REGIONS FOR HEALTH NETWORK in Europe

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CONTENTS

Introduction and Summary.................................................................1

Opening..............................................................................................1

Setting the Scene – The Ten Theses......................................................2
  1. Health, Wealth and Regions - introduction and background to the Ten Theses....2
  2. Healthy People are good for the economy - also in the European regions ..........4
  3. ‘Health Region’ North Rhine-Westphalia - what is the political idea?...............6

Discussion on the Ten Theses on the regional dimension of ‘health and wealth’ ..........10

Regions, Resources and Performance ...............................................12
  1. Information for health - operationalizing the regional health economy ..........12
  2. HealthClusterNET – health care boosting regional health development .........14
  3. Governance of Regional Health Systems – the performance of the Regional Health Systems in Italy ................................................................. 18
  4. Human resources for health policies......................................................21
  5. Ways to steer in decentralized health systems ...........................................23

Closure ..............................................................................................27

Annex 1. The origins and development of the WHO European Regions for Health Network ..... 28
Introduction and Summary

The 2007 RHN Annual Conference represented a happy anniversary. After 15 years of successful work, the network returned home – to Düsseldorf – where, in 1992, the founding documents were signed and an ambitious effort was launched to bring European regions together.

Fifteen year later, the WHO Regions for Health Network faced the challenge of a larger Europe striving for political and economical integration and looking for new transnational solutions in health care and health system development. The 2007 Annual Conference contributed to this by providing insight into new international trends – especially in the regional health economy.

There was a special focus on ’regional health and wealth’. The conference considered Ten Theses on the regional added value of ‘health and wealth’, the ways in which healthy people are good for the economy, including in industrial regions, and how the concept of health and wealth was interpreted in the host region – North Rhine Westphalia.

The conference also included practical projects and studies concerned with the health economy and health systems at the regional level. There were presentations on five related topics: two projects – an English project on information technology in the National Health Service and the Europe-wide HealthClusterNET, on governance performance of regional health systems and on human resources for health policies, and on ways to steer in decentralized health systems. Working group sessions discussed issues arising out of each of these five topics.

A summary of the Ten Theses was presented at the RHN Ministerial Forum, held immediately afterwards, for adoption and signature.

The Conference included an exhibition and presentation to celebrate the Network’s 15th anniversary.

The conference contributed successfully to the formulation of an important and promising policy proposal (health and wealth), which will be further developed within the WHO, EU, national and regional contexts, and offered the opportunity for in-depth discussion of various aspects of regional health policy more generally.

Opening

Dr Helmut Brand, Director of the North Rhine Westphalia (NRW) Institute for Public Health in Bielefeld (Lögd), and the focal point for the region with the Network, opened the Conference. On behalf of the host region, he welcomed those attending from the World Health Organization (WHO), the member regions of the RHN and the European Union, and said that the discussions offered an important opportunity to influence the 2008 European Ministerial Conference on ‘Health and Wealth’ in Tallinn.

Dr Francois Decaillet, the Senior Adviser and WHO European Regional Office Representative to the European Union, thanked Professor Brand on behalf of Dr Marc Danzon, the Regional Director of the WHO Regional Office for Europe (EURO). He congratulated the network on its
15th anniversary and on its achievements. He said that WHO – at all levels and working together with many other stakeholders – had made considerable efforts to improve the understanding of the relationship between health and economic development and raise awareness on the need for investing in health.

Examples were the report of the Commission on Macroeconomics and Health and in Europe the work with the Council of Europe and health and finance ministers in the Balkans to produce the analysis of Health and economic development in South-Eastern Europe. At the global level, it there was now greater recognition that health is a key determinant of economic development and poverty reduction.

He stressed the fact that the Regional Office for Europe was currently in a dialogue with all European countries on health systems, health and wealth, which was the central theme of the next European Ministerial Conference, to take place in Tallinn, 25–27 June 2008. Preparations for that conference took into account that many European countries had decentralized health systems and that regions played an important role. He wished the conference success.

Mrs Shouka Pelaseyed, the WHO/EURO Focal Point and Technical Officer for the Regions for Health Network, welcomed all present and thanked the host region. The meeting agreed the choice of a chair and rapporteur.

Setting the Scene - The Ten Theses

1. Health, Wealth and Regions – introduction and background to the Ten Theses

Dr Josef Hilbert from the Institute for Work and Technology (IAT) at the University of Duisburg/Essen in Gelsenkirchen spoke about the development of the Ten Theses. He had done so in collaboration with a number of colleagues. He said its basis was an appreciation of the power of the health industry to create jobs in an area where jobs were disappearing.

The background was the established view – dating back to Bismarck (in Germany) and Beveridge (in the United Kingdom) – that health care is a social and political duty of government. Their aim had been, through creating social safety nets, to avoid political turmoil, improve human capital and meet the obligation to provide support to the population.

The authors of the Ten Theses had considered how this related to regions. Since many considered health as a basic social right and the public had expectations about health and often clearly made these known, regions that clearly responded to the health agenda would win the approval of their citizens. Furthermore, he said, high-performing health care systems contributed to strengthening the regional economy, and health in itself was a promising industry. Health should therefore be seen not as a burden on the economy but as a motor for development, especially in relation to high technology.
He said that the health sector extended far beyond hospitals, doctors and nurses, and presented an ‘onion model’. Around a core of health service providers were a range of other services and activities. In this situation, many organizations could see if they could find a market opportunity, such as developing health tourism or safe housing. He said that already 4.5 million people in Germany worked in this sector, compared with about 1 million in the motor industry. This was the most promising industry for the future, and the fastest growing in the world. In Germany, the sector’s value was €250 billion a year, about the same as the motor industry. The main drivers were ageing, technical development and people’s willingness to pay more to protect and develop their own health.

Healthy people are key to a productive economy. Health had links to individual and social security, and to learning capacity and employability. The latter are especially important in the sort of knowledge economy now developing. It also gave an incentive to invest in individual well-being.

A weak health care system would lead to health deficits; a strong system would have significant economic benefits. These included jobs, a demand for a broad set of skills, opportunities for local procurement, and poverty reduction by means of improved access to health and improving employability.

Health care was not just a precondition for economic development with positive economic side effects. In advanced regions, the health system was the biggest job provider, and a hidden champion of structural change. In North Rhine Westphalia, it had created over 1 million jobs in the previous two decades. Dr Hilbert said that health was ranking higher and higher in people’s and consumer preferences. Health was the main field for modern high technology applications, with some 50% of innovation in nanotechnology, biotechnology and microtechnology being health-related.
Health products and services were expected to become the world’s largest growth industry over the next 20 years. Against this background, a paradigm shift was occurring, with health no longer seen as a drag on the economy, but rather as a self-sustaining and dynamic sector of industry. He said that the Ten Theses were valid not just for Germany and similar countries, but also for the developing world.

However, a question that inevitably arose was what this would mean for the rest of the economy; might it weaken it? His response was that regions were already alert to the possibilities health offered as an economic powerhouse. Health services were of course already provided on a local and regional basis. There was a strong and developing international market for life sciences, health service design and medical expertise. High performing health regions could seize the opportunity to join this market, and enter into international cooperation and exchange. By targeted cooperation with medically advanced players, even weaker regions had a chance to make progress.

Concluding, Dr Hilbert said that the attraction of regional investment in health was that it married social rights, duties and responsibilities with the dynamics of a self-sustaining sector of industry, achieving a powerful synergy. Health spending must not be thought of or allowed to hobble the economy, rather it could have a multiplier effect and a stimulating impact on the economy, acting as a driver of technology, private consumption, and exports, and as a job generator. In this way, the traditional welfare state could mutate into a change agent in a modern economy.

2. Healthy People are good for the economy – also in the European regions

Dr Francois Decaillet said that his purpose was to present arguments that might help persuade policy-makers of the value of investing in health. He said that he was a public health specialist, not an economist, but that he had spent many years working closely with economists. His intention in his presentation was to consider where investment should be undertaken, how much should be invested, and who should invest and pay.

His immediate response was that these questions were difficult to answer, as both theoretical work and empirical evidence was lacking, so that there was no unequivocal answer. For long, health had been seen as a by-product of economic development, and so the focus for investment had been the economy itself. Much of the research had therefore looked at the relationship between health and economic growth, mainly focusing on developing countries. Only relatively recently had there been research on the importance of human capital for economic growth, and there the main interest had been in education. An indication of how recent the change had been was that the World Bank’s World development report: investing in health had appeared only in 1993. Although there had been more studies since then, the landmark Commission on Macroeconomics and Health had also mainly looked at developing countries.

He then reviewed some of the evidence. One focus had been the cost of illness. Its importance in terms of both the direct cost, including loss of productivity, and the cost of treatment was undoubted. The cost was higher in more developed countries.

There was also evidence relating to the macroeconomic effect – the effect on the national economy, but the results were not definitive. The historical contribution of health to economic
development was high, and, drawing on for example studies of the United Kingdom suggesting that 30% of growth had been due to improved health, it was estimated that 30–40% of today’s economic wealth was derived from health. The findings of Beraldo and his team suggested that in some cases, health improvement had had a greater impact on growth than education. Cross-country studies suggested that a one-year increase in life expectancy corresponded to a 4% growth in GDP, and that for high-income countries a 10% fall in cardiovascular mortality triggered a 1% rise in GDP.

Dr Decaillet said that there was a need to look also at the microeconomic effects, the effect at the individual and household level, where there were three sorts of argument. The first looked at labour productivity, labour supply, education, wages, earnings and savings. The second related to the impact on retaining and attracting people, and he said on this that, though there was little evidence to date, it was an important issue in light of the ageing of the population. It was clear that, where the health system was poor, people would try to move away to where prospects appeared better. He cited the flow of immigration to Lozère, where life expectancy was high. A third issue was the role of the health industry as a driver for employment, innovation and growth.

He proposed a framework that showed how health might influence the economy through its effect on labour productivity and supply, and through education and savings. There was quite good evidence that better health led to more work being done. Poor health on the other hand had been shown to lead to early retirement, and could affect the availability for work of relatives of those in poor health. There was good evidence for the links between education and health, but that for the impact on saving was not so strong.

His conclusion from reviewing the evidence was that a well-nourished, healthy, educated, skilled, alert labour force was the most productive asset, and that this was especially true today and for Europe, in a globalized world, with changing patterns in the economy and an ageing
population. This suggested a strong case for generating more evidence, and especially more directly European evidence, establishing both the economic rationale for government intervention and the cost-benefit basis of intervention (especially in relation to prevention). Finally, he drew his audience’s attention to the 2005 book The Contribution of Health to the Economy in the European Union, written by Marc Suhrcke and others and published by the European Commission.¹

### 3. ‘Health Region’ North Rhine-Westphalia - what is the political idea?

Uwe Borchers from ZIG, the Centre for Innovation in the Health Economy, in East Westphalia-Lippe, gave the presentation on behalf of his colleague Mathias Redders. His intention was to explain the political rationale underlying the concept of North Rhine-Westphalia (NRW) as a Health Region, and its practical prospects. His presentation had two parts. The first set out the rationale, and the second looked in more detail at the health cluster in the East Westphalia-Lippe area of NRW in relation to its role as a regional network and methods of cooperation management.

On the first, he said that, particularly in those sectors where structural changes in NRW had led to job losses in recent years, new jobs had been created in the health economy sector. More than 1 million people were working in the sector, and up to the year 2015, an increase of up to 200 000 additional jobs was anticipated. The target was to make NRW a leading region in health economy in Europe and beyond.

NRW’s minister for employment and social affairs, Karl-Josef Laumann, had a fully developed concept for the promotion of the health economy, comprising several steps and based on five priorities.

1. The first was a state-wide competence centre for the health economy. NRW’s Premier, Dr Jürgen Rüttgers, had commissioned the health ministry to set up an institution, pooling the competences in health economy in a “network of excellences”. Working with international institutes, this would give incentives for further development of the health care system in NRW. Talks had been held with companies, research institutions and organizations of the health care system, and the organizational structure, main activities and way of working of this new institution were to be made public in December 2007.

2. The decision to establish a Cluster on “Health economy and application-oriented medical technology” was made in March 2007. It was the first in Germany, and by far the biggest in NRW. Clusters were a well-known concept and intended to contribute to establishing highly competitive associations within a value creation chain.

3. One of the biggest competitions launched within the framework of NRW’s cluster policy was launched in November 2007, in order to discover the best ideas for an innovative health economy in NRW. Through the targeted promotion of innovative services and products, the quality of medical care would be improved on a sustainable basis, while at the same time developing new areas of economic growth in the health economy. Existing jobs would be secured, new future-proof jobs created and the position of North Rhine-Westphalia as a competitive location for the health sector strengthened.

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It would act as a catalyst for innovation for: products and/or services in the field of prevention and occupational health promotion; application-oriented medical technologies; telematics in health care including telemedicine; innovations for hospitals; health and wellness spas; and regional and state-wide cooperation structures in health economy. For this initiative €70 million including EU funds had been earmarked, which would mainly sponsor cooperation projects, above all those dealing with the transfer of research activities and results into marketable products and services.

4. A further main priority of the competition, in line with the focus across this concept, would be the setting up of regional health economy structures in the five very different regions NRW: the Ruhr area, the region of the Münsterland, East Westphalia-Lippe, the Cologne/Bonn area and Aachen. Each region should be allowed to create an image for itself as a health region with its particular strengths, following a common approach. The first step would be, based on an analysis of the actual situation, to draw up regional development concepts – “perspectives”, which would be made public in the region. Those adopted in regional conferences, comprising the relevant local authorities and chaired by the State Secretary, would be implemented. In East Westphalia-Lippe, development concepts had been agreed with the municipalities, the health care sector, industry and research.

5. There were to be lead projects, to show what cooperation between the health care sector and industry could look like in practice, for example, one on telematics infrastructure for health care. In this, all the hospitals, doctors’ and pharmacists’ associations, and hospital societies were working with leading health care information and communication technology providers and NRW’s commissioner for data protection. An estimated minimum of €500 million would be invested in telematics infrastructure within the following five years.

The electronic doctor’s letter project, launched in October 2007, for the first time allowed a structured doctor’s letter to be sent, signed with an electronic Health Professional Card and containing master data and diagnoses, a patient’s case history, and findings, including laboratory data and even images. As the letter was based on a world-wide recognized standard, it offered the basis for a major international breakthrough.

Uwe Borchers then described the cluster of East Westphalia-Lippe. The region of East Westphalia-Lippe had over recent decades lost jobs as the economy changed, but had gained jobs in the health sector and had very solid foundations for development that could both improve health care and support economic growth. The health economy sector was the industry with the highest number of jobs, employing almost 120 000 people. As part of further development of the health cluster concept in the region, the first of what were intended to be annual meetings of Regional Health Economy Conference was to be held in January 2008. The regional health economy had a number of great strengths including:

- modern health care based on state-of-the-art medicine;
- a strong tradition of science and research, education, and basic and further training;
- rehabilitation and prevention facilities including 21 of the 42 health and wellness spas in NRW, which in recent years had very clearly focused on modernization strategies, and been complemented by new projects and services in the fields of prevention and health promotion, with particular reference to children and young people, women’s health, occupational health promotion, nutrition, cardiovascular diseases and diabetes, as well as sports medicine;
• telemedicine and e-health, with a range of experience including solutions for medical care in telediagnosics and telemedicine as well as services in geriatric care and nursing through telecommunication and telecare;
• life sciences, reorientating the traditional university natural, biological and technological sciences, with a focus especially on genome and cell research, development of technologies for the support of research and generation of new products, and man-machine-communication; through spin-offs, universities contribute to the setting up of a wide variety of industrial businesses;
• services revolving around living for older people’s accommodation, the driving force being the local and cooperative housing societies; and
• links across health, wellness and tourism, using the highly attractive landscape and existing health infrastructure, and the growing interest in fitness, spas, beauty and lifestyle.

The area had a large number of leading companies in the field of health care and social work and together all these elements offered a very strong basis for economic development in relation to health and well-being. A development agency had been set up with more than 30 partners, and the Ministry of Health had established an agency to support economic development in this sector across all the regions of NRW.


Jeni Bremner, the Director of the European Health Management Association (EHMA), started by describing her organization. She said it had been founded in 1980. It was a European membership organization with over 240 institutional members in 27 countries. It was committed to improving health care in Europe by raising standards of managerial performance through fostering activities between health service organizations and institutions in the field of health care management education and training. It also targeted better health. Its members included policy makers, senior managers, academic institutions, research organizations, and educators.

She then discussed the impact on health of the European Union (EU). She said that it had competence in relation to the determinants of health, and health promotion. In relation to the financing and organization of health systems, which were national matters, the EU had an interest in the impact of patient mobility, which had become a major issue. Successive Presidencies had also moved the agenda forward, with the Finnish interested in ‘health in all policies and the Portuguese in migrants.

The new EU Health Strategy ‘Together for Health’ was based on a number of core values – universality, access to good quality health care, equity and solidarity, and the Council of Ministers had invited the European Commission to integrate the dimension of gender as the strategy developed. The strategic approach for the period 2008–2013 addressed three key problems:

• the ageing population, which had significant implications for resources, not just money but also carers, and implied a need for much more effective investment in prevention, to reduce dependency and increase healthy years of life;
• threats to health, such as physical and biological incidents, bioterrorism, and the impact of climate change; and
• new technologies, such as ICT, genomics, bio and nanotechnology.
The response was based on four principles – shared health values, health as the greatest wealth, integrating health in all policies, and strengthening the EU’s voice in global health. It had three objectives:

- fostering good health in an ageing Europe
- protecting citizens from health threats
- supporting dynamic health systems and new technologies.

Clearly, delivering the strategy had become the vital question. She said that the funding in the second health programme was rather less than before and the mechanism for implementation was still unclear, though, if there was a new approach, she suggested there might be an enhanced role for regions. Implementation would be linked to a new directive on cross border health care that was imminent.

In relation to the tasks that now faced countries and regions, she said that good health in an ageing Europe was a serious challenge in terms of the care agenda, housing, transport, and social infrastructure. Caring was already a big industry and source of employment and securing staff would be an issue, as well as technology. Better health would require action on the prevention agenda, transport, economic and social regeneration and employment, improving the influence of the citizen and tackling inequalities. This last must be seen as going far beyond just advice around diet and exercise. Services need to be more citizen-focused, and more balanced. This would require far better evidence about community-based as against hospital-based services. Professional mobility was also an issue – and regions would need to ensure that they were attractive to mobile professionals.

She cited a number of nongovernmental organizations (NGOs) which could assist regions in implementation of the strategy and in furthering their own aims, including her own organization – EHMA, EuroHealthNet, EUREGHA, HealthClusterNET, which was also represented in the meeting, the European Public Health Alliance and other representative associations. She said that EHMA was already working with the DG SANCO of the European Commission and other stakeholders including EuroHealthNet, EUREGHA and HealthClusterNET, and one issue was around what sort of health professionals could advance public health and health development.

There were a number of risks to progress. One was the tension between improving health and the broader policy agendas of the EU and countries, which might prioritize reducing regulation to foster competition ahead of health. Another was the need to be sensitive to regional variation.

Evidence might be an issue. Health impact assessment certainly brought evidence into the political arena, but posed the problem that, as it is easier to assess the impact of health care than broader based public policy actions, more evidence might be generated for health care than other options, and health care might seem more attractive for investment. Similarly, the opening of debate to stakeholders might allow the well-funded, well-connected commercial lobbies to drown out the voices of citizens. To counter this, regions might use NGOs to support citizen engagement. Above all, regions needed to address the urgent need to improve public health capacity.

She concluded by emphasizing that the proposition that ‘Health is Wealth’ is an important EU agenda, and that the overall health agenda is going to get more important not less. Regions
would be fundamental to delivery of ‘Health is Wealth’, and NGOs can support the regional voice as this agenda develops.

**Discussion on the Ten Theses on the regional dimension of ‘health and wealth’**

Dr Brand then introduced a general discussion. Dominic Harrison, the Deputy Regional Director of Public Health for North West England, said that this was one of the most important issues facing Europe, but that there was a danger of adopting a neo-liberal model. He proposed an alternative model – that health was the result of all the collective structures and actions of society. This required a constant questioning of existing policies, for example challenging the EU’s approach to unhealthy food production methods. He said the issue was to secure a balanced set of policies.

Carlos Pereira Alves from the Portuguese Association for Hospital Development (APHD) said that there was a challenge in balancing health and health care on the one hand against the commercial interests of the health business. Citizens wanted health and well-being. He cited Voltaire who said ‘I decide to be happy, because it is good for my health’. As a doctor, he said that he was worried that reforms were turning doctors into technicians.

Jérome Boehm from the DG SANCO of the European Commission said that the importance of regions had been accepted by the European Union, but it was unclear how they would be involved. He said that only 10 regions had responded to the draft strategy, 8 of them from the United Kingdom. Regions needed to be more active. He cited Italy, where a structure allowed regions to agree a common position, and suggested others might do the same. He also suggested that regions contribute to future consultations. He also drew attention to funding that the EU provided and suggested that regions might use some in responding to Dr Decaillét’s challenge about the need for more evidence, and might also look at how to use regional funds better.

Dr Marco Biocca, from the Regional Health Agency of Emilia-Romagna, argued that change could not be left to the market system, because the social context, the need to support individuals and what people understand would influence the health care network.

Dr Brand said that the issues emerging related to governance in relation to both the industry and social institutions, and also how to handle inequalities.

Dr Hilbert, responding to Mr Harrison, said that he agreed that it was not a matter of letting the system just run ahead. The biggest challenge was ageing. He said there must be more investment in prevention strategies, and in public or obligatory insurance. If people wished to invest more in their own health, that was good both for them and for jobs. There was also a need for more voluntary action.

On governance, he said that this was a regional matter. Innovation came from the regional level. Collaboration at local level was the basis, with caregivers, professions and others involved, and perhaps major players, such as major chains. Regions were capable of self-organizing as drivers of change, but of course needed help from governments and European bodies, and needed to exchange information.
Dr Brand noted the novelty of the idea that what is good for the economy was good for health. After all, the Minister for Health could not control finance and industry. How could bad investment be avoided?

Carlos Pereira Alves said that the basis must be the evidence, and suggested that the best economics was good clinical practice, which balanced costs and benefits.

Neil Riley, Health Knowledge and Intelligence Adviser, with the government of Wales, said that he could see the benefit for NRW of building on their spas and pharmacy industry, but wondered whether others had a similar opportunity. Was this a NRW solution designed around the NRW situation?

Uwe Borchers said that governance arrangements and development would be different in regions, depending on their local circumstances. Some had strong NGOs. He said that the approach in NRW had been rejected 15 years earlier and so its advocates had developed local projects bringing together entrepreneurs and hospitals, taking the example of the car industry. Discussion among information technology experts, engineers and doctors about how to reduce patients’ stay in hospitals had led to the creation of a telemedicine centre. Modernization of the clinical process could use good elements from industry.

Dr Hilbert said that to ensure success, industry must combine evidence with high quality. Competition could drive high quality and generate information for the public. However, there must also be an active state to support the process.

Jeni Bremner said that there was a need to look at both the vertical and the horizontal dimension. The basic problem was complexity. Hospitals had to engage with the community and avoid making doctors into ‘machines’. This required political leadership. The shift of focus to the community required close engagement with the community. There would need to be careful consideration about how the health market developed over the longer term.

Dominic Harrison said that there was a danger of confusing the health system and the health industry. He said that the public were willing to pay for non-evidence-based health products. He said that there should perhaps be a wellness system, as there was no system to manage wellness.

Dr Brand said that the debate was addressing health, costs and benefits. Perhaps the evidence-base was less important for wellness products. There was a need for clear definitions and some guidance on the governance issues. He thought that regions already worked as clusters, and that probably all regions wanted a health cluster.

Uwe Borchers disagreed, as building health was a task for society, and a health industry was not essential everywhere. There were two issues. Those with poor health needed care. Those who wanted to pay for health could do so. A framework could bring the two together, where all concerned could talk face to face.

Dr Brand said that countries would need additional staff as the population aged. Where would they come from?

Jeni Bremner said that employers had a major role, and there might need to be entitlements for staff, as in the case of childcare. In addition, people might offer care when younger and create an entitlement to receive care in their turn when older. Competition to attract carers would grow.
Dr Hilbert said 80,000 people spent retirement in southern Europe and north Africa. This needed further research. Perhaps it offered opportunities for regions to work together, perhaps collaborating on investment and research.

Carlos Pereira Alves said that Europe needed reference centres to support very rare conditions, and each country needed them for more common conditions. The health system should be free when needed but all should pay for what was not needed.

Uwe Borchers noted that Poles working in Germany were in practice supporting their parents and Germans were supporting their own compatriots living in Germany.

Dr Göran Henriksson, Senior Public Health Adviser in the Västra Götaland Region, said that it was essential to see the Ten Theses within the environmental context. Both globalization and localization were important. In his region, Gothenburg was a magnet for development and was attracting people from the country, which led to a redistribution of health chances. This should be addressed in the paper.

Dr Brand concluded the discussion.

**Regions, Resources and Performance**

**1. Information for health - operationalizing the regional health economy**

Dr Jeremy Thorp, the Director of Business Requirements the United Kingdom NHS Connecting for Health project, said that he was going to speak about a Regional Approach to ICT (Information and Communication Technology) in England. He was himself an IT professional with the Technology Office of the National Health Service (NHS) in England, within the United Kingdom. His topic was how could information technology support health professionals and patients in sharing and exchanging information, through making use of the range of architectures and standards available.

The background was the report of a banker, Sir Derek Wanless, who had been asked by the United Kingdom government to report on how best to invest in health care. One of his recommendations was that, because investment in IT was so small, compared with a say a large bank, the level of investment should be greatly increased.

The essential argument for change was that the NHS relied too much on paper systems. This meant that it was difficult to find information or link information produced by different clinicians. The need was an information system for the 21st century, and the aim of the project was to support the implementation of broader government policy for the NHS. In 2002, this had included making care more patient-centred and offering greater choice to patients, providing more local care and greater autonomy to providers, introducing private providers but in a managed way, a strong emphasis on standards, and better use by professionals of IT. The project aimed to support this by ensuring that those who gave and received care had the right information at the right time, the fragmentation of care was reduced, and policy and research improved.
The intention was to provide a long list of clearly defined benefits to patients, including greater choice about services and support and confidence that professionals had accurate information both on the problem and on the best treatment. Health professionals would get ready access to information about patients when, where and how they wanted.

The programme contained a number of elements. IT infrastructure and broadband would be available to the whole English NHS. There would be an individual electronic NHS Care Record for every patient in England, and a central e-mail and directory service for the NHS. An electronic booking service would offer patients greater choice of hospital or clinic. There would be a prescribing and dispensing service and a PACS system (picture archiving and communications system) able to capture, store, display and distribute static and moving digital medical images. The scale of the programme was huge – it would include over 20,000 connections and nearly 300,000 users.

Reviewing progress, Dr Thorp said that the policy context had changed little between 2002 and 2007 and there was still a strong commitment to IT as a means of enabling the achievement of policy goals. Patient information available under the project included signposting to useful web sites to support personal health and care choices, and access to individual patient records. A great deal was being done to support those commissioning health services, in relation both to population health needs and to data comparing the performance of providers. For providers, the aim was to help a shift towards patient-based care pathways, and give them far better information on costs and service quality. A comprehensive set of indicators was under development, following a logical path from population needs, through expressed demand for services and an assessment of the performance of services, to population outcomes.

Current aims included to ensure that patients were both empowered and active, that all organizations were providing services appropriate to the needs and choices of patients, that there was real-time information, and that social care was brought within the project’s scope.

Concluding, he referred to opportunities open to regions to build their own projects in this topic area. One was the development of e-health ‘roadmaps’ within each Member State. Regions could also deliberately try to learn from the experience of others (e.g. from his project). Certainly, they should aim to take advantage of technological advances and standards. Finally, he mentioned that regions might wish to take up the opportunity presented by the EU Call for Proposals for ‘Large-Scale Pilots’ to enable inter-operability across Europe.

**Workshop on information for health**

The session commenced by further analysing the programme presented by Dr Thorp, and the benefits it was aiming to achieve for clinicians, managers, government and patients. Its focus was on developing four components: the infrastructure throughout England; a better flow of information between providers and commissioners; better provision of information in differing published forms; and the National Care Records Service, which gave online access to patient records, eliminating paper transactions. Dr Thorp thought that this investment was going to improve substantially the health system by improving efficiency and effectiveness for all participants in health.

He said that discussion in England focused on three main issues: confidentiality, data protection and security; the creation and use of standards for the 21st century; and the need to work with clinicians and patients.
There was discussion about the implications of the National Care Record System for patients’ rights and expectations of data security. Dr Thorp explained that the level of access to the information would depend on need. For example, a clinician could only open a record in an emergency, in relation to care, or with prior patient authorization, in a fully auditable system. Participants related experiences in their own regions and endorsed the principle behind this approach, while recognizing potential difficulties both in the development of the technology and in convincing and educating patients and clinicians about its validity.

There was discussion about the need for standards in recording information. An example from Portugal showed how subcultures of shorthand had emerged within health care settings, creating difficulties in exchange of information between locations. In addition, standards were needed to enable the inputted information to be of use to clinicians and for secondary analysis. This was especially important as the European population became increasingly mobile. It was noted that the WHO standard for coding mortality and morbidity, ICD-10, had not been completely implemented across Europe. The group believed there was scope for communication with WHO and the European Commission to ensure that there were standards.

The final strand of the discussion examined the need to engage with all sectors health care systems, especially patients and clinicians. Dr Thorp said that in his work clinical involvement was very important and that patient groups ensured that the work was patient-centred. This was considered essential to make systems fit for purpose.

The group concluded by recommending that:
- investment in IT was important and could support better use of existing resource.
- in developing IT systems patients, clinicians and other participants in the health sector must be involved to build trust and give endorsement
- Standards should be developed and implemented to support the best use of information resources and to allow for Europe’s mobile population.

2. HealthClusterNET - health care boosting regional health development

Tony Batty, from the United Kingdom Department of Health, said that he had worked in the area of Health and Wealth, particularly in relation to economic development for a number of years. For the previous three years, he had been involved in HealthClusterNET at lead partner and network partner level. The final conference of the Interreg IIIC project phase had taken place in Brussels the previous week.

His region, North East England, was the smallest in England with a population of just over 2.5 million. With a history of primary industries and engineering, such as coal mining, steel production and shipbuilding, the region had struggled with deindustrialization. In both health and economic activity, the North East ranked at or near the bottom on most indicators. There had been substantial improvements in recent years, but the distance from the best performing English regions remained very challenging.

The Department of Health had begun looking at the opportunities for developing health and economic activity in parallel, through joint work at regional level, in about 2000. This was in part a response to the creation of Regional Development Agencies in 1999, whose role was to lead a regional focus on economic development, primarily through a regionally developed and owned Regional Economic Strategy.
Following the publication in 2002 by a British health services research centre, the King’s Fund, of an influential report, Claiming the Health Dividend, a study identified the contribution of the National Health Service (NHS) to the regional economy in North East England. Over the following couple of years, a simple framework was developed in relation to the economic aspects of health and wealth:

- Health and Work, the importance of having a healthy population as an input for economic activity;
- Work and Health, the role of employers and the workplace in promoting and improving health; and
- the NHS as an economic entity.

In 2003, a small regional project began entitled ‘Maximizing the Contribution of the NHS to the North East Regional Economy’. Building from this, two years later, following a lot of preparatory work, including several meetings with prospective partners and one failed application, a European Collaboration, HealthClusterNET was approved.

HealthClusterNET was an INTERREG IIIC project operating under the network model. It comprised 13 regional partners from 12 European countries. Partners ranged from universities to regional governments. The North East of England Regional Development Agency acted as the lead partner for the project.

Total project funding was just over €1.5 million, including €0.96 million funded through the European Regional Development Fund (ERDF) and individual partner funding from €15 000 and €182 000. It began on 1 April 2005 and was due to end on 31 December 2007.

The overall aims of the project were to:

- share examples of policy development and good practice relevant to the four HealthClusterNET knowledge themes;
- identify and sustainably exploit regions’ potential, increasing engagement with their own health and economic systems, and strengthen regional policy and planning in the four selected areas of cooperation;
- ensure durability by achieving recognisable results and disseminating them publicly;
- strengthen regional administrative capacities in order to maximize the value of regional assets; and
- influence policies and other instruments at regional, national and EU levels, based on insights developed by Health ClusterNET.

Mr Batty said that the project had achieved all these aims.

The four knowledge themes were local procurement, inclusive employment, capital investment and managing innovation. These were chosen based on an analysis of public sector health care spending by the NHS in North East England, as the major spending areas, which therefore had the potential to make most impact, to a greater or lesser extent, on the regional economy for all European health care systems. They fitted closely with regional economic drivers (productivity,
entrepreneurship, a skilled workforce, a knowledge economy, infrastructure, and community regeneration) and were consistent with the Lisbon Agenda.

The project adopted a modular approach to each of the themes, which ran broadly consecutively during the project. For each theme, there was first a workshop, where regional representatives presented examples and case studies of relevant activity in their region. Network partners were then encouraged to discuss as widely as possible within their region what they had seen and learned at the workshop. At a further meeting, described as a Policy Forum, the regions discussed and reviewed each other’s feedback and experience as a way of identifying and agreeing key issues and developing policy recommendations.

From this emerged four Policy Agendas, one for each theme and each named after the hosting region. These agendas were made available to policy makers at regional, national and EU level. For each knowledge area, he selected one recommendation as an example.

On procurement, addressed in the Bilbao Agenda, considerable differences were found in defining ‘value for money’ across the network and the EU, ranging from lowest cost to delivering organizational goals. One interesting approach developed in the United Kingdom was the LM3 or Local Multiplier 3 model, which aimed better to represent the value of goods and services to the local community.

On capital investment, addressed in the Graz Agenda, an issue was the need for better coordinated cross-sector integrated planning on capital schemes, which could substantially improve benefits to communities, particularly regarding services and regeneration.

On inclusive employment, addressed in the Pecs Agenda, a need was recognized for better coordinated cross-sector manpower planning information, to help training providers to ensure that the labour market better reflects the skill needs of the region.

On managing innovation, addressed in the Liverpool Agenda, a need was identified for health care organizations to work with business development agencies in the transfer and exploitation of intellectual property, to improve services to patients and create dynamic local and regional business communities.

He said that the complete Policy Agendas were available on the project’s website, along with regional case studies and a wide range of supporting resources. The network was also developing a wider Consumer Guide, to include tools offering practical help to regions.

He identified some lessons from the project:

- all regions contained health sector assets that could support regional economic growth and social cohesion; often there was a need to look at these from a slightly different perspective;
- to leverage these assets effectively, there was a need to look beyond institutionally and professionally defined policy fields;
- the skills and experience needed might not be those currently the focus of investment; there needed to be wider strategic understanding in institutions and professions of the Health and Wealth agenda encouragement to managers and policy makers to work outside their traditional areas; and
• no single approach would be valid for all; evidence, policy and action might be better framed through either (i) common foundations, i.e. where regions had similar systems, or (ii) regional clusters, i.e. where there was shared development and thinking.

Mr Batty said that HealthClusterNET had been invited to join a working group co-hosted by the Commission and the European Health Management Association to develop a coordinated approach to the health sector investment and Structural Funds agenda. It was intended that HealthClusterNET would continue as a not-for-profit paid membership network, supporting its members and undertaking funded projects and wider policy activities across Europe, and invited the audience to look at its web site. Project partners were considering new proposals under the European FP7 and INTERREG IVC programmes on sustainable procurement, regional centres of excellence, health innovation hubs and nodes, and integrating health into regional master planning, and he offered to act as a link to these.

Commenting at the end, Dominic Harrison said that the value of the project had been in developing evidence that investment in one area could show an impact in other sectors. Mr Batty agreed, adding that it had helped health sector managers better understand the contribution of health care to the achievement of broader policy objectives.

Notes from the workshop on health care boosting regional health development

The discussion took place around the four knowledge themes that had been developed by HealthClusterNet.

On procurement, addressed in the Bilbao Agenda, there were a number of findings about how countries had different approaches. Procurement in the United Kingdom, for example, tended to focus on long-term ‘best value’ rather than just low price. The approach was to start from European Union rules and consider the freedom that they allowed. An aim was more local procurement but not based on subsidy.

Communities of action supported analysing the local situation to identify gaps and work with agencies to fill these. Use of data was often poor. Used imaginatively, information could be used to identify opportunities for supplying products that had to be acquired from elsewhere. It could also identify what organizations did well and opportunities for expansion.

Another finding in the United Kingdom was that a large proportion of suppliers did not want to supply the private sector and that the private sector did not want to deal with small suppliers.

On capital investment, addressed in the Graz Agenda, there were issues around what working model was best, and how information and communications technology should be used. There was discussion about whether a regional integrated development programme was better than a master plan.

On sustainable development, issues included for example the advantages of e.g. greenfield compared with brownfield sites.

On inclusive employment, addressed in the Pecs Agenda, there were two issues – professional employment and social employment.

Wider community role of the health sector raised interesting questions – was there a moral role for public sector to help excluded groups through its employment policies? How far should work be seen as helping well-being, and how far should public sector employers be seen as exemplars? Should the public sector consciously increase the pool of trained employees by accepting that is should let staff go rather than retain them? This raised the question of whether there should be intersectoral workforce planning. In
practice, health services tended to have a monopoly in relation clinical staff, and a semi-monopoly in the case of technical and scientific staff, while other grades could work anywhere.

Other issues that the initiative looked at included economic integration, health tourism, healthy work places and workforce regulation. This included the role of the latter in how to keep older people active.

On managing innovation, a need was identified for a regional development organization, and shared stakeholder values. There was a need both to promote innovation in organizations and to combat the attitude that suspected or rejected outright ideas from outside. Innovation could benefit from a regional innovation infrastructure, which aimed to both promote and exploit innovation.

3. Governance of Regional Health Systems – the performance of the Regional Health Systems in Italy

Professor Vittorio Mapelli, of the University of Milan said that ten years previously he had written on the effect of the health sector on the economy. He was now interested in the effect of spending on outcomes in the sector. Did Germany, which spent 11% of its income on health care, get more than the United Kingdom or Italy, which spent 8%?

His presentation drew on research carried out for the Italian Ministry of Public Administration. He suggested that the methodology might be useful to assess the regional health systems in other countries.

The purpose of the study had been to (i) assess the intrinsic consistency of the different regional health systems in Italy (e.g. comparing levels of need, demand, supply, efficiency and outcomes) and (ii) evaluate their overall performance against different criteria (e.g. budget equilibrium, quality of care, responsiveness, equity, and outcomes).

Italy had a population of 58.7 million people. It had a decentralized National Health Service (SSN), formed in 1978 and organized in three tiers: state, regional and local. The 21 Regions enjoyed considerable autonomy in this area, since they raised taxes for the SSN, owned and controlled the 180 Local Health Enterprises (ASLs) and 95 Hospital Enterprises (AOs) and could adopt different institutional and organizational arrangements. The regions were very different in terms of population (ranging from 0.1 million in Valle d’Aosta to 9.2 million in Lombardy), history, income, demography, and health conditions. Each had an elected Regional Council and had a different pattern of governance in its health system. The 1992–1993 reform had introduced some elements of public-private competition, but only one Region (Lombardy) had made a complete split between purchasers and providers, while most Regions ran wholly or substantially integrated health systems.

Professor Mapelli demonstrated how the introduction of the SSN had helped equalize spending on health across the Italian regions. However, this prompted questions as to whether equal spending led to equal results, and how far different institutional or governance models affected outcomes.

Looking at institutional arrangements, Professor Mapelli classified the regions according to whether they were integrated – meaning that all the hospitals were inside the ASL, the Local
Health Enterprise – or separated. The analysis showed that seven were integrated, nine mixed/quasi-integrated, four were mixed/quasi-separated, and one separated.

A second analysis identified three governance models in the regions.

- In the ‘bureaucratic model’, the region was dominant and maintained control by making clear its expectations to local bodies.
- In the ‘centralized model’, the region held final responsibility for issues such as budgets and deficits, but the process allowed two-way communications.
- In the ‘contractual model’, the region managed the system in a way which allowed harmonization of conflicting interests.

The regions were then assessed according to two explanatory models – internal consistency, and governance and results. A set of some 50 regional indicators, available from official sources and covering different areas, were identified and synthesized in each key-result area, through appropriate (subjective) weights.

To examine internal consistency, there were two approaches. The first took demand as being related on the one hand social context/needs and on the other to expenditure/supply and assessed whether these appeared to be proportionate. The assessment was based on whether the ranking by quartile for the region was the same for both dimensions. The other compared expenditure, quality/efficiency/effectiveness and health outcomes and looked for consistency in relation to high levels of quality and health (i.e. if the region was in the 3rd or 4th quartile). The results were that ten regions were consistent, five partly inconsistent and six inconsistent.

In the governance model, the regions were assessed on the relationship between their availability of tools and capacity (e.g. the information system, strategic planning) and their performance in key-result areas.

The conclusions for Italy were that ten regions, in the north and centre, showed an intrinsically consistent health system, while six in the south showed serious inconsistencies due to low per capita health expenditure and poor managerial and outcome indicators, in the face of high levels of need. Again, the north and centre regions showed that they are better equipped in their governance systems and had higher performance indicator values.

Expressed in a more general way, the performance of the regional health care systems did not seem to depend on either the institutional model (integrated/separated) or the governance model (centralized/contractual), apart from the fact that the bureaucratic model did not perform very well. However, it did depend on the steering capacity of regions and the richness of their instruments and capacity for governance. The level of health expenditure did not seem crucial either for the performance of health services (quality, effectiveness) or for health outcomes. High levels of expenditure were often due to managerial incapacity.

It appeared that governance developed in a favourable context. The performance of the regional health care systems depended on the regional context, prompting the question: what factors were modifiable? From a broader understanding of the Italian background, it appeared that financial transfers alone were not the solution. Rather, improved governance would require investment in human capital in health (more professional resources, better managerial education, and a result-oriented culture), investment in information systems, and investment in social and environmental
capital. Structural conditions appeared to have a far stronger influence than pro-competitive reforms.

Dominic Harrison of North West England asked whether Professor Mapelli had been able to take into account the broader impact of society and public health issues on health and health care outcomes in his study. Professor Mapelli said that the study had focused only on the health care system.

Notes on the workshop on the governance of regional health systems

The working group discussed methodology. Professor Mapelli described the methods he used in his study in more detail. In selecting the indicators used in the study, first, important areas were identified and then indicators were chosen in each area. The areas were: needs, demands, supply, process and expenditure.

Indicators for the area of needs were given as subgroups with specific needs (older people, the poor, the unemployed), health determinants (smokers, alcohol use and obese people) and some indicators on health status (the percentage of people who are chronically ill for a certain time, total mortality, disabled persons).

Indicators for the other areas are available via the web site. Indicators of each area were synthesized by calculating a weighted sum.

The combined indicators for each area were divided into quartiles and the position for each area for each region were compared, to see if they were in the same quartile or not. If all the combined indicators were in the same quartile, the health system of a region was categorized as balanced, if not, regions were marked as unbalanced.

In discussion, it emerged that the model was based on global expenditure, and a split into spending on prevention, primary care and hospital costs might have been useful but was not done. Furthermore, only public expenditure was taken into account, but it was unlikely that the results would alter substantially by looking also at private expenditure, because the analysis based on quartiles was quite rough.

Some regions presented their indicators and their method of health reporting:

Kaunas, Lithuania – There was an assessment comparing regions of Lithuania, but it was fragmented; there was no sound methodological basis and, as the health system was centralized, many data were only available at the national level.

North Rhine-Westphalia, Germany – There were many indicators on the regional and county level (54 counties/cities in NRW), and county profiles were provided on the web, containing also some indicators on needs, health determinants, supply and health status. An analysis similar to the Italian one was not done.

Alsace, France – There was a national data base with regional data, divided into 54 thematic sheets, which were updated regularly but not yearly.

Varna, Bulgaria – There were many indicators at regional level, but there was analysis only at the national level.

Italy – The study presented was a specially commissioned particular project and would not result in routine reporting on these topics.

2 http://sanita.formez.it/.
4. Human resources for health policies

Professor Zilvinas Padaiga, Head of the Department of Preventative Medicine at Kaunas University of Medicine, and former Minister of Health for Lithuania, said that he had personal experience, as a Minister of Health that, if regions did not accept national policy, it was of no value. He said that negotiations with the regions in his country had been difficult because they had had their own concerns and challenges, but that there had been good progress on reforms, for instance in tackling inequities. The process of engagement had been important but satisfying, and had resulted in real benefits.

He said that he had worked on issues regarding human resources for health since 1998. He said that this was a priority issue. There had been a WHO report on the topic and it was in the WHO work plan. Unless this topic was firmly linked to service plans, these would be meaningless. His talk was in four parts.

The first related to global and European trends within the GP workforce. He illustrated how GP numbers varied across the countries of Western, Central and Eastern Europe, though noted that numbers alone were not the issue – the equipment available to them and the system in which they worked were also important. In some systems, they operated as gatekeepers; in others, patients could go directly to specialists. Generally, numbers across Europe were rising, and especially in some parts of Eastern Europe, where there had been hardly any in the Soviet period. In some of the CIS countries, numbers remained very low. The main point from this was that the situation was very different from country to country.

For his second point, he turned to the many issues and conflicts in planning human resources for health. These would vary, depending on the strengths and interest of different institutions, such as universities and the professions, numbers of staff and geographical distribution, and the way services and specialists were organized. There would be a need for diplomacy and negotiation to make progress. To illustrate the issues, he used examples from Lithuania.

One issue in Lithuania had been a lack of timely and precise information. He had found that no one database or registry relating to human resources for health in Lithuania could provide all the needed information in a timely manner. The various sources were not linked, and some were not computerized, making it difficult to establish a system that pooled all the material.

Another issue was migration; a real concern in that European enlargement offered Lithuanian doctors a new opportunity to work elsewhere. Using a French instrument, surveys were undertaken in 2002 of the attitudes of physicians and medical residents, and in 2004 of pharmacists. Shockingly at the time, 60% of medical residents and nearly 30% of physicians indicated an intention to consider emigration. The main incentives to migrate were higher salary, a better quality of life, and better career possibilities. Actual emigration had now settled at about 2% a year, but the possibility remained. Subsequent research indicated that many who had left retained links with Lithuanian sick funds.

Research was also undertaken into retention, to discover how many qualified doctors remained active. This found that 70% of graduates were still licensed, though only 60% were practising. Women were more likely to still be active than men. About 17% of students failed to complete their medical course. In a number of specialities, there were high percentages still active above the age of 60.
Professor Padaiga then described some examples of planning the GP workforce in different countries, taking the examples of the USA, Australia and Lithuania. The US model envisaged a pool of practitioners, fed by those who left training choosing this option over other specialties, emigration, teaching administration or research, and depleted by retirement, death or other activities. Various assumptions around these different factors were built into the model. The Australian model explicitly addressed population changes and utilization patterns, sources of GPs and their work patterns, and applied a number of scenarios, including a breakdown by Australian state.

The Lithuanian model also included a number of variables – current supply, mortality rate, and drop out due to retirement, migration, and non-completion of undergraduate studies or residency studies. A Delphi exercise was performed in 2000 for physicians and GPs and in 2005 for pharmacists, nurses, public health specialists and dentists. A utilization approach was then applied for GPs, taking into account current use, population changes and system reform. This suggested that the numbers of GPs who would be available were reasonable, but the results would be monitored every two years. A particular issue that was examined was whether, if GP numbers fell, those remaining would be able to deal with patient demand. Modelling suggested that they could not, and it was unlikely that e-health approaches could fill the gap.

The fourth area covered was Lithuania’s response to the challenges it faced. Four particularly were mentioned. On pay, there was now a clear policy to raise the relative value of medical salaries. There was now a commitment to link human resource planning firmly into system restructuring, which would strengthen outpatient and GP services. A project on e-health would improve the quality of and access to services and information, including the competence and efficiency of human resource planning and improved management and planning, ensure linkage and communication of existing human resource registers, and ensure better working conditions for physicians with regard to filing documentation, e-registration, feedback, exchange of information, and other areas. Finally, structural funds would be used for the renovation of regional hospitals, to improve services for cardiovascular diseases, cancer, mental health and injuries, and to support e-health.

Professor Padaiga concluded with two points: Achieving a balance between the supply and the demand for human resources for health was very complex, but was the important task in order to ensure the appropriate and efficient functioning of the health care system in the future. Second, merging health care reform with planning human resources for health should be seen as a regional, national and international challenge with research, regional and national examples and international cooperation.

Notes from the workshop on human resources for health policies

Workshop members shared their experiences and a number of issues emerge.

1. Policy changes such as proposals for change e.g. hospital closures or service reorganization were having a significant influence on the workforce, and at worst could prompt migration to other regions or emigration – Germany United Kingdom, Hungary

2. Significant differences existed within countries in terms of professional capacity in different regions, with salary level often a significant factor – Germany, Poland, France
3. There were problems in integrating training and deployment because responsibilities lay with different ministries (typically Health and Education), or the professionals and politicians took a different view – Italy, Poland, France

4. Without national/regional coordination progress would be hindered – Italy, Lithuania

5. There were imbalances between professions, typically too many doctors and too few nurses – Italy,

6. Financial uncertainties and failure to match policy intentions with funding could make long-term planning difficult – Hungary, Greece

7. Data weaknesses or organizational deficiencies made long-term planning difficult – Greece, Poland

8. Creating a good system took a long time – United Kingdom, France

9. Linking staff levels to proven quality remained a challenge.

5. Ways to steer in decentralized health systems

Dr Helmut Brand made the presentation on behalf of Jon Magnussen, Professor in Health Economics at the Norwegian University of Science and Technology.

He said that all countries had economic objectives in managing their health care systems. These included cost containment – controlling the growth in costs and promoting rigorous budgeting – and technical efficiency, eliminating slack both at provider and purchaser level. They also wanted allocative efficiency, mostly through either explicitly or implicitly setting priorities, as well as equity in the allocation of resources between regions or insurers.

Given these goals the question arose as to whether centralization or decentralization offered a better chance of success, with decentralization defined here as ‘transfer of financial and/or policy powers from a central to a local authority’.

However, even then a number of other issues need to be clarified:

- the number and type of agents to whom power is transferred (for example, if the transfer is to regions, counties, districts or municipalities, then how do these manage priority setting against their other responsibilities, and if to private bodies, is the process in fact privatization?);

- the degree of financial discretion allowed (this can range from very little, with the funding allocated from the centre, to full control over a local income base, whether by setting local tax rates, by user fees or by a combination of these; Norway and the United Kingdom are examples of the first model, Sweden, Denmark and Italy are examples of (attempts) of the second);

- the relationship between local authorities and/or private actors (if there is strict partitioning of the market, e.g. by geographical boundaries or types of enrollees, there will generally be little competition, but introducing consumer choice will generally lead to an altogether different and competitive environment);
the types of decisions that are decentralized or not (local authorities may be restricted to purchase or to provide a set of nationally determined services, or able to supplement these, or free to decide themselves, and the centre may reserve control over capacity decisions);

the organization and selection of health care providers (is there to be a split between purchasers and providers? Are purchasers and suppliers free to contract with whom they will? To what extent is the health care market one of concentration on the demand and/or supply side?);

the flexibility and type of contracts used between purchasers and providers (are the actors free to develop contracts, or constrained to use say cost-based remuneration, or global budgets, or prospective payment systems?).

He said the evidence that decentralization was better was thin, because it was difficult to separate the variables. There was a need to answer specific research questions related to each of, or combinations of, the points above, trying to do the analyses ceteris paribus. To date, there had been few comparative analyses that specifically aimed at exploring the link between (aspects of) decentralization as a variable and one/more economic variables, whether comparing on a cross-country or before/after basis. Dr Brand noted that such decisions were often politically based rather than evidence-driven.

Some evidence could be summarized from recent experience, on both the demand and supply side:

### The Demand Side:

<table>
<thead>
<tr>
<th>Policy/Basic idea</th>
<th>Germany / Netherlands</th>
<th>Nordic countries/UK</th>
<th>Italy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/Basic idea</td>
<td>introducing competition between sickness funds/free choice of sickness funds will induce competition, thereby increasing quality and efficiency</td>
<td>devolution/deconcentration but also reconcentration of purchasing power/fiscal federalism; closeness means responsiveness to needs and higher levels of efficiency</td>
<td>devolution to regions, but recentralization within regions/fiscal federalism; closeness means responsiveness to needs and higher levels of efficiency</td>
</tr>
<tr>
<td>Decentralization?</td>
<td>perhaps not strictly, but in that a (quasi) market is less centralized than a monopoly (be it private or public)</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Effect</td>
<td>consumer switching, less price variation, verdict out on cost containment</td>
<td>not documented, but soft budgeting is a major theme, discussion about lack of ‘political space’</td>
<td>soft budgeting is major theme, ex-post bailing out by central government</td>
</tr>
<tr>
<td>“Confounder”:</td>
<td>interaction between purchasers and providers</td>
<td>degree of fiscal autonomy, centralized health policy (priorities/capacity) and type of contracts with providers</td>
<td>Italy also changed their financing of hospitals, introducing DRG based payment</td>
</tr>
</tbody>
</table>

### The Supply Side:

3 DRG - ‘Diagnosis-Related Group’ is a system to classify hospital cases into one of approximately 500 groups, on the basis that they are expected to make a similar use of resources.
<table>
<thead>
<tr>
<th></th>
<th>United Kingdom (1980–1997 (approx))</th>
<th>Sweden (early 1990s)</th>
<th>Norway, Austria, Portugal, Italy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy</strong></td>
<td>purchaser/provider split, internal markets</td>
<td>purchaser/provider split, internal markets where politically feasible (suitable)</td>
<td>PPS (prospective payment system)/ case based financing</td>
</tr>
<tr>
<td><strong>Basic idea:</strong></td>
<td>competition will enhance technical efficiency</td>
<td>competition will enhance technical efficiency, local purchasers will find contracts that fit local needs</td>
<td>change provider behaviour through incentives to perform more efficiently</td>
</tr>
<tr>
<td><strong>Decentralization?</strong></td>
<td>by changing market structures – yes.</td>
<td>by changing market structures – yes</td>
<td>well… but important “confounder”</td>
</tr>
<tr>
<td><strong>Effect</strong></td>
<td>technical efficiency might have increased</td>
<td>technical efficiency substantially increased in counties with internal markets; lack of cost control (?)</td>
<td>technical efficiency increase</td>
</tr>
<tr>
<td><strong>“Confounder”:</strong></td>
<td>this was not a “real decentralization” according to Enthoven…</td>
<td>political pressure</td>
<td></td>
</tr>
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Overall, it appeared that competition in insurance markets induced switching behaviour, though less than expected, and had limited effect on the curbing of costs. Convincing evidence was lacking on the question of municipalities vs. districts vs. regions, mostly because the countries with variations here also had variations in autonomy in tax-setting as well as different financing mechanisms. Internal competition and prospective payment systems did seem to improve efficiency. The evidence was incomplete on allocative efficiency.

The case of Norway was then presented. Norway had had four phases of health policy.

- From 1980–1990 the approach had been ‘small is beautiful’, with services in the 19 counties financed by (fixed) taxes and matching grants, local decisions reflecting local preferences, and global budgeting of hospitals.
- The period 1990–1997 had seen increased central involvement, with a national waiting time ”guarantee”, an increased focus on the distribution of functions, increased amounts of extra funds from the central government, and experiments with activity based financing.
- During 1997–2002, county autonomy had been gradually eroded, with activity-based financing introduced in 1997 first at 30%, then at 55% in 2001, and with mandatory regional health plans from 2000, and increased patient choice.
- Finally, since 2002, there had been in effect a state takeover, with ownership transferred from the 19 counties to one state organization, a shift from devolution to deconcentration, with the sector managed as 5 regional health enterprises, and politicians excluded from their boards. In 2006–2007, there had been further fine-tuning with local politicians back on the boards of the enterprises, now reduced to four in number.

Major political issues during this process had included the degree of centralization (state vs. regions vs. counties), the type of financing (global budgets vs. case-based financing) and patient choice (between public hospitals, and between public and private hospitals). The two major reforms had been the introduction of activity-based financing, with the subsequent reliance on the DRG system, and the recentralization of the hospital sector from county to state ownership in 2002.
The first had been introduced in the face of long waiting lists, as it was believed to give incentives for activity growth, while the existing global budgets led to inefficient use of resources. Because of an initial fear that its incentive effect might be too strong, it was initially organized from the state to the county, and only at 30% of average DRG cost.

Experience showed positive effects, in terms of increased efficiency, increased activity, reduced waiting lists, and an increased focus on management and accounting, but negative effects included a rise in costs, DRG creep and a tendency to cream-skimming.

The recentralization had been prompted in part by economic criteria. One was a determination to improve cost containment by ending arguments over responsibility and establish one clear owner and one health policy. A second was technical efficiency, to achieve economies of scale and scope, and reduce duplication of services in and between regions and counties, and a third better allocative efficiency, primarily through a strengthening of patients’ rights. There was also an intention to create a more professional management approach.

The empirical evidence from the Norwegian experience was that:

- **financial control** – deficits (in four out of five regional health enterprises) and soft budgeting (both from parliament and, with some variations, from regional to local health enterprises) had been persistent since the reform
- **efficiency** – hospital efficiency (i.e. technical efficiency) had increased because of the recentralization by an estimated 4–5%, but Norway still seemed to have a substantially lower level of efficiency than e.g. Finland (which had a decentralized municipally-based system)
- **activity** – while goals were not precise, activity had increased because of the reform, even after controlling for changes in financing, population growth, etc.

So the question arose of whether all countries should recentralize? In terms of cost-containment, it appeared not, with large deficits, more extra funds, and activity less in line with expectations. On the other hand, responsibility was clearer. Technical and cost efficiency had improved, but the effects of DRG-creep and the effects on patient selection were less clear. The evidence on the effects of hospital mergers and restructuring was also unclear.

One future challenge remained the need to clarify whether a market or a planning approach was better, including such issues as the role of choice as against regulation of capacity and structure, and the relationship between activity-based financing and cost containment. Another was how best to use DRGs, which might be right on average, but applied crudely might result in severe local distortions. Fair allocation of resources between geographical areas remained a difficult issue, and it was also far from clear how best to manage situations where there appeared to be a conflict between what was good for physicians and their practice and what best served society more generally.

The conclusion was that decentralization as a strategy to improve economic performance was characterized both by different solutions in similar systems (Nordic countries) and by a different focus in countries with either a national health services system or one based on social insurance (supply side orientation vs. demand side orientation). However, knowledge about the effect of decentralization was limited because of the variations in the solutions adopted and the lack of
cross-country and before/after analyses that specifically focused on “decentralization” as a policy instrument.

**Notes from the workshop on decentralization**

The group considered the question – was decentralization a panacea? Decentralization strategies were an attempt to simplify very complex matters – every system was imperfect and you had to live with that.

Decentralization was more about values than evidence. The context in which decentralization was attempted would be crucial – which suggested that political decisions on decentralization were most important for their symbolic value.

In considering decentralization, the ‘private/public’ distinction was appropriate, as representing the very different approaches characterized by profit-seeking or non-profit organizations. Some regions (e.g. Wales) were consciously moving away from using internal markets towards more collaborative solutions. There appeared from the discussion to be a trend towards public commissioning but the providers could also be actors in a private market.

Was there a centralization-decentralization pendulum? The Norwegian examples suggested that history could go backwards, with the shift towards decentralization followed by a move back towards a more centralized model.

Control and follow-up in decentralized systems could be difficult. Control was often a nuisance to professionals but satisfying for residents and users. One way to improve system-steering might be to be more efficient in giving consumers information on system errors/failures rather than on central targets; this would mean better defining system errors, and collecting the data.

There should be ‘health marketing’ to expose inequities. One example might be hospital acquired infections; here giving information to the public made the hospitals clearly responsible for their actions.

There was a need to distinguish between the objectives of professionals and politicians – they are not necessarily the same. Public money was being spent, and there needed to be fairness also in the economic field if it was to be used well.

**Closure**

Dr Brand said that the day and a half had allowed a very interesting discussion. He observed that this had been different from a normal scientific meeting. The agenda that the Conference had been discussing was a political agenda. It could not therefore be treated as abstract or ignored. Action must follow.

He thanked all involved in its organization and delivery – the speakers, the interpreters, WHO and the secretariat, and his local team.
On the 15th anniversary of the Network, Dr Birgit Weihrauch, the former focal point for North Rhine-Westphalia, spoke about its history. She welcomed the Network to Dusseldorf, saying this was its third time there, following earlier meetings in November 1992 and October 1996.

The first followed initial gatherings of regions with an interest in health in Lugarno in the canton of Ticino in Switzerland and then in Cardiff in Wales in the United Kingdom. She had been present in Cardiff when all present had agreed that there needed to be some organization separate from the national level, and she had spontaneously invited those attending to a meeting in Dusseldorf, where eleven regions had signed a Statement of Intent and Direction that led to the founding of the Network. The document had set out three objectives – dynamic alliances, knowledge transfer and intersectoral action, that had remained a focus for the Network since then. She recalled three highlights of that event – the Regional Director of the WHO, Dr Asvall had attended; the Chief Minister of North Rhine Westphalia, Dr Johannes Rau, had made his own residence available for the signing ceremony; and despite rain over two days there had been a wonderful visit to Benrath castle.

The second occasion in Dusseldorf had been the Annual Conference and Annual General Meeting in 1996. The topic had been the fact that there were many WHO networks – such as those for regions, cities, prisons, schools – which could work in isolation from each other. The Conference aimed to bring them together under the title, Networking for Health.

She said that for some years there had been an aspiration to attract WHO’s interest in what the Germans called Gesundheitswirtschaft. This, their third meeting, indicated that the time was now right to recognize that health was hugely important for the economy, for exports and jobs. The meeting’s organization reflected North Rhine-Westphalia’s strong commitment to health and to the regional role.

She had seen the beginning and development of the Network. She had been head of her department through until 2005, and was now very active with the hospice and palliative care movement at the federal level.

Questions facing the Network at its foundation had been – What is a region? What can it do for health? What is the role of a focal point? Who should have the role? What tasks should the Network take on? What projects? How should its meetings be organized? How should it work with other regions, and with the European Union?

She had helped bring the Committee of the Regions into working with the Network. In 2002, the Network had moved from just administrative working to include political engagement. The first Ministerial Meeting had taken place in Sicily, followed by a second in 2004 in Venice.

She said that, looking back, the Network had had an important impact on many regions. For the first ten years, an important role had been to bring about cooperation between regions from
eastern and western Europe. A second benefit had been to sharpen the profile of the regions in Europe. The modern German constitution was based on the role of the Regions – the Länder, and the regional role was now far better developed right across Europe. A third benefit had been to help regions develop their own policies. North Rhine-Westphalia had found that in developing its policies it had friends abroad to work with.

She mentioned others who had played an important role in the Network’s development. Without Anna Ritsatakis of the WHO Regional Office, she doubted whether the Network would have had that success. Morton Warner from Wales had been very important at the Cardiff meeting and throughout the first ten years. Vilius Grabauskas from Kaunas had been very important in bringing an involvement from Eastern Europe in the early years, and Gianfranco Domenighetti from Ticino had provided continuing support through from the first meeting in Lugarno. She said that the Network for her meant political commitment to improvement, but also a gathering of friends.

For the future, she hoped that the Network would survive and flourish. She said that the understanding of Europe had grown over the Network’s lifetime. No country could now be successful without looking over its boundaries; each would need creativity and processes that allowed it to work with others across frontiers. They would need vision, ideas, and opportunities for cooperation. This the Network could provide and she hoped it would continue to do so.