"European Regions for health. Changing Today for Tomorrow"

6th DECEMBER 2018 - FROM 10.00 TO 13.30

Emilia-Romagna Region Delegation to the EU

21 Rue Montoyer, Brussels

REPORT

The EUREGHA high level conference "Changing Today for Tomorrow" gathered around 70 participants from across Europe representing a wide array of organisations, all interested and engaged in the discussion of the health care of tomorrow. The main objective of the conference was to gather input and to discuss what crucial changes are needed in today's health care systems, to ensure and maintain sustainable and effective care for tomorrow's needs. The conference especially aimed to underline the important role that regions can play to make these changes. To this end, EUREGHA members presented several best practices on primary care reform and integrated care. Other conference speakers discussed how the regional and local levels can contribute, not only in terms of joining the ongoing debate among policy makers and stakeholders, but also in terms of executing and implementing necessary changes.

Lorenza Badiello, Head of the Emilia-Romagna Region Delegation to the EU, and host of the event, welcomed the participants and underlined how important it is to not view healthcare from a silo perspective. She said that continued healthcare policy must remain a success story in the region of Emilia-Romagna and concluded by saying that their commitment to EUREGHA continues to be strong.

In his introductory remarks, **Nick Batey**, Chair of EUREGHA, said that he was proud to see that EUREGHA's mission of ensuring that the regional perspective on health is heard and taken on board by the institutions, is gaining recognition. Introducing the campaign "Health in all Regions", EUREGHA's position on the Future of Health in Europe beyond 2020, he said that even though in the EU healthcare is predominantly a national competence, regions and local authorities share responsibilities and competencies in the sector. Therefore, sub-national authorities have a vital

supportive role to play in collaboration with the European Commission, the European Parliament, and the Member States in achieving the overarching objective of improving health for all European citizens and achieving the UN Sustainable Development Goals in the EU. He underlined that health should not be seen as just a cost, but as an economic agent.

Edoardo Reviglio, Chief Economist at Casa Depositi e Presti, Edoardo Reviglio, set the scene by exemplifying the need to view investments in health as a beneficiary, fundamental public good, and rewarding for society as a whole and not as a costly, avoidable burden. He said it is time to focus on and give back to citizens. To this end, it is important to keep social Europe on top of the agenda, to ensure people do not turn their back on Europe. With this in mind, Europe must pay attention to the demographic challenge of the ageing population to keep the welfare state sustainable. In 2016, 30% of EU citizens were over 50, a figure which will increase over the next decades. In addition, Reviglio underlined the need to rethink public and private partnerships in the health sector and work together to find viable solutions in a new paradigm for long-term investments.

Alexander Dozet, Health economist at the Skane County Council, moderated the ensuing three panels of the conference. In the first two panels, EUREGHA members presented cases studies on primary care reform and integrated care. Two discussants per panel were then invited to reflect on and discuss the best practice examples, aiming to crystalize the elements needed in terms of policy, investments and skills sets to ensure a viable health care service for tomorrow.

Panel 1

Tom Vermeire presented on the complete primary care reform that has taken place in Flanders, Belgium over the past 8 years. Between 2010 and 2017, the region of Flanders redesigned its approach to primary care. In 2014, more healthcare competences were devolved to the regions, which enabled the transformation. The starting point was to focus on the strengths that primary care offers already, instead of reinventing it. The aim of the transformation was to move from a disease-oriented approach to a patient-centred approach and a culture of demand. To this end, policy initiatives were necessary to get primary care and social care professionals to work together. Sharing of data and information turned out the be the catalyst for change and a bottom up approach was favoured throughout the process in order to create ownership. In 2015 the implementation phase started, which should be concluded in 2019. After the reform, there will be a new care structure consisting of 3 levels: primary care zones, regional care areas and a Flemish Institute for Primary care. Some of the challenges encountered during the process pointed out by Vermeire include finding the right governance level between the different stakeholders; defining explicit outcomes for the primary care zones; and synchronizing the needs between hospital care and primary care and social care. Key learning points have been to:

- respecting each other's competencies and capacities to avoid conflict
- taking the time needed for implementing change
- strengthening connecting factors- scientific support, evaluation, financing
- setting clear goals
- doing what the patient needs and not what an organisation/group with personal incentive wants
- gaining international experience because other regions are struggling with similar problems.

Etty Nilsen, representing Buskerud, Norway, presented the Digital Night Surveillance Project as a best practice example addressing the needs of municipal healthcare services. The Digital Night Surveillance Project helps nursing home staff to monitor when patients suffering from dementia get up at night. When patients get up, nursing staff will immediately be alerted.

The rationale behind the project is the ageing population as well as a lack of qualified staff in the health sector. In addition, due to a healthcare reform, municipalities now have different and new kinds of patients under their responsibility.

Healthcare workers worked closely with the innovators during the development of the technology in a co-creation type of collaboration. In cooperation with 15 SMEs, healthcare professionals and researchers, a start-up company developed an IOT based monitoring technology system in order to address needs of municipal healthcare services. For this project, two companies got access to public care services in eight municipalities. Funding from public R&D programs minimised cost and risks for all partners.

Benefits were realised for the patients, the relatives and the partners in the network as it became easier to share expertise and new procedures and routines were established as a result of the project. All the municipalities involved in the project have later increasingly implemented digital technologies. The technology developed in this project is currently in use in Norwegian and Swedish municipalities and the vendors are operating in the market.

Some of the challenges encountered during the course of the project, according to Nielsen have been:

- Instability of necessary infrastructure as many nursing homes lack internet access
- Ethical issues and legal questions related to privacy
- On a national level, lack of funding and political will
- Lack of project management skills
- Communication problems between healthcare workers and technology vendors
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The discussants, **Federico Paoli**, Policy Officer, Structural Reform Support Service, European Commission and **Ruth Kalda**, Professor of Family Medicine, University of Tartu, Estonia, were

invited to give their reflections on the best practices. Paoli commented on the importance of trust, inclusion and co-creation in realizing successful changes. Something he said was well demonstrated in the two examples. Kalda agreed and added the need for leaders and drivers to instigate systemic changes.

In a discussion on what motivated the regions to introduce the changes, Flanders responded that the main driver was a shared sense that change was needed due to great inefficiencies and a momentum had been building up, facilitating reform. In Buskerud, the reform was driven by the idea that great technology exists and should be shared and be made accessible to healthcare workers. To the questions if changes in legislation were needed to drive the reform, Buskerud answered no, but legislation might be changed due to the project. Flanders, on the other hand, is going through a momentous legislative change right now.

Panel 2

Donna Henderson, representing Scotland, presented the first best practice example on the second panel on integrated care. Scotland provides a top-down example of implementing integration of adult health and social care services, through the adoption of the Public Bodies Act 2014. Henderson said that citizens hold high expectations for health and care and healthcare providers need to step up to this challenge. The problems for Scotland were clear before the introduction of the legislative change; unsustainable, unaffordable care models, delivering unsatisfactory quality of care. She said that in Scotland, they understood that simply making plans and strategies would not have been enough. Instead, key ingredients for change included national agreed outcomes supported by all, along with a single budget for health and care services.

The 31 Integration Authorities throughout Scotland are required to prepare strategic commissioning plans outlining what the planned Integration of services will look like. Integration Authorities have real power to drive change. They manage approximately £8.7 billion of resources that NHS boards and Local Authorities previously managed separately.

The main purpose of the integration planning and delivery principles is to improve the wellbeing of service-users and to ensure that those services are provided in a way which:

- ✓ improves the quality and consistency of services for patients, carers, service users and their families
- ✓ provides seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and
- ✓ ensures resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.

The main take home message, Henderson gave was that even though progress is slow, it is still progress and the outcome and impact should always be kept in mind.

Emilia-Romagna, represented by **Donato Papini,** described how integrated care is ensured through primary care in the region. The organisation of the integrated care approach emphasises the role of Community Health Centres in detecting and managing chronic conditions. The essential component of the change management approach is the inter-sectoral planning; a multidisciplinary and participative approach and the availability of ICT based information systems. Within these key principles, the Emilia-Romagna model can be transferred and adapted to fit within other organisational contexts.

The system showcases a change management approach based on multi-professional and proactive care of "at risk" patients These patients are identified through 'Risk-ER', an innovative population-based model which uses longitudinal administrative databases (health and social care) to estimate the risk of hospitalisation and death for the resident adult population. Based on the Risk-ER analysis, 'patient risk profiles' are created. In the RiskER model the population of the region is divided into risk categories. The categories indicate how likely it is that someone will be hospitalised. For all (very) high risk patients a report is made with a strategy for their care, allowing proactive case management within Primary Health and Social Care services network. Risk profiles are provided to GPs. Experience shows that people without care plan reports are hospitalised more often. In addition to Risk-ER, Emilia-Romagna also uses the Sunfrail tool, which focuses on low and medium risk people and complements the RiskER model by timely identification of people who move up a risk category. The Community Health Centres, the Community Hospitals (CH) and the Specialist Care Centres (SCC) are the main structures ensuring integrated care between primary and hospital care, avoiding inappropriate hospitalisation and facilitating hospital discharge. Papini said that one of the main challenges have been getting people to work together.

Discussant **Brian O'Connor**, Chair of the European Connected Health Alliance (ECHAlliance), said that he was optimistic seeing genuine change across Europe, exemplified by the EUREGHA best practices. He noted that many regions face similar challenges. This is where the connected ecosystems, facilitated by ECHAlliance can support change, dialogue and sharing of best practices. As was mentioned by previous speakers, O'Connor repeated that the health care sector can be seen as an engine for economic growth. In Northern Ireland, 50% of public spending is spent on health and care. As a result, the Northern-Irish department of health represents a great body of knowledge when it comes to spending, employment and procurement. This is something to tap into.

Filip Domanski, Policy Officer, Directorate-General for Health and Food Safety, European Commission, concurred with O'Connor and asked the presenters what problems they still face and what went wrong in the projects. Donna Henderson answered that cooperation is difficult and that it

is not enough to bring people to the same place, co-location is not the same as cooperation. They need to work together as well. Papini answered that it is still a problem to get GP's, social workers and specialist to work together. Benchmarking is an effective way to motivate change and progress, Henderson added.

Panel 3

A third panel with external speakers from international organisations, presented concrete initiatives pushing for change to be included in the discourse. First up was **Nathalie Moll**, Director General EFPIA. Moll congratulated EUREGHA on the well written "Health in all regions" campaign and said this was forward thinking and a much-needed initiative. She also referred to the EU Health Summit which took place end of November and was co-organised by a multitude of health-related organisations, among which EUREGHA. This multi-actor collaboration is the way of moving forward the agenda of an affordable and sustainable health care system for the future. Moll emphasised the need for a change to value-based healthcare, using standardised outcome measurements. She underlined that early intervention and prevention must be more prevalent, optimising the delivery of care.

Tatjana Buzeti, policy officer, Division of Policy and Governance for Health, WHO, Venice office, spoke about the importance of focusing on health inequities. Like several other speakers, Buzeti underlined that healthcare systems are often seen only as a cost but that in fact, they can also contribute to social and economic benefits for the region. To make this clear, WHO aims to show that healthcare systems can also be 'drivers' of inclusive and sustainable regions and communities by addressing the determinants of health and improving the conditions needed for all to live healthier prosperous lives. Some of the determinants of health, Buzeti mentioned include:

- income (in)security
- housing
- social inclusion
- access to health care
- working conditions

Building safe and resilient communities needs to be at the heart of strategies for accelerating progress towards health and prosperity for all. As a roadmap for action, WHO focuses on addressing key health and equity challenges and the need to invest in fair, sustainable and smart solutions. Buzeti presented the new WHO Regional Health Equity Solutions Platform which is a collaborative space to generate know-how and dynamic solutions for governments and wider actors in society on how to share ideas and work together.

Mariana Dyakova, Consultant and Honorary Clinical Research Fellow, Public Health Wales, WHO Collaborating Centre on Investment for Health and Well-being introduced the WHO Collaborating Centre on “Investment for Health and Well-being”. This centre is part of a global network of more than 800 collaborating centres in 80 countries. The rationale behind investing in health and well-being is to show that these can be the enablers of sustainable development and prosperity for all. In this regard, the sustainable development goals (SDG’s) have become a political lever putting health on the table.

Throughout the conference, it became clear that in healthcare, business as usual is unsustainable with high costs for everyone. However, in order to create sustainable solutions for healthcare, a change in the narrative is needed. Instead of discussing “spending”, “investment” should be the core principle. Instead of only thinking in terms of return on investment (ROI), we should think broader and include a social and economic return on investment (SROI). Dyakova also stressed the need to link health investments to investments in other sectors, so as not viewing health as an isolated case, an important point that was also mentioned by other speakers. Dyakova concluded by explaining the programme of work and the practical application of facilitating a sustainable investment approach.

Toni Dedeu, Director of Programmes, International Foundation for Integrated Care, concluded the third panel on initiatives pushing for change by presenting the value and advantages of integrated care. Without an integrated approach there are typical problems of disintegration, which can be seen as a complex “web of care” around a patient, often leading to:

- Lack of “ownership” of the person’s problem
- Lack of involvement of users and caregivers in their own care
- Lack of communication of partners in care
- Simultaneous duplication of tasks and gaps in care
- Treating one condition without recognising others
- Poor outcomes for the patient, the caregiver and the system

Dedeu explained the hypothesis for integrated care and said that it can contribute to meeting the triple aim goal in health systems by improving:

1. the user’s care experience (satisfaction, confidence, trust)
2. the health of people and populations (morbidity, mortality, quality of life, reduced hospitalisations)
3. cost-effectiveness of care systems (functional and technical efficiency)

While most countries have integrated care on their political agendas so far, no country has truly challenged the status quo or pre-dominance of a hospital-led and medical approach to healthcare. This shows that it is not enough to focus on the “how to” of integrated care. A complete systems

change is needed. Dedeu concluded that building systems of integrated care is a complex task involving simultaneous attention at macro-, meso- and micro-level. Key factors of success are dependent on technical skills and capacities, but also on cultural norms and values, management and leadership, and sensitivity to the context in which systems grow.

Martin Seychell Deputy Director General, DG SANTE, concluded the event by highlighting some of the outcomes from the discussions. He welcomed the reinforced partnership with the health sector and said that the role of the regions is crucial in meeting the challenges of a future-proof, sustainable health care system. Regions are key in the delivery of care and he emphasised the importance of strong primary care and integrated care as part of the solution. The Commission recognises the importance of health as is reflected in the proposed multi-financial framework (MFF), with many references to health priorities including digital health, health workforce and project opportunities in European Social Fund + (ESF+) and Horizon Europe. With this in mind, Seychell welcomed the participants to the second part of the day, the final conference of the EU-funded project ESI Funds for Health.

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