EUR 292 000 from 2017-2020 but faced cuts in 2021, reducing it to EUR 250 000. The number of projects funded annually varied significantly, with a decline from 116 projects in 2017 to 40 projects in 2022. Since the total budget was relatively stable during this period, the average project funding increased by about 150% from EUR 2 517 in 2017 to EUR 6 250 in 2022 (Panel C).

Figure 4.3. Number of projects and average amount of support by financing source



Note: Average amounts in EUR. Public – Health – Municipalities refers to the projects financed via Development of Local Health Promotion Programmes grant. Public Health – Schools refers to the projects financed via Development of Actions Aimed at Promoting Physical Activity among Students grant. Addictions refers to the project financed from Addictions programmes and marked as supporting community action in health by the DHBC.
Source: Questionnaire filled out by the DHBC.

In addition to the four previously described grants, the addictions and public health budget lines allocate funding to three additional grants that can support community action projects. Two of these grants (the bottom of Chapter 3, Table 3.1), funded from the public health budget line, had budgets of EUR 300 000 each with a budget of EUR 300 000. Another grant, belonging to the addictions budget line (the bottom of Chapter 3, Table 3.2), provided funding for professionals working in municipalities who are responsible for, among other things, organizing addiction-related community action. In 2022, this grant helped to co-finance posts in 36 municipalities, providing an average of EUR 32 614 per municipality. This funding level typically allows for the employment of one professional per municipality to carry out these tasks.

4.1.3. The mechanisms for financing community action by the DHBC encounter some legal and regulatory challenges

There are recurring legal concerns whether grants financed by the DPHA to municipalities (see Chapter 3, Table 3.1 and Table 3.2) might constitute an encroachment on local competences and should be discontinued. Lack of clarity with respect to the division of competences by each level of government or their interpretation is at the heart of this discussion. On the one hand, according to the Article 17 of the Law 2/2016, of Local Institutions in Euskadi, the promotion, management and protection of public health is a municipal responsibility.[8] From this perspective, a cash transfer from the DHBC might be seen as influencing priorities that municipalities should finance with their own funds. On the other hand, Law 13/2023, of Public Health in Euskadi, establishes the Basque Public Health System with the mission of exercising strategic leadership in population health, promoting its protection and promotion in cross-sectoral policies (Art. 6-g) and enhancing health and well-being through interventions aimed at increasing knowledge, skills, and changing social conditions (Art. 6-i). Therefore, the DHBC's provision of grants to support community action for health, is in principle aligned with its legally established mission.

There is a need to find more structural solutions to avoid uncertainty and administrative costs. So far, this legal challenge has not prevented the DHBC from funding projects that meet the grant criteria. However, DHBC's legal advisors have to analyse and justify the terms and conditions of each call for tenders. This funding is crucial for municipalities, especially small ones, as it enables them to initiate and sustain various projects and retain experienced professionals. Several solutions could be examined:

- Clarify the legal division of competences regarding the promotion of community health. This should involve the Commission of Local Governments which, so far, has not expressed a firm position on this matter. It would be interesting to analyse the possibility that the DHBC provides this funding through the Basque Municipalities Association and if this alternative avoids a legal challenge.
- Align the budget and the competences. If operational actions to promote community health are deemed municipal responsibilities (and hence the DHBC should not provide cash transfers for them), then their budget should be adjusted accordingly, with municipalities being accountable for outcomes in this area.
- Change the terms of the public call for the projects. To streamline the process and reduce the need for regular and tedious revisions and justifications, it is recommended to modify the terms of public calls for community projects. This adjustment should be informed by the analyses that have supported the acceptance of DHBC funding in recent years.
- Explore other instruments to support community projects. The agreements system (*convenios*), often used in the socio-health area, might be an interesting alternative as it is more flexible and does not raise the issue of stepping into the competences of municipalities. Involving the future Basque Institute of Public Health, which has a clear mandate to support community action based on the new law of Public Health in the Basque Country (see Chapter 2, Section 2.2.3) could also be a tool to co-ordinate and support community action for health at all levels.[9]

4.2. Human resources for promoting community action are scarce and do not always have the right skills

The previous section shows that the budget allocated to finance community action projects constitutes a very small share of the DHBC budget. This section analyses the role and work of the DHBC in community action from the human resources point of view.

4.2.1. Few staff within DHBC are officially allocated to work on community action in contrast to Osakitdetza

A large share of DPHA staff works in health protection or in laboratories. In 2022, the DPHA employed an estimated 338 people,[10] including the central services, laboratory professionals, the three sub-directorates based in Vitoria-Gasteiz, Donostia-San Sebastián and Bilbao, as well as personnel in the nine district offices (see Table 4.2). These professionals fulfil various roles: 58 of them (15% of the total) are managers or administrative staff, 66 (20%) work in the analysis laboratories, slightly more than 20 (6%) are in the Health Promotion and Addictions units, 163 (48%) work in the Health Protection unit (including slaughterhouse veterinarians), and 30 (9%) fulfil monitoring tasks.

Staff time dedicated to community action constitutes a small fraction of the total. The Health Promotion unit, while focussed on community action, dedicates approximately 35% of their time to it. In full-time equivalent terms, this corresponds to approximately five persons, representing less than 2% of the total DPHA workforce. Most of these professionals are based in central services or sub-directorates in provincial capitals, which limits their direct engagement with communities in the health districts. The unit focusses on developing a strategy to promote community action for health, allocating funding, co-ordinating projects and, whenever possible, the providing of technical support to stakeholders working in the field.

Table 4.2. Staff working in the Directorate of Public Health and Addictions, 2022

Geographic area \ Function	Administrative	Managers	Laboratory	Addictions	**Health Promotion**	Health Protection	Veterinarian[2]	Monitoring	Total
Central Services	6.0	2.0		6.0	**3.0**	8.0		4.0	29.0
Analysis Lab	8.0	1.0	66.0						75.0
Sub-directorates	20.0	3.0	0.0	0.0	**10.5**	31.0	0.0	26.0	90.5
Alava – Vitoria-Gasteiz	4.0	1.0			**2.5**	10.0		4.0	21.5
Gipuzkoa – Donostia-San Sebastián	8.0	1.0			**4.0**	11.0		9.0	33.0
Bizkaia – Bilbao	8.0	1.0			**4.0**	10.0		13.0	36.0
Districts[1]	18.0	0.0	0.0	0.0	**0.8**	106.3	18.0	0.0	143.0
Araba	4.0				**0.8**	12.3	4.0		21.0
Alto/Bajo Deba (Eibar)	2.0					10.0	1.0		13.0
Goierril-Tolosa (Tolosa)	2.0					14.0	2.0		18.0
Bidasoa (Irun)	2.0					11.0	3.0		16.0
Urola (Zarautz)	2.0					8.0	3.0		13.0
Gernika-Lea Artibai (Gernika)	1.0					11.0	0.0		12.0
Encartaciones/Margen Izquierda (Portugalete)	2.0					15.0	1.0		18.0
Uribe-Kosta (Leioa)	1.0					11.0	2.0		14.0
Interior (Amorebieta-Etxano)	2.0					14.0	2.0		18.0

Note: Staff working the Health Promotion unit often focus on community action. In exceptional situations, staff from other units can also be involved in these programmes. However, and depending on the nature of projects, Addictions and Health Protection staff might be involved in projects with the community.
1. In each District Centre (see Chapter 3, Box 3.1) there is a co-ordinator who has been included in the column "Protection".
2. All veterinarians work in slaughterhouses except for two, in the Interior district, that should be considered as working in Protection.
Source: Questionnaire filled out by the DHBC.

The lack of staff allocated to community action in health districts hinders direct engagement with communities and the expansion of community activities. As discussed in Chapter 3, Section 3.2, staff in health districts is working mostly on health protection as their mandate is to focus on health protection. At the same time, the OECD mapping survey undertaken to document currently ongoing community action initiatives as well as information gathered during the fact-finding mission revealed that many DPHA employees at the district level engage in community action. The OECD mapping survey estimates that at least 32%[11] of all district-level employees are engaged in community action initiatives (see Chapter 6, Sections 6.1 and 6.2 for more details).

Additionally, some district staff engage in community action on their own initiative, often alongside their primary health protection duties. This engagement is typically not officially recognised by the senior management.[12] The OECD mapping survey further shows that about 45% of DPHA staff at the comarca level who replied to the survey work on community action during their free time (see Chapter 6, Sections 6.1 and 6.2). An explicit mandate for community action, accompanied by sufficient time allocation, would facilitate greater community action and project implementation. This could be achieved by adjusting existing responsibilities or recruiting additional staff to support these initiatives.

Osakidetza's decision to hire community nurses indicates a significant commitment to community action in terms of absolute staff numbers. While it does not fund community action projects directly, Osakidetza's Sub-directorate of Primary Care has allocated human resources to serve as a bridge between public health services and the organisers of activities to improve community health. These professional, known as "community nurses", are attached to the OSIs. In 2022, there were 37 community nurses. On average, each nurse is responsible for a population of over 61 000 people, with significant variations across different geographical zones (see Table 4.3). Moreover, every primary care unit appoints a person responsible for community activities. Yet, their commitment to community work is only-part time and their primary role can differ across primary care units. While the proportion of Osakidetza's staff dedicated to community action is relatively low (less than 0.02% of its total workforce of over 30 000), the absolute number of staff involved is significantly higher than in the DHBC. This indicates that Osakidetza is likely to play a pivotal role in directly engaging with communities and co-ordinating community health initiatives.

Table 4.3. Community nurses working in different units of Osakidetza

By OSI, data from 2022

OSI	Population (2022)	Community Nurses	OSI	Population (2022)	Community Nurses
Araba	304 799	5	Rioja Alavesa	10 529	1
Barakaldo Sestao	129 112	2	Barrualde Galdakao	306 002	5
Bidasoa	86 188	1	Bilbao Basurto	356 908	6
Debabarrena	74 471	1	Debagoiena	66 130	1
Donostialdea	379 354	6	Ezkerraldea Enkaterri Cruces	161 893	3
Goierri Urola Garaia	100 814	2	Tolosaldea	65 860	1
Uribe	221 581	3	**Total**	**2 269 951**	**37**

Note: The geographic distribution of districts used by Osakidetza (*Organización Sanitaria Integrada*, OSI) does not coincide with Department of Health's districts (see Chapter 3, Box 3.1).
Source: Osakidetza, (2023[3]), "Estrategia para el abordaje de la salud desde una perspectiva comunitaria en Atención Primaria", https://www.osakidetza.euskadi.eus/contenidos/informacion/osk_trbg_planes_programas/es_def/adjuntos/Estrategia-abordaje-salud-C-_2025.pdf.

4.2.2. The DHBC is consolidating staff contracts and may need to reevaluate future hiring profiles to enhance community action initiatives

To establish robust links with communities and better understand their needs, it is essential to minimise staff turnover within the DPHA. The DPHA aims to reduce the number of staff on temporary contracts, which should decrease turnover and facilitate long-term community action. Currently, the DHBC employs part of its staff on temporary contracts.[13] This situation is not unique to health workers but also exists in other public administration areas. To address it, the Basque administration has initiated a selective process for consolidating temporary employment. The aim is to transition individuals who have been working on temporary contracts, sometimes for several years, into permanent civil servant positions.[14] Interested temporal stuff must apply for a job consolidation tender and undergo a selection process. The selection is based on a scoring system that assigns points for educational background, language skills (Basque language is mandatory for some positions), previous work experience, in particular in similar positions, and additional tests. Box 4.1 presents two examples of the employment consolidation process in the DHBC.

In terms of employment policy, the Basque public administration adheres to strict rules derived from the European Union directives, as well as Spanish and Basque legislation. Access to civil servant positions in the public administration is conducted through a selection process known as the "opposition system" (*sistema de oposiciones*).[15] An "opposition" is an examination based on the principles of equality, capacity and transparency. Generally, the process involves one or more tests aimed at assessing candidate's ability to perform the functions of the position. To succeed, candidates need to be thoroughly familiar with each phase of the process and prepare well in advance, as it is highly competitive. Additionally, in recent years, the administration has emphasised principles of equal opportunities, respect for minorities and diversities, balanced representation and gender perspective, as well as the linguistic standardisation of Basque language.[16]

While this system ensures transparency and the recruitment of well-qualified staff, it has faced criticism for being somewhat outdated and mainly knowledge-based. It does not place sufficient importance on other skills, or adequately consider candidates' professional experience.[17] A significant drawback is that positions are not classified according to the specific functions required, nor are they attached to specific knowledge requirements in public health matters. Additionally, the newly develop additional principles for equity makes the recruitment process slower and more cumbersome.

Box 4.1. Examples of the employment consolidation process at the DHBC

Laboratory Assistants

Applicants were required to hold a Senior Laboratory Technician in Analysis and Quality Control Laboratory diploma or equivalent, to hold European citizenship, and other, relatively standard, requirements such as experience, physical and mental condition compatible with the functions, etc. For this position the specific professional experience as laboratory assistant for the Basque administration was assessed at the rate of 0.170 points per month worked in the last 25 years up to a maximum of 45 points. This rule recognises the work done by internal candidates, especially those who have been working for the Basque administration for many years. For example, someone who has worked as laboratory technician for the DHBC for five years would increase their score by (5*12)*0.170=10.2 points, which is a significant plus given the fact that the maximum score for this position was 100 points.

Corps of Technical Assistants. Health and Environment Laboratory and Inspection Scale

In addition to the standard requirements, applicants were required to hold any of the following diplomas: Higher Technician in Industrial Chemistry, Higher Technician in Analysis and Quality Control Laboratory, Higher Technician in Clinical and Biomedical Laboratory or Higher Technician in Chemistry and Environmental Health. In this case, several different jobs were eligible to credit specific experience, assessed at a rate of 0.277 points per month worked up to a maximum of 40 points. Again, someone with five years of a specific experience would have increased his/her score of 0.277*60=16.6 points (out of a maximum total score of 120 points).

Source: More details about the position of Laboratory Assistants available at: https://www.euskadi.eus/empleo_publico/ayudante-de-laboratorio-proceso-excepcional-de-consolidacion-de-empleo-concurso/web01-sedeopec/es/. More details about the positions of Corps of Technical Assistants, Health and Environment Laboratory and Inspection Scale available at: https://www.euskadi.eus/procesos-selectivos-de-consolidacion-de-empleo-temporal-informacion-general/web01-sedeopem/es/

The profiles hired within the DPHA are limited and not focussed on competencies that facilitate community action. Despite the increasing emphasises on a community approach in public health, the recruitment process at DHBC is predominantly geared towards health protection roles. Current vacancies for health promotion positions are often designated for public health technicians and epidemiologists. There are no guidelines for recruiting candidates with specialised education and training in community action or experience and training as a social worker. This gap highlights a need for a more diversified recruitment strategy to include professionals skilled in community action.

Osakidetza operates an independent recruitment system. In 2019, Osakidetza introduced a new a new model for staff selection (Department of Health - Osakidetza, 2019[4]). This model addresses strategic challenges related to generational changes and the demand for new professional profiles. The new approach composed of three steps:

- **Stabilisation of current staff**: As of 2018, many Osakidetza employees worked on interim or fixed-term contracts. The consolidation of employment, similar to the DHBC process, began in 2016 to provide more stable employment conditions.[18]
- **Renewal of personnel**: With a significant portion of the workforce nearing retirement, there is a need for generational replacement. This step focusses on adequately covering posts that will become vacant in the coming years.
- **Redefinition of professional profiles**: Adapting to scientific and technological advances (like genetics, robotisation, 3D, biotechnology, etc.), new work dynamics from digitalisation, redesigning public health services, (like adoption of a community approach in public health), and the demographic challenge is essential for future recruitment.

Both the DHBC and Osakidetza make efforts to improve the contractual situation of their current staff. Osakidetza is also focussed on renewing professional profiles to meet current and future public health challenges. This process follows a well-designed recruitment strategy and is being implemented gradually. However, the DHBC's recruitment policy does not seem to have a similar strategic approach. By recruiting suitable professionals under stable contractual conditions, DHBC has an opportunity to enhance its work in community action for health.

4.2.3. Access to formal education and training in community action has expanded in recent years

Specific efforts have been undertaken to provide training in community action. The lack of training among professional was acknowledged in the DPHA's "Methodologic guide to address health from a community perspective" (Dirección de Salud Pública, Gobierno Vasco, 2016[5]). In 2015, Osakidetza organised two

courses to address this training gap. An introductory course on the community approach to health was included in the training itinerary for primary care professionals. Additionally, Osakidetza offered an advanced course for 54 Osakidetza and DHBC professionals. These trainings led to the reinforcement or initiation of 38 community work processes across all OSIs and district units of DPHA. Following this, in 2015/16, Osakidetza launched an online training course aimed at raising awareness about community action among health professionals, focussing on the benefits of community participation and identifying health community assets.

In recent years, the academic background and professional profiles of those working in community action for health in the public sector have become more distinctly defined. Consequently, the offer of academic trainings on community health has been consolidated and adjusted to new needs. For instance, as of 2024, the University of the Basque Country[19] offers comprehensive training in health promotion and community health, including:

- **University specialisation in Health Promotion and Community Health:** This programme aims to equip students with basic skills for work in health promotion and community health. It adopts a biopsychosocial approach to health and cover elements such as social determinants of health, health promotion, and the positive vision of health, both conceptually and practically.
- **Masters in Health Promotion and Community Health:** Building upon the university specialisation described in the previous bullet point, this lifelong learning programme explores various approaches to community health, from action in communities, to the promotion of healthy environments and policies, and improving health behaviours. It also provides essential skills for designing, developing, and evaluating interventions in health promotion and community health.

In the coming years, the development of professional profiles specialised in community health should be reflected in the hiring requirement for specific positions (e.g. community nurses or technicians in community health). The future Basque Institute of Public Health could play an important role in co-ordinating this process and ensuring the overall coherence of the academic curricula and the training of the many professionals within the health system. In fact, the Law 13/2023 indicated, as one of the objectives of the Basque Institute of Public Health to "… *promote and encourage, in collaboration with the responsible bodies, universities and research centres, the training of professionals and research in public health*."

References

Department of Health - Osakidetza (2019), *Osakidetza, Nuevo modelo de procesos de selección*, https://www.euskadi.eus/contenidos/informacion/nuevo_modelo_ope/es_def/adjuntos/nuevo-modelo-ope.pdf. [4]

Dirección de Salud Pública, Gobierno Vasco (2016), *Guia metodológica para el abordaje de la salud desde una perspectiva comunitaria*, https://www.osakidetza.euskadi.eus/contenidos/informacion/publicaciones_informes_estudio/es_pub/adjuntos/guia-metodologia-esp.pdf. [5]

Government of Basque Country (2022), "General Budget of the Autonomous Community of the Basque Country", *Chapter 9 (Health)*, https://www.euskadi.eus/contenidos/informacion/presupuestos_cae/es_def/adjuntos/pdfs/2022A/09_Osasuna_Salud.pdf. [2]

Ministerio de Sanidad (2022), *Estadística de Gasto Sanitario Público*, https://www.sanidad.gob.es/estadEstudios/estadisticas/docs/EGSP2008/egspPrincipalesResultados.pdf (accessed on 17 July 2024). [1]

Osakidetza (2023), *Estrategia para el abordaje de la salud desde una perspectiva comunitaria en Atención Primaria*, https://www.osakidetza.euskadi.eus/contenidos/informacion/osk_trbg_planes_programas/es_def/adjuntos/Estrategia-abordaje-salud-C-_2025.pdf. [3]

Notes

[1] Throughout this section, references are made to fiscal year 2022, unless stated otherwise.

[2] The term *budget lines* employed in this chapter correspond to what is called "*programas*" (broken-down in various items or "*partidas presupuestarias*") in the Basque budget. They do not fully overlap with the organisational structure presented in Chapter 3.

[3] To learn more about the foundation, check here: https://www.matiafundazioa.eus/es.

[4] To learn more about the project, check here: https://www.pharmcareesp.com/index.php/PharmaCARE/article/view/685.

[5] It is difficult to clearly determine the perimeter of community action projects. Figures presented here correspond to what the DHBC considers as community action projects. Some funding coming from the Health Protection unit of the DPHA, and to a lesser extent from the socio-health, and pharmacy programmes, might be added and will increase the amount to some extent.

[6] Estimates based on the questionnaire filled out by the DHBC. Applies to all numbers in the remaining part of the Section 4.1.

[7] As explained in Section 3.2, the cash support provided by the DPHA to community action projects is organised in several thematic grants. Each grant has an overall maximum budget that is used to fund different projects. The figure only includes those projects considered as community action by the DHBC.

[8] Though, the expression "exclusive competence" is not used in the Law 2/2016.

[9] The agreement system is one of the formulas available to public administrations to organise the provision of services, either through direct management or through indirect management within the framework of public administration contracting regulations and agreements with non-profit organisations. See for example, the Decree 168/2023 of 7 November, in the area of social services.

[10] Not all of them work full time. Therefore, figures in this section are expressed on a full-time equivalent basis.

[11] This number is computed as the number of reported staff working on community action by survey respondents who replied to work at a district office of the DPHA as a share of the total staff of the DPHA working at the district level.

[12] This can even lead to paradoxical situations where Health Protection unit personnel that are key for the survival of an activity involving the community (and often highly appreciated by it) are, from a strictly institutional point of view, acting completely out of their mandate and somehow in contradiction with it (mainly focussed on control, supervision and auditing).

[13] During the fact-finding mission, this situation appeared as quite frequent, especially among people working at local level, both in the DHBC and in Osakidetza (DPHA technicians, nurses and other).

[14] For more information check https://www.euskadi.eus/procesos-selectivos-de-consolidacion-de-empleo-temporal-informacion-general/web01-sedeopem/es/.

[15] For a concrete example taken from Osakidetza check: https://www.opositor.com/landing/osakidetza?piloto=V82&.

[16] A good example of these rules and principles can found here: https://www.euskadi.eus/contenidos/empleo_publico/.

[17] An example the type of criticism to the oppositions system has received in past years can be found here: https://www.industrialesoposicion.es/2018/07/oposiciones-ventajas-e-inconvenientes-analisis.html.

[18] To this process belong the OPE (tenders) launched in 2016-2017 and 2018-2019.

[19] The University of Vitoria-Gasteiz also proposes online training called “Expert in health promotion and community health”.

5 Mechanisms for co-ordination of community action for health in the Basque Country are scarce

This chapter explores the different co-ordination mechanisms in the Basque Country, both vertical co-ordination across different levels of government and horizontal co-ordination across sectors. It identifies existing strengths and gaps, and offers insights into how co-ordination can be enhanced to better support community action for health and well-being.

Introduction

Involving the community in health-related initiatives can significantly benefit from structured co-ordination mechanisms. To effectively inform, consult, and involve communities in policies, strategies, and programmes, it is crucial to establish robust networks and exchange mechanisms. The Basque Country features a diverse range of stakeholders involved in community action for health, including various levels of government and sectors. Effective planning and implementation of community action programmes for health and well-being can be facilitated through appropriate co-ordination between administrations with competencies in different policy and territorial areas, as well as through collaboration between institutional and non-institutional actors. Vertical co-ordination, which aims to align activities across different levels of government, and horizontal co-ordination across sectors, are particularly relevant for community action in the Basque Country.

5.1. Co-ordination for community actions at local level depends on voluntary engagement of professionals

Currently, while a theoretical framework exists for establishing local teams for community action (see Chapter 3, Section 3.2.1 for guides description), its implementation depends on local circumstances. There is no structured network for linking local initiatives to facilitate sharing of experiences and good practices. The OECD mapping survey confirms that information and experiences are almost exclusively shared within individual organisations, not beyond (see Chapter 7, Section 7.5).

The two methodological guides published by the DPHA (see Chapter 3, Section 3.2.1) provide a framework for creating teamwork at the local level for community action in health. According to the guides, the first step is to form a promoting group comprising staff from the DPHA at local level and from Osakidetza. However, the guides do not specify which institution should initiate the action. This initial group should then collaborate with municipal authorities and local networks, focussing on expending and engaging with community assets. If municipal support is lacking, the guide advises seeking alternative local institutional partnerships or directly engaging the community. The second guide (Guide for Participation Generating Well-being and Health) emphasises the importance of working closely with public service employees at municipal or provincial levels. It advocates for utilising local health centres, pharmacies, and other health-related entities' resources from the onset of community health initiatives, highlighting the critical role of engaging with local communities early in the process.

There is no consistent pattern for initiating community actions in health. Sometimes, community action projects are initiated by district staff of DPHA (who officially have no mandate for health promotion, which leads to challenges in initiating and maintain community networks), and/or health centres who then reach out to municipalities to form a promotor group. In these cases, the promotor group would engage local associations to form a network, jointly assessing local health needs and designs and implements programmes. In other cases, where the district staff of DPHA and/or local staff from Osakidetza are less involved, municipalities take the initiative to form networks with local associations, with or without the involvement of the district units of DPHA and Osakidetza.

This lack of established pattern is not a drawback *per se*, but it might lead to duplication in activities or hinder the sustainability of projects by not involving all relevant actors. This further compounds with the fact that both DPHA staff at the district level and in Osakidetza do not always have sufficient time to understand the local circumstances and engage with the community due to the other duties and the scale of the population they cover.

The degree of involvement of various actors in creating a promotor group and promoting intersectoral work varies across municipalities and is influenced by local government preferences and resources. Larger cities

tend to have more structured strategies or protocols for horizontal co-ordination between health and social services for community action. For instance, the three province capitals in the Basque Country have dedicated resources for public health within the local administration and their own municipal health plans. In Vitoria-Gasteiz, co-ordination protocols exist between social services and health centre staff, and community networks have been established in certain areas of the city for joint projects. In Bilbao, each primary health centre has a community health table, which includes representatives of the DPHA, Osakidetza, municipal social services, associations, a general practitioner and two nurses, providing a platform for exchanging experiences and making joint decisions for health. In smaller cities, the existence of community action initiatives and intersectoral work depends on the goodwill of the involved actors rather than structured mechanisms. The initiatives led by DPHA district units (see Chapter 3, Section 3.2.3) are also good examples of local co-ordination in health community action.

5.2. There are interesting examples of co-ordination mechanisms that could serve as an inspiration

Specific bodies and protocols exist to facilitate vertical and horizontal co-ordination among various directorates of the DHPA, Osakidetza and other institutions. Although the examples presented in this section do not include community action among their objectives, they can serve as inspiration for a future strategy.

A notable example of such co-ordination is the Addictions unit, which has an established vertical and horizontal co-ordination mechanism. The Interinstitutional Commission on Addictions in the Basque Country fosters collaboration across various sectors to address addiction-related issues. Chaired by the Counsellor of the DHBC and co-ordinated by the DPHA, this commission includes representatives from several directorates of DHBC, other government departments, municipalities, and provincial councils. Established by Decree 25/2018, it aims to develop and recommend key strategies, tools, and proposals for tackling addictions across Basque public administrations, enhancing inter-administrative co-ordination through clearly defined collaboration criteria, including legal competencies, budgeting, and financial support.

Horizontal bodies and protocols also enhance co-ordination between health and social policies, especially for individual requiring joint care. The Directorate for Social and Health Policies Integration has implemented strong governance mechanisms across health and social sectors and various levels of government. Socio-health commissions, which meet biannually to address socio-health needs, have been established. Additionally, the recent strategy of the directorate plans to implement a governance degree on socio-health with clear structures and co-operation instruments. Protocols for social and healthcare initiatives ensure that professional from both sectors share the responsibility of providing high-quality services to those in need.

A specific guide, “The Guide for the Development of Sociosanitary Primary Care Protocols in Euskadi” (*Guía para el desarrollo de protocolos de Atención Primaria Sociosanitaria en Euskadi*),[1] published in 2014, develops protocols to enhance co-ordination in social and health initiatives, focussing on the continuity of care within the socio-health space. The protocols outline a structured four-step process. The process begins with the detection and analysis of cases. Following this, a comprehensive assessment of the case is conducted. The third step involves developing a co-ordinated intervention plan, which consists of selecting the appropriate professionals from both health and social sectors, securing consent from the individual receiving care, evaluating available resources, and formulating a detailed action plan. The final stage of the process is dedicated to monitoring the case, ensuring continuous oversight and adjustment of the intervention as necessary. The protocols have been positively evaluated and suggest potential for establishing them for other intersectoral collaboration (Dirección de Atención Sociosanitaria de Euskadi,

2022[1]). Although most regions have developed socio-health protocols, the adoption of specific local co-ordination procedures remains inconsistent across regions.

Osakidetza has introduced co-ordination mechanisms specific to community action. Its strategy includes governance measures such as setting up a steering committee, ensuring sufficient human and financial resources for community action, building alliances and synergies with stakeholders, providing broad guidelines, and evaluating results. The steering committee is composed of the director of Healthcare, the deputy director for the Primary Care Co-ordination, the deputy director of Nursing, representatives of the reference team for community action in the Subdirectorate of Primary Care Co-ordination (all from Osakidetza), the director and deputy director of DPHA, and director of Social and Health Policies Integration. Additionally, the strategy includes the creation of a reference team for community action, consisting of two nurses and administrative staff to co-ordinate a community action network within Osakidetza, promote best practices and facilitate training within primary care units. The strategy emphasises the need for co-ordination with DPHA at the district level and establishes structures to address this need.

Osakidetza's community nurses, as a part of the multi-disciplinary team, play a critical role in these co-ordination mechanisms. As established in the Osakidetza strategy, community nurses will work closely with the OSI community liaison officer to facilitate intersectoral co-ordination and relationships with the DPHA, ensuring a cohesive approach to community health initiatives.

5.3. The Public Health law sets a framework for co-ordination that could be used for community action but more is needed

The 2023 law on Public Health of the Basque Country will establish a more structured institutional framework for co-ordination in public health, potentially benefiting community action. The Interinstitutional Public Health Commission, as outlined in Article 41, is the primary body for aligning public health policies and facilitating collaboration within the Basque Public Health System. This commission consists of senior representatives from various government levels and departments, tasked with reviewing legislation, proposing strategies, and managing health emergencies. Additionally, the new law mandates co-ordination between the Public Health System of the Basque Country and Osakidetza (Article 44), with the DHBC responsible for defining the necessary criteria and mechanisms for this co-operation. The aim is to protect and promote health, prevent disease, provide health education and respond to emergencies. Co-ordination mechanisms will also be established at the territorial level with Osakidetza, ensuring effective communication and co-ordination in public health prevention, promotion, and surveillance.

The DHBC is further mandated with setting up monitoring and evaluation mechanisms for collaborative programmes with Osakidetza. Once it is established in 2025, The Interinstitutional Commission could serve as a space for vertical co-ordination between the DHBC and municipalities. Alternatively, given its broad scope, other bodies such as the recently created Steering Committee under Osakidetza's strategy could incorporate representatives from municipalities to enhance co-ordination. The co-ordination mechanism with Osakidetza at the territorial level could also further enhance joint work in community action through the DBHC and Osakidetza.

There is a broader need to establish a network of community action initiatives linking local actors across the Basque Country. There are currently many initiatives in community action. Sharing experiences and learning from others on setting up similar projects would be beneficial. Establishing local community health tables and networks can promote the topic, recognise those working in the field, share best practices, co-ordinate initiatives more effectively. Initiatives like Ttipi-Ttapa highlight the value of experience sharing, suggesting that regular meetings among public health technicians could facilitate mutual learning and better co-ordination. Such networks could also aid in diagnosing challenges and setting policy priorities.

Currently, concrete examples of consultation processes with communities are infrequent. A network can help prioritise community action at the local level, but it will also require adequate human resources.

Enhancing horizontal co-ordination through more structured processes, such as establishing protocols for joint work between health and other sectors, could significantly improve intersectoral projects. The municipality of Vitoria-Gasteiz and the Directorate of Social Services and Health Policies Integration have promoted the use of such protocols and provide useful examples of how structured guidelines for intersectoral work can benefit community action. Broadening participation to include sectors like culture, sports, education, and urban planning, beyond just health and social services, is essential for comprehensive community health promotion.

References

Dirección de Atención Sociosanitaria de Euskadi (2022), *Diagnóstico de situación de los instrumentos de coordinación sociosanitarios*, https://www.euskadi.eus/contenidos/documentacion/doc_sosa_inform_instr_coord_22/es_def/adjuntos/Informe_diagnostico_Intrumentos-coordinacion-sociosanitaria_07.02.2023_es.pdf (accessed on 17 July 2024). [1]

Notes

[1] The guide is available here: https://www.euskadi.eus/contenidos/documentacion/doc_sosa_c2/es_def/adjuntos/c2_b3.pdf.

6 Community action initiatives are widespread in the Basque Country

This chapter describes the results of an OECD survey to map community health actions in the Basque country. It provides an overview of the level of involvement of different actors and the population groups targeted, as well as resources involved.

Introduction

Community action has gained importance in the Basque Country in recent years. However, a comprehensive overview of the scope and purpose of initiatives, the involved actors, and the processes in place to organise, co-ordinate, and finance community action is missing. Such information could serve as a foundation for a future strategy for community action, by integrating existing efforts into a unified and coherent approach. To gather information on ongoing community action initiatives, an extensive online survey was widely distributed to stakeholders throughout the Basque Country (Section 6.1 describes the details of the OECD survey). The OECD survey complements a survey undertaken by Osakidetza among its staff about ongoing community action within Osakidetza by expanding the set of actors and therefore providing a more complete picture of ongoing efforts (refer to Chapter 3, Section 3.3.3 for more information on the mapping undertaken by Osakidetza). The OECD survey also complements the information on the role of the DHBC summarised in Chapters 2 to 5.

This chapter starts with a description of the OECD survey, its distribution process, and the respondents, followed by a detailed overview of the scope of community action in the Basque Country (Section 6.1). It highlights the number of initiatives run by various institutions and across localities and gives an overview of the level of involvement in community action of different actors in the Basque Country (Section 6.2). The chapter also discusses the population groups targeted by current community action initiatives (Section 6.3) and ends with a description of the involved costs and funding sources used by various institutions (Section 6.4).

6.1. Information on community action was collected via an online survey

To collect information on ongoing community action, an online survey was distributed as widely as possible among various stakeholders involved in community action in the Basque Country. The survey was implemented in LimeSurvey[1] and was designed to be completed in about 30 minutes. It asked respondents about the number and context of community action initiatives they are currently involved in, how they organise, co-ordinate and finance initiatives, the initiatives' target groups, monitoring and evaluation tools used, as well as their general feedback on community action.

The survey link was sent via e-mail by the DHBC to various stakeholders involved in community action, including:

- all municipal governments
- all community nurses and reference persons in health centres (refer to Chapter 3, Section 3.3.3 for an overview over staff working on community action within Osakidetza)
- all public health technicians[2] and health promotion technicians from within DPHA (corresponding to almost the entire workforce within the DPHA)
- all affiliated pharmacies to the three official colleges of pharmacists in the Basque Country
- third sector actors engaged in community health who are known to the DHBC.

To increase response rates, the e-mail also asked respondents to forward the survey to anyone working in community action. The first e-mail was sent on the 23 January 2024 to close to 900 staff of municipalities, Osakidetza, and the DPHA as well as contacts from the third sector, and on 31 January to more than 4 300 pharmacists working in the 843 pharmacies in the Basque Country. Pharmacists were therefore by far the largest recipient group, followed by Osakidetza employees. A reminder was dispatched to all recipients on 15 February 2024.

The e-mail hence reached the representative sample of all municipal governments and all pharmacies in the Basque Country, as well as all relevant staff working on community action within Osakidetza and the DPHA. The sample is less complete for the third sector as it relied on the contacts available to the DHBC.

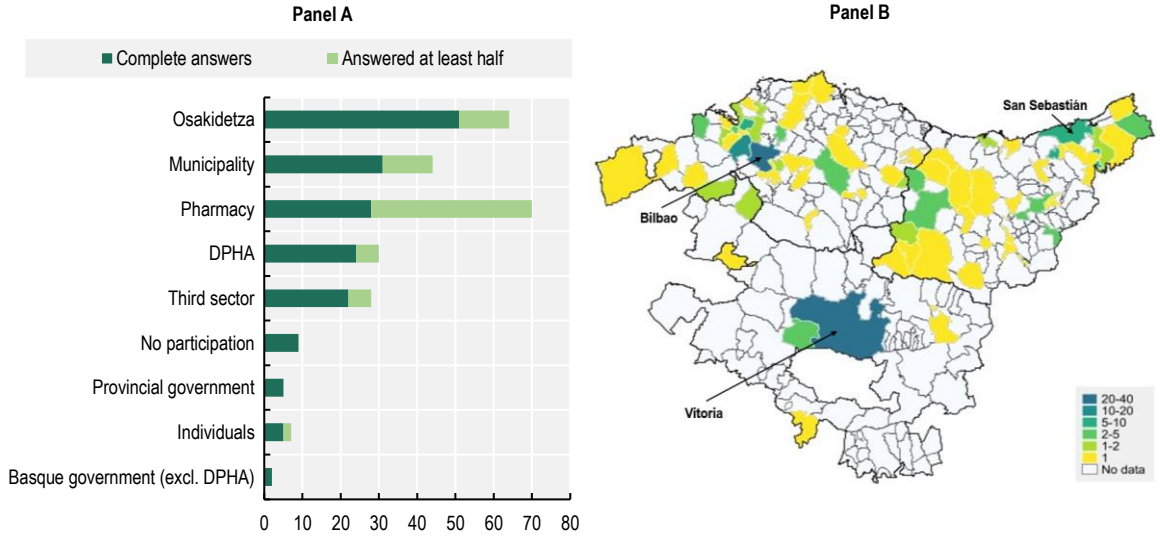
A total of 256 respondents answered the survey, of which 177 respondents completed 100% of the questions included in the survey and another 79 respondents answered at least half of them (see Figure 6.1). Of the 177 people who completed the survey, nine replied that neither they nor anyone else at their organisation is involved in community action, corresponding to about 3.5% of responses. These responses are dropped from the analysis. Among those involved in community action who filled in the survey completely, the largest share of respondents works for Osakidetza (51 respondents), followed by 31 respondents working at a municipal government and 24 working at the DPHA. Also counting responses who answered at least half of the survey increases responses from Osakidetza to 64, from municipal governments to 44 and from the DPHA to 30. Among those 44 however, several are employed within the same municipality but in different services, reducing the count of responses from unique municipalities to 32. Of the respondents from within Osakidetza, about half report to be working in primary care (32) and a quarter are employed as community nurses (17). Only one respondent reports to work in a mental health centre.

While pharmacists were by far the largest recipient group who received the e-mail with the survey link, only 28 filled in the survey completely. An additional 42 started but did not complete the full survey. These numbers correspond to a response rate of between 0.6-1.6%. The low response rate and the low completion rate confirm feedback from pharmacists collected before and after the survey who often found that the survey did not correspond well to the type of projects that pharmacies are involved in (see Box 6.1 for an overview) and was therefore difficult to answer. As discussed in Chapter 1, the health promotion initiatives run by pharmacies do not fall strictly within the category of community action, as they are often run in isolation and without collaboration with other local actors. For this reason, the evaluation of the survey responses in Chapters 6 and 7 excludes responses from pharmacists and focusses on the 180 responses (140 complete and 40 answered at least half) obtained from other institutions instead.

Respondents are geographically well distributed, as 58% of all responses are from individuals working in municipalities outside the three biggest cities. One exception to this pattern are respondents from Álava, who report to work in Vitoria-Gasteiz almost exclusively. Given the overall population distribution of Álava, with almost 80% of the population living in Vitoria-Gasteiz, this response pattern is not surprising (Instituto Vasco de Estadistica, 2023[1]). The geographical distribution of respondents from the individual institutions is very similar to the total distribution of responses plotted in Figure 6.1, with the exception of respondents from the third sector who are much less dispersed and report to mainly work in one of the three big cities.

Figure 6.1. Distribution of survey respondents across institutions and locations

Number of respondents from each institution by completeness status (Panel A) and number of respondents who report to work in each municipality (Panel B), 2024



Note: "Completed answers" refers to respondents who filled in all questions of the survey and submitted their answers. "Answered at least half" refers to respondents who have proceeded to answer at least the first half of the questionnaire. "No participation" refers to respondents who report that their institution is not involved in community action. If this answer option is chosen on the first page, the survey automatically terminates, and the answer is therefore recorded as completed. The municipality refers to the respondent's place of work. Panel B is computed using the total of 180 responses. This includes responses who filled in at least half of the survey but excludes all responses from pharmacists. DHBC is the abbreviation of Department of Health of the Basque Country and DPHA is the abbreviation for the Directorate of Public Health and Addictions within the DHBC.
Source: Data collected via the OECD community action survey.

Box 6.1. Health promotion initiatives run by pharmacies in the Basque Country

Interviews with representatives from the official college of pharmacists of Gipuzkoa and members from the Pharmacy Directorate within the DHBC revealed that pharmacies often run various initiatives for their local communities. A typical example of such initiatives is the Methadone Maintenance Programme, which offers supervised treatment with methadone to individuals suffering from addiction. Other programmes offer free fast tests for sexually transmitted diseases such as HIV or free tests of cholesterol levels or blood pressure. For more details on these programmes offered by pharmacies refer to Chapter 3, Section 3.3.1.

While these initiatives make a significant contribution to health promotion and prevention in the Basque Country, they typically do not fall strictly within the category of community action. This observation is also reflected in the low number of pharmacies that are part of local networks for health and well-being, a finding from the OECD mapping survey (Section 6.2) and confirmed in a mapping undertaken by the official college of pharmacists of Gipuzkoa on pharmacies' involvement in local networks in the second quarter of 2024 (Otaegui Arrazola, 2024[2]). That survey found that, in the first half of 2024, only 12 of the 288 pharmacies in Gipuzkoa were part of a local network. Nevertheless, many pharmacies expressed a strong interest in becoming part of such networks in the future and some new networks will be established before the end of the year.

The survey in Gipuzkoa additionally uncovers two initiatives involving pharmacies that employ a community action approach. The first is the initiative *Farmazia Lagunkoia*, which is part of *Donostia Lagunkoia,* the San Sebastián Friendly City project. Farmazia Lagunkoia utilises focus groups consisting of pharmacies, representatives from the colleges of pharmacists, pharmacy users (in particular older people), professionals from health and social services as well as representatives from various associations to develop criteria for *friendly pharmacies* for older people. The programme is currently extended to all of the Basque Country under the name *Euskadi Lagunkoia.*

Erlauntza, operating across neighbourhoods in Donostia-San Sebastián, is another initiative of pharmacies that employs a community action approach. The core of this initiative are neighbourhood networks linking various actors who work at the neighbourhood level with the aim of sharing knowledge and establishing connections to facilitate joint work and new projects. Typically, the network members include local pharmacies, health centres, representatives from the department of health, from local sports centres, from local culture centres, from local associations, as well as technicians from social services and health promotion from the city council of Donostia-San Sebastián.

The success of these two initiatives has demonstrated the value of including pharmacies in community action work. Through their accessibility and daily interactions with the community, pharmacies receive real-time information on both health concerns and resources of the local community, and they are in an ideal position to disseminate information and promote various offers and services available within the community to the community. The mapping survey undertaken by the official college of pharmacists of Gipuzkoa further revealed strong interest by pharmacies to be more engaged in community action in the future and the official college of pharmacists of Gipuzkoa is aiming to increasingly promote community action among pharmacists in the Basque Country.

Source: Otaegui Arrazola (2024[21]) and discussions of the authors with representatives of pharmacies in the Basque Country.

Assessing the response rate for the remaining institutions excluding pharmacies, reveals that of the about 900 recipients who received the e-mail with the survey link, slightly above 20% filled in the survey at least half and 16.5% filled it in completely. It is at first glance challenging to understand whether this response rate allows for a representative picture of ongoing community action in the Basque Country. On the one hand, it is likely that mainly the organisations who are most involved in community action replied to the survey and the survey is therefore unlikely to be fully representative of all institutions in the Basque Country. Further, only a selected sample of third sector organisations who are known to the DPHA received the survey link, making it unlikely that the respondents from the third sector are representative of all the work on community action by the third sector. On the other hand, several considerations demonstrate that the survey is likely to have reached a fairly representative share of organisations among the DPHA, Osakidetza and municipal governments that are currently actively involved in community action in the Basque Country.

First, the wide distribution of respondents both across locations and across institutions is reassuring as it shows that the survey reached a diverse set of institutions and locations across the Basque Country. Second, a closer look at the number of possible respondents by institution reveals that among municipalities and Osakidetza, for instance, a sizeable share of all possible organisations active in community action responded to the survey.

Benchmarking the 32 distinct responses from municipal governments with the 56 municipalities that have received support from Bherria, an organisation aiding municipal governments with various aspects around community action over the last 7-8 years,[3] sets the response rate among municipal governments active in community action at close to 60%. A similar exercise for Osakidetza shows that the survey has potentially been answered by about 50% of all health centres (excluding mental health centres), with 63 responses

from local health centres (excluding one response from a mental health centre) and a total of 122 health centres in the Basque Country (Open Data Euskadi, 2023[3]).[4] A response rate of close to 50% among Osakidetza is also plausible as 17 out of a total of 36 community nurses answered the survey questionnaire. Comparing the total responses from district staff of the DPHA to the total number of staff employed by the DPHA at the district level (refer to Chapter 4, Table 4.2 for an overview of staff at the DPHA), shows that the response rate among district staff of the DPHA is very close to the overall response rate of 20%.

Overall, although the survey responses are unlikely to be a good representation of all community action in the Basque Country, they are likely fairly representative of the actors who are currently most actively involved in community action in the Basque Country. The survey hence allows to draw valid conclusions on aspects related to the organisation of community action in the Basque Country within all surveyed organisations.

6.2. Many actors are active in community action

In a first step, the survey aimed to assess the extent of community action in the Basque Country by asking about the number of ongoing projects of an organisation that can be classified as community action. To ensure the collection of comparable data, the survey defined community action on the first survey page as follows:

> "Community action is, above all, a type of social action. Community action for health is defined as the social relations of cooperation between people in a given area or space of coexistence (community), with a triple transforming function:
>
> - Improve the living conditions of those who inhabit the coexistence space (improve the social determinants of health and reduce health inequalities in that space).
> - Strengthen links and social cohesion, without forgetting groups in situations of exclusion.
> - To enhance the capacities for individual and collective action in processes to improve their health and well-being (to favour the autonomy of the community and its capacity for self-management and organisation).
>
> The community is defined as:
>
> The population living together in a specific geographical space (neighbourhood, village, town, city...) and is aware of its identity as a group sharing needs and resources.
>
> A community is defined by three key factors:
>
> - Proximity around a common territory.
> - Links of interest, identity or functional ties. Its members are aware of their identity as a group and share needs and resources.
> - The agents, who jointly play a leading role and condition collective life in that space. These agents are the citizens (organised and unorganised), the technical resources (that offer their services to the citizens) and the administrations (managers of the public)."

The survey results show that there is considerable community action ongoing in the Basque Country. Summing up the number of initiatives reported and removing potential duplicates[5] reveals a conservative estimate of 1 180 active community action initiatives (Figure 6.2). This number is significantly more than the 337 active initiatives collected on the Euskadi Aktiboa platform run by the Health Promotion unit from DPHA to gain an overview over ongoing initiatives (see Chapter 3, Section 3.2.1). Part of this discrepancy could be explained by a different understanding of the concept of community action by different actors however, the structure of the OECD community action survey does not allow for a more in-depth analysis

of the initiatives mentioned. The survey only asked respondents for the total number of ongoing community action initiatives but did not require the respondent to provide more details on the nature of the initiatives. It is hence difficult to assess whether these initiatives covered in this report indeed all adhere to the definition of community action mentioned at the beginning of the survey. Other reasons for this discrepancy could be a higher visibility of the OECD community action survey due to renewed interest in community action by the DPHA and related communication activities.

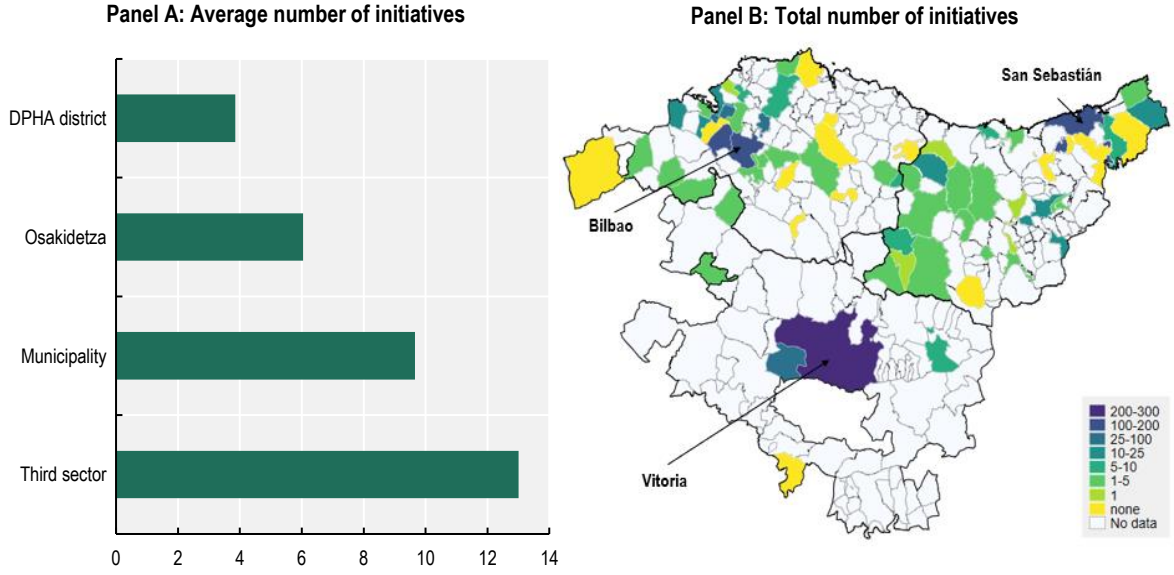
The initiatives are spread out geographically across municipalities, with 53 out of 56 municipalities with at least one respondent reporting ongoing initiatives. More than 700 of the initiatives are concentrated in the four largest cities of the Basque Country, with most happening in the Bilbao area (307 initiatives).

The intensity of participation in community action among different actors is not easily quantifiable with the data gathered in the OECD community action survey. This section elaborates on several measures for assessing the intensity and significance of community action, highlighting their respective advantages and disadvantages when evaluating community action intensity for a specific organisation.

The most straightforward measure of community action intensity within an organisation is the total number of ongoing initiatives. On average, third sector organisations report the highest number, with a mean of 13 initiatives per organisation (Figure 6.2). Following are municipal governments, with an average of 9.7 initiatives per municipality, and Osakidetza with an average of 6 initiatives per respondent. Respondents from the DPHA at the district level report an average of 3.8 initiatives and a total of 51 ongoing initiatives spread across 14 municipalities. It is important to recognise that the average number of initiatives per organisation is linked both to the strategic orientation and main task of an organisation, as well as its size. While neither Osakidetza nor the DPHA's nor municipal governments sole focus is on community action, it may well be the main focus of certain third sector organisations.

Figure 6.2. Distribution of community initiatives across institutions and locations

Average number of initiatives per organisation within an institution (Panel A) and total number of reported community action initiatives by respondent's municipality of work (Panel B), 2024



Note: DPHA is the abbreviation for the Directorate of Public Health and Addictions within the Department of Health of the Basque Country. The figure is based on 180 responses.
Source: Data collected via the OECD community action survey (see Section 6.1).

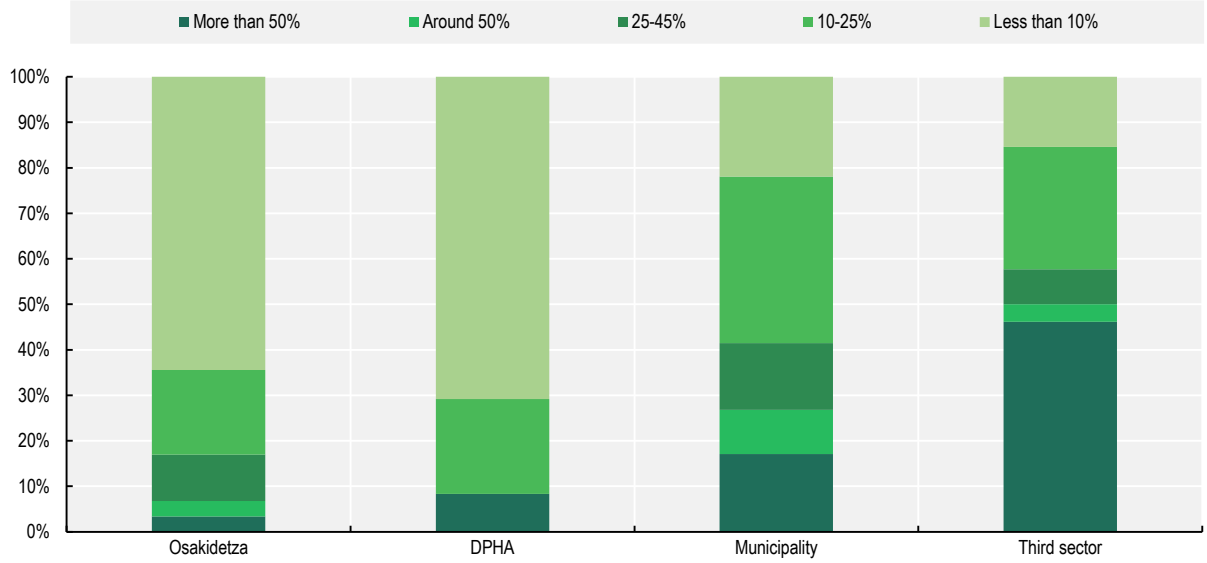
Further corroborating evidence that third sector organisations are more likely to focus mainly on community action than other institutions surveyed is shown in Figure 6.3. The figure demonstrates that among surveyed third sector organisations, many report that their employees work 50% or more of their time on community action. This finding is in stark contrast to Osakidetza or district level DPHA staff who mostly dedicate less than 10% of their time to community action.

Analysing the number of staff involved in community action as a measure for intensity by computing the full-time equivalent reveals that an average of 2.7 full-time equivalent employees work on community action in third sector organisations.[6] Osakidetza respondents report an average of 1.7 full-time equivalent employees, followed by an average of 0.75 reported by municipal governments, and an average of 0.54 by district staff of the DPHA.

Close to 90% of third sector staff reports having a mandate for health promotion, making community action an official part of their work duties.[7] This percentage is similar or higher among all other institutions shown in Figure 6.4, with the exception of the DPHA at the district level (see Box 3.1 of Chapter 3 for a description of the territorial organisation of the DPHA). Among staff at the DPHA district level, 35% indicate not having such a mandate, suggesting that more than a third of the DPHA staff at the district level engage in community action despite it not being part of their job description. This finding is in line with the observation that only very few employees of the DHBC (in full-time equivalents only 5) have a mandate for health promotion and that all of them work either at the central or sub-directorate level as discussed in Chapter 4, Section 4.2.1. DPHA employees at the district level do not have a mandate for health promotion.

Figure 6.3. Distribution of working hours spent on community action work

The percentage of work hours employees spend on community action work, 2024



Note: The different shades of green denote the share of their work time that employees devote to community action. DPHA is the abbreviation of the Directorate of Public Health and Addictions within the Department of Health of the Basque Country and district refers to the DPHA district employees. The figure summarises the 164 responses from the institutions listed on the horizontal axis.
Source: Data collected via the OECD community action survey (see Section 6.1).

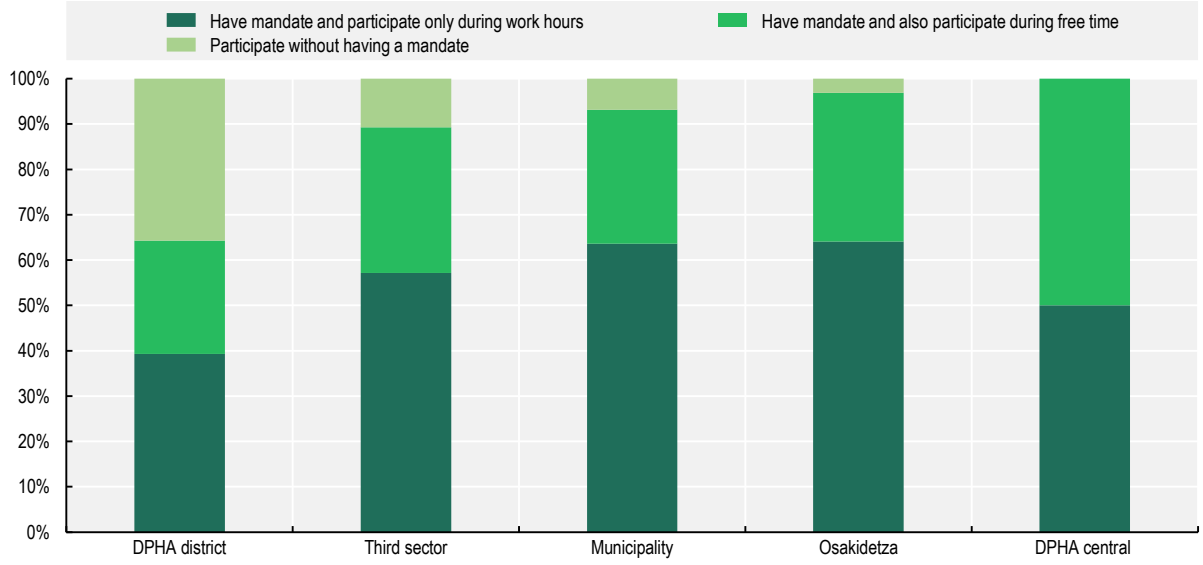
Figure 6.4 further shows that, in line with most respondents having a health promotion mandate, a total of 60% respondents report to work on community action only during their work hours. The rest either divide their time spent on community action between work hours and free time, or work only on their personal time. Working on personal time is particularly common among district staff of the DPHA with close to 45%

of such respondents reporting to work on community action in their free time. This share is around 33% for the other respondents. In all cases, personal time spent on community action is often considerable, with a reported five hours per week on average.

An organisation's focus on community action can also be assessed by the strategic priority placed on it by the (local) leadership of an organisation. Figure 6.5 shows the respondents' perception of the strategic priority of community action at their local organisation by institution. Respondents from the third sector perceive a longstanding and high importance of community action in their organisation, while the perceived importance of community action in municipal governments and Osakidetza is larger today compared to the past. In contrast, the perceived strategic priority remains low among staff of the DPHA. This finding might reflect the discordance between the work undertaken at the central level of the DPHA, which has had a high strategic priority for community action for many years, and the lack of an official mandate (and resources) for the DPHA professionals working in the sub-directorates and district offices (see Chapter 3 and 4 for a discussion) In line with the low perceived strategic priority among respondents from DPHA, 56% of respondents from district offices of the DPHA name lack of a global strategy as one of the top three major challenges for community action in the Basque Country, the highest percentage among all institutions considered (see Chapter 7, Section 7.7).

Figure 6.4. Distribution of respondents with and without mandate to work for health promotion

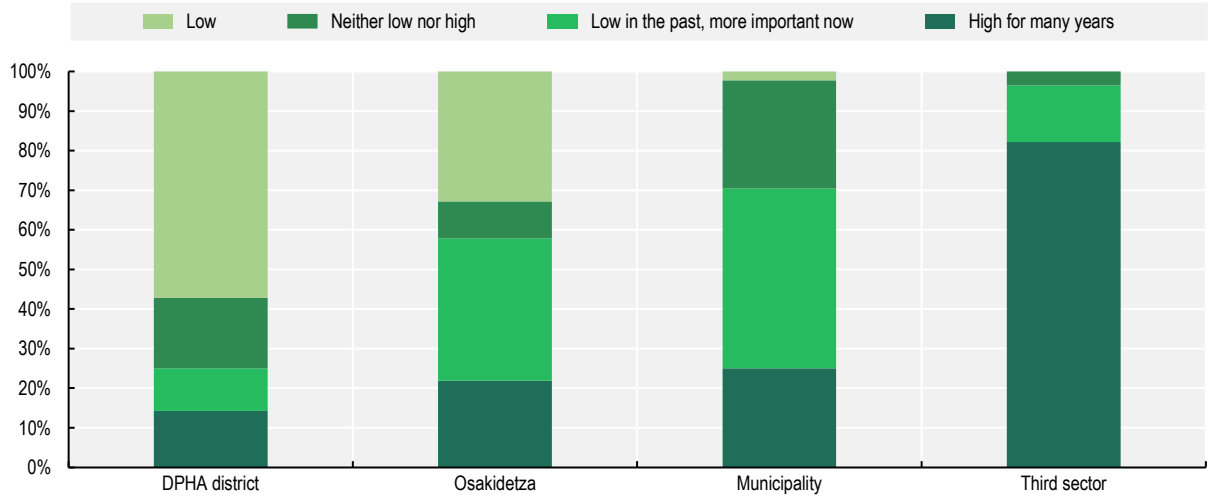
Share of respondents who work in community action with and without a mandate for health promotion, by institution, 2024



Note: The share of respondents who report not to have the mandate for health promotion but who work on community action nonetheless is shown in light green. In dark and medium green are those who do have the mandate for health promotion. Among those, those who participate in community action only during work hours are shaded in dark green, and those who participate both during work hours and during personal time are medium green. DPHA is the abbreviation of the Directorate of Public Health and Addictions within the Department of Health of the Basque Country. The figure summarises responses by 166 respondents from institutions on the horizontal axis.
Source: Data collected via the OECD community action survey (see Section 6.1).

Figure 6.5. Perceived strategic priority of community action

Share of respondents who agree with a statement about the perceived strategic priority of community action at their local organisation, by institution, 2024



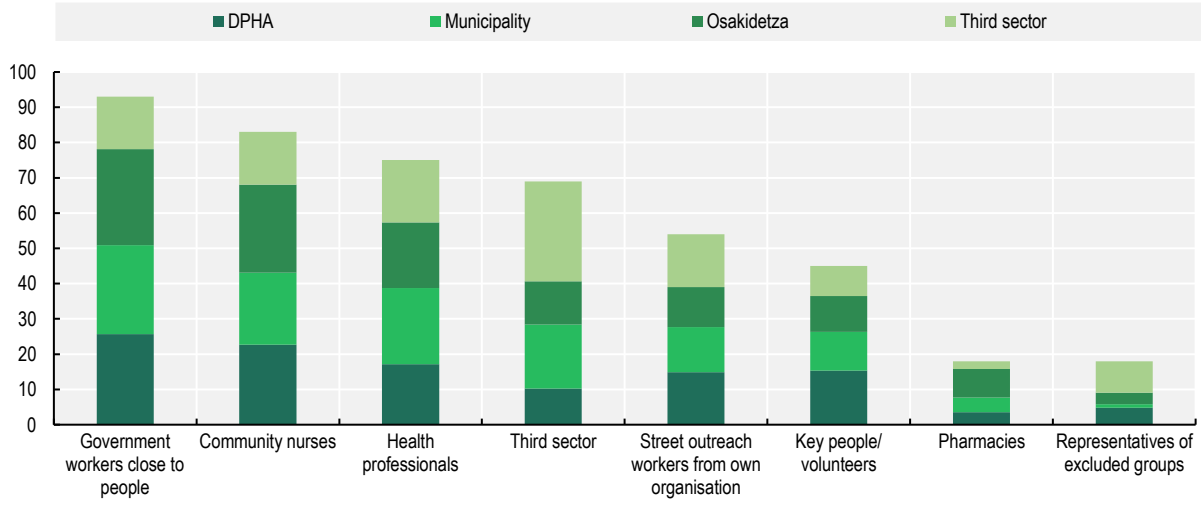
Note: The figure shows the share of respondents who report that their perception of the strategic priority that the leadership of their local organisation assigns to community action is "low", "neither high or low", "low in the past", "more important now", or "high for many years". DPHA is the abbreviation of the Directorate of Public Health and Addictions within the Department of Health of the Basque Country. The figure summarises responses by 164 respondents from institutions on the horizontal axis.
Source: Data collected via the OECD community action survey (see Section 6.1).

A last measure for the importance an organisation assigns to community action is whether an organisation participates in networks for community action. Such networks are a common way to co-ordinate and organise stakeholders involved in community action and are recommended by the Basque Government in the *Methodologic guide to address health from a community perspective* (Chapter 3, Section 3.2.1) to promote community action. The OECD community action survey first inquired whether the organisation a respondent works for is part of a local network (network with local stakeholders such as individuals, representatives of associations, etc.) and/or an institutional network (network with mainly institutional actors such as municipal governments, the DPHA, etc.). Results show that participation in both local and institutional networks is frequent among most institutions with 87% of respondents from Osakidetza, DPHA, municipal governments and the third sector reporting to be part of at least one network and 62% reporting to be part of both types of networks. A geographical analysis reveals that although networks are prevalent across the three provinces, they are most common in Gipuzkoa.

Additionally, the survey asked respondents to indicate the other organisations that are part of their networks. Examining the groups most frequently mentioned as other local network members by respondents reveals that government staff working closely with people (such as social service workers, district staff of the DPHA, teachers, etc.) are the most prevalent members of local networks, closely followed by community nurses and other healthcare professionals (Figure 6.6). There are only few mentions of non-institutional members such as representatives of excluded groups (immigrants, isolated groups, ethnic minorities, and low socio-economic status groups), suggesting that even local networks seem to remain mainly at the institutional level.

Figure 6.6. Distribution of members of local networks

Number of times a group on the horizontal axis was mentioned as a member part of the same local network as the respondent, split by the respondent's institution, 2024



Note: The figure plots the number of times a group is mentioned as being part of the same local network as a respondent, with the respondent's institution highlighted in different shades of green as indicated in the legend. To green shades are rescaled to reflect the share of answers coming from a certain institution among the total times an answer on the x-axis was chosen. The rescaling avoids that, for example, Osakidetza would occupy a much larger share of each bar simply because the survey was answered by more respondents from within Osakidetza compared to other institutions. The rescaling also allows to compare answers from different institutions both within and across bars. DPHA is the abbreviation of the Directorate of Public Health and Addictions within the Department of Health of the Basque Country. Government staff working closely with people includes, among others, social service staff, district staff of the DPHA, and teachers. The figure summarises responses by 131 participants.
Source: Data collected via the OECD community action survey (see Section 6.1).

Combining the results from the various measures suggests that work on community action is particularly important among the third sector. But also municipal governments, Osakidetza, and to some extent the DPHA are increasingly involved in community action.

6.3. Initiatives often focus on specific target groups

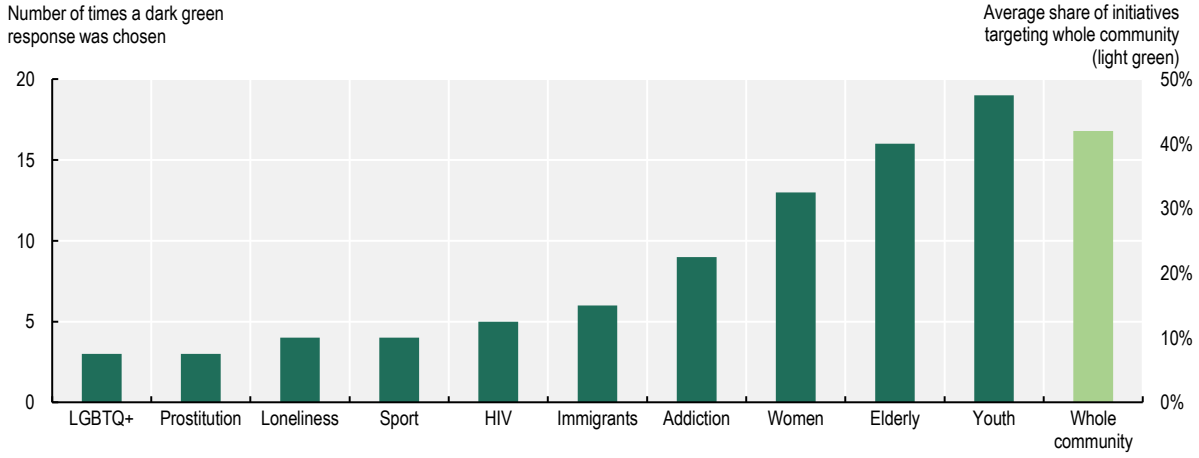
Although a significant share of community action targets the entire community (around 42% of all reported initiatives, see Figure 6.7), the majority of initiatives in the Basque Country focus on a specific segment of the population. Asking respondents to list the main target groups of their initiatives shows that initiatives most often target young people and the elderly. Other common target groups are women or individuals with substance use disorder (Figure 6.7). Especially among Osakidetza and the third sector, initiatives targeting specific health issues are also common.

The OECD community action survey aimed to not only evaluate the primary target groups of initiatives, but also the key issues being tackled by ongoing community action initiatives. As the literature puts forward that one important motivation for relying on community action is its potential impact on social cohesion and inequalities (Popay et al., 2021[4]; Popay, Whitehead and Povall, 2007[5]), the survey asked respondents to estimate the proportion of initiatives they believe to affect either. At 51% and 45% respectively, the results indicate that respondents believe about half of initiatives to improve social cohesion and slightly fewer of them to reduce inequalities.

Lastly, respondents were asked to gauge the reach of their initiatives by commenting on the share of the eligible population they believe participates in their initiatives. The majority of respondents estimate their reach to be slightly less than 30% of their target population, with most estimates falling between 25-35%. Notably, the figures provided by staff from the DHPA are lower, reported at 18% of their target population.

Figure 6.7. Target groups of community action initiatives

Number of times a specific target group/concern was mentioned by the respondents of the survey (left axis) and share of initiatives that target the whole community (right axis), 2024



Note: The figure shows the number of times a specific target group or concern is mentioned by respondents as the target group/concern of at least one ongoing initiative for community action in dark green. The corresponding axis the left-hand side axis. The light green bar shows the reported share of initiatives that target the whole community. This is based on 137 responses. The corresponding axis is on the right-hand side.
Source: Data collected via the OECD community action survey (see Section 6.1).

6.4. Most initiatives rely on external funding

The OECD community action survey reveals that approximately 70% of ongoing initiatives require additional funding beyond salaries paid to employees working on community action. The percentage varies slightly across institutions and is highest among municipalities (77%) and lowest among Osakidetza staff (63%).

Institutions employ varying strategies to finance the additional costs for community action initiatives, where additional costs refer to all costs incurred to set up and run an initiative apart from the salaries paid to staff members. Examples for additional costs might be costs to advertise an initiative (posters, flyers), the provision of food or drinks for an initiative, buying/renting material, etc. Osakidetza entities indicate that they pay around 61% of these additional costs from the budget of their OSI or local health centre, while municipalities cover about 50% of the additional costs with municipal funds. Staff working at the DPHA district level report no own contributions, in line with district offices of the DPHA not having a separate budget from the territorial vice directorate offices of the DPHA.

The remaining costs are funded through various external sources, with grants from the central DHBC being the most popular (Figure 6.8) (see Chapter 3, Section 3.2 for an overview over the grants available from the DHBC and to Section 3.1.2 for a discussion of the amounts).[8] Despite the relatively small budget devoted by the DBHC to community action compared to the total budget of the Department (see Chapter 4), DHBC grants are utilised and appreciated by numerous institutions implementing community action initiatives in the Basque Country. Grants from municipal governments, from other departments of the Basque Government, and from provincial governments are also important external funding sources,

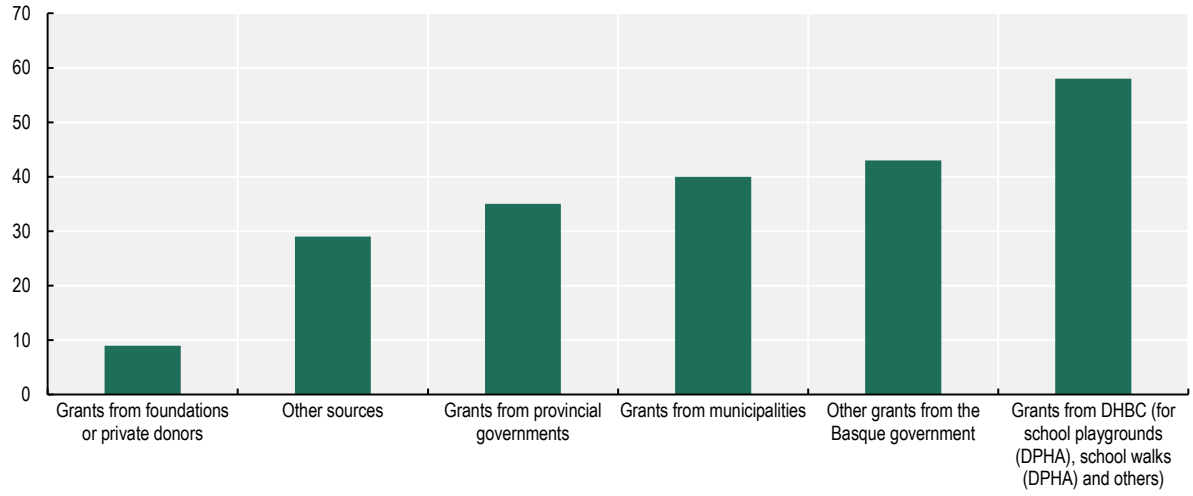
with municipal grants being particularly important for Osakidetza, the third sector, and pharmacies. Conversely, grants from foundations or private donors play a negligible role.

The OECD community action survey demonstrates that DHBC grants are not only used widely, but also receive high satisfaction ratings from respondents who use them regarding the application and reporting process. Among those who have received funding, nearly 80% of respondents find the criteria for obtaining the DHBC grants transparent, and approximately 60% consider both the application and reporting process after receiving the grant to be straightforward. Osakidetza employees stand out with 75% reporting that both processes are cumbersome. There is more consensus among respondents on grant amounts, with less than 46% finding DHBC grant amounts adequate to cover a substantial portion of the costs of a community action initiative. This indicates that the maximum grant amounts set by the DPHA described in Chapter 3, Section 3.2. might be inadequate to cover most initiatives.

Aside from DHBC grants, many respondents also benefit from support for community action provided by municipal governments. The most common form of support from municipalities is the provision of facilities such as meeting rooms and gyms, offered free of charge. Nearly 90% of respondents from municipal governments state that their municipality provides such access, and more than 55% of other respondents currently benefit from this offer. In addition to facilities, over 70% of municipal governments further provide financial support for community action initiatives, and slightly more than 60% offer technical support when needed. Other contributions from municipal governments, such as providing food or drinks for events or offering sponsored items like T-shirts for sports events, are less common, with only 10-20% of municipal governments providing such in-kind support.

Figure 6.8. Funding sources for community action projects

Number of times a funding source was mentioned in the top 3 of financing sources used by respondents, 2024



Note: The underlying question asked respondents to pick the funding sources used from the list of sources shown on the horizontal axis, and to then rank them according to usage. The figure plots the number of times a funding source was chosen by respondents in the top 3 of funding sources used. DHBC is the abbreviation of Department of Health of the Basque Country and DPHA is the Directorate of Public Health and Addictions within the DHBC. The underlying question for this figure was answered by 116 respondents.
Source: Data collected via the OECD community action survey (see Section 6.1).

Despite the grants from the DHBC and support from municipal governments, respondents nonetheless name funding as third most important challenge for further improving community action in the Basque Country. Other challenges to community action as perceived by respondents are described in more detail in Chapter 7, Section 7.7.

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Notes

[1] https://survey.oecd.org/.

[2] This group includes food safety and environment safety inspectors. Refer to Section 3.2.4 for more details on mandates and functions of DPHA staff.

[3] https://bherria.eus/es/.

[4] While it is not possible to rule out that some of the 63 responses refer to the same health centre, the fact that only the four largest municipalities, all with multiple health centres, register more than one response from Osakidetza suggests that most of the 63 responses are from unique health centres.

[5] Removing potential duplicates is not always straightforward as the survey only asked limited information on the place of work that would allow to understand whether two respondents work for the same organisation/institution or department and would therefore report on the same initiatives. For workers at municipal governments and from the DPHA, the information on the department where they work, combined with the municipality of work, should allow to eliminate duplicates with high certainty (note that the survey asks about all initiative of their workplace, not just the ones they are working on personally). For example, it is highly likely that two respondents who both report to work for the economic department of a certain municipal government, do indeed work for the same institution. The same goes for third sector

organisations since the name of the organisation and its location are known. The approach is however much less straightforward for respondents working for Osakidetza as the municipality of work combined with the information that someone works in a primary care unit does not uniquely pin down a primary care centre. Two respondents working for a primary care centre in a certain municipality therefore could but need not work in the same one, especially in larger municipalities. The reported number of initiatives by such two respondents could therefore either be duplicates or indeed distinct initiatives. In such cases, a conservative approach is taken and only one response from the same department/institution and the same municipality is considered (usually the largest one).

[6] The full-time equivalent is computed by multiplying the number of employees reported to work on community action by the average percentage of time they devote to community action.

[7] The survey specifically inquired about a mandate in health promotion and not a mandate for community participation in general. However, only about half the third sector organisations that replied to the survey specifically work on health, hence it is likely that at least some interpreted the question to refer to a mandate for community participation more generally.

[8] The survey question asked respondents about their use of grants from the DHBC and named two grants from the DPHA as examples. The framing of the question was (translated to English): “Do you use health department grants (such as grants for playgrounds, or grants for safer school walks, or others) as a funding source to finance community action initiatives for health and well-being?”. Hence, while the two examples given are grants from the DPHA, it is possible that some respondents refer to grants from the DHBC that are not coming from the DPHA but from another directorate within the DHBC.

7 Different tools for the organisation of community action exist in the Basque Country

This chapter draws on a survey on community action in health in the Basque country to outline the extent of co-ordination between actors and evaluation of initiatives. It focusses on strategies to motivate participants and engage them as well as on information sharing, efforts to monitor the impact and implementation challenges.

Introduction

To gain a deeper understanding of the tools used to implement community action in the Basque Country and the co-ordination mechanism in place connecting the various stakeholders involved in community action, the OECD community action survey was widely distributed among different stakeholders involved in community action in the Basque Country (for more details on the survey and its distribution as well as the respondents refer to Chapter 6).

The results of the survey are summarised in this chapter, starting with an overview over the array of tools utilised in implementing community action initiatives, encompassing guides (Section 7.1) and strategies employed to motivate participant involvement (Section 7.2). It also highlights collaboration of stakeholders with private companies or universities for various aspects of community action (Section 7.3). Subsequently, the chapter focusses on the depths of co-ordination of stakeholders involved in community action (Section 7.3) and the extent to which information is shared between actors (Section 7.5), followed by details on ongoing efforts to monitor and evaluate initiatives (Section 7.6). The final section of this chapter outlines the primary challenges respondents encounter when implementing community action initiatives on the ground and their suggestions for strengthening community action across the Basque Country (Section 7.7).

7.1. Guides for community action are rarely used

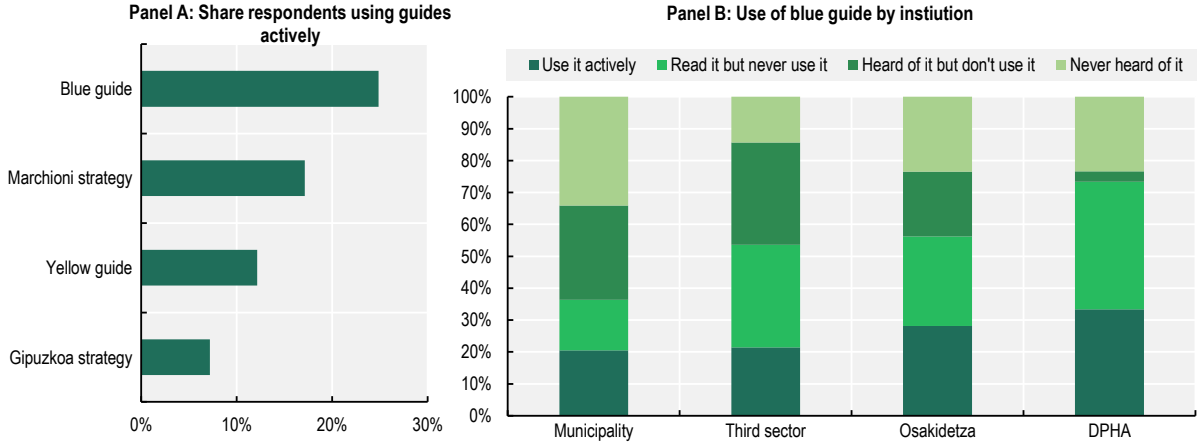
Guides with instructions on how to best implement community action initiatives may present a first tool to support stakeholders in the implementation of community action initiatives on the ground. While there are numerous such guides available, both internationally and in the Basque Country (see Chapter 3, Section 3.2.1) the OECD community action survey focussed on the use of four guides produced in the Basque Country, among which two are co-written by the DPHA within the DHBC.

The “blue” guide, co-written by the DPHA and Osakidetza in 2016, titled *Methodologic guide to address health from a community perspective* (for a more detailed description of this guide refer to Chapter 2, Sections 2.2.2 and Chapter 3, Section 3.2.1) is the most commonly known among the four guides, with more than 75% of survey respondents having heard about it. However, only 53% report to have read it and less than 25% report to use it actively (see Figure 7.1, Panel A). Not surprisingly, the main users are from within the DPHA and Osakidetza, while the guide is least known among municipalities (see Figure 7.1, Panel B). A similar pattern is observed for the second guide co-written by the DHBC and other stakeholders in 2020, titled *Guide for Participation Generating Well-being and Health* (iLab, 2020[1]) (see Chapter 2, Section 2.2.2 and Chapter 3, Section 3.2.1). Overall usage of this guide is even lower at 12%, with 43% of the respondents unaware of the guide.

The strategy for community action proposed by Marchioni and Morín Ramírez (2016[2]) is used slightly more often, with almost 17% using it actively. Contrary to the other guides, the model by Marchioni and Morín Ramírez is most utilised by respondents from the third sector and municipal governments, and primarily by respondents working in Bizkaia. Lastly, the strategy by the provincial Government of Gipuzkoa (Diputación Foral de Gipuzkoa, 2022[3]) to promote community action in their province is the least known and used, with almost 75% reporting no knowledge of it. The few active users mainly stem from provincial governments.

Figure 7.1. Usage of guides for community action

Share of respondents who report to use any of the four guides actively (Panel A), and percentage of respondents who responded to a given statement about their use and knowledge of a guide called *Methodologic guide to address health from a community perspective* co-written by the DPHA (Panel B), 2024



Note: The figure in Panel A shows the share of respondents who report to use a certain guide actively. The blue guide refers to *Methodologic guide to address health from a community perspective* co-written by the DPHA in 2016, the Marchioni strategy refers to Marchioni and Morín Ramírez (2016[2]), the yellow guide refers the *Guide for Participation Generating Well-being and Health* (iLab, 2020[1]) and the Gipuzkoa strategy refers to Diputación Foral de Gipuzkoa (2022[3]). Panel B shows the percentage of respondents who replied with a certain answer in the legend about their use and knowledge of the guide for community action called *Methodologic guide to address health from a community perspective* co-written by the DPHA in 2016. DHBC is the abbreviation of Department of Health of the Basque Country and DPHA is the Directorate of Public Health and Addictions within the DHBC. The question was answered by 181 respondents, Panel B excludes 15 responses from institutions excluded in the panel.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

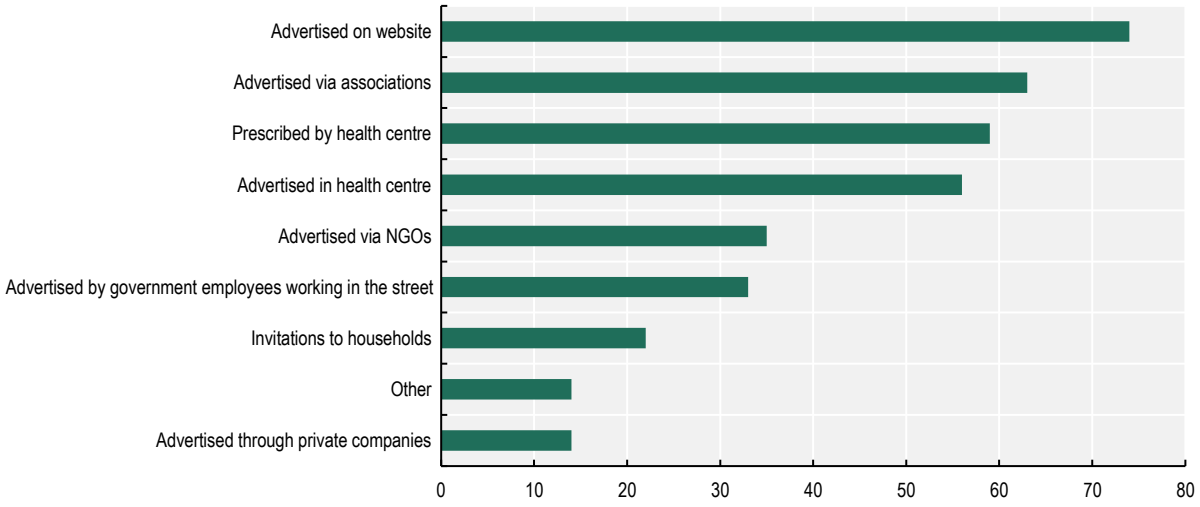
7.2. Various tools are used to motivate participants to join community action

The above-mentioned guides contain specific instructions and tools for successful community action. Even if the respondents are not aware of the guides or do not actively use them, they might still use some of the methods and tools proposed in those guides. The OECD community action survey therefore asked about the respondents' use of a set of nine tools to motivate participants to join community action initiatives.

Overall, the most popular strategies to motivate prospective participants to join community action initiatives include advertising on the organisation's website, reaching out to local associations, posting advertisements in local health centres, and asking health professionals to advertise among patients (Figure 7.2). The latter two are particularly popular among respondents from Osakidetza and the DPHA. Some respondents additionally mention to advertise via local TV or radio stations or via existing WhatsApp groups (covered under "Other" in Figure 7.2).

Figure 7.2. Tools used to advertise community action initiatives

Number of times a tool is mentioned among the top 3 of tools used to advertise community action initiatives, 2024



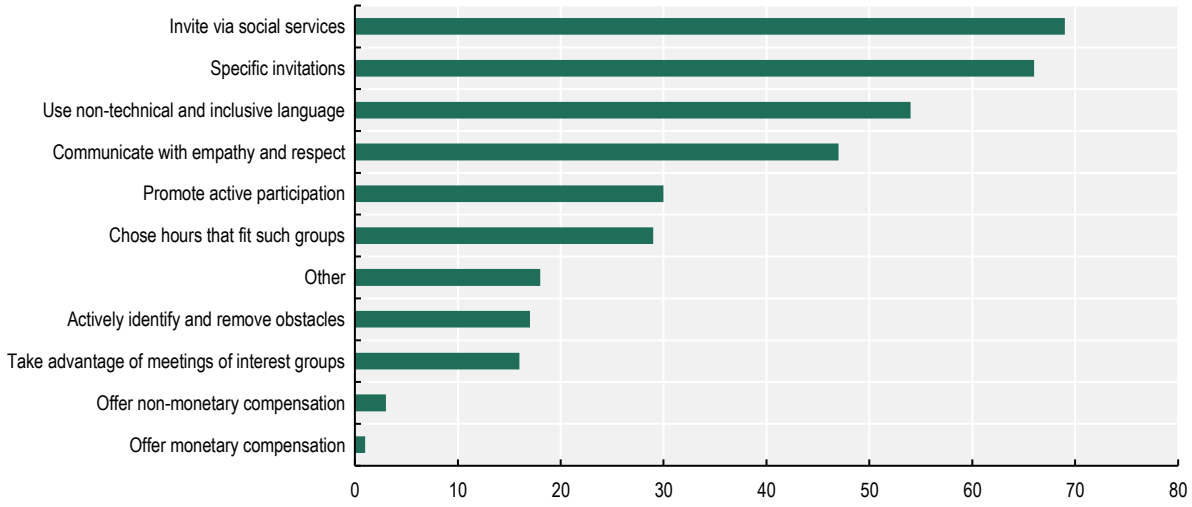
Note: The underlying question asked respondents to pick the tools/methods used to promote community action initiatives (among all options on the vertical axis) and to rank the ones chosen by frequency of use. The figure plots the number of times a tool was chosen by respondents in the top 3 of tools used. 152 respondents replied to this question.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

The guides for community action also emphasise the importance of involving members from disadvantaged groups in community action initiatives. Figure 7.3 shows that respondents to that end focus on specifically inviting members of such groups, often by taking advantage of pre-existing connections between social services and members of excluded groups. They further often mention thoughtful communication, with using non-technical and inclusive language and valuing empathy and respect as an important tool to reach disadvantaged groups. Monetary and non-monetary compensation (such as offering food or drinks during or after meetings) are rarely used.

In addition to encouraging initial participation, sustaining continued participation often poses challenges for community action initiatives. Respondents report to mainly rely on two tools to motivate participants to remain engaged: (1) ensuring that meeting times and locations are convenient for all participants, and (2) establishing a meeting atmosphere conducive to all participants feeling comfortable expressing their opinion freely (see Figure 7.4). Similarly to initial participation, monetary and non-monetary compensation are rarely used to motivate continued engagement.

Figure 7.3. Tools used to advertise community action initiatives among disadvantage groups

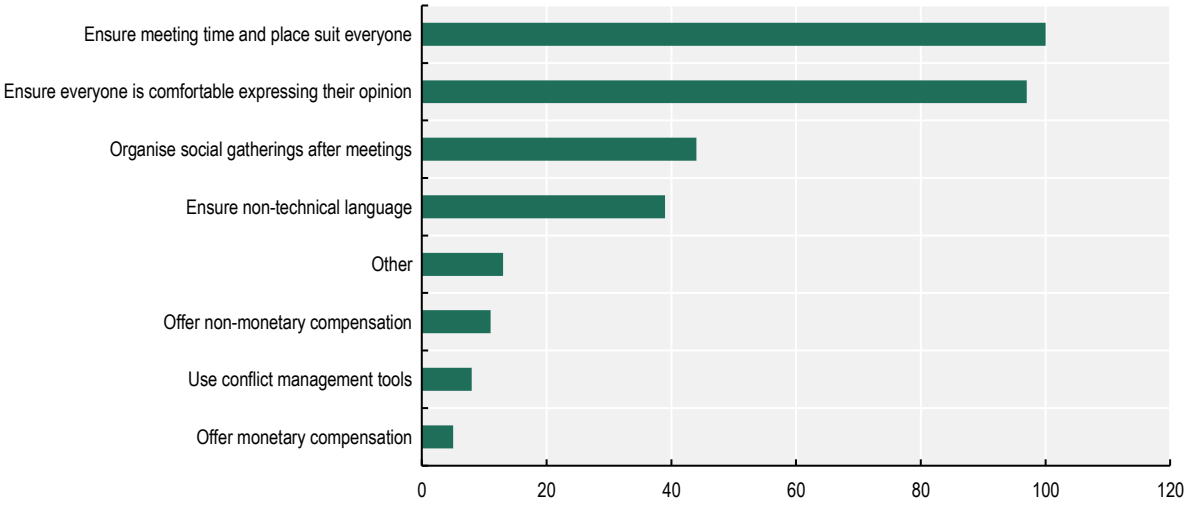
Number of times a tool is mentioned among the top 3 of tool used to advertise community action initiatives among disadvantaged groups, 2024



Note: The underlying question asks respondents to choose the tools used among all options on the vertical axis to reach and include individuals belonging to one of the following groups for community action initiatives: immigrants, isolated individuals, ethnic minorities, and individuals with low socio-economic status. Respondents are further asked to rank the chosen tools by frequency of use. The figure plots the number of times a tool was chosen by respondents in the top 3 of tools used. 151 respondents replied to this question. Non-monetary compensation refers to offering food or drinks during or after meetings.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

Figure 7.4. Tools used to motivate participation in community action initiatives

Number of times a tool used to motivate continued participation in community action initiatives is mentioned among top 3 tools, 2024



Note: The underlying question asks respondents to choose the tools used among all options on the vertical axis to motivate participants to continuously join community action initiatives. Respondents are further asked to rank the chosen tools by frequency of use. The figure plots the number of times a tool was chosen by respondents in the top 3 of tools used. 150 respondents replied to this question. Non-monetary compensation, for example refers to offering food or drinks during or after meetings.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

7.3. Only one in five initiatives involve the community as a co-manager

Many definitions and theories of community action distinguish various levels of involvement of the community in community action (see Chapter 1, Section 1.1). The OECD community action survey asked respondents to classify their ongoing initiatives into *consult, co-design*, and *co-management*, with brief descriptions of each category. *Consult* is described as initiatives where the community participates in the identification of problems to be addressed, *co-design* is described as initiatives where the community participates in the design of appropriate initiatives and *co-management* are initiatives where the community participates in the implementation of the chosen initiative, such that the initiative will ultimately be managed by the community.

Respondents classified 31% of their ongoing initiatives into the *consult* category, indicating that a third of their initiatives only involves the community to consult on specific issues. 21% of ongoing initiatives are classified as *co-design* and hence additionally involve the community in designing a specific intervention. Finally, another 20% are classified as *co-management* and involve the community as an equal partner throughout the process. While most institutions align with this distribution across categories, Osakidetza stands out with a higher share of initiatives in the *consult* category and only few initiatives in the other two categories.

There are two reasons that the above reported numbers do not sum up to 100%. One, respondents were asked three separate questions regarding the share of their initiatives falling into the categories of consult, co-design, and co-manage. Each question provided predefined percentage ranges as answer options. The survey did not enforce that respondents' answers across these three questions would collectively sum to 100% due to the nature of the percentage range options.[1] Two, to calculate averages across respondents, the midpoint percentage value was considered for each answer range. For instance, selecting the range option of 10%-25% would be considered as 17.5% when computing overall averages. If respondents tended to select numbers towards the higher end of the percentage range, using these midpoint values would result in lower aggregate percentages that do not necessarily total 100%.

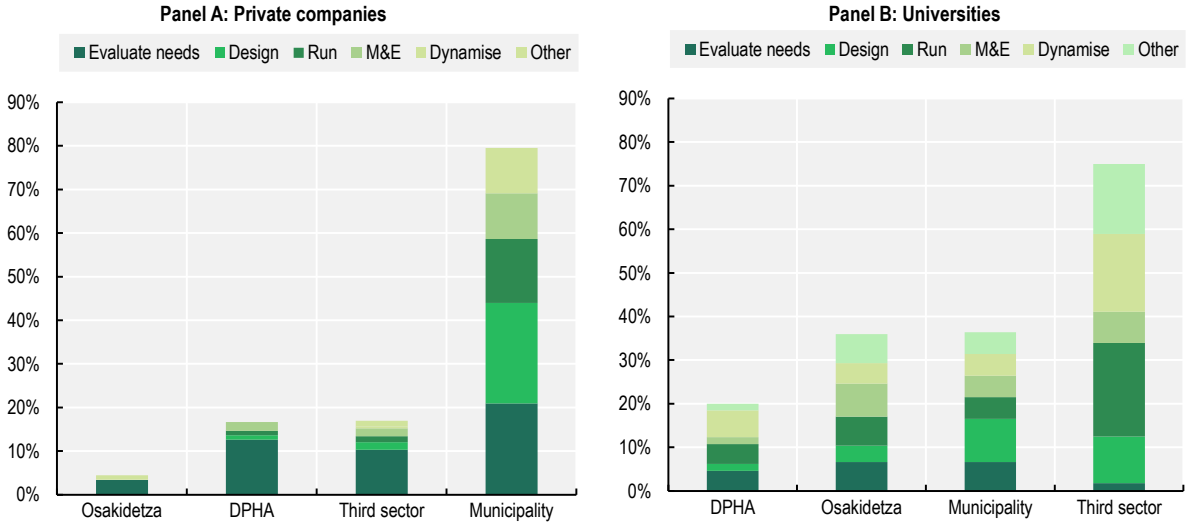
7.4. Collaboration with private companies and universities depends on the stakeholder

The OECD community action survey also inquired about respondents' collaboration with both private companies and universities. Municipal governments are the primary stakeholders working with private companies for community action, with almost 80% of municipalities having hired a private company for at least some tasks related to community action (see Figure 7.5). These companies are typically hired to evaluate the needs of a community and to design appropriate initiatives. Among the other institutions, employing private companies for community action is uncommon, with not even 20% of respondents from third sector, pharmacies, Osakidetza or DPHA reporting to hire such services.

Collaboration with universities is also concentrated within one institution, although the pattern is less strong compared to hiring private companies. About 75% of respondents from the third sector report to collaborate with a university on community action initiatives (see Figure 7.5). They mainly co-operate on designing initiatives and monitoring and evaluating them. Osakidetza and municipal governments also collaborate with universities to some extent, with around 35% of respondents from either institution reporting at least one collaboration. The DPHA collaborates the least with universities, with only 20% of respondents mentioning such co-operation.

Figure 7.5. Participation of private companies and universities in community action initiatives

Share of respondents who hire private companies for community action, by institution (horizontal axis) and task the company is hired for (legend) (Panel A), and share of respondents who collaborate with universities for community action, by institution (horizontal axis) and task of collaboration (legend) (Panel B), 2024



Note: The figure Panel A shows the share of respondents by institution who hire private companies for community action. The shades of blue within a bar indicate the tasks the private companies are hired for. Panel B shows the share who collaborate with a university for community action. The shades of blue indicate the task on which the institutions collaborate with universities on. DPHA is the Directorate of Public Health and Addictions within the Department of Health of the Basque Country. 173 respondents answered this question. The figure excludes 14 responses from institutions not shown in the figure.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

7.5. Information is mainly shared within organisations

As suggested by the guides, effective co-ordination and information sharing among the various actors in community action can have several benefits for community action. It may foster collaboration across institutions, eliminate duplication, and improve initiatives by learning from others' mistakes. As seen in Chapter 6, Section 6.2, most actors and institutions are part of a network, which is one form of co-ordination.

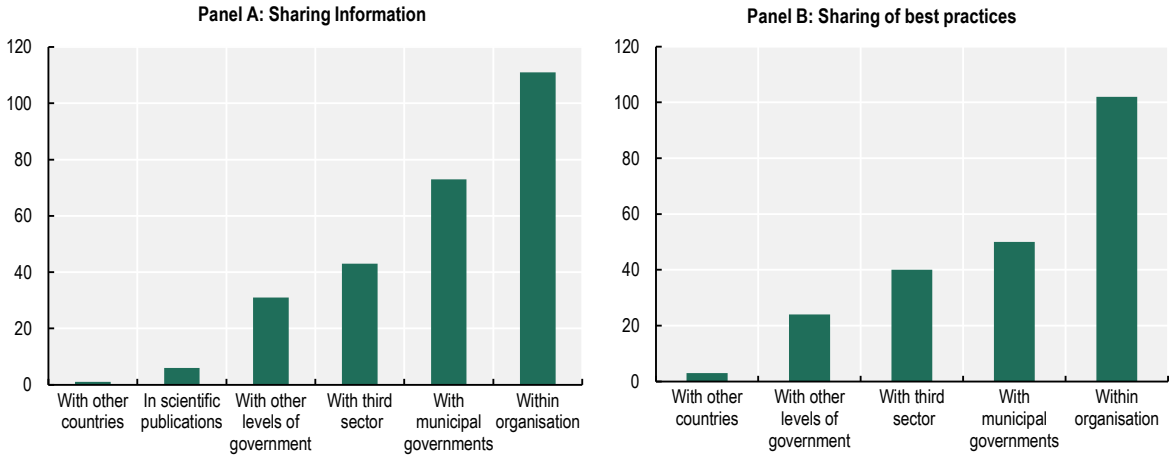
Apart from co-ordinating specific initiatives via community action networks, information sharing on other ongoing initiatives or exchange on best practices for community action with other actors is not common in the Basque Country. Such co-ordination is mainly done within the institution, but to a much lesser extent with other stakeholders (see Figure 7.6). Although some respondents share information or exchange on best practices with municipal governments, very few report to share with other levels of government, and almost no one interacts with other countries to exchange information or best practices.

Respondents furthermore only share information on an ad hoc basis when a need arises. Except for Osakidetza, most respondents report to not have regular meetings or events to share information and exchange on best practices.

These findings support the conclusions reached in Chapter 5, Section 5.1 on how community action in the Basque Country could benefit significantly from the introduction of co-ordination and information sharing protocols and infrastructure.

Figure 7.6. Sharing of information best practices regarding the community action

Number of times each institution with which a respondent shares general information on community action (Panel A) and with which respondent exchanges on best practices for community action (Panel B) is mentioned in top 3, 2024



Note: The underlying question asks respondents to choose among the options on the horizontal axis to denote with whom they either share general information on community action (Panel A) or with whom the exchange on best practices (Panel B). In both cases, respondents were asked to rank the options chosen by frequency of use. The figure shows the number of times an option was chosen among the top 3. 137 respondents replied to the questions underlying Panel A and Panel B.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

7.6. Consistent monitoring and evaluation efforts are undertaken mainly by the third sector

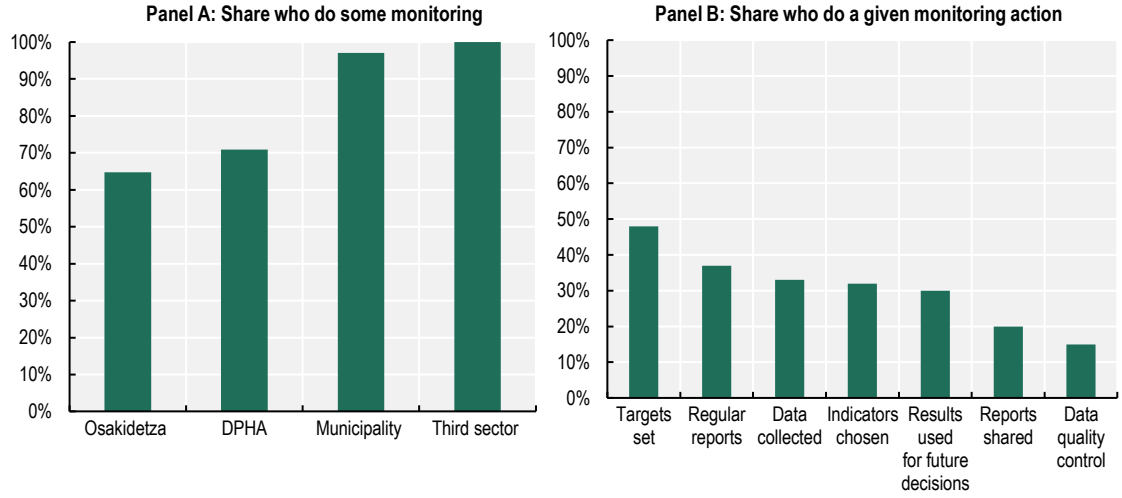
The OECD community action survey inquired about respondents' monitoring and evaluation practices. To ensure clarity, the survey provided brief explanations of the concepts of both monitoring and evaluation, followed by a set of actions that constitute a comprehensive monitoring and evaluation strategy. Respondents were then prompted to indicate which of these actions they routinely implement for their community action initiatives.

Among respondents from both the third sector and municipal governments, nearly all indicated that their organisations engage in some form of monitoring (Figure 7.7, Panel A). The share is lower for Osakidetza, and the DPHA, with one-third (30-35%) of those organisations not conducting any monitoring. Comparing the kind of monitoring activities (Figure 7.7, Panel B) shows that respondents do not consistently implement the majority of monitoring activities. Even within the third sector, only 43% of respondents report performing at least five out of the seven specified monitoring activities, with this figure dropping to as low as 4% among Osakidetza respondents.

Respondents to the OECD community action survey cited several challenges hindering rigorous monitoring efforts. A notable 58% identified a general shortage of personnel, while insufficient financial resources were cited by 37% of respondents as a significant obstacle. The DPHA, and Osakidetza also identified a lack of political will as a hindrance to monitoring (39% of respondents from these two institutions), while lack of personnel trained in monitoring was frequently mentioned as a challenge among DPHA respondents.

Figure 7.7. Monitoring of community action initiatives

Share of respondents who do at least some monitoring, by institution (Panel A), and share of respondents who perform a certain monitoring action specified on the horizontal axis (Panel B), 2024



Note: Panel A shows the share of respondents from each institution who report that their organisation does at least some monitoring. Panel B shows the share of respondents who confirm that their organisation performs a given monitoring action on the horizontal axis. Both figures are based on 142 responses. DPHA is the abbreviation of Directorate of Public Health and Addictions within the Department of Health of the Basque Country.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

In line with the results on monitoring, the third sector is most active in evaluating (see Figure 7.8). Almost 60% of third sector respondents report to evaluate all their initiatives, and another 27% evaluate selected initiatives. The share of respondents who do not evaluate at all is largest among Osakidetza, with 35% reporting to not evaluate any of their initiatives.

Similar to monitoring, the biggest obstacle to evaluation is a general lack of staff (55% of respondents), as well as lack of staff trained to design and execute evaluations (37% and 29% of respondents, respectively). Lack of financial resources is another challenge, with 37% reporting insufficient funds for evaluations, and Osakidetza, the DPHA and pharmacies are again missing political will to implement evaluations (37% of respondents from these three institutions compared to 21% for the remaining institutions).

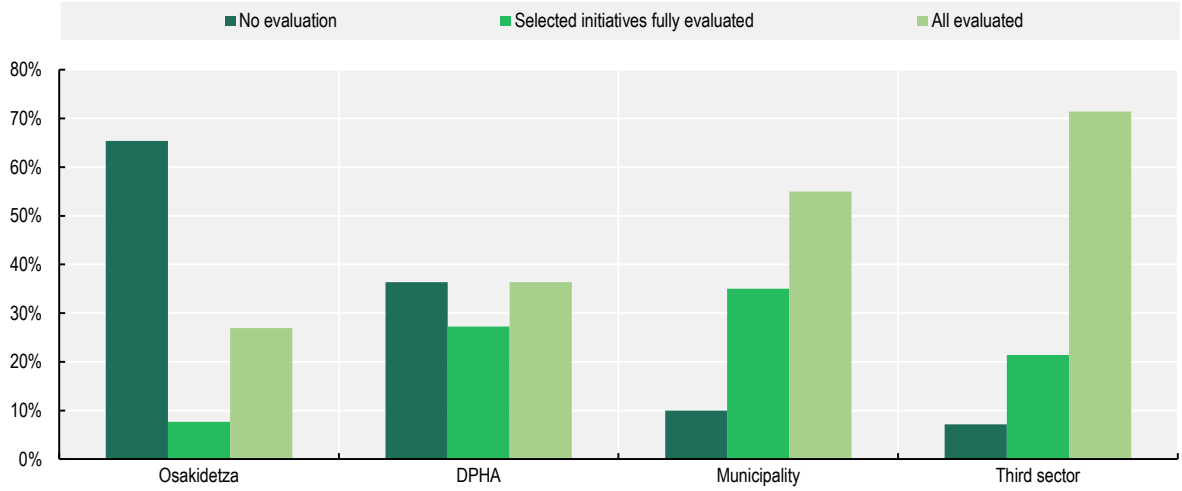
7.7. The survey highlights the key challenges and provides avenues to promote community action

The last section of the OECD community action survey inquired about the major challenges to community action that respondents experience, and potential avenues to improve community action in the Basque Country.

Most respondents see the lack of a global strategy as the main obstacle to community action in the Basque Country, followed by low awareness about community action and lack of financial resources (Figure 7.9). Lack of clear responsibilities is almost as important as lack of financial resources, but lack of co-ordination both within and across organisations as well as lack of political leadership are mentioned less often. As with obstacles to rigorous monitoring and evaluation, lack of personnel is also perceived as a more general issue for community action.

Figure 7.8. Evaluation of community action initiatives

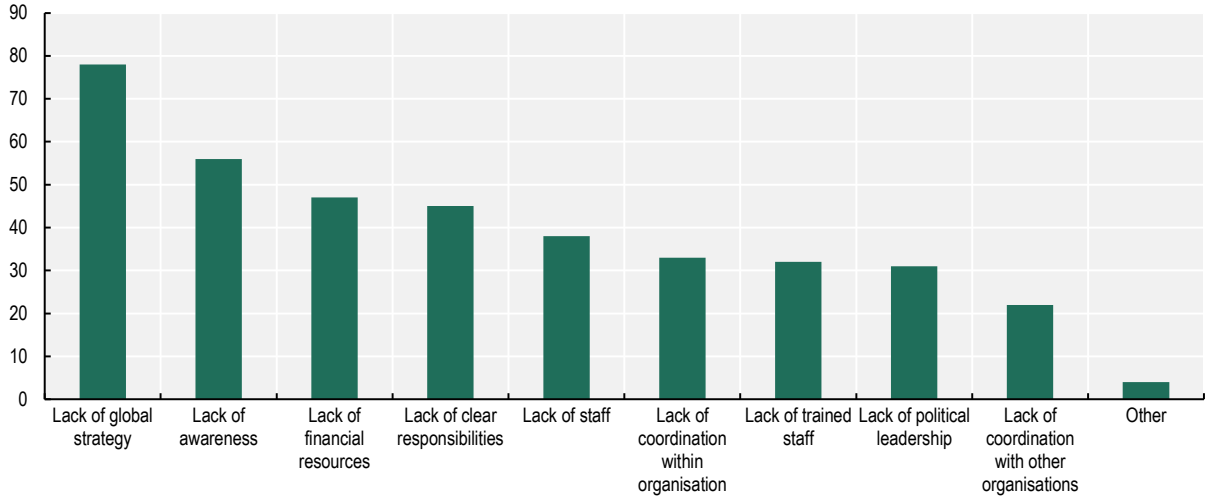
Share of respondents that do not evaluate at all, that evaluated selected initiatives, and that evaluate all their initiatives, by institution, 2024



Note: The figure shows the share of respondents who reported to do no evaluation in dark green, some selected evaluation in medium green and those who report to always evaluate are marked in light green. The question underlying this figure was answered by 142 respondents. DPHA is the Directorate of Public Health and Addictions within the Department of Health of the Basque Country.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

Figure 7.9. Global challenges in community action

Number of times a challenge was mentioned under the top 3 global challenges in community action, 2024



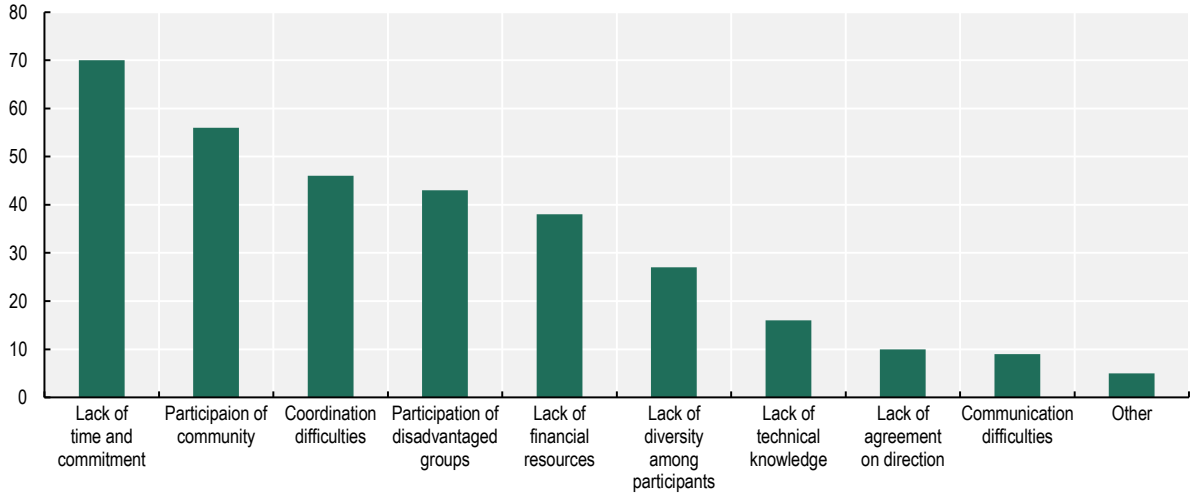
Note: The underlying question asked respondents to choose the perceived global challenges to community action in the Basque Country among all the options on the x-axis. Respondents were then asked to rank the chosen challenges by severity. The figure shows number of times a given challenge was mentioned under the top 3 global challenges to community action in the Basque Country. 136 respondents replied to this question. Lack of awareness refers to awareness about community action.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

When it comes to implementing individual initiatives, respondents' main perceived obstacles are a limited availability and commitment of the involved individuals, followed by difficulties to motivate the community to participate (Figure 7.10). Keeping the community interested in joining is also the biggest concern mentioned by participants when asked about challenges to keeping initiatives running. A further challenge to setting up successful initiatives is the co-ordination among participants on finding meeting times and places that suit everyone.

To improve community action in the Basque Country, most respondents agree that co-ordination not only between the different institutions but also with the local level needs to be improved (Figure 7.11). This finding supports the conclusions reached in Chapter 5 of this report on how a co-ordination strategy linking efforts of different government bodies and levels is key to strengthening community action in the Basque Country. Relatedly, respondents hope for the establishment of clear responsibilities between the different sectors and institutions, again supporting the recommendations in Chapter 3 and in particular in Section 3.3.3. Further wished for are opportunities to better train staff in community action and a more secure financial backing of community action initiatives.

Figure 7.10. Challenges faced when implementing community action initiatives

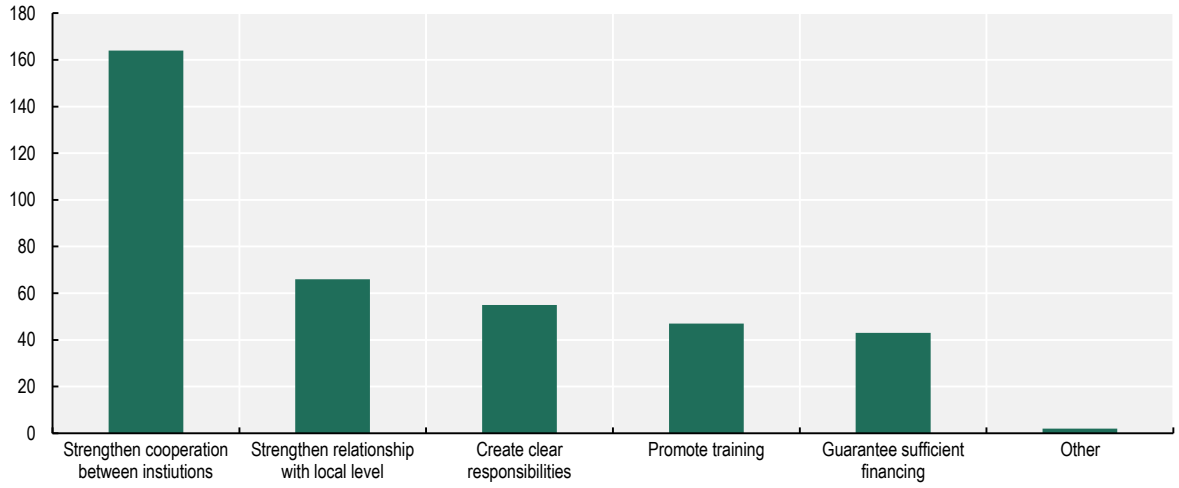
Number of times a challenge was mentioned by respondents among the top 3 challenges faced when implementing community action initiatives, 2024



Note: The underlying question asked respondents to select the challenges (listed on the x-axis) they face when implementing individual community action initiatives. Among those selected, respondents are asked to rank them by severity. The figure plots the number of times a given challenge was mentioned among the top 3 challenges when implementing community action initiatives. 137 respondents replied to this question. Co-ordination difficulties refer to finding adequate meeting times, etc.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

Figure 7.11. Actions to improve community action

Number of times an action is chosen among the top 3 actions to improve community action in the Basque Country, 2024



Note: The underlying question asks respondents to select the best actions to take to improve community action in the Basque Country among the options on the x-axis. Respondents are further asked to rank the selected actions by importance. The figure plots the number of times a given action was selected as one of the top 3 actions to take to improve community action in the Basque Country. 136 respondents replied to this question.
Source: Data collected via the OECD community action survey (see Chapter 6, Section 6.1).

References

Diputación Foral de Gipuzkoa (2022), *Acción comunitaria. Marco coneptual, estratégico z operativo enfocado a la acción pública de la Diputación Foral de Gipuykoa z ayuntamientos del territorio.*, Diputación Foral de Gipuzkoa, https://www.gipuzkoa.eus/documents/917770/27303951/Accion_Comunitaria_MARCO_es.pdf/a7ad979c-b201-2add-b413-8791b59c0a94?t=1667376919851 (accessed on 27 May 2024). [3]

iLab (2020), *Guía para una participación generadora de bienestar y salud*, https://www.ogp.euskadi.eus/contenidos/proyecto/ogp_compromiso_3/es_def/adjuntos/Guia_ILAB.pdf. [1]

Marchioni, M. and L. Morín Ramírez (2016), *La intervención comunitaria*, https://comunidad.semfyc.es/wp-content/uploads/Comunidad-_-La-intervenci%C3%B3n-comunitaria.pdf (accessed on 16 April 2024). [2]

Notes

[1] This condition was not introduced in the survey due to the answer options in the form of percentage ranges which made it impossible to sum over the percentages chosen in the three questions.

8 Recommendations for a strategy on community action for health and well-being

This chapter outlines recommendations for designing a strategy on community action in the Basque country. The recommendations detail three strategic lines: developing a governance structure, promoting community action at the local level and fostering awareness and policy evaluation.

Introduction

Community action for health in the Basque Country builds on a strong existing foundation. Basque communities have a long-standing tradition of community action, and as shown in Chapter 6, the landscape is vibrant with numerous projects and actors across the region. In addition, recent legislative developments, highlighted in Chapter 2, supports the participation of citizens in public health interventions. The community focus is further embedded in strategic planning documents, such as the new Health Plan 2030 (2023[1]), the Osakidetza Strategic Plan 2023-2025 (2023[2]) and the Basque Pact on Health (*Pacto Vasco en Salud*) launched in 2024, all of which emphasise the importance of community-oriented health services to promote well-being.

At the same time, the analyses conducted in this report reveal significant potential to further strengthen community action for health and well-being. Chapter 7 shows that initiatives are often fragmented and there is a lack of co-ordination among various stakeholders. This highlights the need for a more structured and community-centred approach. As community action is inherently intersectoral, support for community projects should be organised through partnerships that include health stakeholders as well as other non-health stakeholders representing policy areas such as social services, environment, sport, and education. Operating within the health-in-all-policies framework, these stakeholders can support initiatives to address social determinants of health and foster population health and well-being.

The DHBC, along with Osakidetza, has already begun addressing these challenges through strategic efforts. Building on this momentum, the present chapter sets out a series of recommendations for establishing and implementing a dedicated, overarching strategy for community action on health and well-being, led by the DHBC (including Osakidetza). This strategy should serve as a unifying framework and governance structure to co-ordinate efforts across Basque institutions and local authorities, ensuring cohesive, sustainable, and impactful support for community-based health initiatives.

8.1. Recommendations for the strategy are developed around three main strategic lines

This section presents the structure of recommendations for a strategy on community action for health and well-being in the Basque Country. These recommendations are intended to serve as a reference for the DHBC as it develops its official strategy.

The recommendations are developed around three broad strategic lines: (1) developing of a governance structure to facilitate community action, (2) promoting community action for health at the local level, and (3) fostering awareness and policy evaluation. Strategic lines cut across several policy areas (e.g. the governance structure should oversee, among other, human resources planning). For the sake of clarity, specific objectives associated to each strategic line are presented by policy area.

Table 8.1 provides a concise summary of the objectives. The remainder of this chapter is divided into three sections that outline the scope of each strategic line and policy area, along with the rationale behind each objective. Additionally, the section includes relevant good practice examples when they close to the thematic of each objective.

Table 8.1. Recommendations for the strategy – summary table

Strategic lines	Policy area	Specific objectives
1 – Developing a governance structure to facilitate community action	Ensuring human resources in health sector to co-ordinate and support community initiatives	Objective 1.1. Ensure sufficient personnel are in place to effectively co-ordinate and promote community action at the local level
		Objective 1.2. Design and implement education and training programmes in the field of community action
		Objective 1.3. Adapt the human resources management strategy to diversify workforce profiles in the DHBC and the healthcare sector
	Building mechanisms and structures to co-ordinate community action	Objective 1.4. Strengthen co-ordination structures among professionals supporting community action at the local level
		Objective 1.5. Include local communities in the co-ordination structure at the local level
		Objective 1.6. Develop institutional co-ordination mechanisms between the departments or sectors which are related to community action for health
2 – Promoting community action at the local level	Incentivising health promotion	Objective 2.1. Strengthen the role of health promotion within the DHBC
	Ensuring stable resources for community action at the local level	Objective 2.2. Implement a mechanism to ensure stronger emphases on the health promotion at the municipal level
		Objective 2.3. Develop a network of local entities to promote community action for health
		Objective 2.4. Build a knowledge-sharing database available to local communities
		Objective 2.5. Facilitate access to public spaces and create new community-friendly public spaces
3 – Fostering awareness and policy evaluation	Designing the communication plan for the community action	Objective 3.1. Develop a dissemination plan for the new strategy
		Objective 3.2. Create a tool allowing citizens to express their views, and health authorities to consult the community, on specific health matters
	Promoting research and capacity building in community health	Objective 3.3. Actively promote research on community action among Basque academic institutions
	Developing a quality framework	Objective 3.4. Create a self-evaluation tool for local communities
		Objective 3.5. Design quantitative and qualitative indicators to monitor progress and evaluate impact
		Objective 3.6. Evaluate the implementation of the new strategy on community action

8.2. Strategic line 1: Developing a governance structure to facilitate community action

Strategic Line 1 focusses on building a governance structure that empowers local communities to undertake health and well-being initiatives, while ensuring they are supported throughout the project. It emphasises two key areas: the allocation of dedicated human resources to guide and assist communities, and the co-ordination between various government actors to ensure cohesive and effective support across different policy areas and at government levels.

8.2.1. Ensuring human resources in health sector to co-ordinate and support community initiatives

Well-trained public health professionals, especially those with expertise and experience in health promotion, can support local communities in the development and implementation of health-related projects. They can help communities to improve the planning and targeting of interventions. By analysing health data, they can identify priority areas and allocate resources to address specific social determinants of health, ensuring initiatives align with broader health objectives. Their expertise in monitoring and

evaluation can support progress tracking and project improvement. Combined with social skills, competencies in project management, leadership, and social work enable public health professionals to empower communities to take ownership of their health initiatives. Drawing from their experience from various projects, they can guide the adaptation and implementation of good practices and play a key role in co-ordinating efforts with professionals from other sectors, ensuring a comprehensive approach to health and well-being.

Public health professionals can also play a role of connectors within the community, sharing information and helping to shape priorities in collaboration with local actors. Based on their expertise and access to health data, they can facilitate the dissemination of information about health risks, preventive measures, and available resources, ensuring that this information reaches the entire community, particularly vulnerable population. This role is not just to inform, but to empower community members to take actions. By building awareness and providing the necessary guidance, public health professionals support the growth of local health initiatives. This community-driven approach strengthens trust in the health sector, which is essential for encouraging participation and achieving a lasting impact.

Nursing, medical, and administrative staff within primary care units are well-positioned to facilitate community action. Their regular contact with individuals from diverse socio-economic backgrounds enables them to support community networks in effective identification of health needs. Their involvement in community projects help ensure inclusive and equitable participation. Rather than leading all efforts, they also act as connectors between local community and the health system, fostering trust, which is crucial for increasing participation and enhancing the overall effectiveness and impact of these initiatives.

To fully make use of the potential of health professionals in community action, several conditions must be met. First, health professionals need recognition and sufficient time allocated to engage with communities, as mapping community health needs and work collaboratively with local actors requires sustained efforts. Second, health professionals should be equipped with the necessary knowledge and skills to address evolving health challenges and support communities in their efforts towards better health outcomes. Objectives 1.1 to 1.3 build the appropriate context for these conditions to occur by ensuring sufficient personnel, implementing training programmes, and diversifying the workforce to support effective community action.

Objective 1.1. Ensure sufficient personnel are in place to effectively co-ordinate and promote community action at the local level

To effectively co-ordinate and promote community initiatives, it is crucial to ensure a sufficient health personnel at the local level, notably including public health professionals as well as nursing, medical, and administrative staff within primary care units. In part, this might require granting staff a mandate on health promotion and competences in community action for health in the territorial units of the DHBC in order to improve the ability to design, implement, and sustain more impactful local interventions Without an adequate workforce, even the most well-designed initiatives can face logistical challenges, as community projects are often complex, labour-intensive, and require sustained effort over time. Health professionals play a vital role in bridging the gap between public health policies, healthcare system and community needs, acting as key facilitators of local health promotion efforts.

The NICE guidelines (2016[3]) emphasise that health staff must have time explicitly and officially dedicated to community action. Many programmes and strategies have recognised the importance of securing adequate staffing for community action. For example, Osakidetza introduced the role of community nurse, providing dedicated time for health promotion, including community initiatives. In Valencia, the Xarxa Salut programme assigns one or two professionals in each health centre to work one day per week on health promotion, supported by the professionals from General Directorate of Public Health. Catalonia's strategy (2023[4]) incorporates time for community health activities into professionals' schedules, with provisions for

compensation if these tasks extend beyond regular hours. In Grunau Moves (2019[5]), effective programme co-ordination required both a health professional and a social worker.

Objective 1.2. Design and implement education and training programmes in the field of community action

Equipping public health professionals with the right mix of skills is key to enhancing the effectiveness of community action for health and well-being. While many public health professionals are well-trained in health protection, they often lack expertise in engaging and partnering with communities. Developing, in collaboration with Basque higher education institutions, training providers, and the Department of Science, Universities and Innovation, dedicated education pathways for community action, including integrated training programmes, is essential. These programmes should cover key areas, as recommended by the Centers for Disease Control and Prevention (United States), including communication, conflict resolution, event planning, evaluation, and monitoring techniques. Additionally, promoting lifelong learning in community action would ensure that professionals in public health continuously adapt to evolving challenges and opportunities in working with communities. Health authorities might also consider creating incentives for health professionals to participate in the training and work with educational institutions to provide training in a flexible way, since participating in training in addition to the work responsibilities can be challenging. This comprehensive training approach would better prepare public health professionals to engage with communities and collaborate across sectors, promoting a more holistic and responsive approach to health initiatives within diverse social contexts.

Across Spanish regions, there is a clear recognition that health professionals are not always adequately trained to promote community action. To address these learning gaps, in 2024 the University of the Basque Country offered comprehensive training programmes in health promotion and community health, including a university specialisation in Health Promotion and Community Health and a (lifelong learning) Masters' in Health Promotion and Community Health. One of the fundamental elements of the Osakidetza's strategy (2023[6]) is the training on addressing health from the community perspective. Similarly, Asturias Community Health Strategy (2023[7]) includes training for professionals at regional, local, and municipal levels, covering public health, healthcare, and social services staff. Castile-La Mancha (2023[8]) prioritises fostering collaboration across various agents involved in community action through its continuous training programmes, including training of trainers. La Rioja (2023[9]) and Madrid emphasise expanding digital training, with a focus on short, practical courses, while Madrid (2021[10]) also advocates for participation in conferences related to community action in health. Both La Rioja (2023[9]) and the Canary Islands (2024[11]) stress the importance of sustaining these training efforts over time, ensuring that new staff receive the necessary education and that evolving methods are integrated. Tracking progress through indicators, such as the number of professionals trained, can provide valuable insights.

Objective 1.3. Adapt the human resources management strategy to diversify workforce profiles in the DHBC and the healthcare sector

Adjusting the human resources management strategy to incorporate more diverse profiles in the territorial units of the DHBC is crucial for aligning the workforce skills-mix with the evolving needs of community action initiatives. In the long run, it is important to ensure that the background and skills of public health professionals are better matched with the specific demands of community projects. This includes hiring individuals with expertise in areas such as community action, social sciences, and health promotion, which are important to ensure effectiveness of support for community action at various government levels.

A similar process of adapting hiring strategies has been outlined in both Osakidetza's strategy (2023[6]) and Catalonia's Community Health Strategy for Primary and Community Care (2023[4]). Osakidetza introduced a new role of community nurse, specialising in family and community care, which integrates expertise from nursing, public health, and social sciences. Likewise, in Catalonia, new units and

professional profiles were incorporated into primary and community care, explicitly focussing on community health. These roles include specialists in emotional well-being and dietitian-nutritionists, further enhancing the community-centred approach to health and care.

8.2.2. Building mechanisms and structures to co-ordinate community action

Co-ordination between different actors ensures the efficient use of resources in implementing a holistic approach to community action for health. Without effective co-ordination, efforts may lack a broader perspective, and resources may be used inefficiently. This can result, among other potential issues, in the duplication of initiatives or even competing projects, which undermines their overall effectiveness. Furthermore, without a co-ordinated effort, the Basque Government's strategy may become fragmented, leading to delayed communication and inconsistent support for community health projects. Beyond the efficient use of resources, there is an urgent need to create clear governance structures and co-ordination mechanisms that take into account the different institutional levels. Defining an organisational structure dedicated to community health also helps streamline and support co-ordination efforts across all levels – from regional governance down to the neighbourhood level.

Currently, the mechanisms that co-ordinate the action of various actors of the Basque health system predominantly follow a top-down approach. This process is led by institutional representatives from local government, public health, and Osakidetza, who take the initiative and guide the community projects. In the initial phase, the co-ordination is largely managed at the institutional level, without direct input from local communities. While this approach ensures that key stakeholders are aligned, it limits the involvement of local communities in the early stages of decision making. As a result, local actors and community organisations are often only brought in after the framework and key objectives are established by higher-level authorities. This top-down structure restricts the capacity of communities to independently initiate projects, reducing the flexibility needed to tailor health initiatives to the specific needs and priorities of local populations.

A key challenge for the current co-ordination mechanism is the lack of a robust institutional framework at the local level. There is no consistent approach for initiating co-ordination efforts across municipalities, resulting in fragmented and uneven implementation. Engagement in co-ordinating activities is often determined by local preferences or voluntary efforts, with smaller municipalities particularly disadvantaged due to limited human resources. A new co-ordination mechanism or structure should facilitate collaboration between professionals in local governments, health professionals, and community organisations, ensuring that health strategies are aligned and responsive to the specific needs of each community.

Objective 1.4. Strengthen co-ordination structures among professionals supporting community action at the local level

Strengthening the co-ordination structures for community action for health can be done by establishing clear, consistent mechanisms, protocols, or structures for the co-ordination process. Such a permanent co-ordination structure should involve public health professionals, healthcare professionals working in primary care units, social services, and representatives of local municipalities. To achieve this, it is crucial to ensure that all municipalities, especially smaller ones, have the necessary resources to effectively co-ordinate its activities across different sectors. By providing municipalities with the support they need, the framework creates a more structured and sustainable approach to community health initiatives. This ensures that all relevant stakeholders are involved in community health projects from the beginning, improving their long-term sustainability and effectiveness across the whole territory.

Efforts to strengthen co-ordination mechanisms are included in the community action strategies of Asturias (2023[7]) and Castilla-La Mancha (2023[8]). In Asturias, the Integrated Community Health Action Network is being established to co-ordinate local actions in public health and guarantee consistent public action

across the entire autonomous territory. This initiative aims to ensure that local governments and community agents work together towards collective well-being. In Castilla-La Mancha, the strategy emphasises improving co-ordination between various sectors, including Primary Healthcare, Public Health, local entities, and other sectors, to create a more integrated and collaborative approach to community health. Asturias' community health strategy stresses the need for close collaboration of health services with education and social services, which includes actions such as expanding municipal intersectoral health tables, reviewing the makeup of existing commissions and technical working groups, and co-ordinating efforts between educational centres and social services.

Objective 1.5. Include local communities in the co-ordination structure at the local level

To foster more effective collaboration, it is crucial to enable local communities to be involved in the new co-ordination structure. Strengthening local co-ordination mechanisms must go beyond institutional involvement to actively include community representatives, such as NGOs, local community leaders, and engaged citizens ensuring their voices are heard from the outset. By creating opportunities for local communities to be part of decision making forums and co-ordination groups, the strategy reinforces a community-centred, bottom-up approach, ensuring that health initiatives are more responsive to local needs and priorities. Direct community participation also helps build trust, strengthen a greater sense of ownership over health projects, and encourages long-term engagement.

Examples of good practice of citizen's involvement in such structures is present in many strategies for community action and community health. The strategy of the Province of Gipuzkoa (2022[12]) stresses that the role of public administration is to facilitate participation of citizen, promoting dialogue, negotiation, mutual recognition, commitments from all parties, and shared leadership. In the strategy of Castilla-La Mancha (2023[8]), enabling citizen participation is seen as essential to promoting dialogue between different sectors and disciplines, enhancing opportunities for community actions, and encouraging social participation. In Switzerland, The Canton of Zurich established in 2004 the "Forum for Prevention and Health Promotion", open to all actors, organisations, and institutions involved in community action. This forum includes local communities in co-ordination efforts and serves as a platform for proposing key topics, exchanging information, and fostering networking among stakeholders. Additionally, the Ministry of Health of Spain (2022[13]) has recommended the formation of governance structures to co-ordinate community health efforts, linking primary care, public health, local authorities, citizens, patient groups, education, social services, and other key actors at regional and local levels.

Objective 1.6. Develop institutional co-ordination mechanisms between the departments or sectors which are related to community action for health

Although the strategy is designed and managed by the DHBC, its implementation involves the co-ordination with other departments within Basque Government. At the central level, the strategy should prioritise the establishment of mechanisms to co-ordinate support for community initiatives across various departments of the Basque Country Government, as appropriate. Given that these initiatives often intersect multiple sectors – such as health, social protection, sports, and culture – effective interdepartmental collaboration is essential. This co-ordination should ensure that critical areas like funding, human resource allocation, expertise sharing, and communication are systematically addressed, fostering comprehensive and holistic support for community-driven actions. This approach will strengthen the sustainability and impact of initiatives by aligning resources and efforts across relevant sectors.[1]

In Spain, several regions provide useful examples of how high-level co-ordination mechanisms can improve interdepartmental collaboration for community health efforts. Extremadura (2022[14]) has created institutional and technical commissions, bringing together social services, healthcare, and socio-health planning departments to ensure a unified approach. Castilla y Leon (2023[15]) has developed networks to address key health issues collectively, working with sectors like education, social services, the

environment, and local governments. The Basque Country also provides examples of such co-ordination efforts. Since 2022, the Basque Council for Social and Healthcare has facilitated co-operation between the Basque Social Services System and the Health System, building an integrated approach to addressing shared challenges.

8.3. Strategic line 2: Promoting community action at the local level

Strategic Line 2 addresses the key areas for the support of community action at the local level. Firstly, it stresses the need to strengthen the role of health promotion within the DHBC, ensuring that it becomes an important component of public health strategy. Secondly, it highlights the importance of securing appropriate funding to effectively support and sustain community initiatives. Together, these actions can empower local communities and reinforce their role in promoting health and well-being.

8.3.1. Incentivising health promotion

Effective health promotion co-ordinated with initiatives to address social determinants of health can significantly reduce health inequalities and offer a high return on investment. However, despite this proven cost-effectiveness, health promotion initiatives are seldom prioritised. Resource constraints, the need to focus on immediate care for sick patients, and the perception that certain public health interventions encroach upon personal decision making often make it difficult to justify investment in health promotion.

Increasing the importance of health promotion places greater emphasis on community actions, both directly and indirectly. Directly, it can increase funding for community projects, enabling more initiatives to take place. Indirectly, raising social awareness about public health issues can encourage communities to act on these topics through various initiatives. As a result, this approach can lead to a rise in the number of community-driven health projects.

Compared to other interventions, well-designed community action projects are a valuable cost-effective tool in health promotion. Additionally, community-led initiatives are better positioned to address local needs, making them more effective. They also contribute to raising general health awareness, generating positive externalities such as improved public health outcomes. Moreover, these projects strengthen local ties, with positive spillover effects that extend beyond health, fostering social cohesion and community resilience.

Objective 2.1. Strengthen the role of health promotion within the DHBC

To strengthen health promotion, the DHBC could consider adopting a broader role for this area, building on the precedent set by the new Public Health Law of the Basque Country, which emphasises citizens' health and the importance of social determinants of health. This it can be implemented by strengthening the current scope of work on health promotion, both at the central and county level. A strengthened health promotion team could oversee organising public health campaigns while also assisting municipal governments with the implementation of health-promoting projects. Possible topics which could be overseen within health promotion could include issues like substance use, healthy eating, and health literacy. One approach to securing these resources is by designating a specific portion of the DHBC's public health budget for health promotion and community health initiatives. Gradually setting this target can help ensure adequate funding without negatively affecting other public health programmes. This phased approach allows for sustainable support for community health while balancing other important priorities.

Several regions and organisations have already established a dedicated structure within their administration to prioritise health promotion. Action 1.2 of Osakidetza's strategy (2023[6]) involves creating a reference team for the community approach within the Sub-Directorate for the Co-ordination of Primary

Healthcare, focussing on prevention and health promotion. Valencia has a subdirectorate for health promotion and prevention which encompasses the services of addictions, health policy evaluation, immunisation, screening, and health prevention at work. The Canton of Zurich has a department focussed on health promotion with a substantial budget and 12 full-time staff. The department works on two fronts: the canton and the municipality. At the cantonal level, it organises health campaigns pertaining to drug addiction or mental health. At the municipal level, the department assists local governments in the implementation of health-promoting projects (OECD, 2025[16]). A good practice example of resource allocation for is found in the autonomous community of Asturias. Asturias has recognised that, internationally, around 4% of total health spending is typically allocated to public health, and the region is planning to progressively increase its own allocation.

8.3.2. Ensuring stable resources for community action at the local level

Community projects need sufficient financial support to cover basic expenses. Without this support, communities may struggle to sustain their initiatives in the long run. Otherwise, over-reliance on volunteers can lead to burnout and negatively affect the mental health of those involved, ultimately causing the project to fail. Sufficient funding ensures the longevity of these efforts and fosters a sense of recognition and value among those involved in an initiative.

Community-friendly public spaces also play an important role in fostering a strong sense of community, encourage civic participation and volunteering, and contribute to overall well-being (Francis et al., 2012[17]). A strong sense of community is linked to feelings of safety and security, increased civic participation, voting, volunteering, and improved well-being. In this context, public spaces that promote gathering and shared belonging further strengthen these community bonds. To maximise their potential, these spaces should be reimagined to better facilitate social interaction and community building. Beyond creating new spaces, it is equally important to ensure communities have easy access to existing public facilities and areas that can be repurposed for organising and hosting community projects.

In addition to financial resources, community projects also need intellectual resources. While a community may identify a health issue and be eager to address it, they may lack the necessary knowledge on how to carry out an effective intervention. Poorly designed interventions can lead to underwhelming results or, in extreme cases, even produce unintended negative effects. Furthermore, without the proper expertise, communities may become discouraged and abandon the idea of initiating an intervention altogether. Sufficient health staff at the municipal level is needed for that purpose.

Objective 2.2. Implement a mechanism to ensure stronger emphases on the health promotion at the municipal level

A mechanism to ensure stronger emphasis on the health promotion at the municipal level should be established in accordance with the new Public Health Law of the Basque Country. This law assigns municipalities the responsibility of developing programmes for health protection, promotion, and addiction prevention, as well as overseeing compliance with health standards. To be effective, the mechanism should guarantee that municipal health promotion programmes are carefully planned, adequately funded and staffed, and integrated into broader municipal plans.

Asturias strategy for community action (2023[7]) suggests that the work at the municipal level is essential for achieving health and well-being objectives for citizens. This approach is supported by a new public health law, which clarifies local-level responsibilities. To facilitate this, Asturias has introduced a catalogue of health promotion activities for municipalities, helping to define their role in implementing the broader strategy.

Objective 2.3. Develop a network of local entities to promote community action for health

Municipal networks can enhance community action in several ways. They enable municipalities to leverage shared resources to address funding challenges that might be difficult to tackle individually (this is particularly important for smaller and rural communities). By forming a network, municipalities can collaborate to develop more targeted and impactful programmes that better serve their communities. Additionally, these networks provide a valuable platform for the exchange of information and expertise, fostering collaboration and knowledge-sharing. This exchange can lead to the adoption of better practices and innovative solutions and build capacity to address local challenges collectively.

XarxaSalut created in the Valencian Community serves as a successful example of municipal networks fostering community action for health. It is a network of municipalities or municipal associations committed to implementing local health promotion initiatives as part of the region's V Health Plan (2022[18]). Municipalities formally communicate their commitment to both health centres and the DHBC and inform their citizens about joining the network. Through this network, municipalities participate in workshops and meetings to exchange experiences, share best practices, and showcase their activities.

Objective 2.4. Build a knowledge-sharing database available to local communities

Community initiatives often struggle due to a lack of know-how among their participants. To reduce the negative effects of this situation, the strategy should include creating a database of tools and resources, developed in collaboration with leading experts. This database could take a form of a website offering downloadable materials such as project guidelines, evaluation reports, and good practice reports. Also, incentives for grant recipients to share documentation of their projects in the database should be created. This would generate a positive spill-over effect, allowing successful initiatives from different parts of the Basque Country to be shared and replicated more easily. This open-access database would enable communities to use best practices for tailored initiatives and serve as inspiration for new groups looking to launch community projects.

An example of such a database can be found in Switzerland, managed by the Health Promotion Switzerland foundation. Projects that receive funding from the foundation are required to provide comprehensive documentation, which is then published on the foundation's website. Additionally, applicants who lack the technical expertise to implement their projects are offered support and guidance from the Department of Health Promotion. This approach empowers local communities by enabling them to apply for funding directly, while also significantly lowering the barrier to entry for those with limited technical knowledge.

Objective 2.5. Facilitate access to public spaces and create new community-friendly public spaces

The DHBC can collaborate with local governments to improve urban space design, particularly in terms of walkability and accessibility for people of all ages, enhancing community action. Making streets more pedestrian- and bike-friendly – through measures such as restricting vehicle access, building more bike paths, and creating additional playgrounds for children – can strengthen community ties. This collaboration could also extend to maximising the use of existing public spaces, encouraging local governments to make these areas available for community projects. Additionally, adapting and opening public buildings and spaces to support these initiatives fosters a more inclusive and active environment, encouraging greater participation in community activities.

An example of the role of community-friendly public spaces can be seen in the strategy of Asturias (2023[7]), which highlights urban development as a crucial sector for promoting intersectoral collaboration in health, particularly at the local level. This approach is significant because municipalities hold responsibility for urban planning, including the creation of technical and regulatory tools to manage land use, as well as its

transformation or preservation. In the Basque Country, the strategy of the Province of Gipuzkoa (2022[12]) propose to introduce changes to the physical design of the space and, above all, adjustments in how services are organised and delivered to better support, accompany, and facilitate interpersonal connections. The Province of Utrecht has put this concept into practice, requiring that all urban initiatives be reviewed by health professionals to ensure that they are assessed from a health perspective, fostering a healthier and more inclusive urban environment. Another example of successful collaboration between community projects and local authorities in the use of public infrastructure is the Mugiment project, which promotes physical activity by utilising existing sports infrastructure managed by local governments.

8.4. Strategic line 3: Fostering awareness and policy evaluation

Strategic Line 3 focusses on raising awareness of community action and developing the framework to evaluate community projects. It begins with the dissemination of the community action and the new strategy, ensuring broad understanding and engagement. Next, it emphasises the promotion of community action among researchers to increase academic interest and innovation. Finally, it highlights the importance of developing a robust quality framework for evaluating community initiatives, ensuring their effectiveness and sustainability.

8.4.1. Designing the communication plan for the community action

An effective communication plan is essential for rising awareness and fostering engagement in community action. Clear and well-managed communication delivers numerous benefits, both within the Basque multi-level governance structure and among potential beneficiaries, including initiative leaders and local communities. It enhances participation and engagement by encouraging local communities to take part in the consultations and planning as well as designing and management of community projects.

A successful communication plan should address two key areas. First, it should effectively promote the new strategy on community action to both institutional stakeholders and local communities. A well-structured communication plan reduces confusion and misunderstanding surrounding the strategy. Poor communication, on the other hand, can lead to resistance, conflict, and the spread of misinformation, which could jeopardise the strategy's objectives.

The second area focusses on enabling citizens to freely express their opinions and ideas about community action. Since the strategy is community-centred, it is crucial to provide tools that allow citizens to share their perspectives. This approach fosters a sense of ownership, strengthens citizens' role in the community process, and creates opportunities for mutual learning and the exchange of ideas and good practices. Moreover, it supports continuous citizen engagement in consulting and designing policies and projects related to community action, which represents the highest level of community involvement, fostering a deeper connection and commitment to these initiatives.

Objective 3.1. Develop a dissemination plan for the new strategy

Communities needs to be well-informed about the strategy, its objectives and implementation. Dissemination plan should rely on various communication channels. Outreach efforts could include providing clear and accessible information through a dedicated online portal creating a space for questions and idea submissions, The portal could also host an evolving set of Frequently Asked Questions, creating a dynamic resource for community members. To increase efficiency and benefit from synergy gains, this online portal can be integrated with the knowledge-sharing database (see Objective 2.4.). Additionally, an information campaign could be launched within the primary care units and pharmacies to raise awareness about the new strategy and benefits associated with it. This approach would enable the strategy to reach a wide audience, including socially disadvantage groups, who might otherwise have limited access to digital resources.

The organisation of awareness-raising campaigns promotes behavioural change, encourages collaboration among different stakeholders, and can mobilise public support for the strategy. Osakidetza's Strategy on Addressing Health from a Community Perspective in Primary Care (2023[6])provides an example of dissemination efforts. A key component of this strategy focusses on raising awareness, with specific actions such as developing a *community notebook* at each primary healthcare centre, providing information and training services to citizens (Osasun Eskola), and organizing Good Practice Conference to foster knowledge exchange. These initiatives aim to increase the visibility of community activities and is designed with an intersectoral and multidisciplinary approach. Asturias has taken a different routh by establishing an annual meeting on well-being and community health, where the Directorate of Public Health conducts training workshops on topics relevant to community action in health (2023[7]). Madrid, in addition to a meeting on community health also suggests the idea of handing in regional prizes on community health, co-ordinated by both the Department of Health and by primary healthcare provider (2021[10]). Finally, La Rioja has developed an online platform, the *School for health*, and plans to offer training sessions for citizens within healthcare centres (2023[9]).

Objective 3.2. Create a tool allowing citizens to express their views, and health authorities to consult the community, on specific health matters

Developing a tool that enables citizens to express their views and allows health authorities to consult the community on specific health matters is an important component of building community-centred strategy. For example, the consultations can be conducted through associations representing people directly or indirectly affected by specific diseases or disabilities, as well as patient associations. A potential framework for this consulting tool might be aligned with the 2023 Basque Public Health Law, which incentivises citizen's participation and consultation on specific health topics. To increase efficiency of community consultations and improve citizen feedback on specific public health issues, it would be beneficial to develop comprehensive guidelines on engaging with citizens to informing health policy**.** These guidelines, designed to support local authorities or DHBC's professionals working on the ground, are crucial to maintain and increase the adherence of potential beneficiaries to community action programmes.

In Austria, the Federal Ministry of Social Affairs, Health, Care, and Consumer Protection launched the *Future Health Promotion* participatory strategy process, engaging experts, stakeholders from multiple sectors, and community representatives to prioritise health measures for the next five years (2022[19]). This process employed participatory methods to define long-term goals and establish short- to medium-term priorities. An online platform was created as part of the initiative, allowing citizens to share their opinions and stay informed about ongoing initiatives and progress in implementing the strategy. Similarly, Scotland introduced national guidance, *Planning with People* (2024[20]), to support municipalities and health services in fostering community action. This guidance emphasises timely engagement and a two-way communication process, ensuring communities are informed and involved in project development. In Spain, XarxaSalut developed user-friendly guides offering practical information on organizing new initiatives and local networks, further supporting effective community engagement (OECD, 2025[16]).

8.4.2. Promoting research and capacity building in community health

Communities themselves are the central actors in community action, supported by professionals who assist in designing and implementing initiatives aimed at improving health and well-being. However, both community members and the professionals supporting them often lack the technical expertise needed to effectively implement and evaluate interventions. They may also face challenges in identifying the most pressing health issues without relying on external sources or frameworks.

Academic research serves as a vital and reliable resource for developing, implementing, and evaluating community projects. It provides evidence on the effectiveness of interventions, designs indicators to measure impact, studies optimal intervention models, develops innovative approaches, and creates

evaluation tools. Research also draws on international experiences, enabling the exchange of good practices across countries, further enriching the knowledge base for community interventions.

Understanding social determinants of health, the influence of living environments, and the role of lifestyles on health outcomes is essential for accurately assessing local needs. Academic research plays a critical role in documenting changes in population health and identifying key factors that shape health outcomes. By pinpointing the main drivers of health inequalities, research enhances the effectiveness of community efforts and raises awareness about the root causes of health inequalities, ultimately supporting more targeted and impactful interventions.

Objective 3.3. Actively promote research on community action among Basque academic institutions

Basque academic institutions are well-positioned to support local community projects through their research on social determinants of health within the Basque context. This research is crucial for informing policy design, setting mid- and long-term health strategy objectives, and developing tools to achieve them. The strategy should actively promote relevant research among Basque universities and research institutions operating in the Basque Country while fostering collaboration between academic researchers, health institutions, and community action networks. This promotion can include targeted grants for designing and evaluating community initiatives in the region. Additionally, Basque research centres can contribute to creating a knowledge database to support communities (see Objective 2.4.). The future Basque Institute of Public Health could play an important role in co-ordinating this process and maintaining the overall coherence of the academic curricula and the training of the many professionals working in the health system.

Promotion of research on community action and health promotion is part of the Osakidetza's strategy (2023[6]) and additional examples of promoting research on community action can be drawn from other regions. In Asturias (2023[7]), one strategic line of action involves creating a Chair on Community Action and Health Promotion at the University of Oviedo and providing funding for related research projects. Asturias also emphasises the importance of incorporating citizens' experiences into research on social determinants of health. Similarly, the Strategy for Community Health in Castilla-La Mancha (2023[8]) prioritises research, with a specific focus on gender perspectives and citizen involvement. The strategy also seeks to strengthen teaching, training, and research as part of its primary care health plan. In Zurich Canton, Switzerland, the Department of Prevention and Health Promotion employs full-time academic staff, including university professors and researchers from the University of Zurich (OECD, 2025[16]). This integration of academic expertise ensures that the latest scientific advances are embedded in health promotion programmes.

8.4.3. Developing a quality framework

Monitoring and evaluation are integral components of the quality framework for community action. Monitoring involves the continuous collection and analysis of data to track the performance of initiatives, enabling the early identification of issues and introducing timely adjustments. Evaluation, in contrast, is the systematic assessment of whether the goals of initiatives are being achieved. It measures the effectiveness, efficiency, and impact of interventions. Together, monitoring and evaluation are crucial for informed, evidence-based decision making and effective policy development.

Additionally, the results of evaluation and monitoring allow for identifying and sharing good practices across communities. Collected quantitative and qualitative indicators should be included in a centralised knowledge-sharing database (see Objective 2.4.). Developing such a database, however, requires defining the standardised set of indicators to ensure consistency across initiatives. The selection of these indicators should be conducted via the consultation process, engaging the DHBC, Osakidetza, local

municipalities, and community representatives. This approach ensures the indicators are both informative and practical, balancing the need for meaningful data with feasibility to avoid overwhelming communities.

However, both monitoring and evaluation are resource-intensive processes. They require significant effort as well as technical expertise, which many communities may lack. This limitation can hinder the ability of communities to conduct these processes effectively, potentially weakening the development of initiatives and leading to inefficient use of available resources. At the same time, it also hinders policymakers deciding on reallocating responsibilities, adjusting budget allocations, and engaging professionals more effectively in community initiatives.

Beyond evaluating and monitoring individual initiatives, it is also crucial to analyse their overall impact. Assessing the influence of all community initiatives on the public health system and health outcomes is essential. This evidence can inform policymakers in adjusting public health policies or reallocating resources to maximise the effectiveness of health policies. Additionally, it helps identify emerging trends, opportunities, and potential challenges in community health.

Finally, the new strategy should also undergo evaluation, with its implementation closely monitored. While the strategy is developed in collaboration with experts and through a consultative process, the dynamic nature of the health landscape means that some recommendations may prove more effective than others over time. Regular evaluation can provide valuable insights for Basque policymakers, enabling them to adjust implemented initiatives as needed and enhance their support for communities in achieving improved health and well-being.

Objective 3.4. Create a self-evaluation tool for local communities

The self-evaluation tool for community action can empower communities to implement effective health initiatives while clearly demonstrating how they are meeting their goals. It should guide community leaders in understanding the characteristics of high-quality community action. Rather than focussing solely on activities, the tool should prioritise outcomes, such as the tangible impact of community projects, changes implemented based on feedback, efforts made to reach socially disadvantaged groups, or the mechanisms for monitoring potential impacts. Additionally, the self-evaluation can include key quantitative indicators such as budget information, participant numbers, frequency of meetings, or other technical details that could be valuable for other communities considering similar initiatives. Developing such self-evaluation tools should be a collaborative effort between local communities, the DHBC, and Basque research institutions.

An example of such a self-evaluation tool can be found in Scotland, where Healthcare Improvement Scotland developed a tool for healthcare providers, social workers, and local authorities. This tool helps to identify shared outcomes and define steps to improve engagement with local communities. Similar tools are also used in Canada, such as the guide published by Active Neighbourhoods Canada (2017[21]), which offers a framework for evaluating local community projects. In Spain, the Escuela Andaluza de Salud Pública published *Tools to Assess the Impact of Public Health Programmes and Community Interventions from an Equity Perspective on Social Determinants of Health and Equity* (Suárez Álvarez et al., 2018[22]), which serves as a resource for assessing the health impact of community initiatives.

Objective 3.5. Design quantitative and qualitative indicators to monitor progress and evaluate impact of community action

Health Observatories play a key role in analysing and disseminating data on various aspects of health, including community health and social determinants of health. The Basque Health Observatory, potentially in collaboration with the Basque Institute of Statistics (Eustat) should contribute to defining the methodological approach for collecting data on community action. It should also take the lead in using and disseminating this data to inform and enhance community initiatives. However, it is essential to approach

such analyses with caution due to several challenges: (i) the effects of community action policies tend to be slow and can only be meaningfully assessed several years after their initial implementation; (ii) isolating their impact from other influencing factors, such as economic conditions, demographic changes, and broader healthcare policies, is often complex; and (iii) data sources on programme outcomes are frequently scarce, incomplete, and difficult to compare.

In other regions of Spain, for example in Extremadura, Health Observatories often monitor the impact of community action on health. Similarly, in Valencia, municipalities participating in the Xarxa Salut commit to sharing information on the implemented activities through the Health Observatory. In Andalusia, the Health Observatory collects and analyses health data to guide and improve community health interventions. Beyond Spain, Finland offers a benchmark with its comprehensive data collection on health promotion across municipalities, covering seven dimensions such as commitment, management, population health monitoring, and public participation. These indicators enable municipalities to assess citizen engagement in service planning and collaboration between municipal authorities and associations, with extra funding awarded based on performance. In the United States, the PLACE project (formerly the 500 Cities project) provides neighbourhood- and city-level data on chronic diseases, health behaviours, social determinants of health, and preventive services across major U.S. cities. The project disseminates its data, methodology, and interventions through a dedicated webpage (Centers for Disease Control and Prevention, 2024[23]).

Objective 3.6. Evaluate the implementation of the new strategy on community action

The comprehensive evaluation of the new strategy should combine both quantitative and qualitative data collection and analyses. Quantitative indicators could focus on measuring the changes in the reach and process of community action, including metrics such as the number of beneficiaries, the diversity of initiatives, and the impact on fostering a sense of community or shifting perceptions on its role and significance. Qualitative feedback from citizens, local municipalities, and Osakidetza's and DHBC's professionals is equally valuable for impact evaluation and for making evidence-based recommendations for adjustments to the strategy. For example, information about the clarity of information or the dynamism of collaboration between health and municipal authorities can help to evaluate whether changes, such as a new co-ordination mechanism, have led to improved collaboration between different public sector units.

Currently, there are limited examples of evaluations assessing entire strategies comprehensively. One such example is the evaluation currently being conducted by Osakidetza. To address this gap, Output 5.3 of this project proposes a monitoring and evaluation framework aimed at addressing the most critical aspects of the strategy, providing a structured approach to assessing its implementation and impact.

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Notes

[1] Suggested solutions for the practical implementation of co-ordination mechanisms, such as inter-departmental councils (*mesas*) and bilateral co-ordination instances are detailed in the Action Plan report.

Community Action to Strengthen Health Equity in the Spanish Basque Country

The Basque Country has a rich tradition of community action, with many initiatives taking place across regions and involving a wide range of actors. Local and institutional networks provide important opportunities for collaboration, but efforts remain fragmented and unequal across different provinces and municipalities, as there is no overarching structure to coordinate activities at the Basque level. Limited public funding and staffing constrain the reach of community action, while approaches to monitoring and evaluation vary greatly between sectors. This report examines how community action is evolving in the Basque Country, focusing on health equity. It reviews the role of the Department of Health, maps ongoing participatory initiatives at the local level, and highlights strengths as well as gaps in current practices. The report also outlines recommendations for a strategy to strengthen community engagement, ensuring that community-led efforts are better supported and more sustainable. Strengthening these processes can help advance equity, improve well-being, and make health systems more responsive to the people they serve.

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