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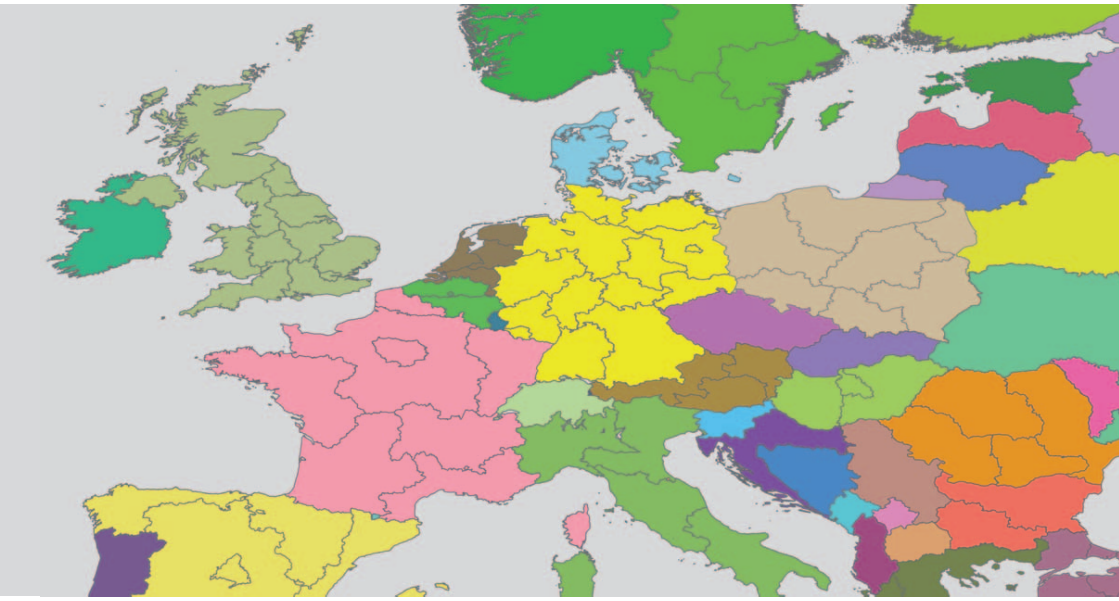

Regional Health Policy – Promoting equity in spite of cross-currents?

Regionale Gesundheitspolitik – Förderung von Chancengleichheit trotz Hindernissen?

Bochum, Germany, 13-14 Sept 2010

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1. Workshop-Zusammenfassung samt Hauptergebnissen

Der Workshop wurde organisiert von LIGA.NRW, insbesondere in seiner Funktion als WHO-Kooperationszentrum für regionale Gesundheitspolitik und Öffentliche Gesundheit. Die Vorbereitung des Workshops erfolgte in Abstimmung mit dem WHO-Netzwerk "Regionen für Gesundheit" (RHN). Der Workshop sollte u.a. zum neuen mittelfristigen Arbeitsprogramm des Netzwerkes beitragen sowie zur Vorbereitung der RHN-Jahreskonferenz „Reduzierung gesundheitlicher Chancenungleichheit aus regionaler Perspektive" in Genk, Region Flandern (Belgien) am 8.-9.11.2010.

Dieser Workshop diente dazu, die Diskussion über regionale Gesundheitspolitik und Gesundheitsgerechtigkeit samt innovativer und besonders anspruchsvoller Ansätze weiterzutragen, und hatte ca. 30 TeilnehmerInnen. Begrüßungen erfolgten von folgenden Seiten: Dr. Eleftheria Lehmann, Präsidentin des LIGA.NRW; Dr. Erio Ziglio, WHO Center for Investment in Health, Venedig (Videobotschaft); sowie Dr. Pina Frazzica and Dr. Lino di Mattia, RHN Secretariat, Sizilien (schriftlich).

Der Workshop umfasste vier Sessions: „Gesundheit in europäischen Regionen", „Förderung von Chancengleichheit", „Methoden und Werkzeuge zur Förderung gesundheitlicher Chancengleichheit auf regionaler Ebene" sowie Ausblick / Diskussion. Die insgesamt 17 Präsentationen stammten von folgenden Seiten: fünf aus anderen Regionen als NRW, nämlich Emilia-Romagna, Flandern, Niedersachsen, Szabolcs-Szatmár-Bereg (Ungarn), Wales; vier von LIGA.NRW; vier aus Universitäten (Bielefeld, Hamburg, Maastricht); drei aus verschiedenen Institutionen in NRW (Kreis-Gesundheitsamt, Institut Arbeit und Technik, Cluster Management Gesundheitswirtschaft); eine aus dem WHO-Regionalbüro Europa, Abteilung Gesundheitssysteme und Öffentliche Gesundheit.

Zu den Leitmotiven des Workshops gehörten:

- Verbindung von Wissenschaft – Praxis – Strategieentwicklung als ein Schlüsselelement zur Unterstützung regionaler Gesundheitspolitik
- Förderung von Chancengleichheit; Rolle der WHO-Strategie „Gesundheit in allen Politikbereichen"

- Strategische Rolle gesundheitsbezogener Steuerungswerkzeuge und von „Forschungs- und Entwicklungs"-Projekten
- Positionierung der Aktivitäten von LIGA.NRW als WHO-Kooperationszentrum.

Aus den Präsentationen und Diskussionen des Workshops ergaben sich umfangreiche Informationen und nützliche Einsichten. Eine Auswahl von Ergebnissen und Folgerungen ist hier aufgeführt unter folgenden Überschriften:(1) Regionaler Ansatz; (2) Regionale Gesundheitspolitik; (3) Gesundheitsbezogene Steuerungswerkzeuge; (4) WHO-Netzwerk "Regionen für Gesundheit" (RHN); und (5) Ausblick.

1. Regionaler Ansatz: Vielfalt und Verbundenheit der Regionen in Europa

Die WorkshopteilnehmerInnen waren sich im Klaren darüber, dass es auf den Ebenen unterhalb der Europäischen Nationalstaaten mehr Vielfalt gibt als gemeinhin angenommen – bezüglich Gesundheit, Gesundheitsdeterminanten, Gesundheitsversorgung etc. Dies trifft schon zu für die Europäische Union, aber noch stärker für die Europaregion der WHO (die von Island bis zur Pazifikküste reicht). Diese Vielfalt lässt sich als Reichtum interpretieren; ähnlich wie Biodiversität für Ökosysteme kann sie evtl. in Krisenzeiten die Widerstandsfähigkeit erhöhen. Ein Beispiel innereuropäischer Verbundenheit bildet die Migration von Pflegepersonal, mit sehr unterschiedlichen Auswirkungen auf Empfängerländer (zumeist profitierend) und Ursprungsländer (z.B. zurückgelassene Familien). Insbesondere Grenzregionen fühlen den „Europäisierungs"-Druck. Dementsprechend sind sie Hauptkandidaten für die Katalyse neuer Entwicklungen.

2. Regionale Gesundheitspolitik

Regionale Gesundheitspolitik bedeutet Gesundheitspolitik auf regionaler Ebene. Es bestand weithin Übereinstimmung, dass die Ebene zwischen Nationalstaat und Kommune (Kreis, Stadt) mehr Aufmerksamkeit als bisher verdient: Es besteht ein ungenutztes (oder zumindest unternutztes) Potenzial regionaler Gesundheitspolitik. In Europa gibt es Trends, in der Gesundheitspolitik den Haupteinfluss von Nationalstaatsebene auf untere

Ebenen zu verlagern, wodurch diese Ebene an Bedeutung zunimmt. Andererseits wird diese mittlere Ebene mancherorts auch (fast) abgeschafft, vgl. Primary Care Trusts in England.

Zu den aktuellen Handlungschancen zur Unterstützung regionaler Gesundheitspolitik gehört Folgendes: Rationale Gesundheitspolitik (u.a. auf regionaler Ebene) ist eng verbunden mit Gesundheitsforschung und gesellschaftlicher Praxis. Hier bestehen noch ungenutzte Verbindungsmöglichkeiten. Dies zeigte sich teilweise an zwei Ansätzen, die in zwei separaten Beiträgen vorgestellt wurden: (i) die internationale Studie „Gesundheitsverhalten von Schulkindern" (HBSC) mit gründlich-akademischem Forschungsansatz aber ohne Ansatz für Intervention, und (ii) das Projekt „Alternativa" als mutige Realitäts-Intervention, jedoch bisher sehr begrenzter Datenbasis und Evaluation. Wie es scheint könnten die Ansätze spürbar profitieren von einem engeren Kontakt miteinander wie auch von einer Einbettung in ein entsprechendes Gesamtprogramm.

Unterschiedliche Steuerungswerkzeuge zur Unterstützung regionaler Gesundheitspolitik stehen zur Verfügung; ohne viel Aufwand ließen diese sich weiter verbessern und intensiver einsetzen (s.u.). – Zusätzlich zum WHO-Netzwerk "Regionen für Gesundheit" (RHN) gibt es andere Netzwerke mit Bedeutung für regionale Gesundheitspolitik. VertreterInnen des deutschen Gesunde-Städte-Netzwerks (GSN) und des Deutschen Netzwerks Gesundheitsregionen (DNGR) nahmen am Workshop teil. Es besteht die Absicht, die beginnende Kooperation auszubauen.

Zu den **Schwierigkeiten** einer regionalen Gesundheitspolitik gehört Folgendes: Die Strategie „Gesundheit in allen Politikbereichen" hat zwei Seiten; zweifellos bietet sie ein beträchtliches Potenzial für Prävention, Gesundheitsschutz und -förderung beim Blick auf die anderen Sektoren außerhalb von „Gesundheit". Jedoch bestehen auch offene Fragen bezüglich Führungsrolle, Finanzierung und Verantwortlichkeiten. – Regionen stehen vor der Aufgabe, mehr über Quellen und Modalitäten für Förderung mittleren und großen Umfanges herauszufinden und solche Kenntnis dann auch systematisch einzusetzen.

3. Steuerungswerkzeuge zur Unterstützung von Gesundheitspolitik

Ein Teil der Diskussion drehte sich um Steuerungswerkzeuge zur Unterstützung von Gesundheitspolitik, einschließlich ihrer spezifischen Stärken:

- Bestandsanalysen: Gesundheitsberichterstattung (inkl. Gesundheitsdeterminanten, Folgewirkungen von Gesundheit und Krankheit) ist gut etabliert; Beispiele guter Berichtspraxis existieren; eine Infrastruktur entsprechender Indikatoren(systeme) ist im Laufe der Zeit entstanden
- Gesundheitliche Bedarfsanalysen (HNA): Es existiert eine systematische Methodik zur Analyse gesundheitlicher Bedarfe in einer Population, mit Gelegenheit zur Partizipation von Bevölkerungsgruppen und für intersektorale Zusammenarbeit
- Bilanzierung gesundheitlicher Folgewirkungen (HIA): Dies ist potenziell ein Eckpfeiler zur Unterstützung von Gesundheitspolitik. In einigen Ländern existieren bereits ausgeprägte Elemente einer HIA-„Kultur". Umfassende EU-kofinanzierte Projekte drängen in Richtung auf Quantifizierung gesundheitlicher Folgewirkungen
- Health Technology Assessment (HTA): Dies ist charakterisiert durch erwiesene Nützlichkeit und verbindlichen Status; in vielen Ländern existiert bereits eine vollentwickelte HTA-Kultur
- Leistungsbeurteilung für Gesundheitssysteme (HSPA): Dieser umfassende Ansatz anerkennt ausdrücklich den Systemcharakter der Gesundheitsversorgung.

Strategische Projekte (finanziert aus EC-Mitteln oder aus anderer Quelle) zur Unterstützung von regionaler Gesundheitspolitik scheinen generell eher unternutzt, zumindest wenn man über das einzelne Projekt hinaus auf Gruppen verwandter Projekte blickt. Dies festzustellen ist leicht; nicht so leicht zu finden sind gute Vorschläge zur Verbesserung. Eine eigene Forschungsfrage betrifft die Optimierung von Austauschprozessen im Grenzgebiet Wissenschaft – Strategieentwicklung – Praxis. Die Frage kam auf, wer die beste Kompetenz zur Nutzung der Forschungsergebnisse hätte. Die müsste nicht unbedingt die Förderseite sein. Es wurde darauf hingewiesen, dass EC-Projekte sich allmählich vermehrt um die Nutzung und

Verbreitung ihrer Ergebnisse kümmern. Neuere Projekte enthalten hierzu häufig spezielle Arbeitspakete.

4. Das WHO-Netzwerk “Regionen für Gesundheit” (RHN)

“Netzwerk” ist bei der WHO weiterhin ein positiv besetzter Schlüsselbegriff. Nach Jahren erfolgreicher Arbeit und dann einer Periode verminderter Sichtbarkeit erscheint das Netzwerk nun wieder voller Energie und auf gutem Wege unterwegs. Zu den aus der Mitgliedschaft erwachsenden Vorteilen gehören: Frühzugang zu wichtigen Informationen; Gelegenheit zum Einholen von kritisch-konstruktivem Feedback; Partner-Pool für Benchmarking, gemeinsame Antragstellungen und/oder gemeinsame Projektdurchführungen.

5. Ausblick

Die Arbeitsergebnisse werden dokumentiert und öffentlich zugänglich gemacht. Als WHO-Kooperationszentrum arbeitet LIGA.NRW gegenwärtig daran, umfangreiche zusätzliche Informationen zur regionalen Gesundheitspolitik zweisprachig (Englisch – Deutsch) ins Internet einzustellen; hierzu ergaben sich im Workshop wichtige Anregungen. – Das Workshop-Format passt anscheinend gut zur Thematik. Der Workshop scheint sich mit bestehenden Veranstaltungen bzw. Veranstaltungsreihen nicht zu überschneiden, vielmehr eine Lücke zu füllen. Vorbehaltlich einer umfassenderen Prüfung könnte es sinnvoll sein, in Abstimmung mit dem Netzwerk “Regionen für Gesundheit auch künftig Workshops dieser Art zur regionalen Gesundheitspolitik durchzuführen.

1. Summary of workshop incl. main results

The workshop was organized by LIGA.NRW, especially in its function as WHO Collaborating Center for Regional Health Policy and Public Health. The workshop preparation was coordinated with the WHO Regions for Health Network (RHN). The workshop was meant to contribute to the emerging mid-range work program of RHN, and to co-serve as a preparatory meeting for the upcoming RHN Annual Conference „Reducing health inequalities from a regional perspective“ at C-Mine, Genk, Flanders Region, Belgium, 8-9 November 2010.

This workshop was used to promote the debate on regional health policy and health equity, including novel and ambitious approaches and was attended by c. 30 participants. Welcome addresses were presented by Dr. Eleftheria Lehmann, President, LIGA.NRW; Dr. Erio Ziglio, WHO Center for Investment in Health, Venice (video message); and Dr. Pina Frazzica and Dr. Lino di Mattia, RHN Secretariat, Sicily (in writing).

The workshop included four sessions: „Health in European regions“; „Pursuing health equity“; „Methods and tools to support equity in regional health“; and Perspectives / Discussion. There were 17 presentations, the origin of which was distributed as follows: five from RHN member regions other than NRW, i.e. Emilia-Romagna, Flanders, Lower Saxony, Szabolcs-Szatmár-Bereg (Hungary), Wales; four from LIGA.NRW; four from universities (Bielefeld, Hamburg, Maastricht); three from various institutions in NRW (local Health Department; Institute for Work and Technology; Health Economy Cluster Management); one from WHO Regional Office for Europe, Division of Health Systems and Public Health.

Leitmotifs of the workshop included the following:

- linkage of science – practice – policy as a key ingredient to support regional health policy-making
- pursuit of health equity; role of the WHO “Health in all Policies” strategy
- strategic role of health governance tools, and of „Research & Development“ projects
- how to position the activities of LIGA.NRW as a WHO collaborating center.

Selected results

The workshop presentations and discussions together provided a wealth of information and useful insights. Major results and conclusions are listed here under the following headlines: (1) The regional approach; (2) Regional health policy; (3) Health governance tools; (4) the WHO Regions for Health Network (RHN); and (5) Perspectives.

1. The regional approach: Diversity and interconnectedness of regions in Europe

The workshop discussion acknowledged that on levels below the European states (countries), there is more variation than is commonly appreciated – in health, health determinants, health care, etc. This is true of the European Union, and even more so of the European region of WHO (ranging from Iceland to the Pacific coast). The diversity can be seen as a wealth; similar to biodiversity for ecosystems, it may secure resilience in times of crisis. An example of cross-European interconnectedness refers to migrant carers, with contrasting impacts on receiving country (mostly profiting) vs. sending country (families left behind). Especially border regions feel the pressure of „Europeanization". As a consequence, the border regions are prime candidates to act as catalysts for new developments.

2. Regional health policy

„Regional health policy" is interpreted here as health policy on regional level. There was wide agreement that the level between state and local (city, county) deserves more attention than it currently receive; there is untapped (or at least under-utilized) potential of regional health policy. In Europe, there are trends in health policy-making to shift power from state (national) level to lower levels, increasing the relevance of this level. On the other hand, the intermediate level is sometimes (almost) abolished, cf. primary care trusts in England.

There is a number of **current opportunities** to support regional health policy-making, including the following. Rational health policy-making (incl. on regional level) is closely connected with the arenas of health-related research and of societal practice. There are untapped opportunities of

linkage of these arenas. This was partially illustrated by two approaches described in two independent presentations: (i) the international „Health Behavior of School-age Children“ (HBSC) study which represents sound academic research but without a mechanism to intervention, and (ii) the „Alternativa“ project as a courageous real-world intervention but with very limited database and evaluation so far. As it seems, these two approaches could both profit from closer contact with each other, and from being embedded into an appropriate policy/program framework.

A range of governance tools to support regional health policy-making is already available; without much effort, these can be improved, and utilized more intensively cf. below). – Beyond the WHO Regions for Health Network (RHN), there are other networks which are important for regional health policy-making. Representatives of the German section of the Healthy Cities Network and of the German Network of Health Economy Regions participated in the workshop. There was agreement to develop and improve the emerging cooperation.

Also, however, there are **difficulties** in regional health policy-making, e.g. the following: „Health in all Policies“ is like a coin with 2 sides; undoubtedly, there is considerable potential for prevention, health protection and health promotion when looking at other sectors outside health. But also, there are unanswered questions of leadership, financing, and responsibility. – Regions have to find out more about sources and modalities of medium- and large-scale funding, and then to make more systematic use of it.

3. Health governance tools

Part of the discussion revolved around health governance tools, incl. their specific strengths:

- Health status assessment: Health reporting (incl. health determinants, health consequences) is well-established; sample reports of fine quality are available; an infrastructure of indicators / indicator systems has emerged over time.
- Health needs assessment (HNA): Systematic methods for reviewing health needs facing a population do exist; such assessments provide opportunities for engaging specific populations and for cross-sectoral partnership.

- Health impact assessment (HIA): The concept of health impact can be a cornerstone for supporting health policy-making. In some countries, there are distinct elements of HIA „culture". Comprehensive EC co-funded projects are pushing forward towards quantification of health impacts.
- Health technology assessment (HTA) is characterized by proven usefulness, statutory status; in many countries, a full-blown HTA „culture" exists.
- Health system performance assessment (HSPA) is another comprehensive approach, acknowledging the „systems" character of health care provision.

Strategic **projects** (EC-funded and other) related to regional health policy seem generally to be underutilized, at least when looking at whole sets of related projects. This is an easy diagnosis, however, it seems less easy to suggest how to overcome this. It is a research question of its own merit how to optimize exchange processes at the science-policy-practice interface. The question was brought up who would have best competency to utilize project results well. This is not necessarily the body funding the projects. Also, it was pointed out that gradually, EC projects seem to care more about the utilization and dissemination of their results. More recent projects tend to include specific work packages for this purpose.

4. The Regions for Health Network (RHN)

„Network" continues to be a buzzword with positive connotation at WHO. The Regions for Health Network (RHN), after years of fruitful working and a subsequent period of reduced visibility now seems to be filled up with fresh energy and moving along a good path. Benefits to member regions include the following: early access to relevant information; opportunities to obtain feedback of critical-constructive nature; pool of potential partners for benchmarking, for writing joint proposals, and/or conducting projects together.

5. Perspectives

Workshop results are being documented, and will be made publicly accessible. Additional comprehensive information relevant for regional health policy-making is currently being prepared for the upcoming bilingual (English – German) website of the WHO Collaborating Center on Regional Health Policy and Public Health; the workshop provided important stimuli for the selection of information. – The basic arrangement of the workshop apparently suits the topic well. The workshop does not seem to duplicate existing meetings, but to fill a gap. Pending a more comprehensive evaluation, there may be a case for continuation of holding such workshops, in coordination with the Regions for Health Network.

2. Workshop overview

Background: The health system is one of the largest organized activities of modern societies. Health care, health protection and promotion all take place on multiple socio-administrative levels, and they call for efficient forms of cooperation and sensible "division of labour". Current trends of health policy in Europe focus on devolution, i.e. shifting responsibilities towards the regional and local level.

As a rule, the burden of disease is distributed unequally among different groups of society, making health equity a priority goal in contemporary public health debate and activities. This is why the World Health Organization maintains "Health for All" as a leading paradigm. The goal is to prevent the widening of health gaps, and – where possible – diminish or even eliminate them. Based on its activities in regional public health, health policy-making, and health assessments, LIGA.NRW is endowed with the status as WHO Collaborating Centre for Regional Health Policy and Public Health. Our mission implies analyzing current trends, as well as identifying challenges and opportunities for health and equity.

2.1 Workshop objectives and arrangement

The workshop intended to promote the debate on regional health policy, illustrating the broad scope of the topic but also trying to link up seemingly separate issues, and "sewing" them together in novel ways. The workshop strived to identify examples of "good practice", facilitating mutual learning for the benefit of all interested regions.

From this background, the workshop was arranged along the following themes:

- The **context** was population health in European regions, and European health policy. This included interregional comparisons; results from a recent analysis of regional health policy; and an update on current EU policies incl. EU structural funds.
- The **core topic** was the pursuit of health equity, utilizing a "life course" model to differentiate existing activities into three groups: for children

and youth; for workers and unemployed persons; and for senior citizens. "Health in all Policies" is one key strategy here.

- In order to support health governance and health equity, v**arious practical methods and tools** are available, including health systems performance assessment; health innovations monitoring; and health impact modeling. The workshop looked at current developments from a regional perspective.

The workshop was organized in coordination with the WHO Regions for Health Network and was meant to contribute to the emerging mid-range work program of this network and to the preparation of the upcoming Annual Conference in Genk, Flaunders Region, Belgium, 8–9 November 2010.

The working language of the workshop was English.

3. Welcome addresses

Eleftheria Lehmann, Director General of LIGA.NRW

Ladies and Gentlemen,

Welcome to Bochum, and welcome to the NRW Institute of Health and Work. I am very glad that this group of public health professionals from Germany and from abroad has found time to join this workshop and to share expertise and experience about "Regional health policy". A short introduction to our institute may help you to understand why we have put this topic on our agenda.

LIGA.NRW was founded in 2008 as a merger of the State Institute for Occupational Safety and Health (Landesanstalt für Arbeitsschutz) and the Institute of Public Health (Landesinstitut für den Öffentlichen Gesundheitsdienst Nordrhein-Westfalen, lögd) with local offices in Düsseldorf, Bielefeld and Münster.

We are engaged in advising and supportive tasks for the state government, the authorities and bodies as well as the municipalities of the state of North Rhine-Westphalia on issues of health, health policy, and health and safety at work. The institute's main areas of activity range from health policy to prevention and health promotion, innovation in health, health management and the healthy design of working conditions as well as drug safety & surveillance, hygiene, and protection against infectious diseases.

The mission of the institute is to promote health for all by reducing burden of disease, focussing especially on 3 settings: community, physical and social environment, workplace and health care system. The institute is part of the new "Health Campus" North Rhine-Westphalia, which is currently developed here in Bochum. The Campus aims to concentrate expertise in health, to endorse innovations in the health economy and to offer a venue for meetings and networking of research, health economy and education.

Obviously, this workshop is closely related to our function as a WHO Collaborating Centre on Regional Health Policy and Public Health. In 2008, the institute was endowed with this status. The mission of the Centre is to contribute to the national and international exchange of concepts, data and professional expertise, and also to improve regional and local health policy

throughout the policy cycle. The objectives are to promote exchange on regional and local health policy including assessments, evaluations and reviews. Local and regional health policy is planned to be connected to European and global developments. Main topics are research, policy and development, health promotion and education, health systems research and development.

The workshop is also related to our role as a member in the WHO "Regions for Health" network. NRW is one of the founding members of this network, and LIGA.NRW with its predecessor institutions has always been responsible for the practical work which is related to this membership. We have always tried to support the network to the extent possible, and we have always felt that the membership in this network was very rewarding. This workshop is organised by the group supporting our function as WHO Collaborating Centre. The workshop intends to promote the debate on regional health policy, illustrating the broad scope of the topic but also trying to "sew" seemingly separate issues together. Here is the golden thread running through the programme:

- The context is population health in European regions, and European health policy. This includes interregional comparisons; results from a recent analysis of regional health policy; and an update on current EU policies incl. EU structural funds.
- The core topic is the pursuit of health equity, utilizing a "life course" model with three groups: children and youth; workers and unemployed persons; and senior citizens.
- In order to support health governance and health equity, various practical methods and tools are available, including health systems performance assessment; health innovations monitoring; and health impact modelling.

Last but not least, the workshop is a contribution to the emerging midrange work program of the "Regions for Health" Network. I am sure this workshop will mean two days of intensive exchange, informative discussions, and fruitful networking. Let me close by saying thanks to my colleagues, who shouldered the burden of organizing this workshop.

Thanks for your attention.

Pina Frazzica & Lino di Mattia, Regions for Health Network secretariat, Caltanissetta, Sicily, Italy

Prof. Dr.med. Rainer Fehr, MPH, Ph.D.
Landesinstitut fur
Gesundheit und Arbeit
Des Landes Nordrhein-Westfalen

Dear Prof. Fehr,

The RHN Secretariat deeply appreciates the invitation to take part to the Workshop on "Regional Health Policy – Promoting equity in spite of cross-currents?" to be held in Bochum on 13-14 September 2010.

We wish to congratulate you and your colleagues for the fine program, for its rich content and for the excellent speakers. The themes are particularly important for Regional policy and they are timely. They are current concerns in Regional work and should be more present on the political agendas of our Regions. Furthermore, these types of meetings that favour comparisons and exchanges offer the best value for benchmarking and mutual support for a more sustainable impact.

It is with great regret that the Secretariat cannot take part to this important workshop because of previous important engagements. You may know that, from 13 to 16 September 2010, the Sixtieth Session of the WHO Regional Committee for Europe will takes place in Moscow and I had committed to participate to this event.

Nevertheless, we wish to send our best greetings to the Political representatives, the speakers, the participants and to the organizers congratulating each one and wishing everyone a very successful participation to the event and a rewarding time in Bochum, which we will miss.

Meanwhile, may we ask you kindly to provide us with the presentations and any other documents coming from the workshop that we can share with the other Regions of the Network that could not participate to this important meeting so that others can benefit from the work done in Bochum.

Finally, we wish thank you for your superb scientific work, for your innovative contribution to Regional policy and, mainly, for your strong support of RHN and of its Secretariat.

Most sincerely,

Dr Lino Di Mattia
RHN Secretariat

Dr Pina Frazzica
Head of RHN Rotating Secretariat
Region of Sicily

Erio Ziglio, Head, WHO European Office for Investment for Health and Development, Venice, Italy

Summary of video message

Erio Ziglio points out that the WHO European Office in Venice is endorsed with the task to maintain special relationship with the WHO Regions for Health Network. He wishes to thank the Bielefeld group for organizing this workshop. He stresses that the chosen topic "Regional health policy – Promoting equity in spite of cross-currents" is very important for Europe today. Unfortunately, Erio Ziglio cannot take part in the workshop because the workshop coincides with the 2010 conference of the WHO Regional Committee for Europe in Moscow.

The Regional Committee plans to renew the "Health for All" policy. Within this renewal, the issues of health, health equity and the need to reduce health inequalities is going to take centre stage in the conference.

For this reason, the discussion at the workshop in Bochum will be very important for the WHO. The Region for Health Network gives a unique opportunity to present the right kind of platform for discussion, exchange of know-how and the provision of evidence. To address these issues at regional / länder / autonomias / kanton level etc., is very important in the cur-

rent European situation where the health systems are being decentralized in many countries, and health policy is more and more becoming a regional matter.

Erio Ziglio wishes all participants well. He regrets not being able to attend the workshop due to the Regional Committee meeting but will coordinate further actions with Prof. Fehr and colleagues to ensure that the results from this workshop will be brought to the upcoming meeting in Flanders, where the issue of health inequalities in European regions will continue to be discussed.

4. Session 1: Health in European regions: Population health – Regional health policy – EU (health) policy

4.1 Wolfgang Hellmeier: Population health in European regions – Interregional comparisons based on EU co-funded projects

Based on international projects, this presentation looked at the status and trends of health analyses concerning populations in European regions. The European Commission needs tools to assess health throughout Europe, to tackle health differences in order to diminish them, and to decide where funding is necessary. It was noted that national indicators often hide regional differences. Health policy-makers in European regions, on the other hand, need information below the national level to find partners for public health projects, and for conducting benchmark exercises for their own region.

The presentation utilized insights from three current EC co-funded projects. The **UNIPHE** project ("Use of Sub-national Indicators to improve Public health in Europe", www.uniphe.eu) focuses on environmental health, looking for indicators to compare regions in socio-demographic, environmental and health aspects. The **EURO-URHIS 2** project ("Urban Health Indicator system", www.urhis.eu) investigates health issues in densely populated areas; it looks for local policy tools, and uses local survey data. The **I2SARE** project ("Health Inequalities Indicators in the Regions of Europe", www.i2sare.eu) defined their own "regions relevant for health policy"; it uses only statistical data which should be available in each region.

On this occasion, it was discussed that the definition of a **"region"** (even when limited to sub-national level) is not unique. The UNIPHE project, e.g., uses EUROSTAT's NUTS system. The URHIS project looks at urban areas, and the I2SARE project defined regions relevant for health policy in another specific approach.

More specifically, the **UNIPHE** project aims to:

- develop a sustainable environmental health monitoring system through a set of sub-national indicators
- improve public health across Europe

- facilitate the comparability of health status data
- identify policies and interventions that deliver positive health outcomes, and
- enable their transferability to other regions in European countries.

The expected outcomes include the following: a standardized system for the collation and reporting of environment and health information at a regional level across Europe; a contribution to a Commission's priority regarding health promotion through a reduction in health inequalities between regions; a consistent and common framework within Europe which will facilitate the comparability of health status data; a system which helps to identify those policies and interventions, and to accommodate their transfer to other appropriate European regions.

The UNIPHE project developed a core set of 22 indicators, including the following: Air quality and noise (mortality due to respiratory diseases, exposure to ambient air pollutants); Water and food safety (incidence rate of acute intestinal communicable diseases and bacterial food toxic infections; drinking water quality / chemical non-compliance); Accident, mobility and transport (mortality from road traffic injuries in children and young people); Chemicals, UV and ionizing radiation (incidence of melanoma in population aged under 55 year); Socio-economic issues (unemployment, living floor area per person).

The **EURO-URHIS 2** project's mission is to construct a methodology, develop and validate tools; and to be useful for policy makers at all levels to make health gains via evidence-based policy decisions for urban populations. Project participants include 30 cities from 12 European countries, and from Vietnam. The objectives are to collect data at urban area level, to provide tools for evidence based policy, to develop methods for cross-sectional and longitudinal assessment for urban population health, to validate the tools and methods by using existing data, and to apply the tools in the field to ensure they are easy and intuitive to use. Data are being collected from (i) routine statistical systems at urban level (incl. population; population density; birth rate, infant and perinatal mortality, low birth weight; life expectancy, causes of death, number of general practitioners, vaccination coverage), (ii) from a youth survey in schools, similar to the "Health Behavior of School-age Children" (HBSC) project (incl. Health status:

atopic diseases, back pain, self perceived health, psychological problems, accidents; Health related behaviour; Problems at school; Environment at home, quality of housing; Social aspects, e.g. contact to friends, parents, etc.); (iii) from an adult survey (personal information: how long in the country, origin, marital status; self perceived health, back pain, some common diseases; health related behaviour; social aspects (contact to friends, parents, etc.); living environment; use of health services); and (iv) from interviews with local policy makers concerning their priorities and interventions in their area.

The **I2SARE** project aims to produce a health profile for each region of the European Union, to create a typology of those regions of Europe and a typology of sub-regional territories in a selection of countries and regions (e.g. France, NRW). Concerning health profiles, it was stated that – beyond regional comparisons – the profiles also help to identify gaps of relevant regional information.

One focus of I2SARE is on producing a classification (typology) of European region. Such a typology is relevant in order to get a comprehensive overview of the regions, to identify patterns, to highlight differences within a country, to encourage exchanges and develop networking activities between similar regions, to build networks with similar regions, and to identify best practice models for one's own region. In this project, a general typology was constructed via a hierarchical cluster analysis (Ward's Method). It was expected that the resulting clusters were formed by regions from different countries, and that the clusters represented different patterns. It was possible to include 168 out of 265 regions participating in the project, and to utilize 10 out of 37 indicators. The analysis identified 8 clusters, each one consisting of 10 to 31 regions. Some countries (or large parts of them) are put into one and the same cluster. On the other hand, some border regions are classified into a cluster mainly residing in the neighbouring country; and often the largest cities are classified into clusters different from the rest of the country.

Textbox 1: Results of I2SARE cluster analysis of European regions

Cluster 1 PL: Youngest group with high mortality

Cluster 2 IT/PT: Oldest group with low education and many people inju red or killed on road traffic accidents

Cluster 3 AT/BE/DE-west: Largest proportion of people injured or killed on road traffic accidents, many hospital beds and low unemployment

Cluster 4 UK/SE: Lowest unemployment, few hospital beds, small difference in life expectancy and low premature mortality

Cluster 5 DE-east: Highest unemployment, many doctors and many "acute" hospital beds

Cluster 6 ES: Most educated group with many old mothers, very low premature mortality, many doctors and few "acute" hospital beds

Cluster 7 CZ: Less educated group with young mothers, young population and high premature mortality

Cluster 8 FR: Smallest proportion of people injured or killed on road traffic accidents, large difference in life expectancy, average premature mortality and low infant mortality

In summary, the need for sub-national data on European level is well acknowledged. The EC is funding several projects. First results have been reached. In the URHIS project, data needs are defined, data are collected, and analyses designed. In the UNIPHE project, discussion on indicators is ongoing, the need is acknowledged, data availability is a problem. The I2SARE project is the most advanced project, data are collected, analysed and presented, dissemination to regional policy makers has started, and the discussion on usefulness for European decisions on funding has started. For the future, it is hoped that these projects will enhance regional availability of data; that (some) results will be used for political decisions on regional funding; and that I2SARE methodology might be improved as a sound instrument for decision-making.

4.2 Claudia Hornberg: Results of a literature search and in-depth interviews with regional health policy experts

The regional level continues to gain importance in health policy-making. Major challenges include: demographic change, technological progress in medicine, and growing competition about funding. Public health interventions increasingly need to be specific with respect to target groups and target regions.

LIGA.NRW in its function as WHO Collaborating Center for Regional Health Policy and Public Health has the mission to "support, promote, evaluate and encourage further work on regional health policies" and to "carry out activities related to the development of health policies and strategies in accordance with the „Health for All"-principles.

From this background, a project on regional health policy was started, aiming to structure and further develop regional health policy, and to focus on decentralisation, innovation management and performance assessment. More specifically, the projects aims to set up a literature database on regional health policy topics in order to clarify current health system-related trends and drivers; to contribute data on health policy development at the regional level within Europe; to collect and disseminate expertise and experience with planned or already implemented measures in regional health policy; to encourage political decision-making using experience which was gained in other regions across Europe; to improve and increase the transfer of knowledge and experience of health policy development among members of the "Regions for Health" network (RHN); and to search for conceptual frameworks as well as performance indicators to achieve effectiveness, equity, efficiency and quality of health systems.

Methods used were literature searches and expert interviews. As for the **literature searches**, public health papers were included which deal with political strategies and developing strategies in the context of public health; and focus on the subnational (regional) level. The initial retrieval was expanded by including the topics of decentralization in European health systems; regional development/implementation of decentralisati-

on concepts; and performance assessment in regional health care. Search terms used were "regional" (incl. local, community), „health" (incl. welfare, care), and „policy" (incl. planning, system, model, governance, „decentralisation" and devolution. The terms were used in various combinations with each other.

The following online databases were used: Pubmed (free access), WHO Library Information System (free access), HECLINET (free access), HealthStar (restricted access), Social Citation Index Expanded (restricted). The hits were narrowed down into three nested lists, starting with a "basic list" of 996 hits, reducing this to the "long list" with 100 hits, and ending up with the "short list" of 35 hits. The selection criteria for papers included the following: relevance of the topic, up-to-dateness, relevance for the European region, access to the literature (free/restricted), and assumed practical relevance for the target groups.

In a second approach, national and international **experts** were consulted who deal directly with public health and health care issues at the regional level. Guideline-based interviews were conducted concerning the following topics: structures in regional health policy; recommendations concerning communication and information management within the RHN; regional health policy vs. national/ European health policy; problems in regional health policy in the context of the global economic crisis.

To illustrate results of the **literature searches**, a few examples are mentioned here. Concerning regional health strategy and targets, these are the following (with annotations in italics):

- Wismar et al. (2008): Health Targets in Europe – Learning from experience. Health targets are instruments for improving public health systems. A critical discussion is given of factors which may either help or hinder these goals.
- Rechel et al. (2009): Investing in hospitals of the future. Using the case of hospital planning, the authors show how planning of investments made into public health facilities require particularly careful strategic deliberations regarding funding and management during a recession.

Two examples concerning regional development and implementation of decentralisation concepts:

- Saltman et al. (2007): Decentralization in health care – strategies and outcome. Introduces the reader to decentralisation of public health systems by means of examples.
- Bohigas (2008): Comment on decentralization, re-centralization and future health policy. Discusses the possible consequences of decentralisation and gives different perspectives of the issue.

A final example on performance assessment in regional public health:

- Spencer & Walshe (2008): National quality improvement policies and strategies in European healthcare systems. An analysis of health policy strategies and approaches to implementation in Europe: Effectiveness and applicability to other public health systems.

The papers assessed provide fundamental information on how to deal with problems in regional health policy; help to find scientific answers to region-specific issues/developments and to examine approaches in the planning stage as well as successfully implemented strategies; help to standardise information amongst the RHN members and to provide a uniform information basis; give the option of linking up with online information providers and communications services within the RHN. Based on this, in the future, a comprehensive scientific database for regional health policy activities could progressively be built up.

Selected results of the **expert interviews** include the following: There are specific opportunities for regional health policy-making to address human health in „everyday" living environments. Spatial and target group-specific public health interventions can promote and increase positive changes in health-related working and living conditions, particularly also for vulnerable groups. Concerning interdisciplinary work, professionals working in different local departments such as public health, social work, education, environmental policy, engineering etc. should cooperate closely, and ensure a consistent level of dialogue and engagement. Not only health promotion and disease prevention, but also health care needs to develop closer connections with other policy sectors.

Viewed against the backdrop of an increasingly European public health system, there are specific risks and opportunities of regional health policy-making, including the following: Changing role of regional health policy-

making in the context of EU policy; the European integration process poses a challenge for European health and social systems; national public health systems are facing a number of challenges: diseases and health risks do not know borders, and the transnational use of health services is increasing; differences in competence and capacity between European Union member states constitute a significant hindrance for transnational exchange; and it is difficult to bring together the wide range of actors whose actions have an impact on human health.

In summary, while the increased demand for cross-border health services and the burgeoning health market can pose a threat to the autonomy of national public health systems, these phenomena also are opportunities to achieve uniform health care standards throughout Europe. The new media allow for a greater informal information exchange and help deal effectively with public health issues and opportunities to reduce inequality and improve health and well-being. Differences in competence and capacity at the EU, the national and the regional level often hinder health policy cooperation. In the context of the global economic crisis, a „Europeanisation" of health policy tends to be associated with negative consequences for the solidarity principle in public health.

4.3 Neil Riley: Between Scylla and Charybdis – Positioning European regions in the 21st century

The contribution was on opportunities and challenges for regions to improve and protect health in Europe, aiming to set the scene for some of the ongoing conversations being had by regions in the field of health in the 21st century. The speaker, in his entire working career, has had the privilege to work at regional level in three countries, Australia, England and now in Wales. What has characterised all three situations is the reality that regions, regional governments and authorities have a balancing act in finding a clear vision between nationalism and localism. There is often pressure coming from both sides – national demands – or if you have been in the UK in the passed 10 years, national targets. And from the municipalities: demands for greater control over local affairs – regions can be seen as bureaucratic and restricting choices at local level.

When asked for a title for this talk, the speaker called it "between Scylla and Charybdis" as he wanted to convey the dilemmas of being between nationalism and localism. A colleague gently pointed out that labelling national and local governments "monsters" might not be helpful; but the point remains that for regions to act deliberately in improving and protecting the health of their population, they need to find clear water and identify the best courses to act to maintain relevance.

Part of this tension is about the nature of regions – why do we have them and what do they do. When ask the same question across Europe, we will get a million different answers. - An example from Wales: In Wales people think they are a country. There are defined borders that have been there for 900 years. There is a language that is unique to the Welch residents. There is a legal identity. However, owing to the loss of a battle in historic times, Wales has lost its status of independency.

Impulsed for further discussion included the following: "We're all on the same side", "We need effective tools", "We need to share experiences", and "It's about turning principles to practice".

4.4 Kai Michelsen: EU Policies, EU Health Strategy, EU Structural Funds, "Regional Health"

This presentation looked at EU health policy-making and EU Structural Funds. Within "Consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union", several articles are related to human health. Article 4 mentions a shared competence of both Union and member states in common safety concerns in public health matters. In Article 6, it says: "The Union shall have competence to support, coordinate or supplement the Member States to protect and improve health", and in Article 9: "The Union shall take into account the protection of human health in defining and implementing its policies and activities".

According to Duncan (2002), we can distinguish three types of health policy-making on EU level: direct; indirect; and unintentional. "Direct" health policy-making means realising health objectives under article 152 (public health), including e.g. regulations concerning the internal market (e.g., tobacco control legislation) or initiatives to tackle communicable diseases. "Indirect" health policy-making takes place when the primary objectives

are different from health, but health considerations play an important role, e.g. common safety standards within the process of economic integration:. Lastly, "unintentional" health policy-making affects health in an unplanned manner. Examples include the common agricultural policy with negative impacts on diets; or the European Court of Justice's court decisions on the free movement of patients.

The EU can only undertake direct health policy activities in a restricted number of fields, and if they have a clear added value to the existing policies of the Member States. But it is necessary to look beyond the notions of EU health competences as defined by the Treaty, e.g. at the completion of the single market that allows for regulations by the Court of Justice with an important impact on national healthcare systems. Regarding the European Court of Justice, it has been criticized that "secondary legislation, such as directives and regulations, and the Court's interpretation of them, must be based on what is in the Treaties. However, the social character of European health systems is not embedded in the Treaties." (Mossialos 2001)

While some observers have a critical perspective on the development of EU (health) policies and the consequences for health systems (e.g. Greer 2006, 2009), others are more optimistic. It was pointed out by Lamping (quoted after Boessen 2008) that "health policy is a challenging example of how to make a formal non-topic one of the Union's major future policy fields – despite the Treaty." The current Public Health program carries the title "Together for Health: A Strategic Approach for the EU 2008-2013". Its principles include the following: (i) shared health values, such as universality; access to good quality care, equity and solidarity; citizen empowerment; reducing inequities in health; built on scientific evidence, (ii) "Health is wealth", (iii) Health in all policies, and (iv) Strengthening the EU voice in global health. Strategic objectives are to foster good health in an ageing Europe, to protect citizens from health threats, and to support dynamic health systems and new technologies.

As part of the strategy, EU Structural Funds are also mentioned. They can be used for investments in health and health infrastructure, esp. in the new EU Member States. Around € 5 Billion, corresponding to 1.5 % of the total EU Structural Funds budgets (mainly of the European Regional Development Fund) should be spent for direct investments in health and health infrastructure (the amount of money has to be seen in the light of the volu-

me of the EU Health Programme with around 300 Million Euro). The potential areas of EU health investment are numerous (cf. Textbox). Non-health sector investments by EU Structural Funds might provide further added value in terms of health gain possible.

Textbox 2: Potential areas of EU health investment (EC 2007)

- Healthy aging: health promotion, screening, tele-medicine, rehabilitation
- Healthy workforce: health promotion, disease prevention, safety at work ...
- Health infrastructure: construction, modernization, equipment ...
- Cross-border cooperation (services, information, knowledge, good practice)
- Health innovation and research
- Knowledge and information society: patient information, e-health, modernization...
- Human capacity: training, education, management

First country and regional assessments for investments in health have been written (http://ec.europa.eu/health/health_structural_funds/used_for_health/info_sheets/index_en.htm). They include the following topics: country assessment summary; eligible regions under cohesion policy objectives; health investments in the National Strategic Frameworks and Operational Programs; non health sector investment with potential health gain. The health impact of non-health sector investments should be evaluated, and health gains should be maximised as part of a Health in All Policies strategy.

While the current EU Structural Funds policies offer new opportunities for investments in health, there are also major challenges. These are related to: EU structural funds architecture (co-financing, time pressure, evaluation); assessment of regional needs; identifying good practice (incl. transferability, sustainability); offering the right support at the right time in the periods of EU structural funds policies; integrating professional perspectives, needs and interests of program management, economists / labour market experts, and Public Health professionals – at the EU, national and regional level.

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4.5 Karl-Heinz Feldhoff: Health in European regions. Euregion Meuse-Rhein – "EuPrevent"

In the so-called "Euregion Meuse-Rhine" (Euregio Maas-Rhein, EMR), there is a tradition of close cooperation including the Public Health services, the provinces, and several other institutions. Ambitious health activities are planned under the headline of „EuPrevent". The presentation describes the main targets and selected program elements.

The overall targets of **„EuPrevent"** are: Promotion of projects in prevention; an operational system in the Euregion Meuse-Rhine for projects in

relation to primary prevention; health for children and young people; adequately dealing with mental health, environmental health, and infectious diseases. Within EuPrevent, several programs are taking place, concerning, e.g., overweight, infection control, addiction, mental and environmental health.

The program on **overweight reduction** is being funded by the Interreg IV program (2008-2012). It aims to improve life conditions (life quality) for children and young people in the region. Activities include the following: nutrition in schools; more sports in schools, kindergarten and leisure time; network of healthy schools and kindergarten; common programs for cooking; common programs for moving; and a campaign: "Count your steps (to reach the moon)".

A second program refers to improve **patient safety and infection control.** It is also funded by Interreg IV (2008-2012). Main targets are: Building a network of quality in the 5 parts of the region (EurQ Health); building networks in all counties of the region; teaching and learning for health workers, doctors, nurses and other groups to improve infection management; building a regional web-based platform concerning questions of MRSA (Multiple Resistance Staphylococcus Aureus) and other antibiotic resistances; promoting hygiene in hospitals, nursing homes and ambulances in the region. – There is a certification procedure for hospitals in the region. This includes: Taking part in the network; surveillance of nosocomial infections; teaching and learning for the health workers; screening of patients; defining risk persons; surveillance of special MRSA-types; fulfilling the legislative orders; communicating with the outpatient-system; establishing a screening system in the hospital.

A program on **addiction** involves cross-border cooperation in the Euregio to decrease risky behaviour by adolescents. It aims to establish cross-border cooperation on prevention and to improve the level of prevention in the region. A youth survey on the prevalence of risky behaviour was conducted in 2006, with the target group of all pupils of secondary schools aged 14 or 16 years (46,000 adolescents). Topics included: school results, healthiness, use of medical and other drugs and alcohol, smoking habits, leisure activities, exercise, sport, safe sex, eating habits, and oral hygiene.

A cross border workgroup on **prevention** is established. In every year since 2005, the month of May was declared Euregional "Month of Prevention".

Activities include the training of professionals. A **mental health program** aims to improve cross-border cooperation of hospitals concerning psychiatric diseases; to develop prevention visits for elderly in households in the region; and to develop screening examinations for children to recognise risk factors of good mental health. The program on **environmental health** aims to improve life quality of citizens in the region, e.g. protection of climate as "Priority 2020".

The EuPrevent aims to combine political aims with necessary practical steps in prevention. It aims to establishe participation of patients on a more regular basis, e.g. by cooperating with the network "European Patients Empowerment for Customized Solutions" (EPECS). – Similar prevention structures should be useful in other cross border regions as well.

5. Session 2: Pursuing health equity: Children and youth – Workers and unemployed persons – Senior citizens

5.1 Petra Kolip: Equity in health projects for children and adolescents

Based on several projects on national and international level, the presentation discusses health equity issues. Two major studies are used as databases to examine the social determinants of health in adolescence: HBSC and KiGGS.

"Health Behavior in School Aged Children" (HBSC, www.hbsc.org/) is a WHO collaborating cross-national study. It began in 1982 as a scientific collaboration between researchers in 3 European countries. Now there are more than 40 participating countries and national teams from Europe and North America. The study cycle is 4 years. Sample sizes are a minimum of 4,500 adolescents (11, 13, and 15 years old) in each country. The study aims to collect cross-nationally comparable data on health and health related behaviours; to monitor health and health related behaviours as well as social determinants of health in adolescence; and to understand social and environmental factors that influence health behaviours & health and well-being (Currie et al., 2006).

In HBSC, social determinants are at special attention. To address this issue, family affluence is used as a social indicator. There is a set of four questions on the material living conditions, including the frequency of holiday travels in the past 12 months and the numbers of computers in the household. From this, a composite score is being calculated providing classification into low, medium, and high family affluence. Concerning health indicators, there is a standard international core questionnaire plus optional packages. Indicators include the following: Positive health including self-reported health, life satisfaction, mental well-being, body image, etc.; risk behaviours: tobacco, alcohol and drug use, sexual behaviour, violence; health behaviours, e.g. eating habits, physical activity, etc. The results show, among others, differential effects of family affluence on health risk behaviour such as consumption of soft drinks (figure 1).

The **German Health Interview and Examination Survey for Children and Adolescents** (KiGGS, www.kiggs.de/) provides information on health and health behaviour as well as social and environmental determinants of health in German children and adolescents. It was conducted in 2003-2006 as a nationwide, representative interview and examination survey for the age group 0 to 17 years. There were 17,641 participants from 167 communities, with a response rate of 66.6%. The KiGGS features a modular structure of core survey plus 5 modules, i.e. environmental exposure, nutrition, mental health, motor fitness, and a specific sample representative for the region (Bundesland) of Schleswig-Holstein. The survey includes objective measures of physical and mental health; parent- or self-reported questionnaires (age 14 to 17) on subjective health status, health behaviour, health care utilisation, social and migrant status, living conditions, and environmental determinants of health. The results show strong associations between social indicators (parental education, income, parents' job position, attended school) and indicators of health and health behaviour (figure 2; Kuntz, 2010).

Although the data give hints on the relevance of social determinants of health a theoretical model explaning the influence of social inequality on health is still missing. Nevertheless several projects try to close the social gap.

The "**DETERMINE**" EU-wide initiative involves novel approaches of intervention in several countries. Examples are: An innovative health promotion project for obese, inactive men with little or no education at workplaces in the Municipality of Guldborgsund, Denmark; raising awareness for planning healthy and sustainable houses amongst a segregated Roma community living in Debrecen, Hungary; and enabling homeless to help themselves and improving their access to health services as well as the public's awareness and perceptions, through a wide range of initiatives in Slovenia. DETERMINE also provides a "European Portal for Action on Health Equity", www.health-inequalities.eu.

As another source for innovative approaches, the "Infoportal Prävention NRW" and the database "Gesundheitliche Chancengleichheit" were mentioned, which include, e.g., the following projects: "Gesund aufwachsen in Münster" implies several health promoting activities including midwives' consultation hours in kindergardens. "Fitkids" supports children

with parents addicted to drugs (“empowerment”). “Frauengesundheitstreff Bremen-Tenever” is a venue for migrant women living in an urban district with high rates of unemployment. It is located in a shopping center („Café“) and offers open meetings, training courses based on the women‘s requests, e.g. German for beginners, alphabetisation, riding bicycles; and counseling, e.g. on baby care and healthy nutrition.

In summary, these studies underline the role of health of children and adolescents as an important topic. So far, there seems to be no clear understanding of the mechanisms producing health inequalities. Empirical data draw attention to the social determinants of health in youth.

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Associations between family affluence and daily consumption of soft drinks

by country/region and gender

NORTH	Boys	Girls
Canada	–	–
Denmark	–	–
England	–	–
Estonia	+	
Finland		
Greenland	–	
Iceland	–	–
Ireland	–	–
Latvia	+	+
Lithuania	+	
Norway		–
Scotland	–	–
Sweden		–
USA	–	–
Wales	–	–

SOUTH	Boys	Girls
Croatia		
Greece		–
Israel		–
Italy		–
Malta		–
Portugal		
Slovenia		
Spain	–	–
TFYR Macedonia†		+
Turkey	+	+

WEST	Boys	Girls
Austria		–
Belgium (Flemish)	–	–
Belgium (French)	–	–
France	–	–
Germany	–	–
Luxembourg		–
Netherlands		–
Switzerland		

EAST	Boys	Girls
Bulgaria	+	+
Czech Republic		
Hungary	–	–
Poland	+	
Romania	+	+
Russian Federation	+	+
Slovakia		
Ukraine	+	+

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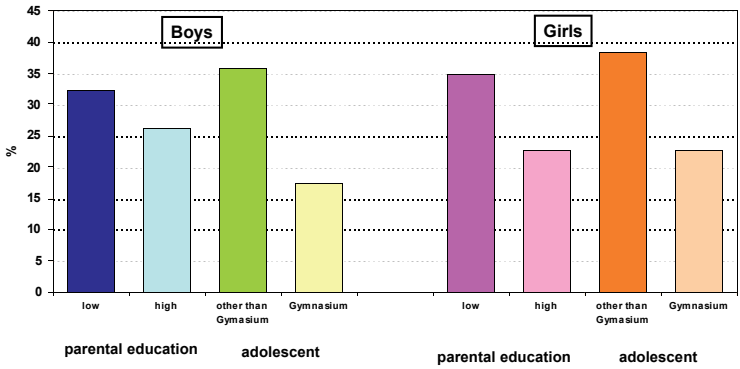
Smoking: adolescent's and parental education

(daily or occasional smoking)



5.2 Mariann Pénzes: Special „Alternative Youth Settings“ in Hungarian shopping centres – aiming to strengthen social cohesion

ALTERNATÍVA Nyíregyháza
Here is your place!

Special „Alternative Youth Settings“ in Hungarian shopping centres – aiming to strengthen social cohesion

The old structures which integrated the youth into the society, have changed well palpably. The classical settings of socialization – family, school, peer groups and media – transformed so fully both in function and partnership to each other that we cannot build on those any more. Moreover we can detect an increased gap between younger and older generations, and even between the youth and the whole society. The loss of values and the deviation can be detected especially in the post-socialist countries. The people who are living here have to cope with the breakdown of the whole social scale of values and the building up of the new system, which was really disappointing for many people.

For youth there is a determining fact to find that setting where they can be independent from the child existence as well as from the adults. Many times the street becomes their setting where they can acquire autonomy – or after transition they find places in the multiplied shopping centres and plazas. These squares give a chance to young people to be outside the family home and at the same time inside their friends' environment, and during that a big building gives them a feeling of security, too[1] (Matthews, Taylor, Percy-Smith and Limb, 2000). Young people spend their free time mostly with friends, chatting, looking around and walking. The Plaza is a possibility for young person to relax while being escaped from responsibilities of school and family home.

1 From Kun Bernadette - Kovacsics Leila - Demetrovics Zsolt - Fábián Róbert - Vadász Piroska - Erdélyi István - Sebestyén Edit - Buda Béla - Felvinczi Katalin: Alternatíva : múlt, jelen és jövQ. ElQzetes elképzelések és megvalósulás publication of the National Drug Prevention Institute, 2010

Many studies discover that behind frequently visiting plazas, there may be a desire of young persons to be independent, the importance of peer connections, and moreover that the Plaza can be a possible place for recreation. These facts, based on scientific data, join to the legal and illegal substance use, but until now we are not informed about international researches to discover drug use habits among young „Plaza visitors" (Kun and colleagues, manuscript). The „Alternatíva" (as a special service) can be a possible answer on this situation. It is an attempt, and if it goes well this can increase the chance for present-day young people to exploit resources when they are grown up later.

The structure of spending free time has changed; it joins more and more to the free time industry working on the market principles, as outcomes of the propagation of consumer's society new models of spending free times appear. This kind of transformation of the free time is named by some authors as a loss of childhood referring to those facts that the age of the first sexual experience and later the formation of the regular sexual life is less and less (Gábor 2004[2]). Recently the most important change of spending free time is its increased role. This alteration has risks on at least 3 areas:

- During the transition from the school to the world of work, the role of free-time turns into an important one, and therefore we can see a contradiction: at the same time with the longer education time the young people get related to the work earlier (already in the grammar school, but especially later as a student). This process intensifies the structural inequalities and differences, and personal problems of the young. Therefore the free time turns into an important part of life from the future carrier's point of view. The Hungarian and West-European studies show that not in the school but rather in the free time those processes of socialization do appear which intensify gender differences.
- Secondly we have to take into account that spending free time requires a prematurely formed independent consumer status. It results that because of economic inequalities present in the society, the young people are significantly differentiated in the free time.
- And lastly the market-depending alteration of free time means that young people carry on those activities as adults do, and these activities (smo-

2 Gábor K. (2003): SebezhetQ ifjúság. SebezhetQség az oktatásban, a munkavállalásban és a szabadidQben Európában perspektívák. Belvedere Meridionale, Szeged

king, alcohol consumption, drug use) are seriously risky for them (Gábor 2003: 8[3]).

In the adolescence the three most important relations from partnerships – regarding to social participation later and quality of life/health – are the family, friends/peers, and the school. In the relation space the position which a person assumes can influence which of the coping strategies of young people are strengthened during generational reproduction. Those personal skills and attitudes which are fixed here later can be hardly modified or only with investing large amounts of energy. In cases when we can recognise the „vector" of rebellion and refusal during adolescence, be it towards constructive innovation and renewing or destructive deviance, we have a chance to influence and turn to the positive direction.

From the health behaviour's aspects, the most important protective factor is the network of supporting social relations. The warm, supportive, helpful family background, the school setting which takes into account the personal capacities, appreciates the small successes, but reflects worth and expectations, and the supportive partnerships, these all together ensure ground for healthy life.

The HBSC study which was executed in 2008 using on-line questioning method, reinforced the well-known facts:

- characteristics of free time (where, how, and with whom the young people spend their free time) is a determine factor in health behaviour;
- friends influence the different behaviours. The other, preliminary studies (in Hungary: Elekes és Paksi, 2004a, 2004b[4]; Paksi és Elekes, 2003[5], 2004[6]) described the young Plaza visitors as the group of people who use legal and illegal drugs more frequently than the average, and feature more symptoms of anomie and depression. Their behaviour is defined by the place they came from. These factors have influence on their attitudes towards programmes and services, how open-minded they are, what programmes they refuse, how they accommodate to frames, and how they behave with their peers.

3 Gábor K. (2004): Globalizáció és ifjúsági korszakváltás. In: Gábor K., Jancsák Cs. [szerk]: Ifjúsági korszakváltás ifjúság az új évezredben. Belvedere Meridionale, Szeged. 28-72

4 Elekes, Zs.; Paksi, B. (2004a): Európai középiskolás kutatás az alkohol- és drogfogyasztásról. Magyarországi projektbeszámoló. OTKA Kutatási zárójelentés, Budapest Elekes, Zs.; Paksi, B. (2004b): A felnQtt népesség alkohol- és drogfogyasztása 2003-ban. NKFP Kutatási zárójelentés, Budapest

5 Paksi, B. (2003): A felnQtt népesség droghasználata Magyarországon. Addiktológia, 2(1): 6-28

6 Paksi, B.; Elekes, Zs. (2004): A felnQtt lakosság droghasználata különös tekintettel a nagyvárosi fiatal felnQttekre. Magyar Addiktológiai Társaság V. Országos Kongresszusa, 2004. október 23-23., Balatonfüred

Financial resources for special programmes – realisation of National Strategy for Tackling Drug problems

One of the main values of our society is our youth. Besides knowledge and recognition of democratic values, there is very important to take consciously advantage of their rights, adapt those to the adult society without shocks and to guarantee their welfare and ambition with innovative approaches as continuously renewable force. Moreover it is crucial that the children, adolescents, and young people take part in their closer and wider communities with a recipient, tolerant attitude. It is very important that their national and European identity should help them in building up a sustainable, peaceful society. It is a basic aim that the targeted age groups consider the family and having children as a value and as a part of successful life, and that they prepare themselves for parenting.

The social renewing operative programmes aim to develop social and economic participation of young age groups (12-29 years old), to support utilization of social resources, to develop consciousness of planning and leading life course, to increase resistance against negative social processes, to decrease shortfalls originating from societal-cultural differences with developing personal and/or community competences, with ensuring high quality information and alternative programmes, and moreover with developing services, institutions which can realise these programme on long term. A further aim is that the young age groups are enabled to realise a productive life style in such a way that the use of psychoactive substances won't be attractive for them because of their health-consciousness, personal life, social and societal relationships, and capabilities to control their environment.

Background – the problem[7]

- expansion of education from the 1990s (longer educational period, high number of persons in the system), from one side the general educational level increased, from the other side there is lack of harmony between workforce supply and demands

7 From the call for proposals in frame of TAMOP (The social renewing operative programmes)

- high number of drop-out from the vocational education system, the low-qualification is regenerated
- general lack of life skills
- low level of health consciousness, unhealthy behaviour, lack of coping skills, (in the last resort that causes public health crisis)
- damage of mental health, unhappiness, unsuccessfulness from the early childhood
- deficits at community level (low level of socialisation in the family and in other institutions)
- negative social and economic tendencies, inequalities
- deeper disadvantageous situation, generational poverty, otherwise plethora of material essentials and information. Loss of values, extreme longing for "experiences".

Pre-life of Alternativa

The National Drug Prevention Institute considered it very important to start such a complex health promotion, low threshold service which works in the Plaza, and targets young people hanging around. In autumn of 2005, two „Alternatíva" advisory youth offices were opened in two big shopping centres in Pécs and Budapest. Nowadays these services work in „franchise system", with similar images, with same key elements, with well defined HR and infrastructures. Of course, designing of the place takes into consideration the local needs and facilities.

Textbox 1: The basic elements of "Alternatíva"

- yellow ladders, logo, unique T-shirts of colleagues
- at least 2 separated rooms, capable for group working
- opening hours: 14-21 o'clock
- target group is young people over 14 years old
- the place offers a low threshold services, and the all other special methods, tools are defined by professional team (life skills counselling, health promotion), taking into consideration the local characteristics
- permissible, unbidden, open groups

- personal counselling
- film clubs, tee drinking, games, other special programmes connected to the actual problems, self recognition groups, and programmes out of Plaza
- HR: high educated people, social workers, doctors, psychologists, and other helper experts

The programme succeeds in meeting the targeted groups, their visitors are the young people who loafing in the shopping centres. Mainly they can be characterised with disadvantageous social, economic background, and frequently having educational and relation problems. The aim of our programme is to increase chances for integration of children (who have to cope with gaps), their families and the young people with prevention programmes outside the education system. These programmes compensate their handicaps, decrease deviation, support school performance, teaching the appropriate social skills, preparing for labour world, and supporting social participation.

The main characteristics of effective, low threshold prevention programmes are those which give services in an environment which is easily accessible for targeted young people, and where they turn up in this setting (for example shopping centre) as a regular part of everyday activities. In that manner the utilisation of this prevention service does not stigmatize but allows easy access and more effective intervention.

The "Alternativa" Office is a free of charge, low threshold prevention advisory office, fitted into the world of shopping centre. The function of it is to ensure special programmes, which aim at optimal social and mental development, to forward young people to the most appropriate social and health care services. Our target group is 14-25 years old young people who are in biggest risk regarding to substance abuse. The mission of this office is to give help and support in time to avoid drug use, and to cope with addiction. The basic services are: personal and group consultations about drug use, health protection, mental hygiene, psychological, and social advisory. The setting gives place for peer programmes, courses, and facilities for spending free time in a healthy, acceptable manner.

The **„Alternatíva Youth Setting"** opened his gate for 14-25 years old young people in April 2009 in Nyíregyháza[8], on the second floor of NyírPláza. The team aimed to form a special place which can transmit values and culture for their visitors, and give social, mental, and community support. The programme is ongoing. More recently we have to work without financial support (experts work as volunteers), but we prepare a new proposal to continue functioning.

The most beloved program components are the following: Information base: learning, travelling, working etc. possibilities, information about freetime, youth exchange programmes, applications; Creative Club: organised itself from the bottom up, and is led by young people; Film Club: with spontaneous discussions; Games: make getting acquainted more easier; Picture-Music-Words Exhibition Series: we give chance to young people who are talented in painting, singing, dancing etc. Those who can present himself/herself feel success, self-confidence, get positive feedbacks from peers; Camera of secrets: this is a support instrument for more effective intervention; a place for counselling and discussion; Games for self recognition; and Life skills and health behaviour advising.

The way forward – Current challenges include the following:

- We have to step „over the threshold", addressing our target groups more effectively, e.g. young visitors who walking aimlessly, or spend time in gaming rooms. On the other hand we have to focus on the most urgent needs, so have to develop programmes fitted to personal needs and demands
- Survive financial „breaks" – the project is based on outside funds, cannot be self-supporting
- Sustain personal motivation on high level
- Recruit qualified experts who are young, motivated, have empathy and good skills
- Involve volunteers but avoid inexperienced, untrained persons as helpers
- Continuous training, knowledge expansion, development of skills, prevent burn-out
- Include target persons without excluding other target ones, e.g. roma and non roma visitors, „gangs"

8 The owner of programme is the AlterEgo Association for Drug Abuse Prevention of North-East Hungary

- Place for what? TV room, playground, entertainment centre, meeting point, etc.? For whom?
- Catch more young persons from Plaza visitors, but not increase the number of Plaza visitors
- Widening good-fruitful partnership
- Fundraising with effective negotiation (Plaza's management)
- Public Relations, social marketing... skills we have to learn.

5.3 Manfred Dickersbach: Unemployment and health – some facts and strategies

The presentation focuses on the following topics: Unemployment and health – what is the interrelation? Improving health equity with unemployed people; the "Regional Hub" North Rhine-Westphalia – strategies and perspectives.

It is not a trivial question to ask which comes first: reduced health or unemployment? As it seems, the relationship can be interpreted as a vicious circle. Disease generates a higher risk to become unemployed. Unemployment increases the risk of disease. Disease then generates a higher risk of long-term unemployment, etc. In this situation, health promotion can help. There are several evaluated model programs, including AMIGA (integrating health promotion into job promotion), AktivA (training to improve mental health), and Job Fit NRW (placing health promotion in qualification institutes).

Options for improving the health of unemployed people include the following: Integrating disease prevention and health promotion into routine employment promotion; qualifying job agents and case managers; utilizing the potential of the medical / psychological service of work agencies and of the local public health service; integrating health modules into measures of employment promotion and qualification; and building local networks.

In North Rhine-Westphalia, such activities take place under the umbrella of the "Regional Hub" (Regionaler Knoten, www.knoten-nordrhein-westfalen.de). Such Regionals Hubs exist in all 16 German states (Bundesländer) and are co-sponsored by the federal program "Health promotion for socially disadvantaged people". The program involves know-how transfer and

trans-sectoral networking. Concerning unemployed persons, there is a wide range of activities. Regional conferences, e.g., are dedicated to networking local health promotion and employment promotion. A web-based manual on "Health promotion for unemployed people" is currently being prepared. It focuses on mental health and provides an overview of relevant programmes as well as guidelines for practical work. A working group on local inter-sectoral cooperation aims at networking the fields of health and of employment promotion; at defining roles for the public health service and the medical service in job agencies; and at improving access to local health care and health promotion.

Challenges include the following: (i) Tracking dynamic social processes – e.g. in the labour world, (ii) Differentiating the target groups (unemployed persons; persons threatened by unemployment; fixed-term workers), (iii) Integrating the settings such as workplace, job agency, temporary employment agency, institutions of qualification and employment promotion, and settings of local health promotion.

Health promotion for disadvantaged people implies a shift of focus „beyond health care". Health is influenced increasingly by proceedings of various other political and social sectors – and, in turn, has the potential to positively influence processes in these sectors. This raises certain questions, such as: Should the responsibility for health promotion be transferred to different policy sectors? Who then would be responsible for financing, methodical innovation and quality standards? Would the health sector be able to keep some general function of steering and control? Accordingly, "health in all policies" is a coin with two sides – making health promotion a general social concern may result in a wider impact and better visibility of the health subject, but also in lower standards and a loss in commitment and obligation.

5.4 Hanneli Döhner: Senior citizen's health projects and equity – Focus on caregiving

The presentation introduces the topic, focuses on several international projects, and draws some conclusions for regional policy-making.

"Who cares?" Due to demographic factors and developments in medical care and social support, increasing numbers of people require long term care (paradigm change from acute care to long-term care). In nearly all European countries, the family is regarded as the main responsible institution of care for older people. In European countries about 80% of this care is provided by informal carers, mainly women (spouses, daughters, daughters-in-law, other relatives, friends, neighbours). Without the work of these unpaid carers, care systems would collapse.

The **EUROFAMCARE** (EFC) study is the largest and most comprehensive study ever conducted on family carers in Europe. The main aim was to provide a European review of the situation of family carers of older people in terms of existence, familiarity, availability, use and acceptability of supporting services. The project explicitly had an intention of social policy. It was hoped that, by providing more insight into carers' work and needs, to increase awareness in different countries, and to promote care policies and practices based on a partnership approach between family carers, professional providers and cared-for older people.

The study methodology included the integration of background reports from 23 countries into a pan-European report. Also, a comparative survey was conducted in 6 countries. There was a baseline study with caregivers, involving face to face interviews with c. 1,000 carers per country providing 4 or more hours of care or support per week to an older relative or very close person (age 65+). This baseline study was not statistically representative for the general population, but was a good representation of groups of carers. Another component was a 12-months follow-up study with carers to monitor main changes, involving face-to-face, phone or postal interviews, with the analysis still ongoing. As a third component, a service providers study involved expert interviews with 30-50 providers per country. Data were collected in the 2004-2005 period.

It was found that family caregivers act as advocates on behalf of the cared-for, e.g. in respect to service characteristics such as: care workers treat the cared-for with respect; improvement in quality of life of the cared-for; help available at the right time; skills of care worker. It was also found that family carers need more help for the cared-for in terms of financial support, emotional support, mobility support, as well as timely and flexible practical support.

Carers more often give positive statements about their caring experience than negative statements. We found high willingness to care. At the same time, the following negative aspects need to be taken into account. Family carers are not well informed about services and illnesses; are overburdened; have a high risk to fall ill themselves; have difficulties in combining care and paid work; have a loss of income; have the feeling to be left on one's own; do not feel appreciated in their care work; have a high risk for physical, psychological, sexual, financial abuse and neglect (often hidden).

For the sustainability of this unpaid work force it is an enormous challenge that more than three quarters of the carers never used specific support services. If services are available and used, however, satisfaction is high. Despite efforts made so far, information and advice (esp. on diseases, availability and access of support services) – considered as the most important offer for family carers in all countries – is still lacking in all countries.

Results of EUROFAMCARE have attracted interest in very different areas, and have been followed by many requests from carers and patients organisations, decision-makers on different levels from local to European, social and health care organisations, political parties, researchers, and the media. The combined knowledge and experience from a scientific institute and a carers' organisation is highly appreciated.

Against this background the project EUROFAMCARE aimed to highlight differences in the situations, circumstances and needs of family carers within and between European countries; to ensure that the valuable work of family care for older people receives more recognition and will be on the political agenda in all European countries; to give more awareness to the urgent need of innovative legal answers to the increasing need for long-term care and the gap in adequate services – realising that more and more families opt for migrant home care workers (mostly cheaper, quality is under discussion – often irregular workers).

The project identified research gaps, e.g. the following: Needs of working carers and their recommendations for better reconciliation of care and paid work; initiatives of employers for reconciliation; role of volunteers in supporting working (www.carersatwork.tu-dortmund.de/); role of migrant carers in supporting family carers (receiving country); problems of families left behind by migrant carers (sending country).

Based on the research results, EUROFAMCARE members contributed to several initiatives, including a European Network for Carers, a European Carers Association (cf. below), and a European Carers Charter. This "Charter of Rights for People in Need of Long Term Care and Assistance", with the undertitle "From Practical Responsibility to Everyday Practice – from Entitlement to Living Reality", covers the following topics: Self-determination and support for self-help; Physical and mental integrity, freedom and security; Privacy; Care, support and treatment; Information, counselling and informed consent; Communication, esteem and participation in society; Religion, culture and beliefs; Palliative support, dying and death. The German version of this Charter has been published by the German Federal Ministry of Family Affairs, Senior Citizens, Women, and Youth and the German Federal Ministry of Health, 2007.

Only some European countries feature a longer tradition of national carers' organisations, but there is no European Carers Association. Based on the initiative of another EC co-funded project (CARMEN), together with EUROFAMCARE, representatives from carers' organisations and research and development groups from eight countries met in 2004 and established a European-wide organisation to represent and provide a voice for carers, namely the European Association Working for Carers (EUROCARERS, www.eurocarers.org). This association identified 10 Guiding Principles as a background for further action: Recognition, social inclusion, equality of opportunity, choice, information, support, time off, compatibility of care and employment, health promotion and protection, financial security.

The **EUROCARERS** association aims to advance the issue of informal care by providing a united voice at European level, influencing policy at national and EU levels, promoting awareness of carers issues, disseminating experiences and good practice, providing information on relevant EU policy developments, developing an informed research agenda, and supporting the development of carers organisations all over Europe.

Stimulated by the EUROCARERS development and initiated by the German EUROFAMCARE team, a German Carers Association has emerged: "Wir pflegen – Interessenvertretung begleitender Angehöriger und Freunde in Deutschland" (We care – voice of caring families and friends in Germany; www.wir-pflegen.net). It has the status of registered non-profit association (Eingetragener Verein) and is supported by the EUROFAMCARE network.

In many countries, working conditions for professional carers are inappropriate and lead to a deficit in formal care and to migration to countries with a system that gives more appreciation to that work. Willingness to care for a relative is decreasing, but still high. The economic value of informal caregiving is enormous. Nearly all of us will be a carer at some time in our life course – for a shorter or longer period. A better support of carers' and self-help organisations could strengthen the social networks and solidarity between citizens. Equity for family carers is strongly connected with equity for older people in need of care.

Numerous policy areas on EU, national and local levels are relevant for the support of family carers. The list includes: health (preventive measures for employed carers), social (insurances, pensions, equal rights), labour market (employment strategies for formal and informal carers), family (gender aspects), financing (financial support, calculations of indirect costs, combined resources), migration (long-term solutions instead of ad hoc), technologies, media, providers, humanitarian and religious organisations / NGOs / carers organisations, and research.

The EC-funded project FUTURAGE aims to create a road map for ageing research in Europe in the next 10-15 years. The project is undertaking the most extensive consultation ever conducted in this field and it is mobilising stakeholders, including medical practitioners, policy makers, industry and representatives of older people. Healthy ageing is seen as the process of optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life (Swedish National Institute of Public Health (2007): Healthy Ageing – A challenge for Europe).

Following Carol Jagger, "Healthy Ageing" as a societal goal requires a range of activities to be implemented, especially the following:

- Monitoring and resolving inequalities in healthy ageing: modelling links between disease and functioning (physical and cognitive) over the life course; disease impact may vary across environments; also links between exit from labour market and pensions, socioeconomic status, cultural expectations
- Interventions for improved health and wellbeing with ageing and comorbidity: diversity of public policy on health related services; comparative effectiveness research; ensuring translation of new and existing knowledge; identifying target groups for promoting health and wellbeing
- Prevention, and promotion of healthy ageing: identification of markers of ageing from cellular to societal level; do markers modify success of medical interventions? can biomarkers measure the efficacy of interventions? how can functional decline and onset of new diseases be reduced in different populations and subpopulations?
- Psychosocial factors and healthy ageing: disentangling genetic, behavioural and environmental influences on healthy ageing; life course transitions: impact of health events on restoration or decline of functioning and social/psychological processes involved; clarifying how personal attributes (personality, ethnicity, gender) impact on healthy ageing; connectedness and orientation; "productive ageing" / "shrinking" of the life space.

5.5 Gunnar Geuter, Gudula Ward: Promotion of health-enhancing physical activity for the elderly – Current activities in North Rhine-Westphalia

The health-promoting impact of physical activity, including its contribution to stress management, is well established. Physical activity plays a particularly important role in preventing chronic disease, averting health risk factors in particular overweight and obesity and in strengthening health resources – wellbeing, self-esteem, social integration. Nevertheless, in Germany and in most industrial countries diseases triggered by a sedentary lifestyle are on the rise. This means that not everyone is in a position or chooses to make use of the opportunities that are out there. Hence, it is necessary to further improve knowledge about the links between sufficient physical activity and health; to motivate people to pursue a healthy lifestyle;

and to create the framework conditions that foster understanding of each individual's responsibility for his/her own health and, by extension, for his/her family. In this context, attention should focus on daily structures, social environment, income, education, environment and transport.

From this background, there is a German national initiative to promote healthy diets and physical activity (IN FORM, www.in-form.de), supported by the Federal Ministry of Health and based on a resolution of the German Bundestag. "IN FORM" draws on existing national action plans and federal programmes. It supplements and builds on them and promotes cross-topic and cross-stakeholder synergy effects. In Germany there are already a number of different measures and projects seeking to counteract poor eating habits, physical inactivity, overweight and the related diseases. The Federal Government stresses the need to draw together and further develop these diverse initiatives in a national strategy seeking to strengthen and establish health-promoting daily structures.

Within the "IN FORM" national action plan, regional centers for promoting physical activity were established as pilot projects in several states. In North Rhine-Westphalia, this is supported by the Ministry for Health, Emancipation, Care and old Age NRW. LIGA.NRW acts as organizing institution. The Center for Promoting Physical Activity North Rhine-Westphalia aims to increase physical activity in everyday life as a contribution to maintain health and as part of a healthy lifestyle. It works on identification, analysis and dissemination of evidence-based intervention plans, strategies and successful examples. The main target group are persons of at least 60 years of age.

It is known that socially disadvantaged groups are less likely to take up existing offers, in some cases because of limited financial resources. Districts and neighbourhoods with a high proportion of socially disadvantaged residents often have deficits when it comes to shaping the living environment and offer few opportunities for physical activity. Therefore, the Center cooperates with the „Regional Hub" NRW (from the nationwide cooperation network „Health promotion for socially disadvantaged groups") and focusses on socially disadvantaged groups.

Implementation strategies include the following: To network and support the stakeholders and multipliers who promote physical activity; to analyse

and communicate information on behavioral and situational prevention; to promote activities and framework conditions; to ensure quality development in the promotion of physical activity. The Center developed a technical concept for the promotion of physical activity: „Physical activity- and health-enhancing municipality“ and currently completes guidelines on „Promotion of physical activity 60+“. The target group is going to be enlarged („Promoting physical activity across the lifespan“).

Literature

◆ BMELV/BMG (2008): IN FORM – German national Initiative to Promote Healthy Diets and Physical Activity. Berlin. Download of the English version under http://www.in-form.de →Publikationen →IN FORM Hintergrundinformationen →Broschüre IN FORM (englische Version)

6 Methods and tools to support equity in regional health policy: Systems performance – Innovations – Impact

6.1 Ann-Lise Guisset: Health System Performance Assessment – contributing to regional health policy

The presentation starts out from a public health vision for the WHO Regional Office for Europe, the Regional Director's priorities, and the case for a renewed European Health Policy. It then narrows in on Health System Performance Assessment.

According to the WHO Regional Office for Europe, a public health vision understands health and disease (measuring health status, carrying out surveillance, and control), promotes health and well-being (understanding determinants, encouraging population health and working across sectors for "Health in all Policies"), ensures and improves efficiency (using evidence based policy and performance measurement), advocates and communicates for better health; and leads and works in partnership positioning health, linking disciplines and shaping the future.

The WHO Regional Director's priorities include: Health policy and social determinants of health; health systems and Public Health; non communicable disease, disease prevention and health promotion; health security and communicable diseases; information, evidence, science, research and innovation; environment and health, and climate change.

Underpinned by the European Study on Social Determinants of Health, WHO Europe identifies a case for a renewed European Health Policy. The vision is to bring the WHO European region closer to the ideal of better health for Europe for the next Biennium and beyond, by giving expression to health across the whole spectrum of government policy making at local, regional, national and European levels. The goals are to strengthen and further articulate the foundations for realising public health as a whole of society endeavour; to foster political, scientific and technical leadership around improving health for all and reducing health inequities within and between countries; to create the conditions which bridge local to national to regional and international processes and serve as an enabling environment for sustained investment, action and impact on population health; and to foster

and maximize the diversity of stakeholders, communities and perspectives engaged in health improvement across Europe and within countries.

There is a global initiative "From an European Health Policy to National Health Plans and Strategies". The Regional Office for Europe proactively embarks on it while recognizing the specificities of the region. The variety of decentralized health system approaches in Europe is an element to be taken into account. Some countries are marked by a federalist structure with the elucidation and implementation of health plans seen as more a regional than a national or central competence, while in others the federal level sets the vision and the regions do the budgeting and implementing. It is clear that the role of national and regional governments in defining the health policy varies greatly across the European region. From this background, tools are being proposed for use at national and sub-national levels. Compared to the national level, all principles remain the same. The tools can be implemented in both ways, "cascading" down, or "bottom-up". One key tool is **Health System Performance Assessment** (HSPA) which "seeks to monitor, evaluate and communicate the extent to which various aspects of the health system meet their objective" (Performance measurement for health system improvement: experience, challenges and prospects, Smith et al. 2008, Tallinn Conference Background Document). Assessing health system performance involves: measuring and analyzing how well a health system is meeting its ultimate goals; how its performance against intermediary objectives contributes to helping serve these goals; and, for performance management, how health system functions perform to contribute to achieving intermediary objectives.

Key message 1, "Towards a strategy-based HSPA": Strategy based HSPA brings a focus on health system performance improvement. It makes sense out of performance measurement rather than "simply" measure it. Assessments are conducted regularly to build evidence more systematically into decision-making. The focus is on performance improvement, by helping to make the various levels of the healthcare system more accountable for better health outcomes. This means aligning performance measurement to strategy and institutionalizing HSPA at the country level for performance management and accountability.

Key message 2, "Towards a system perspective": Since health system functions are interconnected; "improving performance demands a cohe-

rent approach involving coordinated action on multiple system functions. Experience suggests that action on one single function or program is unlikely to lead to substantial progress or the desired outcome" (Tallinn Charter on health systems, health and wealth). The health system's six building blocks alone do not constitute a system, any more than a pile of bricks constitute a functioning building. It is the multiple relationships and interactions among the blocks – how one affects and influences the others, and is in turn affected by them – that converts these blocks into a system (De Savigny et al.: System Thinking, 2009).

Key message 3, "An evidence base for intersectorial dialogue": HSPA does not measure the performance of the ministry of health, health and social affairs, health, environment and veterinary services, health and medical industry, public health. The health system is a universe of all actors and activities whose primary purpose is to promote, restore or maintain health.

Key message 4, "From a rhetoric exercise to institutionalizing HSPA: managing performance systematically in order to stimulate improvement:

(Health System Performance Assessment: Where does equity stand?...)

Concerning next steps towards the development of operational tools for HSPA, WHO pursues a comprehensive workplan for this and next year. This includes the following items:

- Attributes of health system performance -> Content of the evaluation; „What?"
- Practical guide and case studies -> Process – Critical success factors, „How?"
- Compendium of indicators and indicators passports -> Tools, „Bricks"
- OBS Methodological study -> Methodological foundation
- Position paper and meetings to facilitate cross-country learning -> Make sense

6.2 Barbara Pacelli & Nicola Caranci: Health needs and access to health services by migrants across the European Regions – A proposal to build a minimum set of shared indicators

The paper identifies health of migrants in Europe as an emerging issue, looks at several migration-related projects as well as at the Emilia-Romagna experience, and then discusses the MIGHRER I project results and a second edition proposal.

Migrants enhance economic, social and cultural aspects of the communities, eventually changing their perspectives. The right to health implies accessibility to all, especially to the most vulnerable members of society. The health advantage sometimes observed in migrants ("healthy migrant effect") may reduce over time or in subsequent generations.

Concerning the sharing of information across EU regions, UN-ECE and EUROSTAT held a Work Session on Migration Statistics, including models for estimating international flows in the European Union. The EC-funded PROMINSTAT project aimed to promote comparative quantitative research in the field of migration and integration in the European Union. The Global Consultation on the Health of Migrants (WHO and IOM, Madrid 2010) produced a resolution which calls for monitoring and reduction of differences in definitions and datasets across regions. Monitoring migrant health provides a variety of benefits: preventative strategy to preserve the health advantage (espec. concerning chronic disease); early recognition of evolving health influence, e.g. decreasing incidence of many infectious diseases and adoption of health risk factors; development of multi-sectoral policies based on observations where individuals are at risk (e.g., workplace).

In Italy during 2007 to 2009, a task force brought together several national institutions (ISTAT: NATIONAL STATISTIC INSTITUTE; INAIL: The Workers Compensation National Authority) and many Italian regions. A standardized method to monitor the health profile of immigrants was implemented, and a minimum set of indicators using administrative data was developed, referring to both national and regional level, with the option to draw historical series (from 1992 onwards). The minimum territorial detail corresponds to municipality or province area. The study population is based on

citizenship. Immigrants from countries with high emigration flows are being compared to Italian citizens, and to immigrants from developed countries.

Concerning Emilia-Romagna, results include the following: There is a sharp increase in immigrants in the region; this is among the highest rates in Italy (from 3.8% in 2002 to 10.2% in 2009). There are moderate health problems among immigrants which tend to be young and healthy ("healthy migrant effect"). The majority of contacts with the health services are due to physiological events such as pregnancy for women, or caused by the lack of prevention actions such as injuries for men and abortion for women. Infectious diseases still represent a major cause of hospitalization among immigrants, both for men and women. As for antenatal care, if compared to Italian women, the proportion of women undertaking less than 4 visits during pregnancy or having their first visit after the first trimester is higher in immigrants.

This topic was studied in the framework of the project **"Migrants and Healthcare: Responses by European Regions" (MIGHRER I)** which started in 2006, was led by the region Emilia-Romagna and coordinated with the WHO Regions for Health Network. 11 regions participated in the project which implied a "region-centered" approach, aiming to gather and describe strategies and actions adopted at regional level across Europe regarding the health of migrants. The final project report is now ready to be published.

Based on MIGHRER I, it is now proposed to conduct comparisons across regions in the European Union. A proposal for a **MIGHRER II** project is being developed which includes the following strategies: review of existing databases and indicators of international institutions, e.g. OECD, WHO, EUROSTAT, UN-ECE; building a country-specific matrix indicating definitions, data availability and the calculation feasibility of the indicators; definition of a core-set of shared feasible indicators across EU regions. Concerning comparisons across EU regions, some critical key points include the following: different migration history across EU regions (early migration countries vs. long-term migration countries); country-specific legal situation with different operative definitions of migrant (citizenship, country of birth, ethnicity); data availability regarding so called migrant-relevant indicators, i.e. origin, length of residence, and migration history.

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6.3 Karin Scharfenorth: How to develop health regions as driving forces for quality of life, growth and innovation? The experience of North Rhine-Westphalia

In North Rhine-Westphalia (Germany), a cluster "Health Care Economy" as a regional approach to develop health care industries was established in 2008. This is part of the innovation policy of North Rhine-Westphalia. Six "Health Regions" belong to this cluster: Aachen, Cologne/Bonn, Münsterland, Ostwestfalen-Lippe, Ruhrgebiet and Südwestfalen.

The basic idea is as follows: The health care sector is not only a growing cost driver but represents an economic field with important effects on employment, innovation, and quality of life. The aim is to develop "excel-

lence" in NRW health care economy. With its cluster policy, the state intends to support its health regions concerning systematic development and networking. This includes both activities within the individual regions as well as joint activities of several regions. Moreover, there are cross-cluster activities, e.g. with the biotechnology cluster and the medical technology cluster. And there are cluster activities aiming at networking across the different areas of the health care economy, in order to meet patient-oriented treatment solutions and interlinked provision of health care.

The initial phase included the following activities: Analysing regional strength; developing regional concepts; establishing regional branch forums; regional conferences with structural policy partners; defining thematic sponsorships; establishing an inter-regional work group; marketing and fairs participation. The various health regions develop specific profiles, expressed by main topics (Textbox 1).

Textbox 1: Specific profiles of health regions in North Rhine-Westphalia

Health Region Aachen

- Medical Technology/ Life Sciences
- Second Health Market / Health Tourism
- Employment and (Continuing) Education
- Care Provision
- Cross-boarder Cooperation

Health Region Köln/Bonn

- Health for Generations
- Medical Specialist Staff
- Prevention and Rehabilitation
- World-class Medical Research
- International Guest Patients
- Medical Technology/Telemedicine

Health Region Münsterland

- Medical Prevention

- Early Diagnosis
- Innovative Provision of Care
- Nano-bio Technology and Analytics
- Telemedicine, Telematics
- Logistic in Health Care

Health Region Ostwestfalen-Lippe

- Interlinked Health Care Provision
- Care Networks Geriatrics
- World-class Medical Science „for heart and brain“
- Initiative Telemedicine NRW
- Rehabilitation and Prevention
- Knowledge Transfer & Cluster Development

Health Region Metropole Ruhr

- Clinical Economy
- Integrated Care Concepts
- Prevention and Rehabilitation
- Health Care and Demography
- Life Science and Medical Sciences

Health Region Südwestfalen

- Materials and Medical Technology
- Applied Medical Technology/Suppliers
- Medical Care Provision/Rehabilitation and Prevention
- (Continuing) Education in Health Economy
- Health Tourism

In the current second phase, the focus is on continuing development and networking activities; benchmarking with other European regions; and conducting the project „Value-based health care” (cf. presentation by M. Evans).

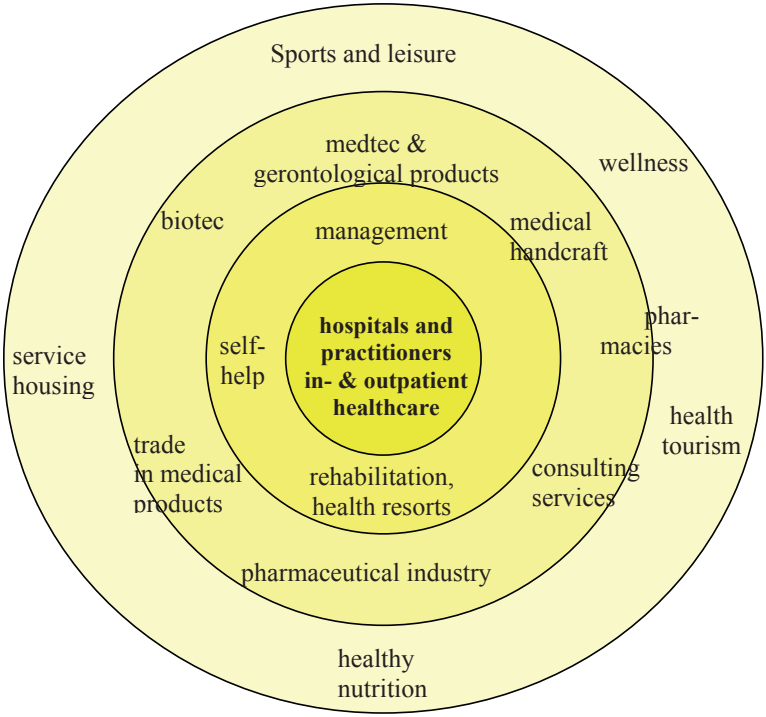
6.4 Michaela Evans: Health economy and health innovation – searching for a patient-oriented model of value-based health care

Regional health care can be seen as a system in transition. The German health care system is (still) in need of reform: rising costs, lack of sustainable financing, uneven quality of care and shortage of skilled personnel establish a need for innovation. On the other hand, the health care sector is also an important driver of innovation for quality of life, work and growth. Over the last few years, health care economy became a vital part of regional structural policy and regional health policy in North Rhine-Westphalia (and Germany at large).

A rising number of German regions brand themselves as "Health regions". The question comes up how the innovation potential can be realised while public, private and common protagonists have to face highly fractional challenges. Demographic change, budget constrains, and a rapid development of health-technologies all contribute to requiring new solutions for regional health care. Businesses as well as regions need analyses for trends, know-how for innovation, and a cross-linked development of potentialities.

The health industry sector is a vast and varied set of (sub)branches, comprising far more than hospitals, doctors and nurses. It is one of the largest sectors of the economy. A recent trend for non-health branches is to try and upgrade their products by adding health components. Many experts expect health to be a growth industry in the years to come, with ageing, innovations for prevention and healing, and growing awareness for health lifestyle as driving forces.

Fig.: Health Industry Sectors (Copyright: IAT; reproduced with permission)



It is currently popular in Germany to establish dedicated regions and networks, in order to bundle the forces available, and improve information exchange. This also applies to health care and biotechnology.

Ongoing activities include the following: Design of integrated health care delivery systems; transparency and (indicator-based) quality assessment; collaboration and innovation in and between hospitals; becoming more and more attractive for health tourists from other regions and from abroad; encouraging and supporting business start-ups in health related fields; to fight upcoming workforce shortages in health care jobs; to make prevention work – from medical wellness and advocating healthy living and working conditions to individualized medicine; to develop internationalization, including exchange of experiences, cooperation in qualification and skill development as well as export of know-how, medical products and technology.

Part of current efforts are focused on a patient-oriented model of innovation. A new innovation-model is needed because, up to now, health policy sets false incentives for innovation. Innovation has to focus on maximizing value to citizens. Quality improvement, quality transparency and the engagement of patients (not only shifting costs) have to become the driving force for innovation.

A new framework emerges with the following characteristics: strengthening outcome- and patient-orientation in innovation processes; Integration of care and outcome research and regional innovation-management; data-based monitoring of trends and innovation activities; identification and communication of best-practice and its prerequisites.

Activities of Cluster management health care economy in North Rhine-Westphalia include the following:

- Monitoring of trends and innovations, with periodic update of key data; innovation reports on selected topics of health care economy; scientific working group in cooperation with "Health Campus North Rhine-Westphalia"
- Hospital Innovation Survey: For the first time, the survey collects data on hospitals service and product portfolios, forms and topics of cooperation, areas of innovation and innovative projects
- Working group "Health Regions North Rhine-Westphalia", devoted to strategic planning, exchange of regional innovation activities, and identification of best practice
- Project development concerning patient-oriented health care economy.

6.5 Odile Mekel: Health impact modeling – Results from an international workshop in Düsseldorf, March 2010

This presentation was based on the upcoming report which summarizes the workshop results obtained[9]. For successful communication and cooperation at the "science – policy" interface, a range of "assessment" tools is available, including the following: assessment of status and/or trends of health, health determinants, and health consequences, i.e. health reporting and health forecasting; assessment of health needs and/or health assets

9 R. Fehr, O. Mekel (2010): Scientific Expert Workshop „Quantifying the health impacts of policies Principles, methods, and models. Düsseldorf, Germany, 16-17 March 2010", LIGA.NRW, Reihe LIGA-Fokus 11

(Health Needs Assessment, HNA; Health Assets Assessment); assessment of impacts on health, essentially forming „What-if" analyses (various forms of Impact Assessment, IA); assessments of health systems performance ((HSPA); and also ex-post assessments (evaluations).

Out of this range, this paper focuses on Health Impact Assessment (HIA) which is a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of population, and the distribution of those effects within the population (Gothenburg consensus paper. WHO-ECHP, 1999) – or more simply: assessment of potential impacts of a policy, program, project on health.

Under the title of "Quantifying the health impacts of policies – Principles, methods, and models", a 1.5-day invitational workshop was held in Düsseldorf (Germany), 16 – 17 March 2010. It was organised by LIGA.NRW, i.e. the Unit "Innovation in Health" together with the WHO Collaborating Center on Regional Health Policy and Public Health. About 35 participants from Germany, the Netherlands, the United Kingdom, Denmark, Finland, Italy and the US attended the workshop.

The motivation was to take the issue of health impact quantification forward, for improved application in health-related assessments in North Rhine-Westphalia as well as in projects like the EC co-funded RAPID project. More specifically, the workshop aimed:

- to provide an overview of the "state of the art" of health impact quantification, and their respective ranges of application
- especially to demonstrate different quantification approaches and models
- to discuss the commonalities, differences and opportunities of application for each model, in the context of considered health policies and resulting health outcomes
- to discuss how to take the issue forward, including issues of model evaluation, general acceptance, and promotion.

Participating institutions included the following: WHO Headquarters. Geneva, CH; WHO European Centre Environment and Health. Rome, I; USTUTTIER – University of Stuttgart, Institut für Energiewirtschaft und Rationelle Energieanwendung, D; UCLA – University of California at Los Angeles.

Health Forecasting Unit. Los Angeles, USA; U BI – School of Public Health (Fakultät für Gesundheitswissenschaften), University of Bielefeld, D; UBA – Federal Environmental Agency. Berlin, D; THL – National Institute for Health and Welfare. Kuopio, FI; SZ – Healthcare Strategy Centre NRW. Bochum, D; SDU – Southern Denmark University. Esjberg, DK; RIVM – Dutch National Institute for Public Health and the Environment. Bilthoven, NL; PHO – West-Midlands Public Health Observatory. Birmingham, UK; NWCIS – North West Cancer Intelligence Service. Liverpool, UK; LIGA.NRW – NRW Institute of Health and Work incl. WHO CC RHPPH. Düsseldorf – Münster – Bielefeld – Bochum, D; JRC – EC Joint Research Centre. Ispra, I; IOM – Institute of Occupational Medicine. Edinburgh / London, UK; IMPACT – International Health Impact Assessment Consortium. University of Liverpool, UK; Erasmus MC – Erasmus Medical Centre. Rotterdam, NL; BSG – Hamburg Authority for Family, Social Affairs, Health and Consumer Safety. Hamburg, D.

A first session dealt with "Principles of quantification of health impacts in health-related impact assessments"; this included: vision and promise of quantification incl. discussion with experts on „when, why and how"; pro's and con's of use of Summary Measures of Population Health (SMPH); equity and quantification.

For the second session ("Models and tools"), model developers were invited to present their tool. Model presentations included: the background of the model (persons and institutions involved, associated projects, date of completion, availability); objectives, application spectrum, target group; model structure and principles, intrinsic (default) data, input data requirements, model results etc.; model validation/evaluation and model sensitivity where applicable; demonstration of an own application; demonstration of an application on a predefined HIA case stud, i.e. prevention of domestic falls in older people. – A range of models and tools was presented (Textbox 1).

Textbox 1: Models and tools presented at the workshop

- Prevent (www.eurocadet.org; www.epigear.com)
- DYNAMO-HIA (www.dynamo-hia.eu) DYNAmic MOdel for Health Impact Assessment
- BoD in NRW (www.liga.nrw.de) Burden of Disease in North Rhine-Westphalia

- HEIMTSA/INTARESE (www.heimtsa.eu; www.intarese.org)
- Impact Calculation Tool (ICT)
- Health Forecasting (www.health-forecasting.org)
- MicMac (www.nidi.knaw.nl/en/micmac)

Key observations included the following: Health Impact modeling is a valuable approach; it can help to understand the complexity of health issues; to facilitate comparisons of potential health impacts across policy alternatives; to tailor structured discussion among stakeholders; and to provide "additional" information for decision-makers; supporting policy-making, e.g. by providing answers to "what-if" questions.

But there is also reason for reservations and caveats of health impact modeling. Required information is not always at hand / evaluated, e.g. how a policy affects risk factors, and how risk factors affect health. Typically, numerous value- and model-based assumptions have to be made that are not always explicit. The approach may give an unwarranted patina of robust science, and it may omit or de-emphasize stakeholder participation. Several models are ‚empty shells' and need substantial input data e.g. population data, risk factors, diseases, and relationships.

Models and tools are being developed in the scientific arena, partly funded by the European Commission. None of the models is commercial. Some approaches provide platforms for (input) data, models, and guidance. Several recent models and approaches are in intermediate stages of development; most of them will become publicly available in spring 2011.

Health impact modeling exists in both the Environmental Health arena and the general Public Health arena. These arenas start to take more notice of each other, and to discuss common perspectives. The workshop contributed to this development. So far, very little evidence seems to exist concerning the demand of health impact modeling expressed by decision- makers and politicians, on the satisfaction of these groups with modeling results provided to them, and on the eventual usefulness of the approach.

The workshop identified a number of open questions, especially the following: Given similar input to different models of health impact quantification, will these models tend to produce similar output? Which model fits for which purpose the best? Once models for health impact quantification are available more easily, will the practice of Public Health and health policy-making be improved? What needs to be done to improve chances that this will happen? How to establish a permanent and reliable basis for the practice of health impact quantification, incl. updating data within systems?

Participants agreed that this type of workshop provided a useful platform for exchange. A second health impact quantification workshop is planned to be held in 2011.

6.6 Ute Sonntag: The Lower Saxony Region for Health

The speaker represents the State Association for Health Promotion and Academy for Social Medicine of Lower Saxony (Landesvereinigung für Gesundheit und Akademie für Sozialmedizin Niedersachsen, LVG&AFS, www.gesundheit-nds.de). Starting out from some basic facts on Lower Saxony (Germany), the presentation discusses several ways to realise a "region for health", especially structure building by governmental support for communities; the settings approach; and networking.

Lower Saxony is one of 16 states of the Federal Republic of Germany, founded on 1st November 1946. There are 37 administrative districts (Landkreise) and eight cities which are administrative districts of their own (kreisfreie Städte). The area is 47.624 km^2 which equals the second rank of all 16 states. Concerning population, Lower Saxony with c. 8 million inhabitants holds the 4th rank.

Concerning **"structure building"**, senior service offices (Seniorenservicebüros) work locally with the following aims: building up an infrastructure; providing services which suit target-groups and their specific demands; providing information and counselling; strengthening the potentials and resources of the elderly; enhancing the quality of life for old persons. The Lower Saxony State Agency for the Dialogue between Generations (Landesagentur Generationendialog, www.generationendialog-niedersachsen.de) works on a state-wide basis. It provides information on application procedures, assesses applications, provides coordination and networking to build

up local infrastructures, supports building up senior service offices, supports public relations work in the communities, and provides evaluations.

The "setting" approach comprises various organisational developments, including health management in organisations; a project "Learning to live healthy", and health management in schools. The latter project worked with internal control groups, external guidance of the processes, external experts from health insurance companies, and a two-year support by prevention specialists. Key topics were: devising a health-promoting school-life; extending health-related activities; and improving the school atmosphere. It was found that the health of schoolchildren and of teachers influence one another; changes of the conditions (?) in schools are the most effective measures to take; and that a systematic approach (beyond single steps) is more successful.

As a second example of the "settings" approach, the Network Health Promoting Universities was presented (www.gesundheitsfoerdernde-hochschulen.de). This nation-wide network was founded in 1995 and is the largest network of health promoting universities anywhere in the world. It includes 300 persons from nearly 80 universities, constituting a combination of an interpersonal and interorganisational network. The focus is on mutual exchange of models of good practice; on steps to realise health management in universities; and on conferences and network group meetings. The network is coordinated by the LVG&AFS. The key communication channel is emailing. "Ten principles of good practice for health promoting universities" were identified (www.gesundheitsfoerdernde-hochschulen.de/HTML/E_GF_HS_international/E1_GNHPU1.html). On the Internet, there are a literature database with more than 800 references, a project database with currently 220 projects (databases in German language), and an archive of network meetings.

As for the third strategy (networking), there are more networks in the LVG&AFS, including the following: Network Age(ing) and Health; Working Group Patient-Information; Network Crèche and Health; Network Social Inequalities and Health; European Women's Health Network. The Network Women/Girls and Health Lower Saxony, e.g., was founded in 1995. It brings together key persons from the fields of health, social affairs, research, politics, and education. The network is organised by the LVG&AFS, the Ministry of Social Affairs, Women, Family, Health and Integration Lower Saxony and

“pro familia Lower Saxony”. There are conferences and newsletters to give impulses for the concrete work with women and girls. Models of good practice are being identified and disseminated.

7. Conclusions, perspectives

7.1 Solvejg Wallyn: Upcoming conference: "Reducing health inequalities from a regional perspective – What works, what doesn't work?"

The presentation introduces the upcoming conference on 8 - 9 November 2010 in Genk, Flanders, Belgium, which is held within the framework of the current Belgian EU presidency and builds, among other sources, on the workshop of the Regions for Health network (RHN), held in Venice, 29-30 March 2010.

The conference steering group includes the following institutions: Flemish Agency for Care and Health; Department Wellbeing, Health and Family; King Boudewijn foundation; Federal level Public Health; Flemish agencies: child health; disabled persons; Regional Flemish European Liaison Agency; Research centre – family policy in Flanders; Belgian Royal Academy of Medicine; RHN members; Venice WHO office, with support from WHO-EURO, Copenhagen.

The key topic of the conference are health inequalities, and reflections on how to deal with them. Policy makers at different level are aware of the need to eliminate and avoid inequalities in policy development, and still there is little success. The complexity of the issue is acknowledged, including diversity of actors and competences. It certainly requires cross-sectoral approaches and multi-level governance.

Main questions of the conference are: "What works, what does not work?" as well as "What and how to tell the policy makers?" Subtopics include the following: evaluation (efficacy, efficiency, economic aspects) and benchmarking (on which basis?); communication both to the public and to policy makers; opening the discussion towards a model to benchmark current and future policy developments; sharing knowledge on how to raise awareness to policy and society on initiatives to reduce health inequalities; highlighting the need that sustainable policy development and specific initiatives to reduce inequalities can and must be evidence-based; highlighting the necessity of an integrated and participative approach. An important goal is to prevent installing structural inequalities due to policy development.

The conference aims to produce "take home" conclusions, i.e. a package of attention points to put health inequity on the political agenda. The program aims at linking research with policy, and bringing it into an international context. There will be statements, workshops, and poster sessions.

On the first day, the start of the conference will be devoted to the "state of the art"; this will be chaired by Hans Kluge, WHO-EURO. The opening lecture is to be held by Jo VanDeurzen, Regional Minister of Welfare, Public Health and Family. A picture of health inequity in Europe, and in European regions will be established. Dave Wilcox, Commission of Regions, will present on "Healthy workforce, health economy". Outcomes of the Spanish presidency conference on social determinants of health will be presented, followed by panel debate and plenary questions and answers.

Then a plenary session will discuss "What works, what does not? Promising practices and lessons from Europe", with Clive Needle as moderator Lieven Annemans (University Gent), Stephan Vandenbroucke (Université Catholique de Louvain), and Jan Semenza (ECDC) as panelists. Erio Ziglio, WHO Venice, will contribute a "Statement on the lessons learned in Europe". Margaret Whitehead is expected to speak on "Evidence based initiatives to remove inequity: consider the complexity and look into methodologically justified evaluation methods". Aagje Leven, Eurohealthnet, will present "Tackling the gradient in health: towards developing an evaluation framework".

In the afternoon, a plenary session discusses "What and how to tell to the policy makers", with Tamsin Rose as moderator and Jonathan Watson (European Health management Association, EHMA) and Pol Gerrits (Belgian Federal Public Health Agency) as panelists. Harry Burns, Chief Medical Officer for Scotland, is going to present on "Tackling health inequalities through intersectoral action – an example from a region". Johan Alleman from the King Baudewijn Foundation and Guy Tegenbosch (Flemish journalist) will together present "Breaking taboos: raise the policy awareness – dare talking about inequity and inequality". Subsequently, Sir Michael Marmot is expected to give a keynote lecture: "Closing the gap in reality" which will focus on implementation of the report in practice.

The second day is planned to start with a plenary session on "Getting the evidence into practice". Chris Brown, WHO Venice, will present: "Evaluation and Benchmarking create opportunities for multi-sectoral and multi-gover-

nance evidence based policies". Yvo Nuyens and Clive Needle are going to present "wild card" statements concerning out-of-the-box-thinking on tackling health inequalities.

There will be workshops on the following issues: Equity from the start, implying a focus on children; social protection across the lifecourse, with a focus on older people; fair employment and decent work, with a focus on vulnerable groups; gender equity, focussing on women; universal access health care; inequalities and psychiatry.

Finally, Charles Price (DG Sanco) and Erio Ziglio are to present on "European perspective on how to proceed – role of regions".

7.2 Summarized conclusions and perspectives

The leitmotifs of the workshop included the following:

- Linkage of science – practice – policy as a key ingredient to support regional health policy-making
- Pursuit of health equity; role of the WHO "Health in all Policies" strategy
- Strategic role of health governance tools, and of „Research & Development" projects
- How to position the activities of LIGA.NRW as a WHO collaborating center.

The workshop presentations and discussions together provided a wealth of information and useful insights. Major conclusions are listed here under the following headlines: (1) The regional approach; (2) Regional health policy; (3) Health governance tools; (4) the WHO Regions for Health Network (RHN); and (5) Perspectives.

1. The regional approach: Diversity and interconnectedness of regions in Europe

The workshop discussion acknowledged that on levels below the European states (countries), there is more variation than is commonly appreciated – in health, health determinants, health care, etc. This is true of the European Union, and even more so of the European region of WHO (ranging from

Iceland to the Pacific coast). The diversity can be seen as a wealth; similar to biodiversity for ecosystems, it may secure resilience in times of crisis. An example of cross-European interconnectedness refers to migrant carers, with contrasting impacts on receiving country (mostly profiting) vs. sending country (families left behind). Especially border regions feel the pressure of „Europeanization". As a consequence, the border regions are prime candidates to act as catalysts for new developments.

2. Regional health policy

„Regional health policy" is interpreted here as health policy on regional level. There was wide agreement that the level between state and local (city, county) deserves more attention than it currently receive; there is untapped (or at least under-utilized) potential of regional health policy. In Europe, there are trends in health policy-making to shift power from state (national) level to lower levels, increasing the relevance of this level. On the other hand, the intermediate level is sometimes (almost) abolished, cf. primary care trusts in England.

There is a number of **current opportunities** to support regional health policy-making, including the following. Rational health policy-making (incl. on regional level) is closely connected with the arenas of health-related research and of societal practice. There are untapped opportunities of linkage of these arenas. This was partially illustrated by two approaches described in two independent presentations: (i) the international „Health Behavior of School-age Children" (HBSC) study which represents sound academic research but without a mechanism to intervention, and (ii) the „Alternativa" project as a courageous real-world intervention but with very limited database and evaluation so far. As it seems, these two approaches could both profit from closer contact with each other, and from being embedded into an appropriate policy/program framework.

A range of governance tools to support regional health policy-making is already available; without much effort, these can be improved, and utilized more intensively cf. below). – Beyond the WHO Regions for Health Network (RHN), there are other networks which are important for regional health policy-making. Representatives of the German section of the Healthy Cities Network and of the German Network of Health Economy Regions partici-

pated in the workshop. There was agreement to develop and improve the emerging cooperation.

Also, however, there are **difficulties** in regional health policy-making, e.g. the following: „Health in all Policies" is like a coin with 2 sides; undoubtedly, there is considerable potential for prevention, health protection and health promotion when looking at other sectors outside health. But also, there are unanswered questions of leadership, financing, and responsibility. – Regions have to find out more about sources and modalities of medium- and large-scale funding, and then to make more systematic use of it.

3. Health governance tools

Part of the discussion revolved around health governance tools, incl. their specific strengths:

- Health status assessment: Health reporting (incl. health determinants, health consequences) is well-established; sample reports of fine quality are available; an infrastructure of indicators / indicator systems has emerged over time.
- Health needs assessment (HNA): Systematic methods for reviewing health needs facing a population do exist; such assessments provide opportunities for engaging specific populations and for cross-sectoral partnership.
- Health impact assessment (HIA): The concept of health impact can be a cornerstone for supporting health policy-making. In some countries, there are distinct elements of HIA „culture". Comprehensive EC co-funded projects are pushing forward towards quantification of health impacts.
- Health technology assessment (HTA) is characterized by proven usefulness, statutory status; in many countries, a full-blown HTA „culture" exists.
- Health system performance assessment (HSPA) is another comprehensive approach, acknowledging the „systems" character of health care provision.

Strategic **projects** (EC-funded and other) related to regional health policy seem generally to be underutilized, at least when looking at whole sets of related projects. This is an easy diagnosis, however, it seems less easy to suggest how to overcome this. It is a research question of its own merit how to optimize exchange processes at the science-policy-practice interface. The question was brought up who would have best competency to utilize project results well. This is not necessarily the body funding the projects. Also, it was pointed out that gradually, EC projects seem to care more about the utilization and dissemination of their results. More recent projects tend to include specific work packages for this purpose.

4. The Regions for Health Network (RHN)

„Network" continues to be a buzzword with positive connotation at WHO. The Regions for Health Network (RHN), after years of fruitful working and a subsequent period of reduced visibility now seems to be filled up with fresh energy and moving along a good path. Benefits to member regions include the following: early access to relevant information; opportunities to obtain feedback of critical-constructive nature; pool of potential partners for benchmarking, for writing joint proposals, and/or conducting projects together.

5. Perspectives

Workshop results are being documented, and will be made publicly accessible. Additional comprehensive information relevant for regional health policy-making is currently being prepared for the upcoming bilingual (English – German) website of the WHO Collaborating Center on Regional Health Policy and Public Health; the workshop provided important stimuli for the selection of information. – The basic arrangement of the workshop apparently suits the topic well. The workshop does not seem to duplicate existing meetings, but to fill a gap. Pending a more comprehensive evaluation, there may be a case for continuation of holding such workshops, in coordination with the Regions for Health Network.

8. Appendix

8.1 Workshop program

8.2 Posters presented at the workshop

8.3 HBSC Reference list

8.4 Venue information

Monday, 13 Sept 2010		
13:00	**Welcome, introductions**	Minister of Health, Emancipation, Care and Old Age (pending); LIGA.NRW; Regions for Health Network
	Session 1: Health in European regions **Population health**	
13:15	Wolfgang Hellmeier, LIGA.NRW	Population health in European regions incl. interregional comparisons, based on I2SARE (regions of Europe) and other EC co-funded projects
	Regional health policy	
13:45	Claudia Hornberg, Dean, Department of Health Sciences, University of Bielefeld	Results from recent literature analysis and in-depth interviews on „Regional health policy“
14:05	Neil Riley, Policy Advisor, Iechyd Cyhoeddus Cymru, Caerdydd (Public Health Wales, Cardiff), UK	Between Scylla and Charybdis: Positioning European regions in the 21st century
	EU (health) policy	
14:15	Helmut Brand, Department of International Health, Maastricht University, NL	EU policies, EU Health strategy, EU structural funds and „Regional health“
14:35	Karl-Heinz Feldhoff, Head, Health Department of Heinsberg County, North Rhine-Westphalia	Euregio Maas-Rhein: euPrevent – „Gezonder leven“, „Viv re plus sainement“, „Gesünder leben“
14:45	Discussion	
15:15	Break	

	Session 2: Pursuing health equity	
	Children and youth	
15:45	Petra Kolip, University of Bielefeld, WHO CC for Child and Adolescent Health Promotion	Equity in health projects for children and youth, incl. „Health behaviour in school-aged children“ (HBSC) study
16:05	Mariann Penzes, Focal point of Szabolcs-Szatmár-Bereg County for WHO Regions for Health Network, Nyíregyháza, Hungary	Special „Alternative Youth Settings“ in Hungarian shop ping centres – aiming to strengthen social cohesion
	Workers and unemployed persons	
16:15	Manfred Dickersbach, LIGA.NRW, WHO CC for Regional Health Policy and Public Health	Equity in workers‘ and unemployed persons‘ health pro jects, incl. „Regional hub“ activities
16:35	(pending)	
	Senior citizens	
16:45	Hanneli Döhner, University Hospital Eppendorf, University of Hamburg	Senior citizen‘s health projects and equity, incl. Carers@Work, FutureAge
17:05	Gunnar Geuter, LIGA.NRW, WHO CC for Regional Health Policy and Public Health	Promotion of health-enhancing physical activity for the elderly - Current activities in North Rhine-Westphalia
17:15	Discussion	
17:45	End of first day work program	
19:30	Informal dinner	

Tuesday, 14 September 2010

08:45	Summary of first day; introduction to second day	
	Session 3: Methods and tools to support equity in regional health policy	
	Systems performance	
09:00	Ann-Lise Guisset, WHO Regional Office for Europe, Copenhagen	Health systems performance assess ment - contributing to regional health policy
09:20	Barbara Pacelli / Nicola Caranci, Agenzia sanitaria e sociale regionale - Emilia Romagna, Bologna, Italy	Health needs and access to health services by migrants across the European Regions: a proposal to build a minimum set of shared indicators
	Innovations	
09:30	Karin Scharfenorth, Cluster Management „Health Care Economy“ North Rhine-Westphalia, Bochum	How to develop health regions as driving forces for quality of life, growth and innovation? The experience of North Rhine-Westphalia
09:45	Michaela Evans, Institute for Work and Technology (IAT), Gelsenkirchen	Health economy and health innovation – Searching for a patient-oriented model of value-based health care
	Impact	
10:00	Odile Mekel, LIGA.NRW, WHO CC for Regional Health Policy and Public Health	Health impact modeling - Results from an inter national workshop in Duesseldorf, March 2010
10:20	(pending)	
10:30	Discussion	
11:00	Break	
	Session 4: Perspectives / Discussion	
11:30	Solvejg Wallyn, Flemish Agency Care and Health, International Relations, Brussels, Belgium	Annual RHN Conference in Genk (Belgium), Nov. 2010
11:45	All participants	Discussion: Conclusions and perspectives incl. capacity building, „Regions for Health“ Network (RHN) perspectives
13:30	Meeting closure	

8.2 Posters presented at the workshop

WHO Collaborating Center for Regional Health Policy and Public Health

Landesinstitut für Gesundheit und Arbeit des Landes Nordrhein-Westfalen

Health-related "Integrated programs" – their views on impact assessment, other policy tools, and inter-sectoral cooperation

R. Fehr[1], C. Böhme[2], J. Hilbert[3], H. Schreiber[4], C. Weth[5]

[1] Institute of Health and Work North Rhine-Westphalia (LIGA.NRW) / WHO Collaboration Center for Regional Health Policy and Public Health (Düsseldorf/Bielefeld), [2] German Institute of Urban Affairs GmbH (Difu), Berlin [3] Institute for Work and Technology (IAT), Gelsenkirchen, [4] Federal Environment Agency (UBA), Dessau, [5] German Healthy Cities Network, Secretariat, Münster

Tab. 1 Integrated programs - Overview	Membership base	Programmatic base and orientation
Healthy Cities network (HCN), 1989	c. 2000 European cities	• primarily based on "Ottawa Charter" and "Health for all" thinking • aiming at comprehensive health protection / promotion
Regions for Health Network (RHN), 1992	29 European regions	
(National) Environmental Health Action Plans (NEHAPs), 1994, e.g. German EH Action plan (APUG), 1999	c. 40 countries of WHO's European Region	• focus on environment and health • "European Environmental Health Action Plan", 1994
Programme Social City (SC), 1999	c. 500 urban areas in D	• aims at improving the local living conditions in disadvantaged urban areas, with health promotion as one of the different action fields
Network of German Health Regions (NDGR), 2008	16 regions in D, with c. 1,000 health-related enterprises	• focuses on innovations for health care, health technology, prevention and health promotion • strong interest in economic dimension

Context, objectives

In addition to traditional (health and health-related) policy approaches, there are "integrated programs", working across multiple topics. With a relative focus on Germany, we investigate how such programs establish inter-sectoral connections, and what policy tools and procedures are being deployed. Results can be utilized to explore common interests concerning HIA as well as to foster cooperation among the programs.

Tab. 2 Relationship with HIA and "Urban Planning"	
HCN	• Work programs of European HCN: Phase IV (2003-08): 3 themes incl. "**Healthy urban planning**" and **HIA**; Phase V (2009-13): "**Health and health equity in all policies**", 3 themes incl. "**Healthy urban environment and design**" • EC-funded "PHASE" project on **HIA** linked to HCN

Methods

Starting from an existing synopsis, 5 programs were selected. Using published information sources and the authors' expert knowledge, qualitative

	• Center of competence on "District-based & citizen-oriented **urban development**" • Website section dedicated to **HIA** • Publications: "**Healthy urban planning**", related to HCN; "A healthy city is an active city: **a physical activity planning guide**" (2008)
RHN	16th annual conference at Varna (BG), 2008, discussed **HIA**, incl. contributions: HIA in Wales; Public health impact assessment experience in Kaunas (LT);HIA - implementation, barriers, enablers, context; WHO Venice: Health in all policies
NEHAPs	• Link to WHO's **HIA** website • German EHAP ("APUG") website refers to the EC-funded **APHEIS** project • North Rhine-Westphalian EHAP (APUG NRW): project on HIA-related planning instruments: "Synergy of local & regional **planning instruments** for ... city / transport planning"
SC	Website presents summaries of **urban development projects** in DK: "Kvarterlöft", UK: "New Deal for Communities", FR: "Politique de la Ville", IT: "Contratti di qurtierre II", NL: "Grotesteedenbeleid", SE: „Outer City Initiative" & „Urban Development Programme"

Tab. 3 Other (cross-sectoral) tools and (cooperative) program features[1]

HCN	• World-wide presence; **differentiation** incl. national & regional HCNs, e.g. 14 cities / municipalities in NRW; Network of European National HCNs; [Advanced] European HCN • City profiles: comprehensive **health reporting** • **Meetings of mayors**
RHN	• Joint **projects**, e.g. EC-funded Health indicators and management projects, e.g. Migrants & healthcare; Indicateurs de Santé (ISARE III), Benchmarking (BEN II) • Participation in **European Ministerial conferences**, e.g. Tallinn 2008 ("10 theses") • **Regional Ministerial Forums**
NEHAPs	• Environmental health action plans connecting **across four levels**: European / national / state / local (e.g. monitoring and surveillance) • **Cross-reference** to HCN and "Local Agenda 21" initiatives • **Specific action plans**, e.g. Children's Environment and Health Action Plan (CEHAPE)
SC	• 13 substantive **action fields**, incl. employment, education, health promotion, etc. • 7 **management areas**, incl. integrated concepts, participation, evaluation, etc. • "Integrated action plans", "Neighbourhood management" • Database of **practice examples**: > 500 entries, searchable by categories
NDGR	• 7 **focus groups** initiated on a range of topics, incl. internationalization, technological innovations, quality, prevention and rehabilitation[2] • **Book publication** on "Health economy", with 7 of 11 founding regions represented • **Project 2009**: "India and Germany - Strategic partners for innovation"

[1] Not included: newsletters, (annual) status reports, (annual) meetings, steering groups, secretariats

and quantitative criteria were applied to characterize the programs and their key approaches. The criteria used in this preliminary analysis include the following: basic features; relationship with HIA and urban planning; other (cross-sectoral) tools.

Results

Results are presented in Tables 1 to 3.

Conclusions

Without claiming to be "exhaustive", the comparative analysis of these selected integrated programs reveals numerous features of interest, incl. with respect to HIA and urban planning. Study results lead to the following conclusions:

- Each program has its **own profile** and specific merits, but in many respects they are closely related, with **overlapping goals and interests**
- Therefore, there is a potential to **transfer policy tools** from one program to the other – this potential, up to now, is not widely utilized
- Along the same line, opportunities of **increasing cooperation** between the programs could be checked comprehensively; this may bring up questions of "transferabilty" of tools which are worth reflecting anyway
- Most of the programs have at least touched the theme of "**HIA**" and "**urban planning**", but up to now, only HCN has made it a focus.

Links and references: on reverse side of handout; and available from the authors

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[09-45]

HIA '09 "On the move" Rotterdam, 15-16 Oct 2009

Health-related "Integrated programs" – their views on impact assessment, other policy tools, and inter-sectoral cooperation (Fehr, Böhme, Hilbert, Schreiber, Weth)

Selected links and references

Healthy Cities Network (HCN)	www.euro.who.int/healthy-cities
European HCN	www.euro.who.int/healthy-cities/city/20040714_1
Network of European National HCNs	www.euro.who.int/healthy-cities/natl/20040714_1
German HCN / Gesunde Städte-Netzwerk Deutschland	www.gesunde-staedte-netzwerk.hosting-kunde.de/
PHASE project	www.euro.who.int/healthy-cities/phase/20040719_1
Barton & Tsourou: "Healthy urban planning"	www.euro.who.int/InformationSources/Publications/Catalogue/20010917_13
"A healthy city is an active city: a physical activity planning guide" (2008)	www.euro.who.int/InformationSources/Publications/Catalogue/20081103_1
Regions for Health Network (RHN)	www.euro.who.int/RHN
"10 Theses on regional health and wealth"	www.euro.who.int/document/E91413.pdf
"Decentralized health systems in transition"	www.euro.who.int/document/E91415.pdf
"The contribution of regions to health and wealth"	www.euro.who.int/Document/E91414.pdf
RHN projects	www.euro.who.int/RHN/20050617_3
National Environmental Health Action Plans (NEHAPs)	www.euro.who.int/envhealthpolicy/Plans/20020807_1
Declaration on Action for Environment and Health in Europe, Helsinki 1994	http://whqlibdoc.who.int/euro/1994-97/EUR_ICP_CEH_212.pdf
Children's Environment and Health Action Plan for Europe (CEHAPE)	www.euro.who.int/document/e83338.pdf
Aktionsprogramm Umwelt und Gesundheit (APUG)	www.apug.de
APHEIS project	www.apheis.net/
Aktionsprogramm Umwelt und Gesundheit Nordrhein-Westfalen (APUG NRW)	www.apug.nrw.de
Federal-*Länder* Programme Social(ly Integrative) City (SC)	www.sozialestadt.de/en/programm/

City (SC)	
Database of (> 500) practice examples on health promotion in “Social cities” (in German)	www.sozialestadt.de/praxisdatenbank/suche/index.php?suchen=suchen&handlungsfeld=12
Summaries of urban development projects (in German)	www.sozialestadt.de/international/
“Health promotion – key integrated urban district development topic”	www.sozialestadt.de/en/veroeffentlichungen/newsletter/gesundheitsfoerderung.phtml
Netzwerk Deutsche Gesundheitsregionen (NDGR)	www.deutsche-gesundheitsregionen.de/home/gruendung-ndgr-e-v/
16 German regions (in German)	www.deutsche-gesundheitsregionen.de/regionen/
Focus groups (in German)	www.deutsche-gesundheitsregionen.de/fokusgruppen/
Goldschmidt & Hilbert (2009): Gesundheitswirtschaft in Deutschland: Die Zukunftsbranche. kma-Medien	
Ottawa Charta	www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf
WHO: Health Impact Assessment (HIA)	www.who.int/hia/en/
Federal Environment Agency / Umweltbundesamt (UBA)	www.uba.de, www.umweltbundesamt.de/index-e.htm
German Institute of Urban Affairs / Deutsches Institut für Urbanistik (Difu)	www.difu.de
Institute for Work and Technology / Institut für Arbeit und Technik (IAT)	www.iatge.de/, www.iatge.de/index.php?article_id=1&clang=1
Institute of Health and Work North Rhine-Westphalia / Landesinstitut für Gesundheit und Arbeit Nordrhein-Westfalen, LIGA.NRW	www.liga.nrw.de
University of Bielefeld: “Integrated programs”, 2001-2002	www.uni-bielefeld.de/gesundhw/ehp/bgpaper.html

WHO Collaborating Center for Regional Health Policy and Public Health

Landesinstitut für Gesundheit und Arbeit des Landes Nordrhein-Westfalen

"Integrated programs" on urban and regional development

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Issue, objectives

Concerning the protection and promotion of health, a large numbers of topics is pursued on local and regional levels in Europe.

In addition to traditional approaches there are "integrated programs" which work across multiple groups and diseases and aim at comprehensive solutions. Increasingly, there are efforts to combine (health) policy programs with economic orientation, especially with local and regional business development approaches.

Methods

Starting from an existing synopsis [1], three such programs were selected:

- German Healthy Cities network (GSN)
- Regions for Health Network (RHN)
- Network of German Health Regions (NDGR).

Descriptive (qualitative and quantitative) criteria were identified and, using published information sources and the authors' expert knowledge, applied to characterize the programs.

Results

The results are presented in boxes 1 and 2. Technically, the activities of all 3 networks show marked similarities. Concerning content, the Network of German Health Regions features a strong economic orientation which is absent in the other two networks.

Using the triple dimensions of *Agenda 21* (1992), i.e.

Box 1: Integrated programs: Basic characteristics

	German Healthy Cities Network (GSN)	Regions for Health Network (RHN)	Network of German Health Regions / Netwerk Deutsche Gesundheitsregionen (NDGR)
Start	1989	1992	2008
Program mission, objectives	Primarily based on "Ottawa Charter" (1986), "Health for all" and "Health in all policies" thinking Aiming at comprehensive health protection, health promotion, community participation, reduction of health inequalities		Fostering innovations for health care, health technology, prevention and health promotion, with strong interest in economic dimension
	Platform for learning, discussion and activities		
	Voluntary association of municipalities, aiming at good health of urban populations Criteria: 9 points program, charter of the network	Voluntary association of regions, aiming at good health of regional populations	Voluntary association of regions, aiming at economic development and health (care) improvement
Target			Economic and health

social, ecologic, and economic dimension, as a yardstick, each program focuses on health (as a key component of the social dimension), HCN and RHN also on ecologic dimension, and NDGR also on economy. None of the programs embraces all 3 dimensions.

Conclusions

1) Given the widespread interest in better health on local / regional level, there continues to be a strong case for integrated programs.
2) It is a constant challenge for all such programs to continuously adjust their missions adequately, incl. a persistent need to (re-) define "integration".
3) All three programs care about "health innovations", with NDGR contributing a particularly strong economic orientation. With increasing awareness of the (mostly) positive effects of health care and disease prevention on regional and local economies, this approach may inspire activities across integrated programs, complementing the more traditional approaches towards health and well-being.
4) Next step: Analyzing the contributions to health / health system performance / health system performance assessment.

groups	Health policy-makers, (health and other) authorities, citizens, incl. persons in precarious situations		policy makers, health business managers, local and regional innovation managers
Members	Germany: 70 cities, Europe: approx. 2,000 member cities	Approx. 30 regions in Europe	16 regions in Germany, with approx. 1,000 health enterprises

Box 2: Integrated programs: Activities, output, evaluation

	GSN	RHN	NDGR
Activities, projects, output, outcome	Regional networks Centres of competence, e.g. on urban development Close cooperation with different players of the health system Annual meeting of all members, accompanied by symposium Bi-annual Healthy Cities Award honours exemplary projects	Annual conference Participation in ministerial conferences (Tallinn 2008), contributing 10 theses on "Regional health and wealth" Engagement in EC-funded projects, e.g. ISARE III, BEN II; Migrants and health-care Affiliation with WHO CC Regional Health Policy and Public Health at LIGA.NRW	Focus groups, incl. internationalisation; technological innovations; prevention and rehabilitation; new professions, etc. International economic co-operation in health-related issues (India) Organizing of and contributions to conferences and workshops
Evaluation	4-year reports from member cities		
Website	www.gesunde-staedte-netzwerk.de (German)	www.euro.who.int/RHN (English)	www.deutsche-gesundheitsregionen.de (German)

Links and references: on reverse side of handout; and available from the authors

EUPHA Lodz, 25-28 Nov 2009 Human Ecology & Public Health

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EUPHA Conference "Human Ecology and Public Health" Lodz, 25-28 Nov 2009
"Integrated programs" on urban and regional development (Fehr, Weth, Eißner, Hilbert)

Selected links and references

Healthy Cities Network (HCN)	www.euro.who.int/healthy-cities
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16 German regions (in German)	www.deutsche-gesundheitsregionen.de/regionen/
Focus groups (in German)	www.deutsche-gesundheitsregionen.de/fokusgruppen/
Goldschmidt & Hilbert (2009): Gesundheitswirtschaft in Deutschland: Die Zukunftsbranche. kma-Medien	
Ottawa Charta	www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf
Agenda 21	www.un.org/esa/dsd/agenda21/ http://en.wikipedia.org/wiki/Agenda_21
Institute for Work and Technology / Institut für Arbeit und Technik (IAT)	www.iatge.de/, www.iatge.de/index.php?article_id=1&clang=1
NRW Institute of Health and Work / Landesinstitut	www.liga.nrw.de

für Gesundheit und Arbeit Nordrhein-Westfalen, LIGA.NRW	
University of Bielefeld: "Integrated programs", 2001-2002 R. Fehr, C. Böhme, J. Hilbert, H. Schreiber, C. Weth: Health-related "Integrated programs" – their views on impact assessment, other policy tools, and inter-sectoral cooperation. HIA'09 "On the move" Rotterdam, 15-16 Oct 2009	www.uni-bielefeld.de/gesundhw/ehp/bgpaper.html

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Modelling the burden of disease in aging populations – crucial input for HIAs

Mekel OCL, Terschüren C, Fehr R

HIA'09
"On the move"
Rotterdam
15-16 Oct 2009

Background

Aging of the population is an increasingly important issue in many countries. In the future, the scrutiny of plans, programmes, policies, and projects with respect to their positive and negative health impacts will face new challenges. In particular, it will be necessary to include the aging of the population and the associated changes in the burden of disease into the scope of considerations.

Box 1
DALY = YLL + YLD
YLL = *years of life lost because of premature death*
YLD = *years of life lived with disability due to illness*

Fig. 1 Location of North Rhine-Westphalia (NRW) in Germany

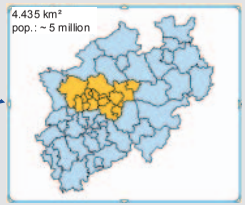

Fig. 2 Ruhr area

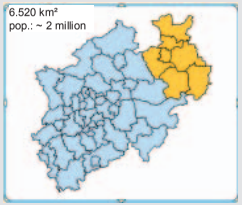

Fig. 3 East Westphalia Lippe (OWL)

Health outcomes	ICD-10
Selected tumour sites	
Lung	C34
Colon	C18

Methods

Adapting the methodology of the Global Burden of Disease Study [1], the burden of disease is calculated as disability adjusted life years (DALY) (Box 1). The future burden of disease for selected health outcomes due to aging of the population is estimated

Fig. 4 Population forecast North Rhine-Westphalia 2005 vs. 2025

Rectum	C20
Pancreas	C25
Stomach	C16
Prostate	C61
Breast	C50
Ovary	C56
Myocardial infarction	I21-I23
Dementia	F00, F03, G30-G31

Tab. 1 Selected health outcomes for BoD prognosis

using the population forecast for North Rhine-Westphalia as well as appropriate morbidity and mortality data for selected health outcomes, i.e. cancer, myocardial infarction (MI) and dementia (Tab. 1). A prognosis for the year 2025 is estimated for two regions in NRW: a highly industrialised urban area (population ~ 5 million; Ruhr area, Fig. 2) and a rural area (population ~ 2 million; OWL, Fig. 3).

Results

While the total population size is shrinking, the proportion of elderly people is increasing in NRW (Fig. 4). The areas examined show specific trends (Fig. 5). Compared to 2004, in the year 2025 the burden of disease for selected tumour sites is expected to increase by 20% in the urban area (for MI by 17%; for dementia by 36%) and by 31% in the rural area (for MI by 38%; for dementia by 40%).

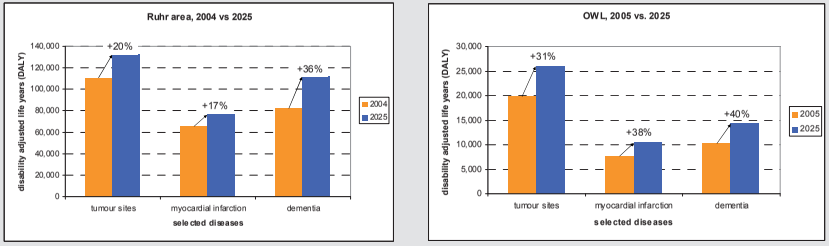

Fig. 5 Prognosis of Burden of Disease 2004/05 vs. 2025 in Ruhr area (left) and East Westphalia Lippe (right)

Conclusions

Prognoses of the development of burden of disease demonstrate large changes, potentially associated with opportunities for considerable health gains via a range of preventive measures across different sectors. The prognoses will be used as baseline estimates in upcoming HIAs, with the effects of different interventions on health to be quantified accordingly.

References

[1] Murray CJL, Lopez AD (1996): The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Global Burden of disease and Injury Series (1). Harvard University Press: Cambridge.

[2] Terschüren C, Mekel OCL, Samson R, Claßen TKD, Hornberg C, Fehr R (2009): Health status of 'Ruhr-City' in 2025 - predicted disease burden for the metropolitan Ruhr area in North Rhine-Westphalia. Eur J Public Health 19 (5): 534-540.

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8.3 HBSC Reference list

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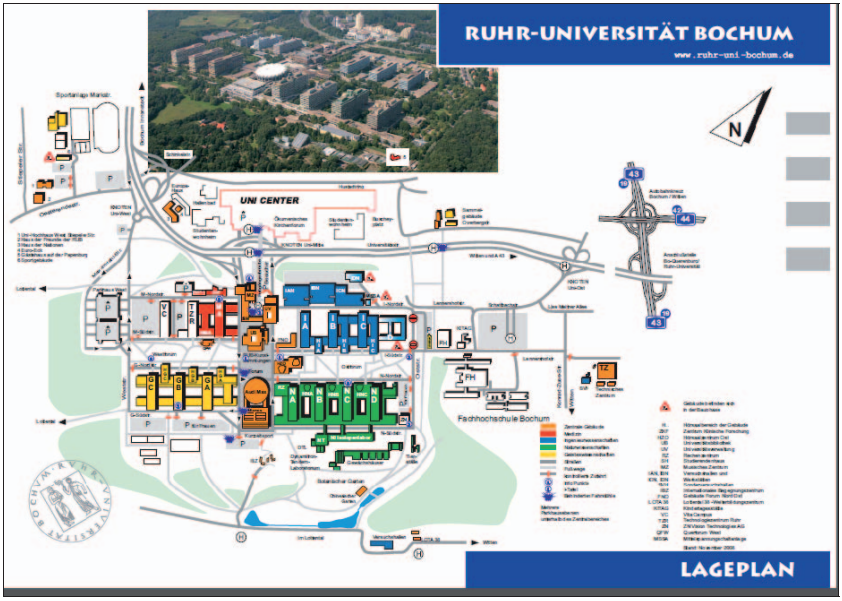
8.4 Venue information

- Map of Ruhr-Universität Bochum, incl. Technology Center / Technologiezentrum
- Travel recommendations



LIGA.NRW, WHO CC Regional Health Policy and Public Health Düsseldorf – Münster – Bielefeld – Bochum 6 August 2010

Workshop „Regional Health Policy", Bochum, 13-14 Sept 2010

Venue and travel recommendations

The workshop venue is in the Technology Center Ruhr (Technologiezentrum Ruhr) on the campus of the Ruhr University, Bochum.

Air travel
Four airports are within reasonable distance of the workshop venue: Düsseldorf International, Dortmund, Münster/Osnabrück and Köln (Cologne)/Bonn.

The largest of these airports is Düsseldorf International (www.duesseldorf-international.de/dus_en/) which features its own train station at the eastern end of the airport grounds. SkyTrain, an automated cable railway, takes you from the airport terminals to the airport railway station. From here, direct trains run about 3 to 4 times per hour to Bochum Central Station (Bochum Hbf) and take about 30 to 45 minutes for this trip. For current train time tables please see www.bahn.de (multilingual information).

Train travel
Bochum Central Station (Bochum Hbf) is served by multiple trains including long-distance ICE trains, at a high frequency (www.bahn.de).

Public transport from Bochum Central Station (Bochum Hbf) to the Ruhr University, Bochum
Take the light rail line „U35" towards Bochum Hustadt until you reach the station „Ruhr Universität". On weekdays, this line runs at 5 min intervals and takes about 10 minutes. The ticket (fee level „A") needs to be bought in a ticket-machine and stamped before boarding.

Walk to the workshop venue „Technologiezentrum Ruhr"
Coming from the light rail station „Ruhr Universität", cross the pedestrian bridge towards the university campus and follow the signs to „Technologiezentrum" (takes about 10 minutes).

It could be useful to print out a map of the Ruhr university campus (attached). The venue is marked as „TZR" in the left-hand center field of the map.

The workshop takes place in room "Bochum / Herne".

Car travel with GPS
If your GPS does not know "Universitätsstraße 142", then you should enter "Josef-Hermann-Dufhues-Platz".

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