

EUROPEAN UNION



Committee of the Regions



Subsidiarity Monitoring Network

Action Plan 2010

Health Policies:
Health Inequalities in the EU

Lead Partner



Regione Lombardia

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Health Inequalities in the EU**

Partners



**The report was written by
the working group on Health Policies, led by Regione Lombardia, Italy
It does not represent the official views of the Committee of the Regions.**

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Health Inequalities

Key Points

1. Background

The working group on health inequalities has tried to assess best ways to tackle this problematic across Europe. In 2009 the Committee of the Regions participated in the assessment of territorial impact of EC proposal "Solidarity in Health". Afterwards the CoR issued its opinion on this matter, for which Mr Dave Wilcox (UK/PSE) was CoR rapporteur. The work of this working group comes to take stock of all this and aims to analyse the problem of health inequalities in terms of subsidiarity by presenting a range of best practices and proposing policy recommendations.

Subsidiarity and in particular horizontal subsidiarity are crucial when addressing health inequalities. Health inequalities is a policy field where subsidiarity can be clearly geared at solidarity. Health inequalities is also a field where stewardship has revealed a very useful figure that as subsidiarity is also rooted in the idea of service and help. Stewardship could uphold subsidiarity to ensure that appropriate responsibilities are allocated properly in the name of solidarity.

2. Group members and their best practices:

The working group was led by Lombardy Region (Italy) and composed by the Valencia Region (Spain), the Association of Finnish Local and Regional Authorities (Finland) and Region Västra Götaland (Sweden). Each member presented examples of best practice in the field of health inequalities:

- Lombardy Region: ROL (*Rete Oncologica Lombarda*)
- Association of Finnish Local and Regional Authorities: Better Health in Northern Finland subproject in the region of Kainuu
- Valencia Region: Action Plan Health
- Region Västra Götaland: Marmot review and Angered's Hospital

3. Conclusions

Health Inequalities

- A. are to be found between as well as within Member States
- B. are possible to reduce if the (political) will is right
- C. may be reduced by initiatives on various levels, from the EU Commission through European Agencies to national, regional and Community levels - ending up with a need to support also family and individual motivation and engagement

- D. may be reduced if there are even better incentives, on an individual as well as on family and local society level, for preventing poor health and promoting a healthy lifestyle

Initiatives to be undertaken

- A. Possibilities at EU level include:
- common measurements, analyses, reports and benchmarking activities;
 - knowledge gained through research;
 - exchange of knowledge and best practices through publications, conferences, projects and by supporting networks;
 - funding and follow-up of the above-mentioned initiatives
- B. at national level much can be achieved when it comes to taking an active part in EU initiatives, such as those indicated above, as well as tailoring such initiatives to fit national needs, preferences and cultures
- C. at regional level, even closer to the populations and often with access to quite strong governmental powers and useful resources, initiatives such as those above may be put into practice, progress followed, data collected and experiences drawn shared with other regions (most of the practices described in the present work)
- D. at EU level, being yet another step closer to the significant needs of various groups of inhabitants and with possibilities to recognize and evaluate such needs, supporting activities focused on reducing health inequalities may be further integrated and put into best possible practice (example “Angereds Närsjukhus, Region Västra Götaland)
- E. “learning by doing”, together with others, is an efficient and stimulating way of making progress. To be able to work with a common problem, adding different views and contributing various experiences is very rewarding and a great possibility in today's Europe. To work as part of the working group “Health inequalities” within the SMN Action Plan has been a tremendous learning experience, best suited to being replicated within the health field as well as many other areas.

Political recommendations to the Committee of Regions

In our view the CoR could, among other things:

- Help spread among the citizens of the EU and its regions a growing awareness of the subsidiarity principle, both in its vertical and horizontal dimensions.
- Ask other European institutions to export this concept also in the health sector, with particular attention to the WHO, where the right relationship between subsidiarity and stewardship in health care should be explored.

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This document contains 36 pages.

1. Group Members

Lombardy Region (IT) (Lead partner)

- Region Västra Götaland (SE)
- Association of Finnish Local and Regional Authorities (FI)
- Valencia Region (ES)

2. State of play

The term "health inequalities" identifies differences, variations or disparities in health status between individuals or groups. The term "inequity" refers to differences in health which are not only unnecessary and avoidable but are considered unfair and unjust¹. Health inequities are systematic differences in health outcomes across different population groups (defined by place of residence or on a socio-economic basis) which arise not from chance or from the decision of the individual but from preventable differences in social, economic and environmental variables that are largely beyond individual control. In common usage, the term health inequality is used as a synonym for health inequity.

Health inequalities are increasingly recognised as a significant public-health issue throughout Europe. The large gaps in health which exist between and within EU Member States is an important challenge facing the EU. In the light of the concerns over the extent and the impacts of health inequalities, the European Union and many countries and regions are addressing them by developing policies, strategies and action plans in a broad variety of ways.

Principal responsibility for action to address health inequalities rests with Member States both at national and regional level, but EU policies could have a role both through their indirect impact on health and by helping to overcome some of the current obstacles to mitigate them. More specifically, the EU intends exploring options to support and complement the efforts of Member States and stakeholders and to mobilise policies towards reducing health inequalities, in full accordance with the subsidiarity principle².

The aim of EU action on health inequalities regards the extent of the health inequalities between people living in different parts of the EU and between socially advantaged and disadvantaged citizens as a challenge to the EU's commitments to solidarity, social and economic cohesion, human rights and

¹ Health21, the health for all policy for the European Region. World Health Organization Regional Office for Europe. Copenhagen 1999.

² COMMISSION STAFF WORKING DOCUMENT, *IMPACT ASSESSMENT accompanying the COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS, Solidarity in health: Reducing health inequalities in the EU*, SEC(2009) 1396 final, Brussels, 20.10.2009.

equality of opportunity. In concrete terms this action addresses improvements in the health of the whole population, with particular emphasis on reducing avoidable and unfair gradients in health between social groups, protecting the health of vulnerable groups and contributing, where appropriate, to more rapid improvements in the health of populations for those EU regions that are lagging behind.

A legal basis for action is provided by the EU Treaty. As a "political" background to action, in June 2006 the Council adopted conclusions on Common values and principles for health systems stating that "they aim to reduce the gap in health, which is a concern of EU Member States"³ and, in November 2006, conclusions on health in all policies recognising the importance of health determinants and calling for inter-sectoral and broad societal action on those determinants⁴. Policy action on health inequalities was foreseen in the Commission White Paper "Together for Health, a strategic approach for the EU 2008-2013" of October 2007 (the EU Health Strategy)⁵ which stressed the need to reduce health inequity between and within Member States involving exchange of best practice and health promotion. The European Parliament, the Council and the Committee of the Regions, in their opinions on the Health Strategy, underlined the need for EU action to help address inequalities in health. Furthermore, in June 2008, the European Council highlighted the importance of closing the gap in health and in life expectancy between and within Member States⁶ and then, in July 2008, the Commission Communication on a Renewed Social Agenda⁷, restated the fundamental social objectives of Europe based on equal opportunities, access and solidarity. Finally in 2009, the Commission Communication⁸ dedicated to the issue of health inequalities launched the debate needed to define potential EU-level flanking measures to support actions by Member States and other actors to address the health inequality issue.

Amongst the EU actions and initiatives which can contribute to reducing health inequalities, a European platform against poverty was recently launched as part of the Europe 2020 growth strategy⁹ under the priority of Inclusive Growth, recognising that health and well-being are a key method of fighting exclusion, while the Cohesion Policy funds, directed to less well-off regions in the EU, can be used to invest in key determinants of health inequalities such as living conditions (water and sanitation), training and employment services, transport and technologies. In this connection, significant investments in health systems have been supported by the structural funds allocated to health infrastructure, capacity building and training of health staff, healthcare provision and support for health promotion and disease prevention.

The EU also provides a substantial legislative framework in other related areas. It has established Community labour law and Community legislation in the field of health and safety at work: the

³ OJ C 146 of 22.06.2006, p.01.

⁴ http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/91975.pdf page 10

⁵ "Together for Health, a strategic approach for the EU 2008-2013" http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf

⁶ http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ec/101346.pdf, page 13.

⁷ "Renewed Social Agenda: Opportunities, Access and Solidarity". COM(2008) 412 final

⁸ COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS, SOLIDARITY IN HEALTH: REDUCING HEALTH INEQUALITIES IN THE EU, COM(2009) 567 final. Brussels, 20.10.2009

⁹ http://ec.europa.eu/europe2020/index_en.htm

improvements in the protection of worker's health and safety represents a significant contribution to reducing health inequalities in Europe by reducing the negative impact of some of their determinants. Moreover, the internal market has the potential to contribute to a reduction in health inequalities by stimulating economic growth, lowering prices, generating employment opportunities and thus improving standards of living. More specifically, "health-related" infringement procedures (for example on the freedom of establishment and provision of services, restrictions to ownership of pharmacies and their location, restrictions to ownership of laboratories and their opening hours, which may lead to sales monopolies and constitute barriers to access) can contribute to lower prices of care and thus particularly benefit citizens from lower social economic groups.

Parallel to the EU effort to tackle this matter, in recent years Member States reiterated the importance of confronting this problem. In 2006 Member States agreed on the objective of addressing inequities in access to care and in health outcomes,¹⁰ within the Open Method of Coordination for Social Protection and Social Inclusion (social OMC)¹¹. Reducing health inequalities within and between Member States was also agreed in 2006 as an operational objective of the renewed EU Sustainable Development Strategy¹². The persistence of health inequalities has been also highlighted in the annual Joint Report on Social Protection and Social Inclusion (Joint Report SPSI)¹³. In the international arena, in addition to Member States' adoption of the 2008 Tallinn Charter¹⁴, which establishes as health systems goals "improving the level and distribution of health, equity in finance and equity of access to care", the 2008 report of the WHO Commission on the Social Determinants of Health (WHO CSDH)¹⁵ described the global burden of health inequalities and called for concerted action at all levels of government to address them.

This broad context demonstrates increasing attention to the large and persistent inequalities in health between and within Member States and growing concerns about the negative consequences for health, social cohesion and economic development if they are not effectively addressed. This evidence is based, inter alia, on the impact assessment consultation among the partners of the Subsidiarity Monitoring Network launched by the Committee of the Regions in 2009 aimed at contributing to the assessment of territorial impacts of possible Community action on reducing health inequalities in the European Union¹⁶.

While the average level of health in the EU has continued to improve over the last decades, differences in health between people living in different parts of the EU and between the most

¹⁰ http://ec.europa.eu/employment_social/spsi/common_objectives_en.htm

¹¹ See <http://ec.europa.eu/social/main.jsp?catId=448&langId=en>

¹² Review of the EU Sustainable Development Strategy. Council of the European Union. Document 10117/06. 9 June 2006 <http://register.consilium.europa.eu/pdf/en/06/st10/st10117.en06.pdf>

¹³ http://ec.europa.eu/employment_social/spsi/joint_reports_en.htm

¹⁴ http://www.euro.who.int/document/hsm/6_hsc08_edoc06.pdf

¹⁵ "Closing the gap in a generation: health equity through action on the social determinants of health." Commission on Social Determinants of Health Final Report. World Health Organization, Geneva 2008. http://www.who.int/social_determinants/final_report/en/index.html

¹⁶ SUMMARY REPORT, Assessment of Territorial Impacts of EU Action to Reduce Health Inequalities, Committee of the Regions, April 2009.

advantaged and most disadvantaged sections of the population remain substantial and in some instances have increased. Between EU Member States there is a 5-fold difference in deaths of babies under one year of age, a 14 year gap in life expectancy at birth for men and an 8 year gap for women. Large disparities in health are also found between regions, rural and urban areas and neighbourhoods. Throughout the EU a social gradient in health status exists where people with lower education, a lower occupational class or lower income tend to die at a younger age and to have a higher prevalence of most types of health problems¹⁷. Workers doing predominantly manual or routine repetitive tasks have worse health than those doing non manual, less repetitive tasks. The gender dimension is another important element causing disparities: women in general live longer than men but may spend a longer proportion of their lives in ill health. Vulnerable and socially excluded groups such as people from some migrant or ethnic minority backgrounds, the disabled or the homeless experience particularly poor average levels of health¹⁸.

Evidence from literature shows that health inequalities are mainly due to differences between population groups in a wide range of factors and determinants which affect health. These include: living conditions, life expectancy and mortality; health-related behaviours and lifestyle (unhealthy diet, lack of exercise, smoking, excessive use of alcohol, road accidents); socio-economic conditions (unemployment and social exclusion, education and cultural level, income, gender, illegal status of migrants, income and distribution of resources); health care, disease prevention, exposure to health risks and health promotion services; accessibility to health services (including general practitioners, hospital stays or admission and pharmaceutical consumption, lack of insurance, high costs of care, lack of information about services provided) and infrastructure; geographical features of the territory (remoteness, fragmentation, islands and mountainous environments, all representing concrete barriers to the use of services and infrastructure), as well as public policies influencing the quantity, quality and distribution of these factors. Even if access is universally guaranteed and free of charge, inequalities may still occur in preventive services, specialised assistance, and any other types of care not covered by the public health system. Inequalities experienced in earlier life in access to education, employment and health care as well as those based on gender and race can have a critical bearing on the health status of people throughout their lives. The combination of poverty with other vulnerabilities such as childhood or old age, disability or minority background further increases health risks.

Within this scenario, the role of regional and local authorities should be recognised both in delivering health outcomes and in delivering the services which address the social determinants of health. The importance of local action to promote healthy lifestyles and prevent the conditions that lead to ill health is laid down in strategies already developed by a number of European regions. As underlined by the Committee of the Regions¹⁹, effective prevention requires a high degree of local activity tailored to the needs of particular communities. While the nature of the problems leading to ill health may be common across Member States, delivering the messages about healthy living often requires

¹⁷ Health inequalities: Europe in profile. Mackenbach J., 2006.

¹⁸ SEC(2006) 410.

¹⁹ OPINION of the Committee of the Regions on SOLIDARITY IN HEALTH: REDUCING HEALTH INEQUALITIES IN THE EU, 84th plenary session 14 and 15 April 2010.

small scale interventions built on local knowledge. These measures may be effective in localities spread across many Member States.

The Committee of the Regions thus welcomes the Commission's determination to support and complement the efforts of Member States and local and regional authorities to tackle health inequalities in the European Union, while accepting the Commission's assessment that the problem of health inequalities is highly complex and that the way the situation develops depends on a plethora of factors, in particular: the recognition that inequalities can be seen at all levels, from European to neighbourhood; the role of the social gradient and the close connection between health and wealth; the health consequences of disadvantage for vulnerable and socially excluded groups; and the differing effects of social policy decisions in the provision of healthcare and social support.

3. Subsidiarity analysis and actions on health inequalities

General remarks

We are called on to contribute to a better insight into how health inequalities can be dealt with by means of subsidiarity-based policies and actions.

As pointed out in chapter 1, health inequalities can mean systematic and potentially remediable differences in one or more aspects of health across socially, demographic or geographically defined populations or population subgroups.

According to the subsidiarity principle *a community of a higher order should not interfere in the internal life of a community of a lower order, depriving the latter of its functions, but rather should support it in case of need and help to coordinate its activity with the activities of the rest of society.* This definition is particularly useful and interesting when we talk of health inequalities, a policy field where knowledge about these problems and the solution to them can be found in society.

We could see society as a machine producing inequalities, where the hand of the public power has to design and implement adjustments.

But that could be quite the opposite way of what we are called to elaborate on here. We would like to point out the role that subsidiarity should have in this policy field, that is: subsidiarity geared towards **solidarity**.

The subsidiarity principle can be considered as having two dimensions: vertical and horizontal. The vertical dimension of subsidiarity refers to the relationship between different tiers of administration, while horizontal subsidiarity concerns the relationship between public administration and citizens. In the case of the latter, public administrators are not just dictating to a “defective” society the corrections it needs.

In the positive anthropological vision which is behind the subsidiarity concept, and which is its foundation, public administrators are not presumed to always know what is best for society, and how to achieve it. Society itself, at large, is the seat of this knowledge.

That is implicit in the so-called horizontal dimension of subsidiarity and fits perfectly when applying it to solve the problem of health inequalities.

As already pointed out, with the so-called “vertical subsidiarity” we deal with different levels or “orders” of public bodies, and basically prescribe that a higher order should not interfere in the functions of a body of lower order, but rather should support it in case of need and help (i.e. giving it “*subsidium*”, which is just a Latin word for “help”). In the horizontal dimension we speak about the public sphere from the European Union down to the smallest municipality - dealing with social players (from individuals, to families, associations, enterprises and so on) in a quite similar approach: being ready to listen, give help where and if needed , rather than posing as all-knowing entity. That is a concept which was included in the new Statute of Region of Lombardy, whose article 3 reads as follows:

"2. The Region, in implementation of the principle of horizontal subsidiarity, recognizes and encourages the autonomous initiative of citizens, both individually and in association, families, social formations and institutions, associations and civil and religious institutions, and guarantees their involvement in the planning and realisation of public intervention and services, according to the procedures set out by regional Law."

Tackling inequalities means caring for the weakest and the voiceless, rather than for those with strong representations. That is an aspect that should be explored in more detail. The concept of **stewardship** is also to be taken into account when studying subsidiarity and health inequalities. This concept was introduced within WHO as one of the basic functions of health care systems, and was reaffirmed in the Tallin Charter of WHO-Europe in 2008 (quoted in chapter 1).

In the context of health care, this concept is used to assess the responsibilities of governments and their health care systems. Stewardship refers to the wide range of functions carried out by governments as they seek to achieve health policy objectives (equity, coverage, access, quality, and patients' rights and so on). Health care policy may also define the relative roles and responsibilities of the public, private and voluntary sectors - as well as civil society - in the provision and financing of health care. Stewardship is a political process that involves balancing competing influences and demands.

In other words governments must ensure that they meet the needs and expectations of their population in health. Yet this does not imply that governments do not build partnerships with public or private players, nor promote active roles for civil society.

A possible way to link the two above quoted concepts, subsidiarity and stewardship, born within different environments, could be to remember that both are rooted in the idea of service, help.

Stewardship could uphold subsidiarity to ensure that appropriate responsibilities are allocated properly in the name of solidarity.

From the point of view of horizontal subsidiarity, the “third sector” is seen as an invaluable source of human energy, knowledge, capabilities. That is present to varying degrees in the projects we present as best practices. An appropriate tool to provide better services in health care, may be the development and implementation of networks (hospital networks, GPs networks, and so on).

A good example provided through the best practices are the different networks presented.

First, networks are or can be a fundamental tool for applying subsidiarity, and in particular horizontal subsidiarity, in the field of health care by involving all relevant actors.

Second, networks are by their very nature equipped to address health inequalities, or at least some dimensions of them, by offering wider and more uniform access to citizens, wherever they live.

That is the case of the Lombard Cancer Network (ROL, Rete Oncologica Lombarda). ROL is an innovative model for delivering healthcare to cancer patients, based on clinical cooperation, exchanging and sharing information, and integration of existing cancer facilities throughout the regional network of organisations and professionals. ROL is aimed at creating an integrated network of health and social services devoted to cancer patients, in order to provide a framework for the exchange of information, capacity, and expertise, and therefore to offer a more accurate diagnosis, treatment, and cancer control.

Another valid example of subsidiarity in the field of health inequalities could be taken from the best practice presented by Region Västra Götaland. This is an example of the kind of work that needs to be done by regional authorities, consisting of gathering data, building knowledge, databases and indicators. The regional level has a unique role in this general activity.

Finally, a general approach that can be said to inform a subsidiarity policy in the field of health care could be the called “*take the health-care service as near as possible to the citizens and their needs*”.

This is also a way to tackle health inequalities and therefore it could be considered as "subsidiarity in action".

In this framework samples of two main typologies have been provided:

1. getting near to the citizen by targeting a specific area;
2. getting near to the citizen by implementing the service through networks.

Of the best practices presented by the members of the working group, two very different areas have been considered in the projects described.

One is a sparsely populated wide region in eastern Finland, Kainuu region, suffering constant emigration and ageing. Some of the main elements are: growing data information collection, participation of citizens by piloting an electronic customer feedback system, definition of responsibilities among administrative levels.

In Region Västra Götaland the area of Angered, in the north-eastern districts of the city of Gothenburg was targeted. That is an area where recent immigration was particularly concentrated, with about 50% born outside Sweden, comparatively high unemployment and scoring high with indicators known to be related to unhealthy situations. The objective of the project is expressed in the very same treatment and care unit whose creation is going to be its result: Angereds Närsjukhus, the “nearby” or local hospital. Among the key features we can underline:

- the close contact with other local social services;
- cooperation across care boundaries (from primary care to the major city hospital).

The latter element links this project to the network building approach, which is exemplified by the Lombardy case.

From the best practices presented by the members of the group, we can draw up the following conclusions on subsidiarity:

1. Horizontal subsidiarity is a key element of tackling health inequalities, where knowledge can be found in the society and where the involvement of all concerned actors is essential.
2. The regional level is in a unique position to gather information and collect data, with the aim of identifying determinants and indicators.

4. Best practices

4.1 Lombardy Region: ROL

Background information

Italy's health care system is a regionally-based National Health Service (NHS), based on the principles of universal coverage (extended to all citizens), equity in health, and solidarity (funding through fiscal taxation). One of the main objectives of the NHS is to guarantee everyone equal access to the ‘essential levels of care’ (LEAs) set each year by the national government, i.e. to a basic package of services which must be available to all residents throughout the country. Access to the LEAs must be guaranteed irrespective of income or geographical location, so as to reduce inequality in the geographical distribution of health care.

The national framework legislation sets out only general principles for organising, financing and monitoring the NHS. The national level sets the LEAs and suggests how resources should be allocated

among levels of care (hospital, district and primary care, community health care). A decentralization process has been taking place in the NHS since 1992, with a gradual devolution of the administrative control over functioning, effectiveness and efficiency of healthcare providers to the Regional Health Departments and to the Local Health Authorities (ASLs). All 20 Italian regions are now fully responsible for the organization and administration of healthcare, and for delivering the LEAs to the respective resident population.

Lombardy is one of Italy's twenty administrative regions located in the north of Italy. With a population of 9.6 million inhabitants, the Region is the financial, commercial and industrial heart of the country, and its economy represents one-fifth of the Italian national economy (GRP >20% of GDP).

The health infrastructure of Lombardy is composed of:

- 95 public hospitals belonging to 29 Public Hospital Trusts (AOs – “Aziende Ospedaliere”)
- 91 private accredited hospitals (6 not-for-profit)
- 24 National Institutes for Scientific Research (IRCCS -Istituti di Ricovero e Cura a Carattere Scientifico), which are research-oriented hospitals (5 public, 19 private)
- 991 specialist ambulatory services, including diagnostic, therapeutic and laboratory services (717 public, 274 accredited private)
- 15 Local Health Authorities (ASLs–Aziende Sanitarie Locali), which are geographically-based public organisations, which purchase services from public and private providers on behalf of the Regional Health System, co-ordinate primary care and residential care for their assigned populations, as well as primary and secondary prevention programmes.
- About 8 300 primary care physicians and paediatricians, working as independent contractors to the ASLs (Lombardy has about 1 GP per 1 100 residents)

Lombardy's health system distinguishes itself from the systems of other Italian regions, through the introduction of tools which effectively transfer power from the health organisation, with its interests and bureaucratic procedures, to the citizen-patient, which is placed at the centre of the entire network of services. A comprehensive reform of the health system was in fact adopted by the region in 1997, and a subsidiary "Welfare Community" was established, based on the following principles:

- universality and solidarity
- subsidiarity and freedom of choice for the citizen to choose the place of treatment
- integration between public, private and not-for-profit organizations (including the Third Sector)
- tailored healthcare services using ITC for personalized, home-based care support.

The Lombardy reform introduced a clear distinction between the functions of the ASLs, who purchase and monitor health services, and the network of public and private “providers” (Hospital Trusts or Enterprises), who produce the service. The third-party payer function of the region is devolved through the ASLs on the basis of a capitation scheme, and the ASLs purchase services from providers

(both public and private), through negotiation mechanisms based on regional tariffs. A mixed health system was therefore developed in Lombardy, made of public and private hospital providers. All providers must go through an accreditation process which is identical (in terms of requirements) for both public and private healthcare.

From the above-mentioned features, it is evident that the Lombardy health system fully implements the principles of both vertical and horizontal subsidiarity. When looking at epidemiological data, a few geographical differences can, however, still be observed in the distribution of diseases (mortality, incidence of specific diseases, etc.), as well as in the use of services (hospital admission rates, uptake of outpatient care, pharmaceutical services, etc.). In particular, we have observed that overall cancer mortality is higher in selected geographical areas.

It should be pointed out that cancer is one of the major causes of diseases in Lombardy, with about 45 000 cancer cases and 21 000 deaths per year. Approximately 370 000 persons are estimated to live in the region with a past diagnosis of cancer. These “cancer survivors” represent a major burden for the health care system, with demand varying according to the phase of care. Cancer expenditure is of greater concern for the government of a region, like Lombardy, where the overall healthcare budget (about 17 000 million Euros in 2008) is more than 70% of the overall regional budget.

Disparities in cancer care are of increasing concern to the oncology community. Disparities in care may exist at many levels, including diagnosis, treatment, and outcomes. The causes of these disparities may be complex, and include economic, cultural, and social factors. The growing introduction of high-cost novel cancer therapeutics and diagnostics is likely to exert increasing financial pressure on patients, oncologists, payers, businesses, and society. We may expect an increasing threat to our ability to ensure access and provide high-quality care to all patients. An integrated network of health and social services devoted to cancer patients provides a framework for sharing best practices and expertise, so as to offer to all cancer patients more accurate cancer management and control.

Objectives

In 2004 the region adopted a “Regional Cancer Plan”, a comprehensive approach to take long-term and sustainable measures to tackle cancer at all stages of the disease, from primary prevention to rehabilitation of cancer survivors, as well as palliative care. The plan includes actions to promote better integration and coordination of cancer care facilities, and to promote cancer research by supporting public-private collaborations, and coordination actions among researchers, hospital units, and private companies. Lombardy has internationally recognized cancer care facilities, which are increasingly attracting patients from other Italian regions and abroad. Lombardy has also a strong excellent science base, with 12 universities (6 medical faculties linked to teaching hospitals), and several science parks focused on cancer-related science.

Following the 2004 Cancer Plan, the development and implementation of a new organisational model based on a Cancer Network named “ROL” (Rete Oncologica Lombarda), was considered by the region as a strategic response to the need to deliver a patient-centered quality service, while reducing costs and enhancing appropriateness of care.

The Lombardy Cancer Network “ROL” is a typical example of “subsidiarity”.

Aims of ROL:

ROL is aimed at creating an integrated network of health and social services devoted to cancer patients, and to provide a framework for the exchange of information, capacity, and expertise. The network is based on two main guiding principles:

- to develop a more patient-centered approach to deliver health care services to cancer patients
- to improve cancer care services, and to achieve better integration of existing cancer facilities and professionals within the 22 provincial oncology departments of the region (DIPOs).

Specific aims are:

- to improve delivery and quality of care for all cancer patients throughout the region, and address health inequalities by improving co-operation among professionals and healthcare facilities
- to promote and strengthen a multidisciplinary approach to address cancer at all disease stages, from primary prevention, to palliative care, and rehabilitation programmes for cancer survivors
- to ensure appropriateness of care by developing and promoting evidence-based best practice in cancer prevention, diagnosis and treatment
- to improve access to healthcare, reduce health migration, patient mobility and waiting times, by developing Information Technology solutions for sharing of clinical data
- to promote continuity of care and optimise diagnostic-therapeutic pathways, within the framework of a disease-management system, so as to achieve better integration of existing facilities, and avoid the duplication of efforts;
- to promote partnerships between a wide range of stakeholders across the region, including profit and non-profit organizations of the third sector, as well as patient and family associations, according to the principle of horizontal subsidiarity, in a collective effort and with a common commitment to addressing cancer and to provide better services in response to patients needs
- to contribute to better use of limited available resources, and reduce costs by promoting efficiency and appropriateness of care
- to facilitate data collection and sharing for statistical purposes, to provide comparable information for benchmarking between hospitals or geographic areas, as well as to support health technology assessment procedures.
- to promote research (clinical, translational, and research on healthcare organisation) by facilitating co-operative partnerships through the network, and fostering innovation and transfer of scientific knowledge to clinical practice, in response to the “cancer emergency”.

Description of the project

The ROL Project was designed in 2005, and launched by the Lombardy Government in 2006, within the 22 Provincial Oncology Departments of Lombardy (DIPOs). ROL has been implemented in subsequent stages, but immediately applied in its partial applications. Initially the 22 hospitals of the Provincial Oncology Department (DIPO) participated in ROL. As at the end of 2010, 90% of public

hospitals joined the ROL, with more than 500 doctors participating and about 25 000 patients assisted by the network. In Phase 2, ROL opened to other public and private hospitals and to primary care physicians. The ROL was built by creating specific applications that progressively established the network with concrete results already from the earlier stages.

The ROL implementation strategy is based on a comprehensive approach, characterized by three levels of activity, each one involving different actors:

1. Clinical Level, concerning development and sharing of best practices within the professional “oncological community” (guidelines, protocols, clinical documents)
2. Technological Level, concerning development of IT solutions for sharing clinical documents, integrated with the regional Health Services Information System (SISS)
3. Organizational Level, concerning all actions needed to implement the network strategy within the cancer facilities located in the 22 Provincial Oncology Departments of Lombardy (DIPOs).

Role for the local or regional authority

The development of ROL was initially proposed by the professional community of specialists involved in cancer care, since the new acquisitions on the bimolecular basis of cancer and their clinical implications in terms of diagnostic and therapeutic approaches, determined an increasing need for knowledge transfer and sharing, within the medical community. The clinical approach to cancer patients requires, in fact, multidisciplinary and multi-professional cooperation.

The main role of the regional authority in the implementation of ROL concerns the 3rd level of activities described above, which is the “Organisational Level”. The regional government was very active in promoting co-operation between cancer care facilities, and facilitating the development of the “oncological lombard community”, represented by specialists in different disciplines (oncologists, surgeons, anatomo-pathologists, etc.), general practitioners, the multidisciplinary and multi-professional “oncology community”.

In order to implement ROL within the 22 DIPOs, the Regional DG Health:

- issued a set of recommendations for better integration and coordination within the DIPOs, and the network of hospital services,
- established rules and regulations of the network
- assigned economic incentives and ROL-specific objectives to general managers of hospitals
- organised training geared towards professionals of the regional health system
- funded joint projects between the DIPOs and the local health authority.

Moreover, the regional government facilitated funding mechanisms of biomedical research and technological innovation.

Resources

The region provides funds for coordination of the network, for developing the IT platform, and for supporting participating hospitals in the start-up phase. Individual hospitals provide extra-funding in order to integrate the ROL information tool within the hospital information system.

Management

Besides the role of the regional authority already described (see above), the management of the project is based on the following collaborations:

- The IRCCS Foundation “Istituto Nazionale dei Tumori” of Milan is in charge of the scientific coordination of the ROL, and coordinates several “pathology groups” of professionals (one group for each type of tumour).
- Lombardia Informatica SpA is the Technological partner of ROL, and manages informatics/telematic aspects integrated with the SISS (Health and Social Services IT System).
- The Regional “Oncology Community” participates in the development of guidelines and reaches consensus on strategic choices and the implementation practice.

Obstacles

The main obstacles we have faced concerned:

- ***The ICT dimension***
 - Doctors are not always familiar with IT
 - Some doctors complained because the ROL-Letter of discharge (ROL-DOC) is a time-consuming activity
 - Management of structured electronic documents require training actions
 - Integration with local EHCR is needed to avoid double data-entry
 - Integration with other information flows may not be immediate
- ***Participation***
 - The oncology community must be motivated in order to cooperate, and should feel they are part of the network
 - A top-down strategy is not recommended.

Results and achievements

Two main results have been achieved by the ROL so far:

1. The oncology community shared semantics and coding systems of a structured “discharge report”/“outpatient clinic report”. Sharing semantics has been a key point of ROL. A “minimum data set” focusing on the discharge report, was adopted as a tool for gathering and sharing information, avoiding data entry in addition to what is already done in clinical practice. The experience of ROL has addressed some innovative IT solutions integrated with the electronic health records of SISS, introducing a structured hospital “discharge letter”. The “minimum data set” is the core information backbone of ROL, open to “teleconsulting” and to interaction among specialists in Lombardy hospitals and among specialists and GPs.
2. For each neoplasia, the oncology community shared guidelines for clinical practice, based on evidence, through a consensus process. The first phase developed the model applying it to

three sample neoplastic diseases, with different levels of incidence (from rare to frequent) in order to study the potentialities of ROL, and gradually addressed all solid tumours.

Today ROL, born as a clinical tool for medical oncology is developing new areas of activity. A new collaboration has recently started between ROL and Nerviano Medical Sciences, one of the largest oncology-focused pharmaceutical R&D companies in Italy, in order to promote clinical research and translate scientific knowledge into clinical practice, and provide a clinical infrastructure for the creation of a 'regional virtual bio-bank of tumor tissues'.

Keys to success

- ***Good clinical co-operation***
 - ROL Guidelines have become a gold standard
 - Periodic up-grading of guidelines
 - Development of a growing “Oncology Community” (exchange of patients/best practices / research collaboration)
- ***Impact on the organisation***
 - Better co-ordination within DIPOs
 - Improved integration between levels of care (primary care, specialists, etc.)
 - Involvement of not-for-profit organizations and the third sector, to supply specific activities (e.g. home care, palliative care, psychological support, etc.).

Potential for replication

There is potential for replication of this model for several reasons, among them:

- Cancer prevalence is increasing
- Problem of cancer survivors and of elderly patients
- High degree of innovation (diagnosis, therapy)
- Cancer care requires a comprehensive approach
- Cancer is a top priority in the EU Health Agenda
- It is expected that cancer networks will increase in number in the EU
- Mobility of patients is increasing.

4.2 Association of Finnish Local and Regional Authorities - Better Health in Northern Finland subproject in the region of Kainuu

Background

The operational environment of health care in the region of Kainuu is different from the rest of Finland due to a regional administrative experiment, which is being carried out in eight municipalities

of the region in 2005-2012. In the model social and health care development activities are concentrated at regional level with the objective of improving their impact, availability and effectiveness. Typically these activities are the responsibility of municipalities. Developing activities form an integral part of the strategic plans of the region of Kainuu: they are present in the regional strategy and in the regional programme as well as in the strategies of social and health care sectors.

The population in Kainuu is ageing and the number of inhabitants has been constantly decreasing from ca 100 000 inhabitants in the beginning of 1980 to just over 80 000 today. According to the estimations of Statistics Finland the population in Kainuu will be only just under 74 000 in 2040. In addition, the number of pensioners has grown as a result of the ageing of the population.

The education structure of the population in Kainuu is different from the rest of the country: at the end of 2005 59.7% of the population over 15 years old had completed vocational training in Kainuu compared to 63.4% among the entire Finnish population. In Kainuu 19.1% of the population had a tertiary degree at the end of year 2005 (25.4% in the whole of Finland).

A project called “Reducing socio-economic health inequalities in Kainuu” was carried out in the region in 2006-2008. Clear knowledge gaps related to, for example, health inequalities of children and young people were identified during the project. In addition there was clearly a strong need for local cooperation in reducing health inequalities and for implementing different programmes. Kainuu’s experience in promoting welfare and health in 2005–2008 has shown that there is a strong need to develop the structures and management practices of welfare and health support. There is also a need to create permanent supporting structures and a working culture for cooperation between the Joint Authority of Kainuu Region, municipalities of the region and other actors.

Objectives and description

The objectives of the Better Health in Northern Finland subproject (2009-2011) are:

- Establishing effective and permanent multi-sectoral and multi-administrational structures and management models of health care and welfare support in the municipalities of Kainuu, in the Joint Authority of Kainuu Region and in the region in cooperation with the municipalities.
- Producing up-to-date information on people of different ages in Kainuu, inter alia in the framework of the Finnish regional health and welfare study. The information will be collected in welfare reports, which are a part of municipal and regional strategies.
- Increasing citizen participation in the design and development of services and activities for example via an electronic customer feedback system.

Organisation and Decision-making

Regional Council

The highest authority in policy-making resides in the Regional Council, elected for a four-year term by the inhabitants of the region. The Council has 59 members. In addition to these councillors, the municipality of Vaala will appoint 2 representatives to the council, acting as council members when matters concerning the Regional Council of Kainuu, structural funds and their match funding are under discussion.

Regional Board

The Regional Board elected by Regional Council runs the region's general administration, preparation and implementation. In addition to the Executive Director, who is also the Chairman of the Board, the board has ten primary members and ten personal vice-members. The self-government experiment law determines the composition of the Regional Board while addressing Kainuu's development financing and tasks in accordance with the Act on structural funds.

The board will be elected for the same duration as the Regional Council, unless the council opts for a shorter term before the election. The Executive Director is the presenting official in the Board meetings.

Social Welfare and Health Board

There are 11 members, each with a personal vice-member, in the Social Welfare and Health Board, and they are elected by the Regional Council. The Board is responsible for the development of the services in its own field, as well as for the financial issues and the whole organisation of the social welfare and health division. The Board's tasks include setting new goals, monitoring and evaluating on-going actions as well supervising the planning and implementation processes.

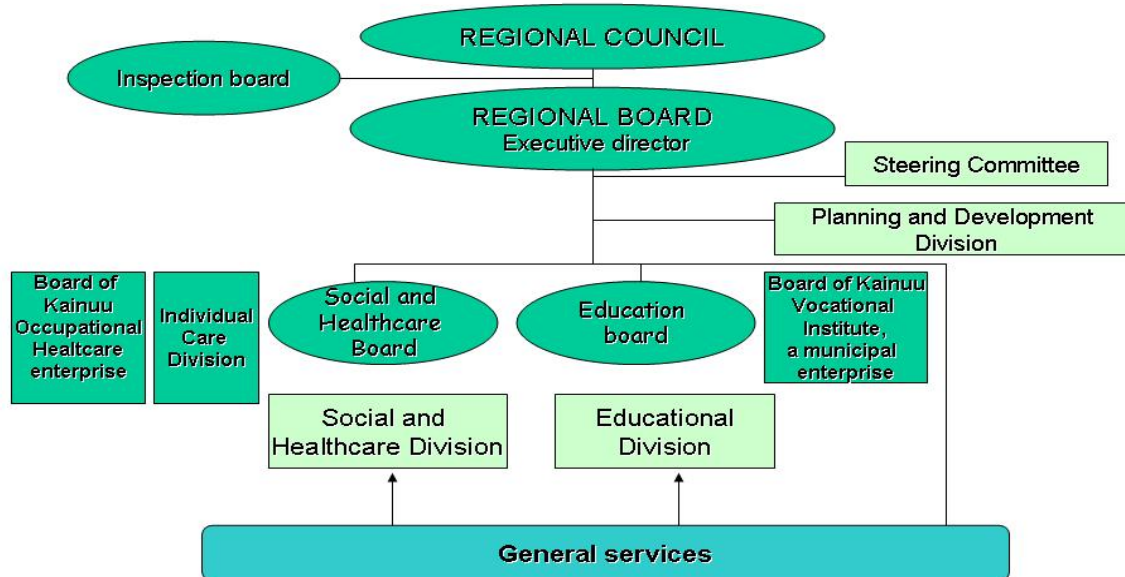
Education Board

The Education Board consists of 11 members elected by the Regional Council. Each member has a personal vice-member. The council will appoint one chairman and one vice-chairman among the board members. The responsibilities of the Education Board include development, monitoring, and planning supervision in the field of education services. The Board is also responsible for financial issues within the Educational Division as well as for the management of the division.

Inspection Board

The Inspection Board consists of a chairman, a vice-chairman and five other members. Each member has a personal vice-member. The chairman and the vice-chairmen are councillors. The board is responsible for, among other things, supervising the auditing process of the Joint Authority.

Organisation of the Joint Authority of the Kainuu Region



Results and achievements

Cross-administrational working groups for supporting welfare and health have been established in all municipalities in Kainuu. A separate regional working group with the same objective is working at the regional level in Kainuu. A regional health and welfare study carried out in Kainuu has produced up-to-date information on the status of the health and welfare of the population as experienced by individuals. In Kainuu the sample size was 9000 people and the overall response rate was about 56 per cent. People between 55 and 74 years of age formed the most active respondent group with a response rate of 65%.

Welfare reports are being produced in all the municipalities of the Joint Authority of Kainuu Region. The reports are tailored to fit the needs of the administrative experiment of Kainuu and they are based on a model developed in cooperation by the Better Health in Northern Finland –project coordination, the National Institute for Health and Welfare and a separate project focusing on the prevention and early treatment of chronic public health diseases financed by the National Development Programme for Social Welfare and Health Care. A separate welfare report is being produced in the region of Kainuu. The reports include data from the regional health and welfare study, which is about to be published, and from the national health questionnaire aimed at children and the young. The reports are part of the strategies and financial plans of municipalities and of the region. An electronic version of the regional welfare report is to be produced at the end of the project. In the framework of the entire Better Health in Northern Finland project the welfare report of the municipality of Haukipudas (in Northern Ostrobothnia) is to be produced in electronic form as well.

During 2011 the project will be focusing on citizen participation with the aim of developing a pilot version of an electronic customer feedback system.

Challenges and key processes

Understanding who is responsible for health and welfare development in the region of Kainuu during the administrative experiment has been a challenge and an obstacle for the project. Understanding and adopting the multi-administrational work policy has been time-consuming. Welfare and health support can be regarded as a responsibility of the social and health care sector, although municipalities are ultimately responsible for the health and welfare of the population. Municipalities, through their decisions and activities, have an impact on the living, working and upbringing environments of residents of different ages. In order to increase common knowledge and understanding, joint meetings and joint designing and targeting of activities are needed. This can only be done by allocating time to cooperation.

Key processes:

- Describing the structures and activities of welfare and health support at regional and local level
- Coordinating welfare and health support at regional and local level
- Defining the responsibility areas of welfare and health support at regional and local level
- Disseminating knowledge on welfare promotion to different actors (widely to municipalities and to the region as well as to companies, organisations and especially to decision-makers)

Potential for replication

A common welfare report model (an electronic version will be produced during the project).

The structural models of welfare and health promotion in the region of Kainuu, the Joint Authority of Kainuu Region and in the municipalities of Kainuu.

Welfare report: The welfare reports of the region of Kainuu and of the municipalities in the region are to be published in electronic form during the project. The welfare reports that are being prepared at the moment already have a structure that corresponds to that of electronic reports. The indicator-based data is presented using the TEHO-tool, a tool for local and regional authorities for measuring the welfare and health of the population. TEHO produces visually clear and easy-to-read graphics and presentations based on data input. The drafting of the welfare reports follows the usual schedule of municipal strategic and financial planning activities.

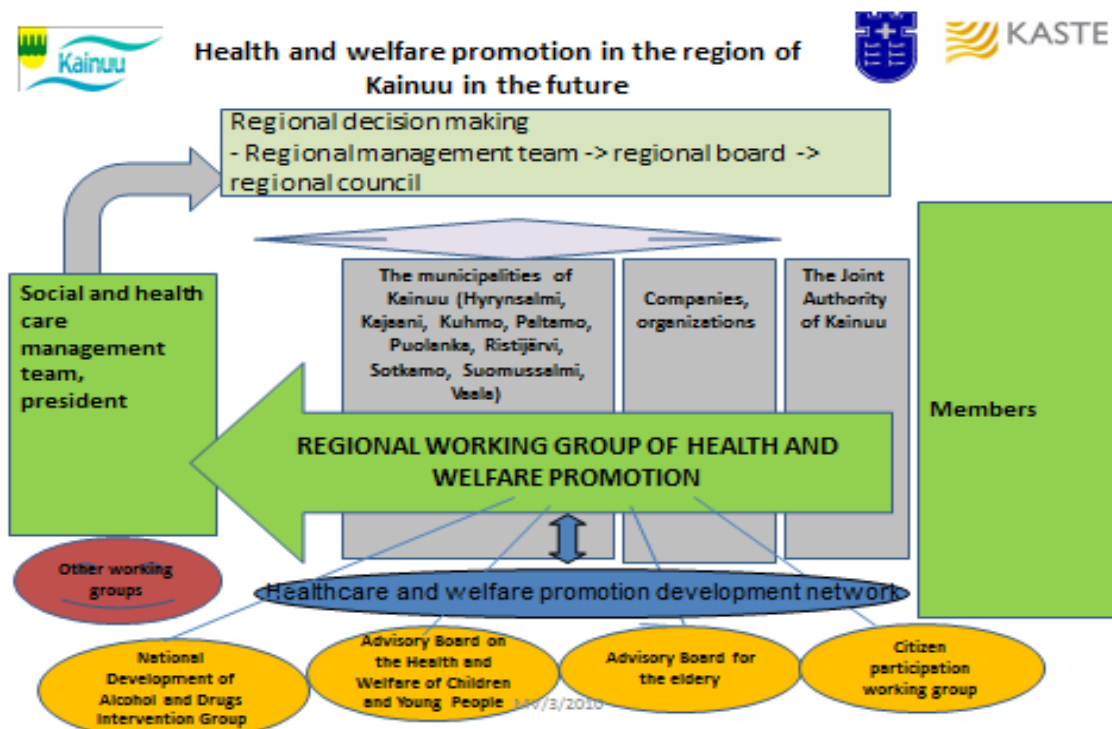
Welfare report drafting as part of the municipal activity schedule

WR= welfare report

Month	Regional working group on health and welfare promotion	Management Team (Social Welfare and Health)	Social Welfare and Health Board
1-2	Evaluation of last year's completed actions → management team and municipal groups WR drafting guidelines - description of services and welfare of the population, background, indicators	Evaluation of last year's completed actions → inclusion in the welfare report Approval of WR guidelines	Completed annual report (previous year)
3-4		Reporting on the progress of WR drafting	Completed financial statement (previous year); Strategy discussions, including health and welfare promotion
5-6			
8-9	A proposal for conclusions and issues to be included in next year's plan (for the management team)	Health and welfare promotion issues to be included in the action and financial plan (summary, conclusions and proposals for action)	Discussion on health and welfare promotion issues → proposals put forward
10-11	Approval of the health and welfare promotion action plan and matching with municipal plans.		Approval of the health and welfare promotion plan
12			

The structure of health and welfare promotion in the region of Kainuu:

The structure, when implemented, enables consistent and logical health and welfare promotion in the region of Kainuu.



The regional working group on health and welfare promotion in the region of Kainuu has members from all municipalities and the Joint Authority of Kainuu Region. The members are either municipal officials or persons elected to a position of trust. The group also has representatives from organisations and from Regional State Administrative Agencies (the Regional State Administrative Agency of Northern Finland).

The tasks of the group have been specified and the director of social affairs and healthcare of the Joint Authority acts as its president. In the future the group will work in an interactive manner through the development network in the corresponding groups in the municipalities. The members of the regional working group should also be members of the health and welfare promotion working group in their respective municipalities in the future.

The specified tasks of the regional working group are:

- Participation in health and welfare communication, contacts with citizens
- Collection, evaluation, treatment and dissemination of regional and municipal data on the health and welfare of the citizens and on the capacity of the service system to respond to welfare needs
- Strengthening the common knowledge and know-how related to health and welfare promotion, developing good practices and disseminating them in the entire region
- Participation in the drafting of the welfare strategy, reports and plans at regional and local level
- Supporting and guiding the municipal groups of health and welfare promotion in accordance with its expert role
- Linking different actors together

The indicator-based data is presented using the **TEHO-tool**, a tool for local and regional authorities for measuring the welfare and health of the population. TEHO produces visually clear and easy-to-read graphics and presentations based on data input.

Indicators:

- Average retirement age
- Persons with higher education qualifications, aged 15 and over, as % of total population of the same age
- Persons with upper secondary education, aged 15 and over, as % of total population of the same age
- Population aged 75 and over as % of total population

Kainuu
Kainuu 2009

Indicators	Kainuu	Change	Finland
Average retirement age <u>(2008)</u>	57.3	↔	57.8
Persons with higher education qualifications, aged 15 and over, as % of total population of same age <u>(2007)</u>	20	↑	26.2
Persons with upper secondary education, aged 15 and over, as % of total population of same age <u>(2007)</u>	41.6	↔	38.4
Population aged 75 and over as % of total population	9.9	↑↑↑	8

↑ value increase


↓ value decrease


↔ no change or under 5%

↑↓ change at least 5%

↑↑↓ change at least 10%

↑↑↑↓ change at least 15%

 change to positive

 change to negative



situation at least 10% better than in benchmark



no difference to benchmark or difference less than 10%



situation at least 10% worse than in benchmark

4.3 Valencia Region – Action Plan Health

Background information

Inequalities in health are systematic differences in health status between different social groups, which are socially produced. It is not only a phenomenon concerning extreme social groups, but a problem affecting the whole population: a gradual decrease in health is observed with decreasing social status.

The factors causing health inequalities in Valencian Community basically relate to the unequal distribution of the structural and intermediary determinants of health, the same as those recently described by the WHO Commission on Social determinants of Health.

There is evidence demonstrating that inequalities in health are avoidable, so we can reduce them with health and social policies.

In the Valencian Community health policies are set out in a document called the Health Plan that contains the principles and values that guide it and the goals and objectives to be achieved and the strategies and measures for reaching them.

The Health Plan is the expression of the Valencia region health policy based on the population needs, taking account of the structural resources in our health care system and its strategic framework.

The needs of a dynamic, changing society, such as the Valencia Region at present, requires the drawing up of a Health Plan that is suited to these processes and which takes account of the new ways of understanding and, therefore, valuing health.

The Health Plan endeavours to put the concept of health at the centre of the health policy debate. It enables us to establish several health scenarios where people may carry out their daily activities and where environmental, organisational and personal factors, producing real gains in health and

improved well-being, will interact. It is an open document, with its aims subject to revision during its validity period.

The principles of the Health for All strategy were accepted and adopted in Spain in 1990.

All of the Health Plans drawn up by the regional authorities are based on this strategy and many of the regional plans have approximately similar health targets.

The Valencian Health Agency (AVS) is responsible for the health care of 5 200 000 people in the Valencian Community, 16% of this population are immigrants, which we have been able to classify in different groups, thanks to our Population Information System (SIP). 17% are more than 65 years old. Since the beginning of this century the regional Health authority – *Conselleria de Sanidad* has made an important effort to improve information systems and TIC throughout the health network in the Valencia Community.

We would like to highlight the database created for Valencia citizens, called the Sistema de información poblacional – SIP, and the fact that it is linked to all the information systems in primary care, with Abucasis, specialized care hospitals, specialized clinics, public health centres and other health resources making use of information from the database.

Objectives and description of the project/initiative

The Health Plan is a tool of health policy for strategic planning, setting priorities and health targets.

There is a mandate in the health law about it (Health Ordination Law from 2003).

It is based on the values of participation (society and health professionals) and consensus with the Haddon Matrix. Health planning is based on the society's health needs and is associated with the Health Survey that we carry out every five years.

It is related to other government plans like: Equal opportunities for Men and Women, Disabled persons, Immigration, Family planning, Youth planning and other health plans like Public Health, health research and plans for the elderly.

The priorities chosen relate mainly to health problems, habits and lifestyles, but also to health services: Disability and chronic illnesses, determinant factors (lifestyles, environmental, social position).

Priority areas are chosen by health experts from the following: health needs from the previous Health Plan, studies on citizens' opinions about health using the Delphi technique, health and sexuality surveys made previously, expert opinions made by nominal groups' techniques. Also we work with epidemiologic information and previous health plans and other health professionals like status reporters.

The areas are:

- 1 Life styles:
 - 1.1 Tobacco
 - 1.2 Alcohol and drugs
 - 1.3 Diet and nutrition
 - 1.4 Physical activity
 - 1.5 Sexual and reproductive health
- 2 Environmental and health:
 - 2.1 Work related health
 - 2.2 Environmental
 - 2.3 Food security
 - 2.4 Perinatal health
 - 2.5 Childhood and youth health,
- 3 Disease prevented by vaccination
- 4 Cardiovascular and brainvascular diseases
- 5 Diabetes
- 6 Cancer
- 7 Dementia
- 8 HIV/Aids
- 9 Tuberculosis as emerging disease
- 10 Osteoarthritis
- 11 Mental Health
- 12 Injury caused by accidents
- 13 Injury caused by domestic violence
- 14 Sociosanitary:
 - 14.1 Aging
 - 14.2 Palliative care
- 15 Rational use of medicines
- 16 Urgency and emergency care
- 17 Inequalities in health

To analyse the indicators of information systems depending on gender, age, education level, economic level and social class.

Results and achievements

The monitoring of the plan is currently being carried out.

We have developed a monitoring system and the main indicators are: health-related behaviours (sexuality, physical activity, nutrition, smoking, alcohol consumption), occupational class, educational level and place of residence, Age-adjusted frequency measures for mortality, self-assessed health, disability, long-standing illness, chronic conditions, heart attack, obesity.

Potential for replication

Benefit and equality in health, guaranteed equality, information, investment in health, efficiency and sustainability.

So we know the importance of the citizen's criteria for our health planning, we are introducing for the new health plan an innovative element organising 10-12 participative and communication forums with an extensive social representation, with about 200 persons participating in those forum. The new Health Plan will employ a methodology in which participation and consensus are put first by both health care professionals and social bodies; this is precisely one of its strengths, with the public telling us what they need to improve collectively their health.

At the same time we are monitoring and developing a strategic framework that will provide our new Health Plan with fundamental values that guide health policies and promote:

- Participation, information and communication
- Sustainable guarantee
- Health Protection, Prevention and Promotion
- Special attention to chronic illnesses
- Application of new health technologies
- Equity in access to health services

We are promoting the following general objectives, among other things, within the framework of the new Health Plan:

- To develop intersectoral health policy cooperation "Health in every policies", involving every different area or group in improving the health of our population.
- To reduce health inequality, acting to support people who are vulnerable owing to social status, especially children, older people, and dependents.
- To develop more efficient ways to obtain the best opportunities for a healthy life for our citizens and the best level of training to enable patients to look after themselves
- To intensify health promotion activities to foster healthy behaviours and a healthy way of life

- To facilitate citizens' participation from the very beginning of the development of the Health Plan, taking into account what citizens feel about their health needs to guide our future actions.
- To intensify the development of new health technologies to improve the management and sustainability of our health system and to improve the health of the population
- To consider that transmission of truthful and high-quality information from health administrations must be constant throughout the duration of the Health Plan.
- To intensify primary care with a focus on the community and the family, adopting an significant integrated approach
- To intensify health research
- Managing integration with the strategic plan of Valencian Health System to increase the synergy between both health planning and strategic management
- To ensure efficient management of available economic resources in the current economic climate
- To increase cross-cutting treatment of chronic illnesses and improve effectiveness of curative, rehabilitation, and palliative treatments
- To promote patient training and involvement in his or her illness so they take joint responsibility for care

4.4 Region Västra Götaland – Marmot review and Angereds Hospital

4.4.1 Action Plan

Inequalities in health are one of the major policy challenges in Region Västra Götaland. In a regional study it was found that about 70 thousand people aged 25 – 74 (approximately 8 percent of the population) was affected by inequalities in health. The same study demonstrated that if the death rate before 75 years of age was the same among those with the lowest level of education, as compared to those with the longest, the rate would have been reduced by one third. The number of potential years of life lost would have been reduced by approximately 40 percent.

Therefore, in April 2010 the Regional Executive decided to launch a project to review regional health inequalities, also suggesting an action plan to counter such inequalities. The Public Health Committee of the Region was assigned this task.

The Swedish public health policy is based on the assumption that political decisions may influence social determinants of health to reduce inequalities in *the distribution* of the determinants. In the project plan the Regional Public Health Committee suggests that an action plan to tackle inequalities in health should:

- Identify the decisions, initiatives and programmes that, given current knowledge and experience, are the most likely to reduce health inequalities,
- Limit the suggestions to a manageable number, based on the regional public health policy, with a reasonable chance of being implemented,

- Involve municipalities and NGOs,
- Refer to similar ongoing initiatives in other parts of Sweden but also to ongoing work in WHO and the European Union

Some areas will be particularly scrutinized. Poverty among households with children is considered particularly important as are opportunities during pre-school and school years. Other important areas are joblessness and healthy ageing.

The action plan will be framed within a partnership, together with municipalities, regional authorities, universities, research institutions and NGOs. There will also be collaboration with colleagues and networks abroad, e.g. WHO/Regions for Health Network.

The project will be launched in January 2011 and concluded by the end of 2012. During autumn 2011 a conference will be held to sum up and review the status of the assignment.

4.4.2 Angereds Hospital

Angereds Hospital is a public local specialist centre being built in the north-eastern part of Gothenburg city. A new hospital building will be built and completed in 2014. Meanwhile we have 8 clinics that are offering customized specialist care, located in temporary premises. The overall aim with Angereds Hospital is to improve the health of the population in the north-eastern part of Gothenburg. The area is best described as a deprived area, comprising four city districts with 95 000 inhabitants. Approximately 50 percent of the population are immigrants or refugees. The level of unemployment is higher than in other areas of Sweden and the income rates are generally low. The area has a poor health status. Mortality rates from cardiovascular disease, COPD/lung cancer and alcohol-related deaths are significantly higher than in other parts of the region. Problems such as obesity, daily smoking, physical inactivity and stress are also more common in this part of Gothenburg.

Since the start of 2007, Angereds Hospital has worked successfully to create an attractive, accessible and welcoming hospital. We have tried to integrate public health and epidemiology as much as possible.

The key success factors in this work have been:

- The establishment of a comprehensive needs assessment in order to design a hospital based on local needs.
- Successful dialogues with residents and stakeholders in order to identify expectations. We have also been able to obtain recommendations on how to design the hospital and create a welcoming atmosphere.
- Ability to recruit skilled staff with a range of cultural skills. Currently 22 languages are spoken among the 127 employees.

- Focus on diagnostics and screening. The average patients that visits Angered's Hospital often have multiple problems (e.g. diabetes, vascular diseases, obesity, sleeping problems and tobacco use). Patients are automatically screened for other common conditions than the ones they seek medical help for. The patients are also given health education information.
- To create several flexible solutions to increase the sense of accessibility. We accept self referrals, appointments can be made in the reception without prior contact as well as over the telephone. Drop-in appointments and mobile units are used when possible. We have in addition to this designed the examination rooms to accommodate family members and interpreters. Baby care services are also considered.
- Strong commitment when it comes to public health. Carried out as campaigns and strategic alliances in order to address key health issues among residents.
- Focus on marketing and communication. Including a high level of intercultural adjustments (both translations and choice of channels) and in the use of social media.
- Raised awareness of health issues among professionals and formalised structure to integrate health discussions in the patient meeting e.g. to mention smoking in every patient meeting.

The multiple actions undertaken to engage the community have given the project team an overall understanding of what the preferences are among citizens from northeast Gothenburg when it comes to health services. Key findings were that citizens want to feel listened to, that communication with health care providers should be a dialogue (rather than one-way), that they want to be treated in a non stressful manner and to receive information about self care. The staff at Angered's Hospital has undertaken ongoing training sessions in order to create a welcoming atmosphere. They acknowledged that more can always be done to improve the patient experience. The work has resulted in actions in order to give the best possible first experience for the patient. For instance, glass screens are not used at the reception and low tables and chairs are provided so that the first contact with the hospital is comfortable and welcoming.

5. Conclusions and political recommendations

5.1 At EU Level

In our opinion the EU level could and should help regions and local governments to do their jobs. For many European citizens the region, or the equivalent sub-national government, is nowadays the main public sphere dealing with health and health care. Regional authorities are accountable for the health of their citizens. One of the fields where regions can expect help (*subsidiium*) from the Union, in our view, is just in getting to know each other better.

European regions are dramatically different from each other in matters such as demographic dimensions or geographical and climatic conditions. But they and their health care systems do definitively share some challenges and opportunities. They can work better if they know each other. One of the former is certainly health inequalities. We are convinced the present one can be only a small contribution on the road to growing mutual knowledge.

We can see this as a long-term task for European institutions. This task needs the active participation of the regions themselves.

Tools for mutual knowledge can be elaborated, from exchange of good practices to wider benchmarking.

This conclusion of ours appears to agree with the most popular view represented by the 13 entities which contributed to the Questionnaire on “*Assessment of Territorial Impacts of EU action to Reduce Health Inequalities*”, 22 April 2009.

5.2 At Regional level

We do have to know how to exercise our governmental or governance role best.

That means we must be able to carefully collect and process and assess data. But that also means we have to listen to society within our own regions or groups of local governments.

That is individual citizens, families, local communities, associations of ill people and their relatives, “*Volontariat*”, *health care professionals, universities and research institutes and so on*. The paramount importance of the **knowledge about and from our citizens** and their needs is the first conclusion we guess we can draw at regional level.

The second lesson we can draw from our common reflection and the concrete practices we have shared here, is that **we should be able to deal with different geographical and social environments in a different way**. Specific areas may exhibit specific needs, and they should be targeted specifically. We gave here two very different situations. From a complex urban area, to a peripheral depopulated large region. We cannot expect the same measures to work in any environment that is so dramatically different. This, we believe, has the potential for possibly more general consideration in connection with the capacities of our health care system to handle situations which are objectively different, dealing with actual or possible major inequalities which may follow as far as the health care service is concerned.

That leads us to the third lesson we are drawing. **Health care networks represent a major possible solution** to the problem of geographical or “geo-social” actual or potential inequalities.

Networking means having access to services nearer to the citizen. And, no less important, that means ensuring high-quality access. Entering a service which is structured as a network, greatly diminishes the meaning itself of being in a far away point of care or in the city hospital.

Of course we are aware that health care services are part of social resources which should be available to promote good health and better equality, but we guess that is a huge step.

These are not to be perceived as different approaches. They are to be considered as complementary.

This way we could:

- first know the needs;

- then customize the answers to the differences which are detected;
- then we can build networks to put these differentiated answers together within high-quality territorial service.

Nobody should be forgotten, in particular those who are least visible and least vocal.

5.3 Our perceptions

Health Inequalities

- are to be found between as well as within Member States
- are possible to reduce if the (political) will is right
- may be reduced by initiatives on various levels, from the EU Commission through European Agencies to national, regional and Community levels - ending up with a need to support also family and individual motivation and engagement
- may be reduced if there are even better incentives, on an individual as well as on family and local society level, for preventing poor health and promoting a healthy lifestyle

Conclusion: according to the principle of **subsidiarity** different stakeholders are particularly well equipped, have particular skills, to take on different parts of the problems caused by health inequalities.

5.4 Initiatives to be undertaken

- Possibilities at EU level include:
 - common measurements, analyses, reports and benchmarking activities;
 - knowledge gained through research;
 - exchange of knowledge and best practices through publications, conferences, projects and by supporting networks;
 - funding and follow-up of the above-mentioned initiatives
- at national level much can be achieved when it comes to taking an active part in EU initiatives, such as those indicated above, as well as tailoring such initiatives to fit national needs, preferences and cultures
- at regional level, even closer to the populations and often with access to quite strong governmental powers and useful resources, initiatives such as those above may be put into practice, progress followed, data collected and experiences drawn shared with other regions (most of the practices described in the present work)

- at EU level, being yet another step closer to the significant needs of various groups of inhabitants and with possibilities to recognize and evaluate such needs, supporting activities focused on reducing health inequalities may be further integrated and put into best possible practice (example “Angereds Närsjukhus, Region Västra Götaland)
- “learning by doing”, together with others, is an efficient and stimulating way of making progress. To be able to work with a common problem, adding different views and contributing various experiences is very rewarding and a great possibility in today's Europe. To work as part of the working group “Health inequalities” within the SMN Action Plan has been a tremendous learning experience, best suited to being replicated within the health field as well as many other areas.

5.5 Political recommendations to the Committee of Regions

In our view the CoR could, among other things:

- Help spread among the citizens of the EU and its regions a growing awareness of the subsidiarity principle, both in its vertical and horizontal dimensions.
- Ask other European institutions to export this concept also in the health sector, with particular attention to the WHO, where the right relationship between subsidiarity and stewardship in health care should be explored.

For further information please contact:

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EUROPEAN UNION



Committee of the Regions