The BSPC Working Group on Innovation in Social- and Healthcare

Final Report - Volume II

Purpose of the Report

The purpose of this extension of the report by the BSPC Working Group on Innovation in Social- and Health Care (WG ISHC) is to provide an in-depth overview of the activities of the WG, the expert presentations received, and the homework it compiled in preparation of its meetings. This Volume II of the Final Report of the WG ISHC therefore has to be seen as a complementary addition to the actual report.

Contents

I.
WG meeting programmes
&
expert presentations

I. WG meeting programmes and expert presentations

Riga, Latvia, 4 November 2013

0930-1300 Meeting, including expert presentation by **Mr Thomas Karopka**, Project Manager of ScanBalt HealthPort

The BSPC Working Group on Innovation in Social- and Health Care (WG ISHC) held its **inaugural meeting** in Riga on 4 November 2013. The meeting was led by the then WG Chairman Raimonds Vējonis. The meeting appointed Olaug Bollestad, Norway, and Wolfgang Waldmüller, Mecklenburg-Vorpommern, as vice Chairmen. An expert presentation on "Innovation in Social- and Healthcare - An Ecosystems Approach" was delivered by **Thomas Karopka**, Project Manager of ScanBalt HealthPort. The meeting was primarily devoted to a reconfirmation of the WG mandate and deliberations over its scope of work, priorities and mode of work.

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Innovation in Health and Social care

An „Ecosystems“ perspective

Inaugural Meeting

Working Group on Innovation in Social and Health Care
Baltic Sea Parliamentary Conference

(BSPC WG ISHC)

Thomas Karopka, BioCon Valley GmbH

Riga, 4th November 2013

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ScanBalt organisation

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ScanBalt fmba,
founded in august 2004

Non profit member based association

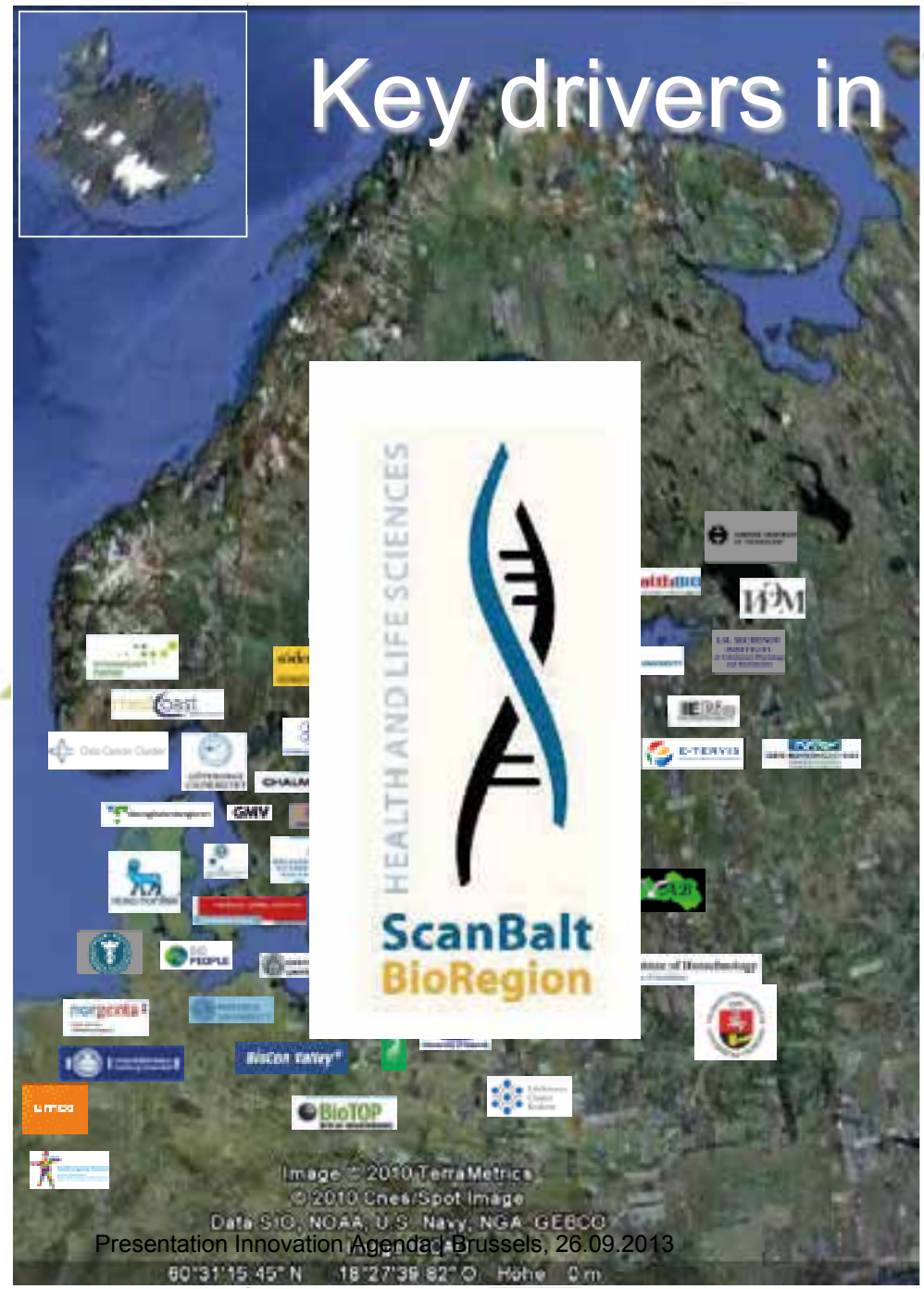
Triple helix
(academia – industry – authorities)

Goals:

- Knowledge formation & education
- Commercialisation
- Forum for discussion on life science – health – society impact

- ~70 members
- Bottom up organisation with lean central secretariat in Copenhagen
- Regional offices and contact points in all Baltic sea states
- Decentralized and project oriented mode of action
- Annual ScanBalt Fora

2



Life sciences and Health

- Stable health care systems affecting a population of approx. 85 Mio. people
- More than 5 Mio. Employees in health care and related industries
- Critical mass of innovative universities with world class basic science with a general strong focus on life sciences
- Well educated, skillful and motived human ressources
- Strong health care/pharma/ medtech industry with more than 2.000 companies

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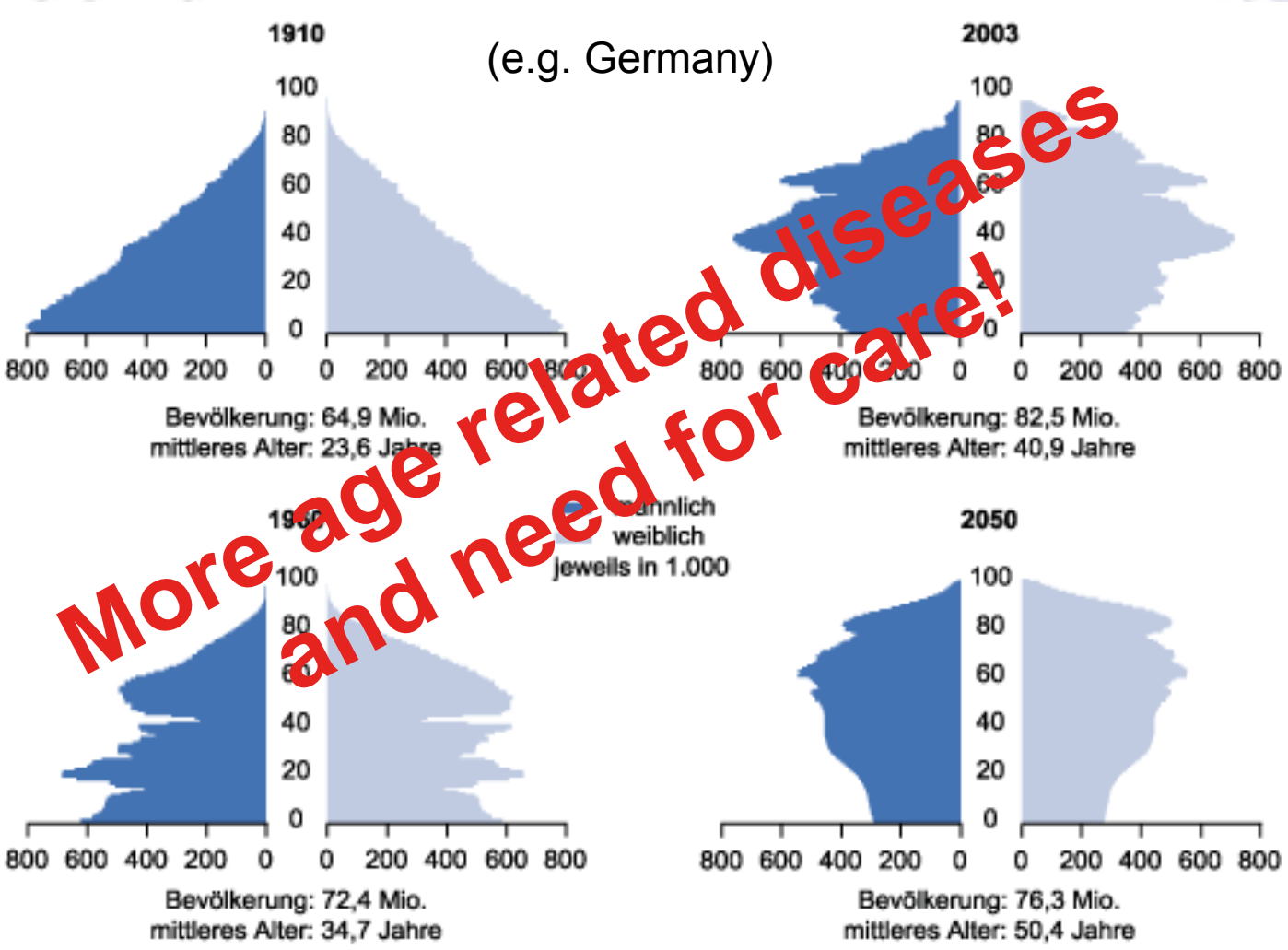
Why Innovation?

(e.g. Germany)



More age related diseases and need for care!

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Why Innovation?

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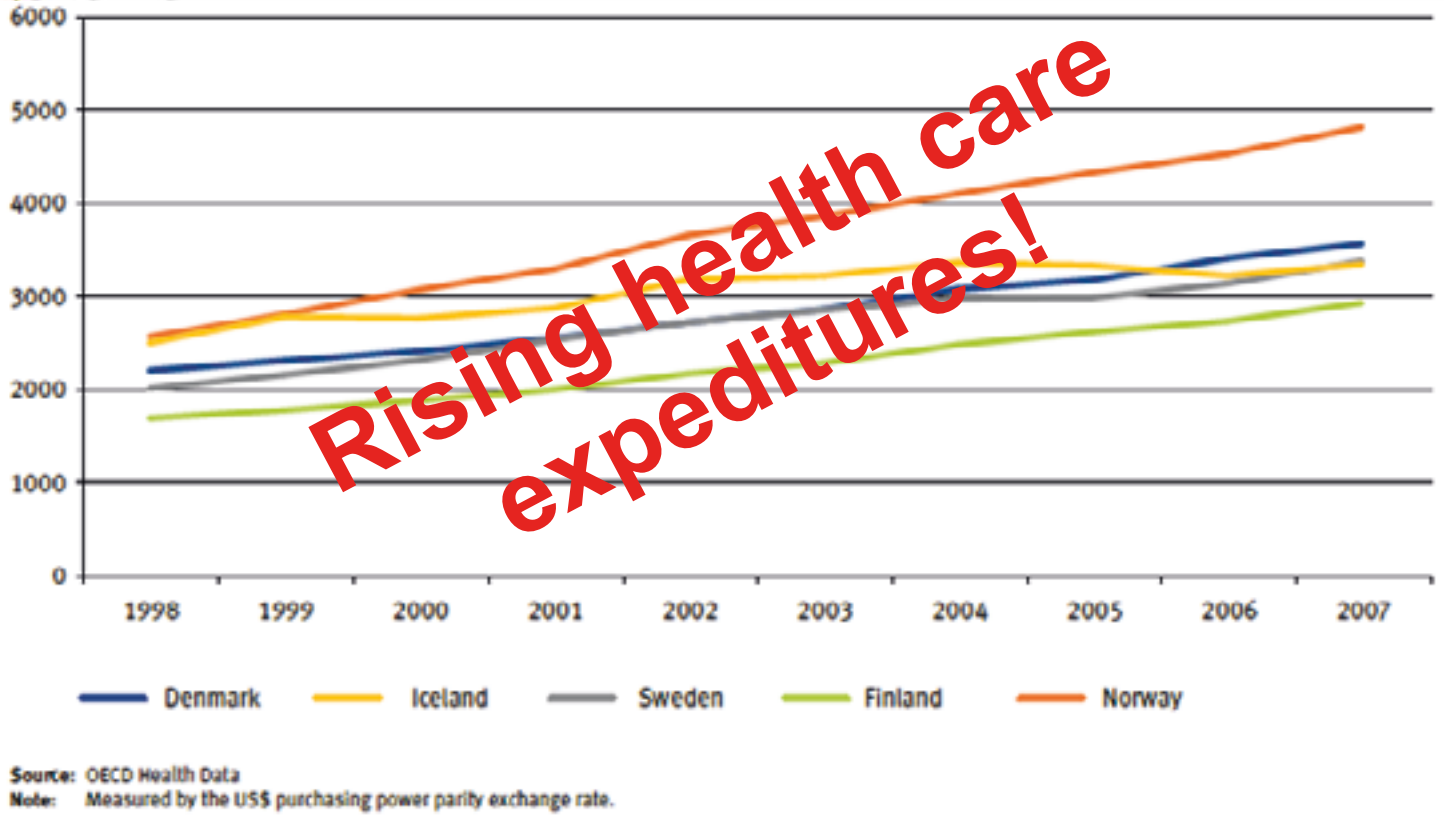
Total expenditure on health per capita in the Nordic countries, 1998-2007



Source: OECD Health Data
Note: Measured by the US$ purchasing power parity exchange rate.

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Regional challenges …

Population Decline

Demographic change

- Competitiveness
- Workforce
- Social Costs

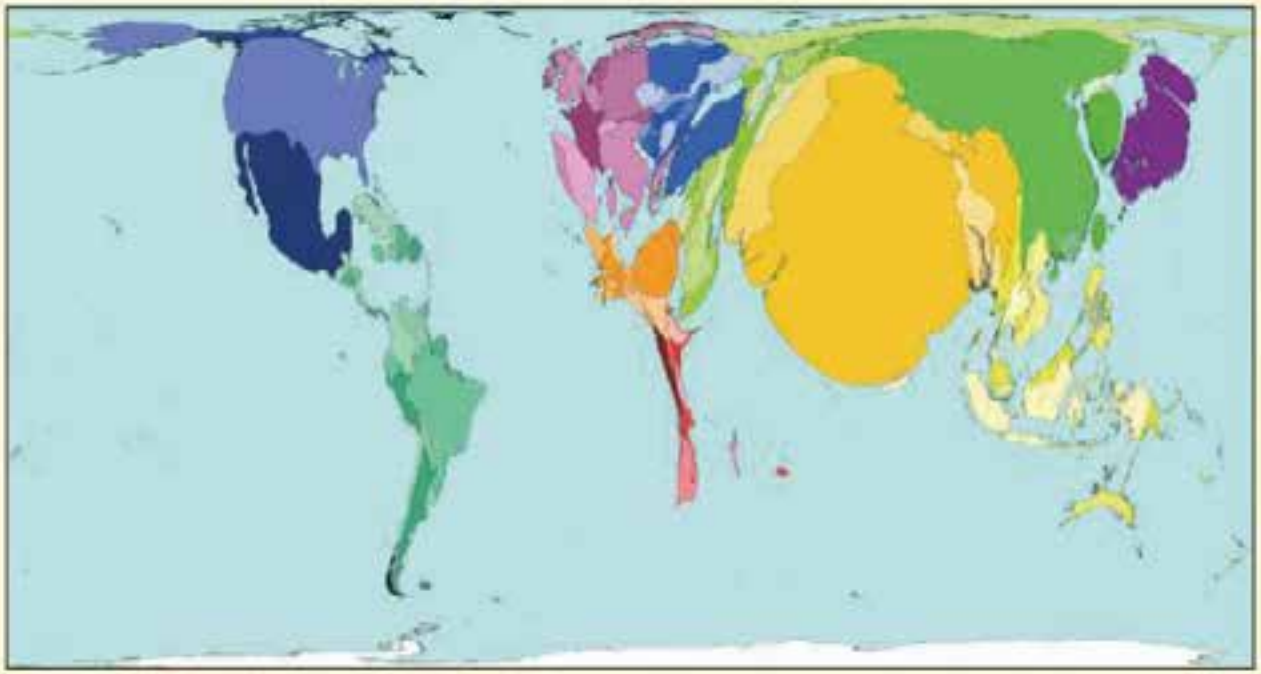
Regional Health Care

Labour market

Regional Development

6

Diabetes Prevalence



There are three types of diabetes, two are related to insulin which regulates our blood sugar levels. Having type 1 diabetes means that you are unable to produce enough insulin, so you need to inject insulin to survive. The more common type 2 diabetes is when insulin cannot be used properly by the body - this type can often be managed through diet and exercise. The third type is related to pregnacy.

The highest diabetes prevalence is in North America. Of the total North American cases, 4% are in Canada, 33% are in Mexico, and 62% are in the United States. The largest population of diabetics in 2001 was in India: 56 million people.

Territory size shows the proportion of all people in the world living with diabetes who live there.

Land area

Technical notes

- Data are from The World Bank's 2005 World Development Indicators
- See website for further information

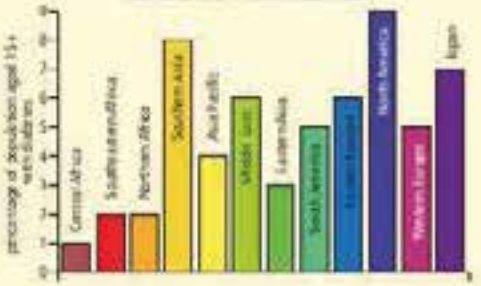
HIGHEST AND LOWEST DIABETES PREVALENCE

Rank	Territory	Value
1	Mexico	14
2	Trinidad & Tobago	14
3	Saudi Arabia	12
4	Mauritius	12
4	Hong Kong (China)	12
6	Papua New Guinea	12
7	Cuba	12
8	Puerto Rico	11
9	Singapore	11
10	Jamaica	11

Rank	Territory	Value
190	Congo	0.9
192	Cote d'Ivoire	0.8
192	Senegal	0.8
192	Uganda	0.8
192	Cameroon	0.8
196	Nigeria	0.4
196	Ghana	0.4
198	Mali	0.3
198	Gambia	0.3
198	Togo	0.3

percentage of people aged over fifteen with diabetes, in 2001

DIABETES PREVALENCE



"Diabetes is responsible for over one million amputations each year. It is a major cause of blindness. It is the largest cause of kidney failure in developed countries and is responsible for huge dialysis costs." Unite For Diabetes, 2006

www.worldmapper.org © Copyright 2006 SASI Group (University of Sheffield) and Mark Newman (University of Michigan)

Map 239

Challenges for the Healthcare system

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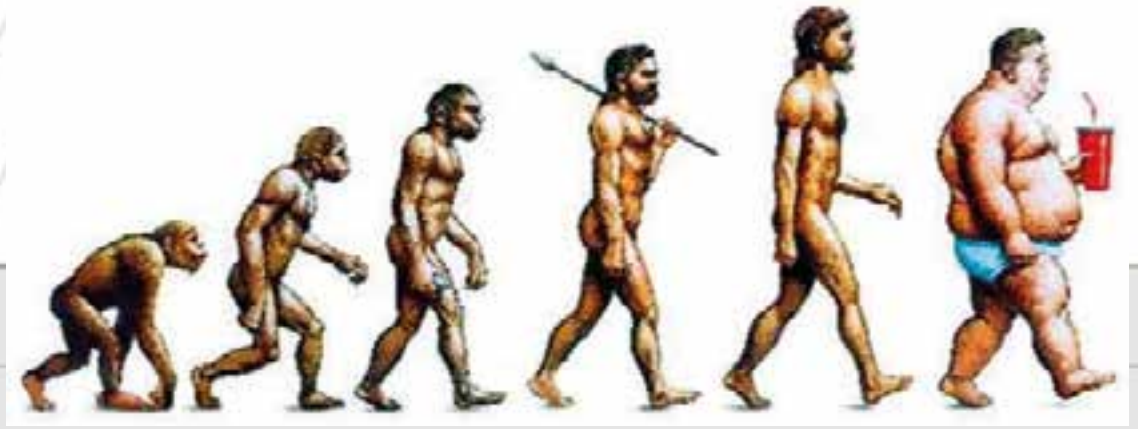

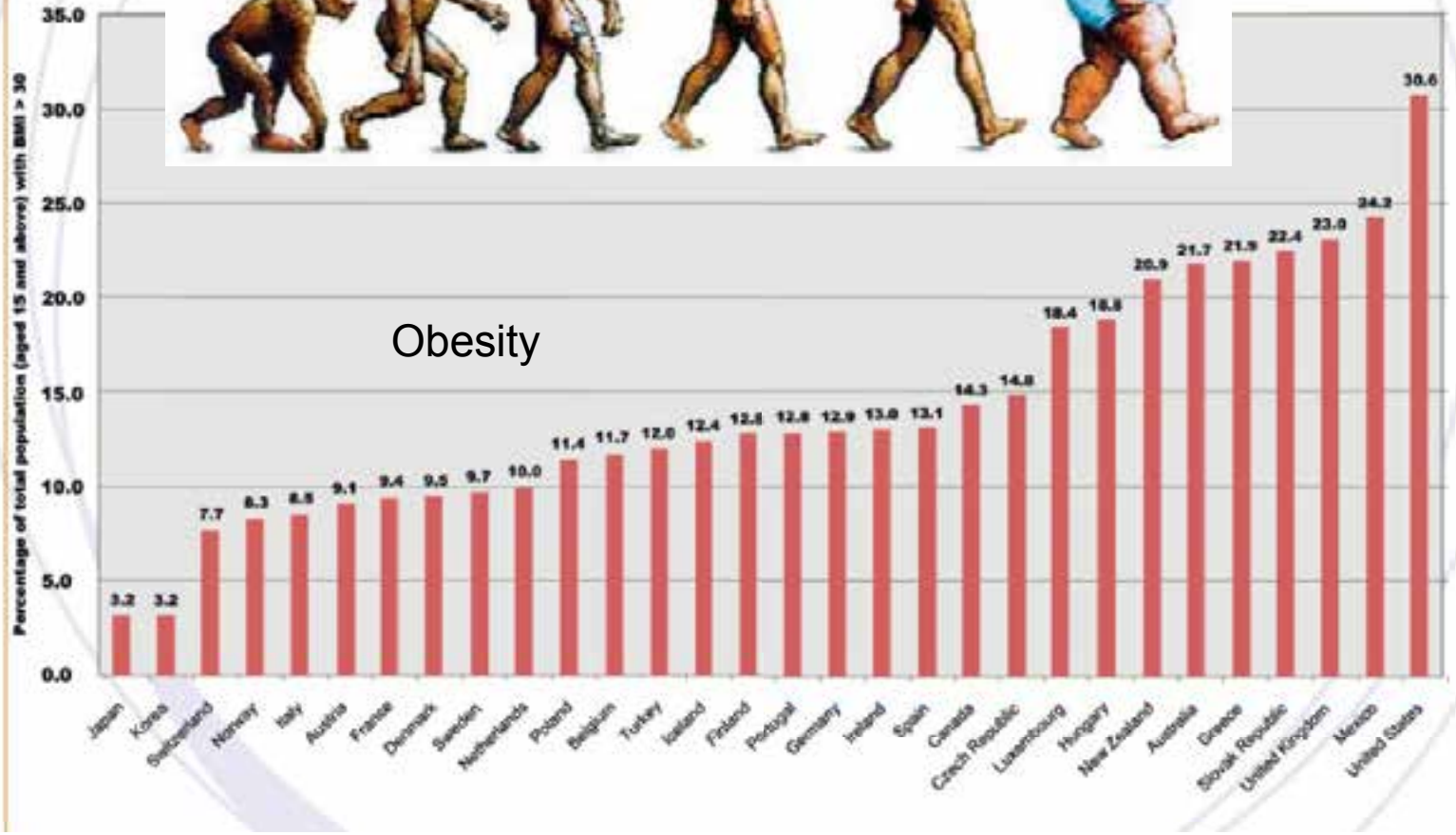

Behavioural Change?

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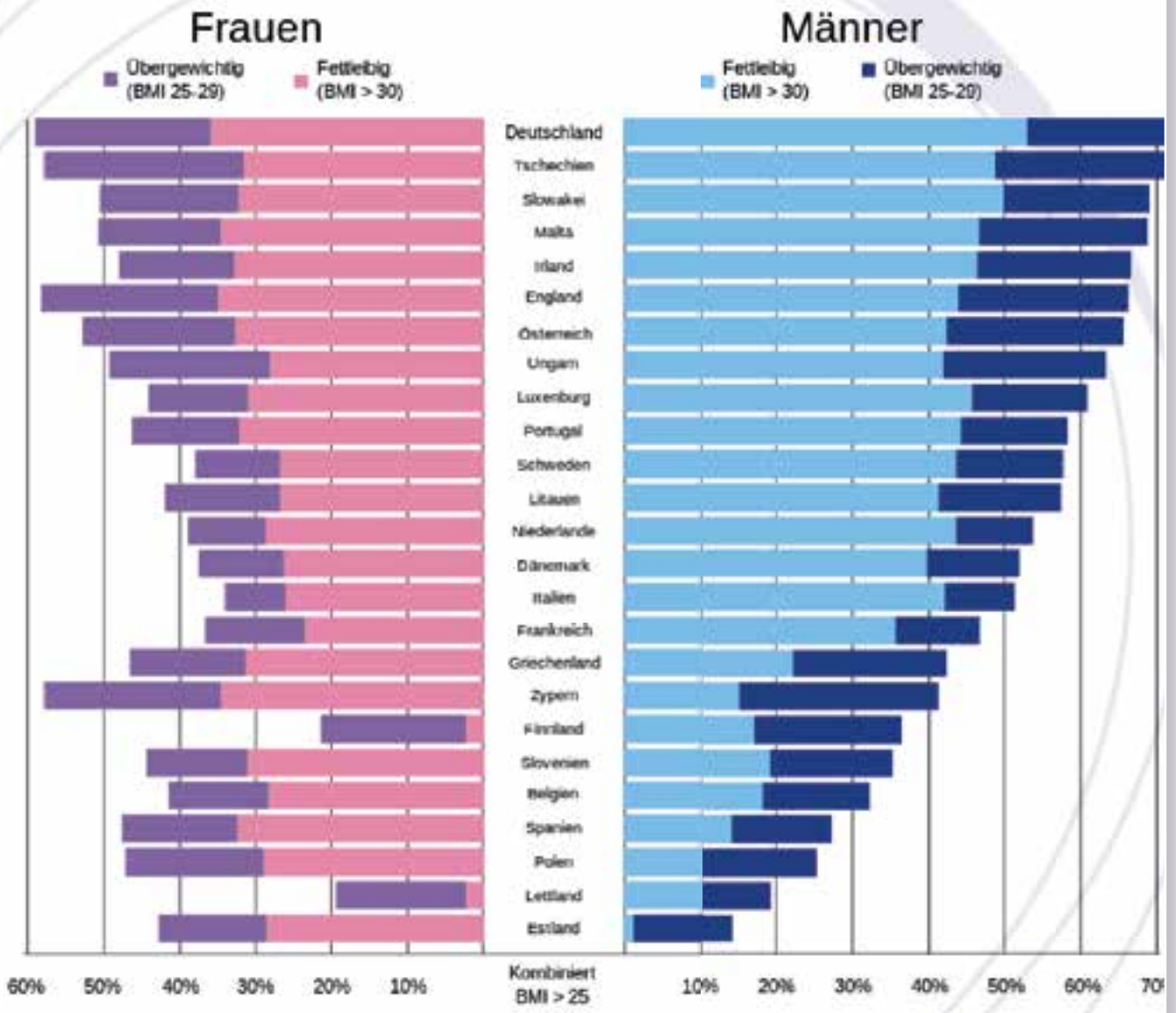
Source: http://www.flickr.com/photos/robadob/88894048



Source: http://en.wikipedia.org/wiki/File:Fettleibigkeit_in_Europa2.svg

Why Innovation?

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Perspective

Ranking 37th — Measuring the Performance of the U.S. Health Care System

Christopher J.L. Murray, M.D., D.Phil., and Julio Frenk, M.D., Ph.D., M.P.H.

N Engl J Med 2010; 362:98-99 | January 14, 2010 | DOI: 10.1056/NEJMp0910054

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Evidence that other countries perform better than the United States in ensuring the health of their populations is a sure prod to the reformist impulse. The World Health Report 2000, *Health Systems: Improving Performance*, ranked the U.S. health care system 37th in the world[1] — a result that has been discussed frequently during the current debate on U.S. health care reform.

The conceptual framework underlying the rankings[2] proposed that health systems should be assessed by comparing the extent to which investments in public health and medical care were

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Obtaining value per dollar

Health Spending In OECD Countries: Obtaining Value Per Dollar

Expand

Gerard F. Anderson and Bianca K. Frogner

Author Affiliations

Jerry Anderson (ganderso@jhsph.edu)

Abstract

In 2005 the United States spent $6,401 per capita on health care—more than double the per capita spending in the median Organization for Economic Cooperation and Development (OECD) country. Between 1970 and 2005, the United States had the largest increase (8.3 percent) in the percentage of gross domestic product (GDP) devoted to health care among all OECD countries. Despite having the third-highest level of spending from public sources, public insurance covered only 26.2 percent of the U.S. population in 2005. The United States was equally likely to be in the top and bottom halves for sixteen quality measures compiled by the OECD.

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Two questions….. Among many others

1) How do we address the health related challenges of demographic change and non-communicable diseases (NCDs)?

2) Is our health economy capable of developing cost effective, high quality products and services for this new environment?

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What is Health Economy?

Health Economy can be defined as:

„The provision and commercialization of goods and services, in order to support the maintenance and restoration of health“

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What is Social Innovation?

Definition:

"Social Innovation is about new ideas that work to address pressing unmet needs. We simply describe it as innovations that are **both social in their ends and in their means**. Social innovations are new ideas (products, services and models) **that simultaneously meet social needs** (more effectively than alternatives) and **create new social relationships or collaborations**."

(European Commission 2010)

Heinze and Naegele:

"We speak of **social innovations** if there is an **intentional, purposeful new configuration of social practices** realised by a certain group of stakeholders respectively constellation of stakeholders."

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What is Social Innovation?

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Heinze and Naegele:

"We speak of **social innovations** if the following preconditions are fulfilled:

- Orientation towards outstanding societal challenges / social issues
- New solutions in the sense of a real understanding of newness
- Specific new configurations of social practices/arrangements
- Overcoming the traditional dichotomisation of technological and social innovations
- Integration/collaboration of heterogeneous stakeholders that usually do not (have) co-operate
- Integrated patterns of action
- Reflexivity and interdisciplinary approaches
- Orientation towards the key goal of societal usefulness
- Sustainability of measures (in the sense of social practice/facts)
- New growth potentials in terms of regular employment
- Integration of the end-users ("user co-production")

Source: Heinze R, Naegele G. Social innovations in ageing societies. Callenge Social Innovation: Potential for Business, Social Entrepreneurship, Welfare and Civil Society. Springer; 2012. p. 153–67.

How about Innovation?

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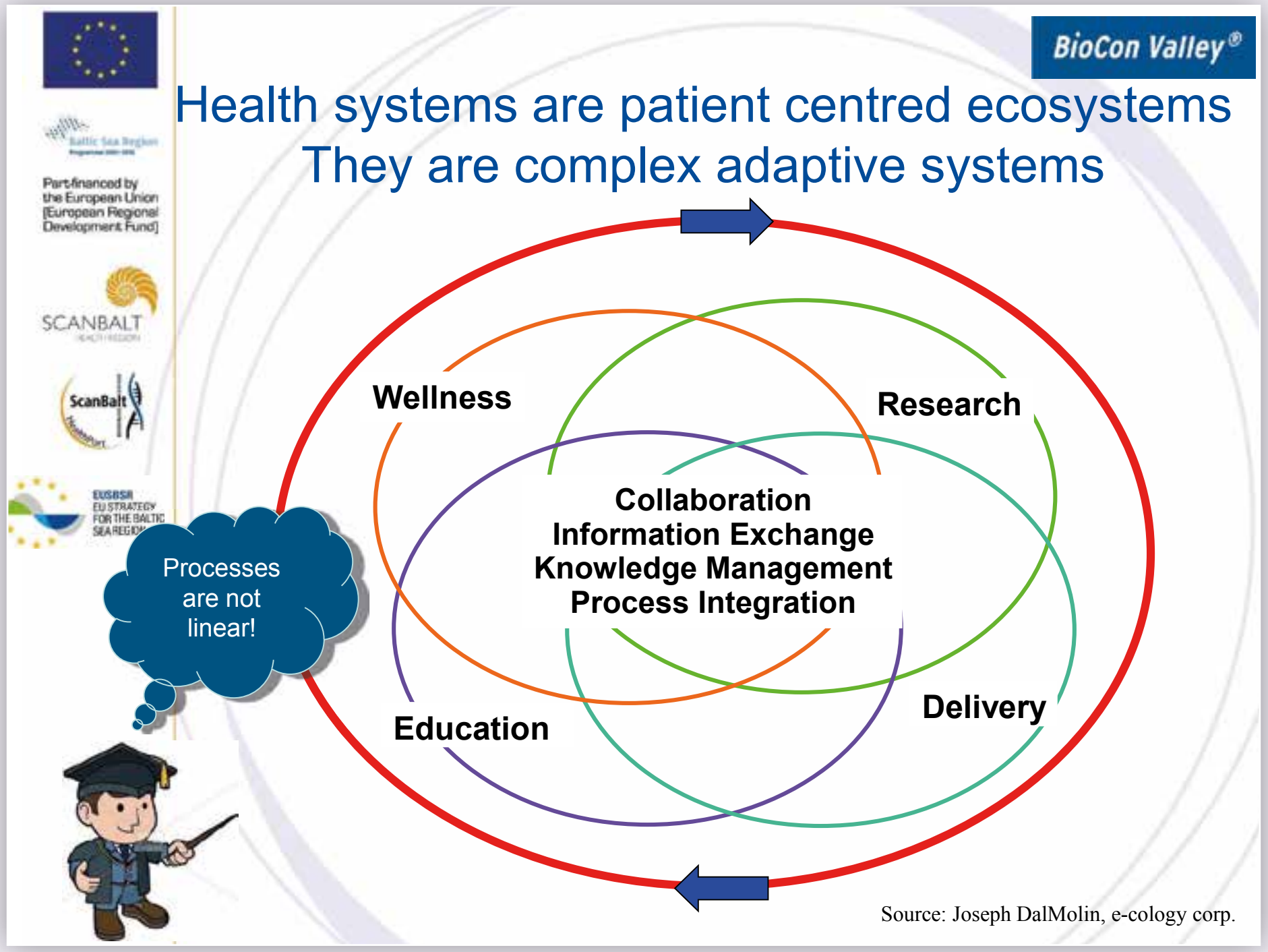
What is Innovation?

In a nutshell:
Innovation is ideas put into practice which then create value

(Cited from Ideas Clinic Aalborg)

Ideas can be completely new ones or existing ideas tuned or combined in new ways.

Value can be heightened quality, improved economy or increased safety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Health systems are patient centred ecosystems
They are complex adaptive systems
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Processes are not linear!
Wellness
Research
Collaboration
Information Exchange
Knowledge Management
Process Integration
Education
Delivery
Source: Joseph DalMolin, e-cology corp.

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We are witnessing a paradigm change in health care!

Past	Present	Future
The individual		The community
Acute diseases dominates		More chronic illness/disability
Episodic care	→	Continous care
Cure of disease	→	Prevention of disease
Reactive	→	Prospective
Physician provider	→	Teams of providers
Paternalism	→	Partnership with patients
Provider centered	→	Patient/family centred
Parochial health threats	→	Global health threats

Cohen, 21st Century Challenges for Medical Education; 9th International Medical Workforce Conference; Melbourne, Australia; November 2005


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HealthPort vision
A „health economy“ perspective
Strengthening
cross-sectoral, collaborative, open innovation
in health and life sciences
to promote
sustainable, cost-efficient, citizen-centric health
systems, strengthen regional economies and
thus improve the health, wellbeing and prosperity
in the Baltic Sea Region (BSR)

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People innovate, not systems

- It is not possible to plan innovation – recognize, facilitate and foster it when it emerges
- Health care systems are complex – collaboration and partnership are essential to successfully market a product or service

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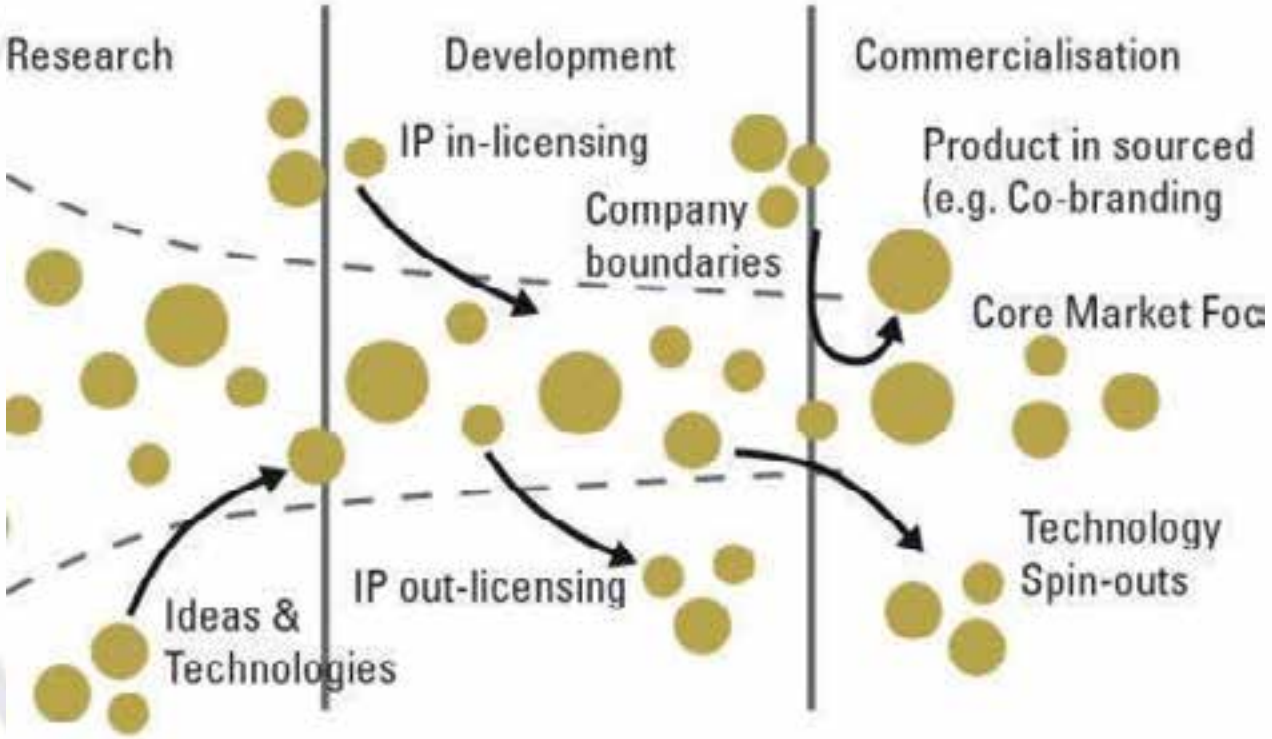
Open Innovation



Source: http://www.openinnovation.eu

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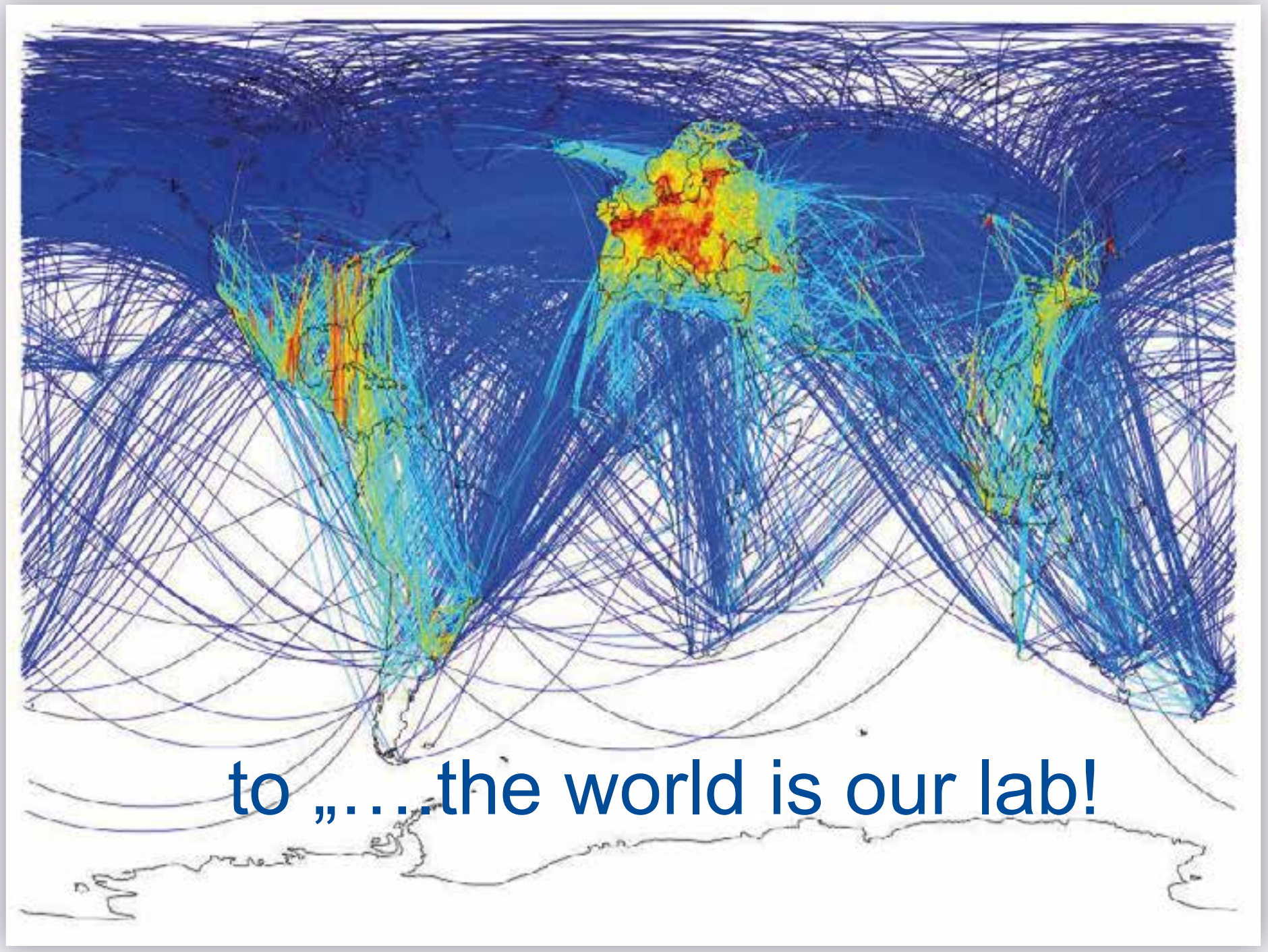
From „The lab is our world…


to „….the world is our lab!

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HealthPort Innovation Agenda to open the frameworks

Lead: BioCon Valley®

Key targets:

Promote a Multidimensional Innovation Ecosystem for health economy

Promote self-sustainable business innovation support services

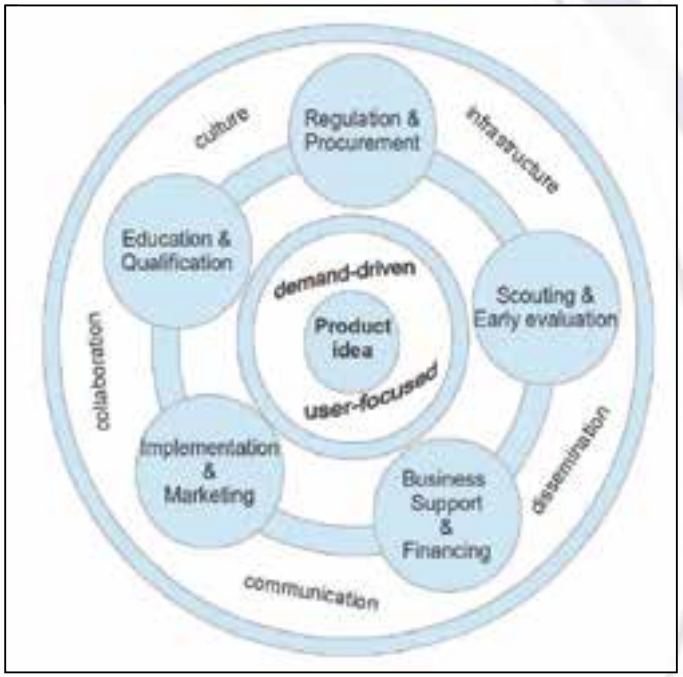

Figure by Thomas Karopka, BioCon Valley, in "Health and life sciences as drivers for regional development and prosperity in the Baltic Sea Region" Wolfgang Blank, Peter Frank, Thomas Karopka, East-West Business, in press

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Innovation Ecosystem for health economy

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Why an Ecosystem?

Hypothesis:

- An ecosystem is only in a „healthy“ state if it is in equilibrium stage.
- A focus on only one aspect will not lead to sustainability and will have negative effects in the long run
- An ecosystem approach allows to address the problems in a holistic way

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(1) Scouting & Early Evaluation

Recommendation:

Challenges:
Assess the potential of an idea to become an innovation

Set up a platform / meeting point for young entrepreneurs and experts for early evaluation and mentoring.

Promote Innovation competitions to filter out innovative ideas

Set up user driven idea management platforms to generate early feedback from potential users

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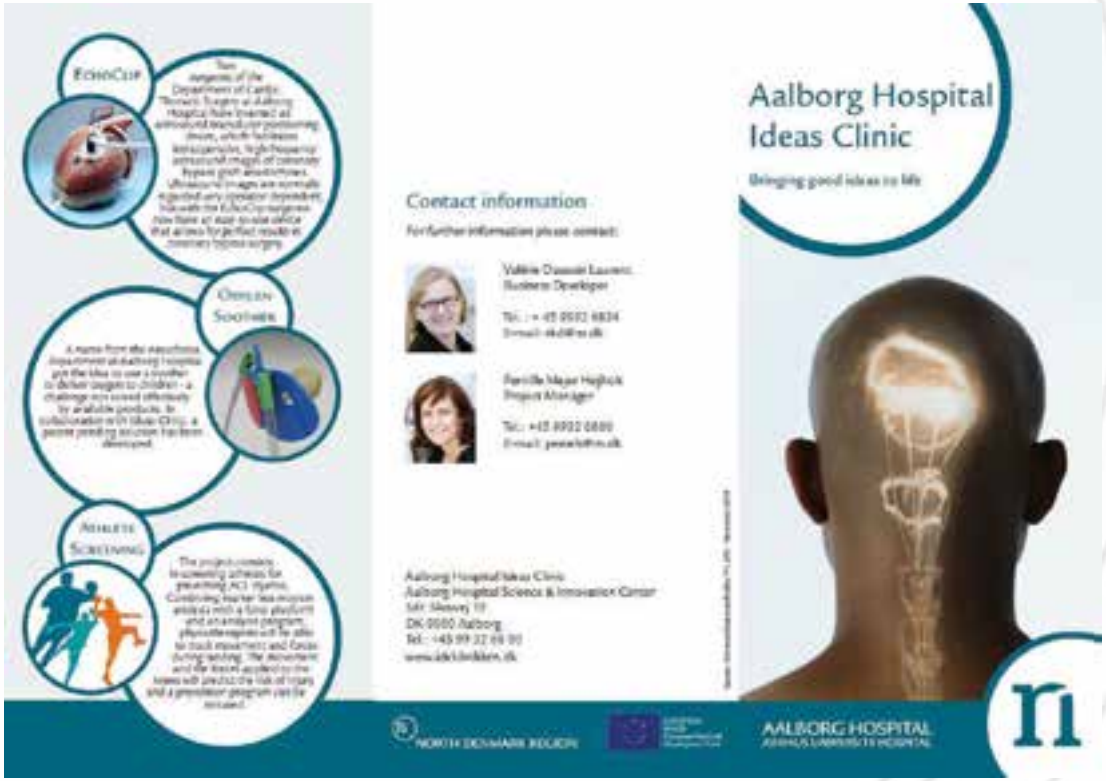
(1) Scouting & Early Evaluation

Ideas Competition: HealthPort Innovation Award

Oxygen Soother



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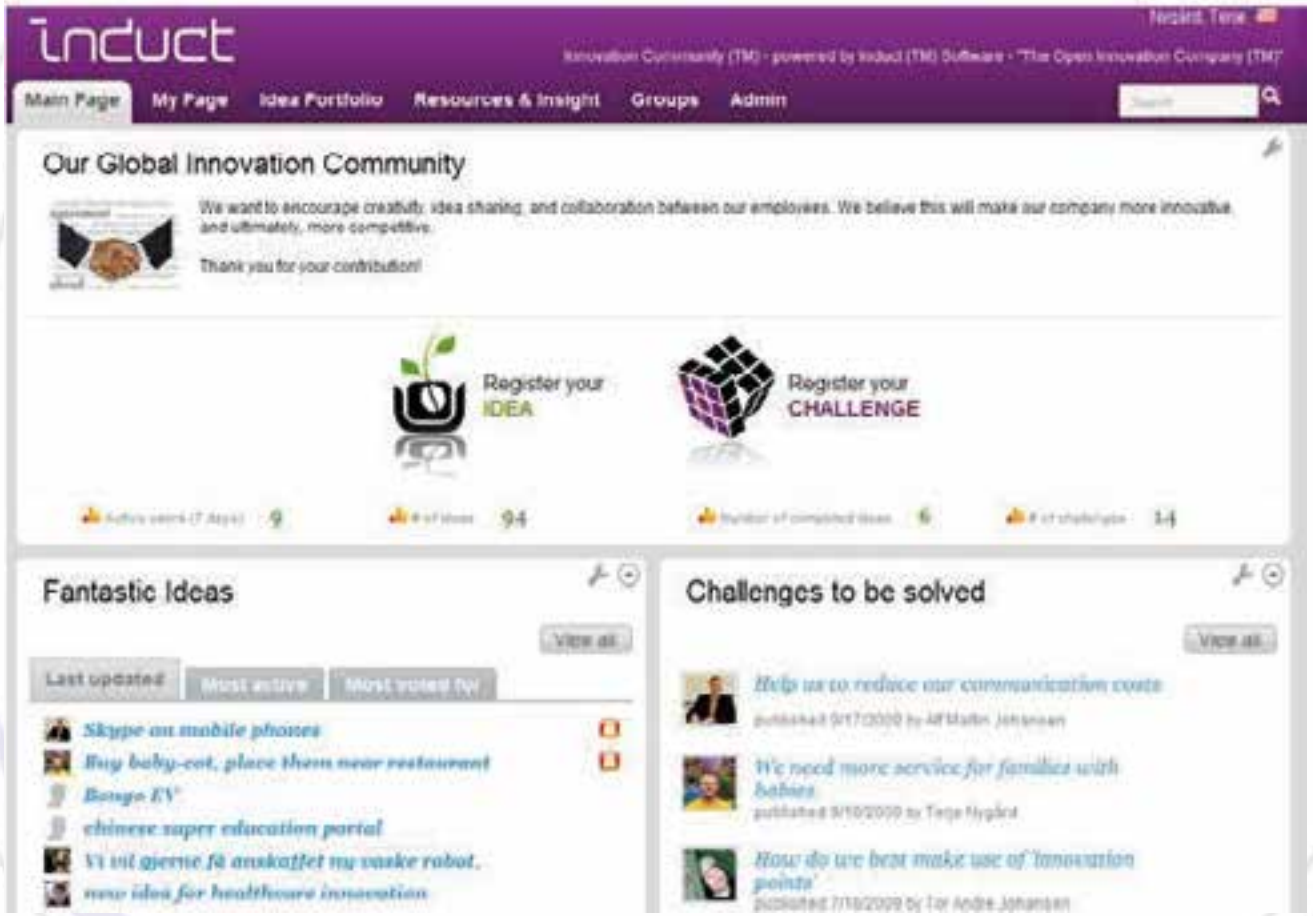
(1) Scouting & Early Evaluation

Idea Management



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(2) Business Support & Financing

Recommendation:

Challenges:
Access to capital especially for early idea evaluation

Develop new forms of transnational financing e.g. crowdfunding or special transnationally available funds for health and life sciences.

Promote successful models for SME support and development to cover the entire BSR

Develop a transnational, cross-sectoral mentoring system for SMEs in health and life sciences

(2) Business Support & Financing

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Crowdfunding for Health & Life Sciences

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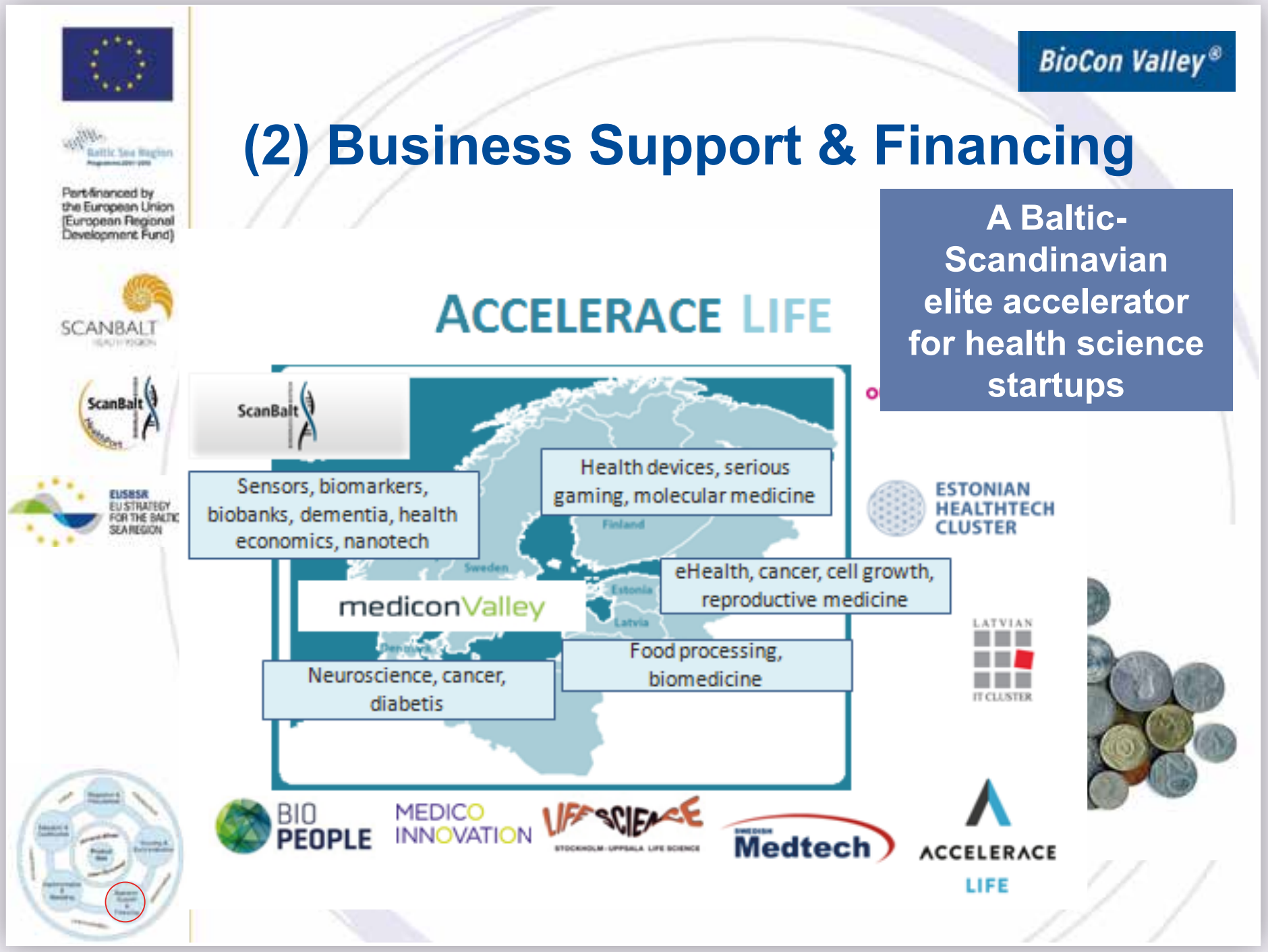
MedStartr

indiegogo

healthtechhatch beta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(2) Business Support & Financing
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Sensors, biomarkers, biobanks, dementia, health economics, nanotech
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Medtech
ACCELERACE LIFE

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(3) Implementation & Marketing

Challenges:
Dissemination of Innovative products and services in a trans-national macro-regional context

Recommendation:

- Provide a platform with modular shared services for SMEs that comprise marketing and dissemination of final products or services, Organise platforms for cooperation between SMEs offering complementary services

- Provide case specific support for transnational market implementation with a focus on BSR macro-region

- Support „strategic communication“ with all relevant actors for products and services from SME´s

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(3) Implementation & Marketing

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(4) Education & Qualification

Challenges:
- Lack of entrepreneurship skills in health and life sciences
- Lack of knowledge about regulation, certification and procurement

Recommendations:

- Develop a platform of practical SME tailored courses on specific topics for working individuals (post-education) up to hands on local coaching for SME consortia .
- Make working conditions innovation friendly …
  Value working conditions and creativity …
  Create room for innovation in the working environment (Improve working conditions, other skill mix (up-/down-skilling) … change the climate to allow creativeness)

ScanBalt Educational Platform

Requirements

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HealthPort Report – Major challenges for SME-s to be commercially successful

Grete Kuura and Boo Edgar, from University of Gothenburg, 2011.

Method: 21 interviews with SME, cluster organizations, science parks and hospitals within the ScanBalt Health Region:

Results

Need of knowledge in Entrepreneural education with BioScience focus

+

Support from cluster organisation

Academic Courses

Local Mentoring

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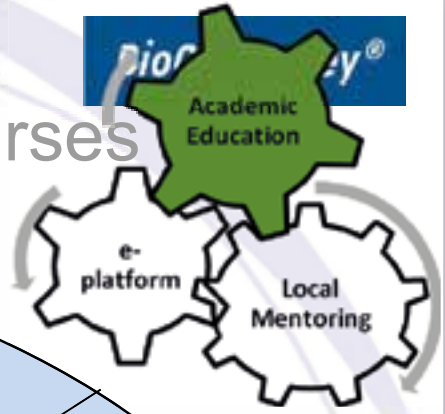
Educational Plan – Potential Courses



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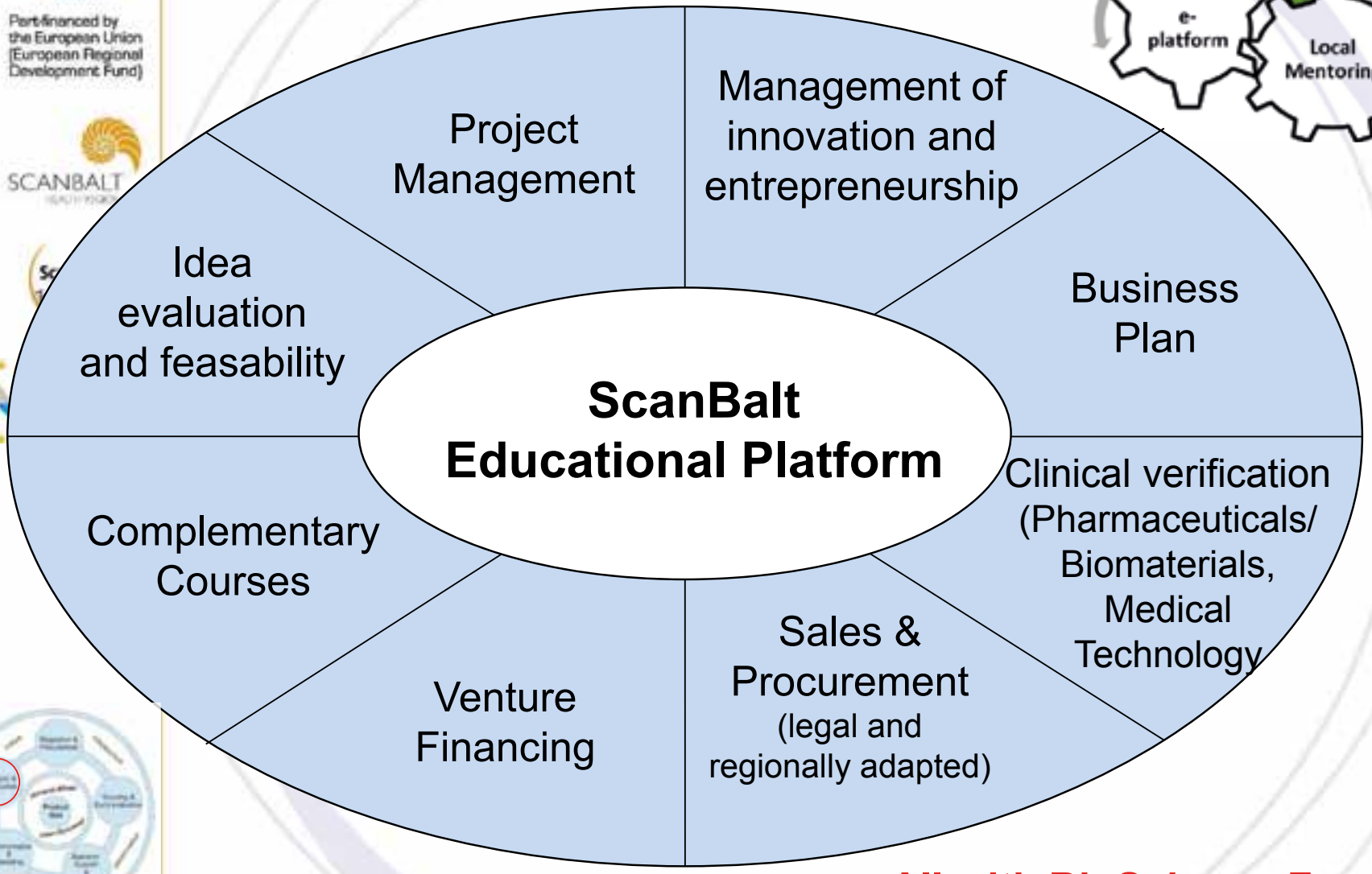

All with BioScience-Focus!

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(5) Regulation & Procurement

The public sector has a dual role in respect to innovation. The public sector acts as regulator and as procurer.

In the Nordic countries 80 – 85% of health spending is funded by public sources.

There is a huge potential to stimulate innovation through public procurement.

(5) Regulation & Procurement

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Challenges:
- It is increasingly difficult to conduct clinical trials.
- It is increasingly important to proof the efficacy and cost- effectiveness of new products and services
- Late stage failure rate and time too market extremely long

Recommendations:

- *Understanding differences in regulation and procurement (governance) in BSR and make entrepreneurs work with them*
- Support initiatives to coordinate clinical trials in the BSR and offer SME support measures
- Support the installation of early HTA expertise as a parallel process to product development
- *Support in certification and other formal requirements with respect to international markets*
- Support PPI and PCP in the health care sector and further work on harmonizing and minimizing (deregulation) regulations on the EU-level

Regulation & Procurement

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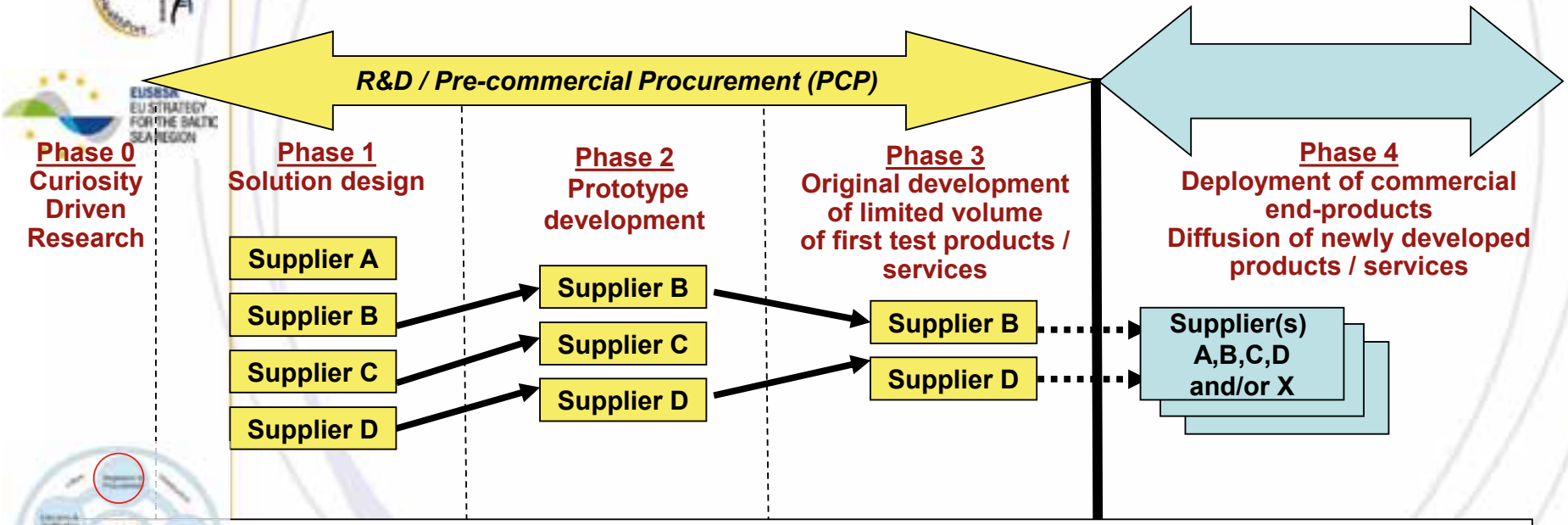
- PCP to steer the development of solutions towards concrete public sector needs, whilst comparing/validating alternative solution approaches from various vendors
- PPI to act as launching customer / early adopter / first buyer of innovative commercial end-solutions newly arriving on the market



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Related Work

High Level Group on Innovation Policy Management

Effective innovation requires a set of 7 key activities:

- Optimize the embryonic European innovation ecosystem
- Improve policy coherence
- Reduce regulatory complexity and rigidity
- Eliminate obstacles and provide new funding to innovation
- Facilitate industrial cooperation and re-interpretation of competition law
- Take an encompassing and inclusive view of intellectual property
- Increase the innovation potential through user and consumer drive

Source: High Level Group on Innovation Policy Management, Report & Recommendations, 2013, p.13

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Related Work

Conceptualising and creating a global learning health system

Charles Friedman and Michael Rigby

- "In any nation, the health sector, ….., in fact operates more on the level of seperated islands of information."
- "There are, in short, no systematic means for the national or global health system to learn rapidly from its experience"
- "A further result of this lack of learning is that it reportedly takes 17 years before a new element o validated clinical knowledge finds its way into routine clinical practice in the United States."
- "In summary, the learning health system – nationally, regionally and globally – can be seen as an ethically required public good. Indeed, given the increasing performance and economic pressures on every national health system, such an approach can be seen as essential."

Source: Charles Friedman and Michael Rigby: Conceptualising and creating a global learning health system, International Journal of Medical Informatics 82 (2013), e63-e71

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Related Work

The OECD Innovation Strategy: Getting a head start on Tommorrow

- "Innovation drives growth and helps address social challenges."
- "Action on innovation must be a priority for emerging from the crisis."
- "Policies need to reflect innovation as it occurs today."
- "People should be empowered to innovate."
- "Innovation in firms must be unleashed"
- "The creation, diffusion and application of knowledge is critical."
- "Innovation can be applied to address global and social challenges."
- "The governance and measurement of policies for innovation should be improved."

Source: The OECD Innovation Strategy: Getting a head start on tomorrow, OECD 2011

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Creating shared Value

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Porter M.E. and Kramer M.R.: Creating Shared Value – How to reinvent capitalism – and unleash a wave of innovation and growth, Harward Business Review, Jan-Feb 2011

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Related Work

BioCon Valley®

Creating Shared Value

How to reinvent capitalism – and unleash a wave of innovation and growth by Michael E. Porter and Mark R.Kramer

- "The solution lies in the principle of shared value, which involves creating economic value in a way that also creates value for society by addressing its needs and challenges. Business must reconnect company success with social progress."
- "A big part of the problem lies with companies themselves, which remain trapped in an outdated approach to value creation that has emerged over the past few decades. They continue to view value creation narrowly, optimizing short-term financial performance in a bubble while missing the most important customer needs and ignoring the broader influences that determine their long-term success".
- "Social needs, not just conventional economic needs, define markets, and social harms can create internal costs for firms".

Porter M.E. and Kramer M.R.: Creating Shared Value – How to reinvent capitalism – and unleash a wave of innovation and growth, Harward Business Review, Jan-Feb 2011

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Related Work

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Social care informatics and holistic health care

The members of the European Science Foundation Exploratory Workshop declare the fundamental importance of:

providing **harmonised health and social care services** that meet the extended needs of the individual, taking into account diversity in need, preferences, ability and support; and also recognising the concurrent resultant rights and needs of informal carers as individual citizens;

- **focussing these services on the individual citizen** as the beneficiary, including the pattern of delivery they find most effective;
- and to this end, **utilising modern Information and Communication Technologies as enabling services**, as part of a wider health and social care toolkit;
- whilst recognising the **importance of e-services being an appropriate enabling mechanism**, and **not an inappropriate replacement for necessary inter-personal interaction**

Rigby M. OECD-NSF WORKSHOP: BUILDING A SMARTER HEALTH AND WELLNESS FUTURE National Science Foundation, Washington, D.C., USA, 15-16 February 2011

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Related Work

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European Research and Innovation Area Board (ERIAB)

Recommendations:

- Smart regional policies going beyond smart specialisation

  There is a need for a radical rethinking of regional policies going beyond the current notions of smart specialisation, but including new concepts and notions such as:

  - Smart public sector specialisation
  - Smart university and higher education specialisation prioritizing e.g. science and technology studies with a strong innovation / entrepreneurship dimension
  - Smart mobility including double career programmes, etc.

- The increasing fragmentation of value chains and the increasing heterogeneity of required knowledge inputs require strong international cooperation in research and a stronger focus on the deployment of ICT based technologies.

Source: 1st Position paper of the European Research and Innovation Area Board (ERIAB): „Stress-test“ of the Innovation Union, November 2012

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BioCon Valley®

Related Work

Community-led local development (**CLLD**)

Main aims of community-led local development:

- encourage local communities to develop integrated bottom-up approaches in circumstances where there is a need to respond to territorial and local challenges calling for structural change;
- build community capacity and stimmulate innovation (including social innovation), entrepreneurship and capacity for change by encouraging the development and discovery of untapped potential from within communities and territories;
- promote community ownership by increasing participation within communities and build the sense of involvement and ownership that can increase the effectiveness of EU policies; and
- assist multi-level governance by providing a route for local communities to fully take part in shaping the implementation of EU objectives in all areas.

Source: Community-Led local development: Cohesion policy 2014-2020, Factsheet, EC 2012

Part-financed by the European Union (European Regional Development Fund)

Related Work

BioCon Valley®

Ernst & Young: Progressions 2012 – Health care everywhere

Companies need to significantly extend their business models to be:

Data-centric: to harness and monetize insights from data obtained from sensors, devices, social media threads, etc.

Behaviorally savvy: to better understand and influence patient behaviors.

Experience-focused: with personalization, mass customization and an increased focus on industrial design.

Holistic: with approaches that encompass the cycle of care and the life cycle of the patient.

Revenue-flexible: as companies capture value in different ways, reflecting the changing ways in which they are creating and delivering value.

Source: Ernst & Young: Progressions 2012 – Health care everywhere – Creatively disrupting business models

Related Work

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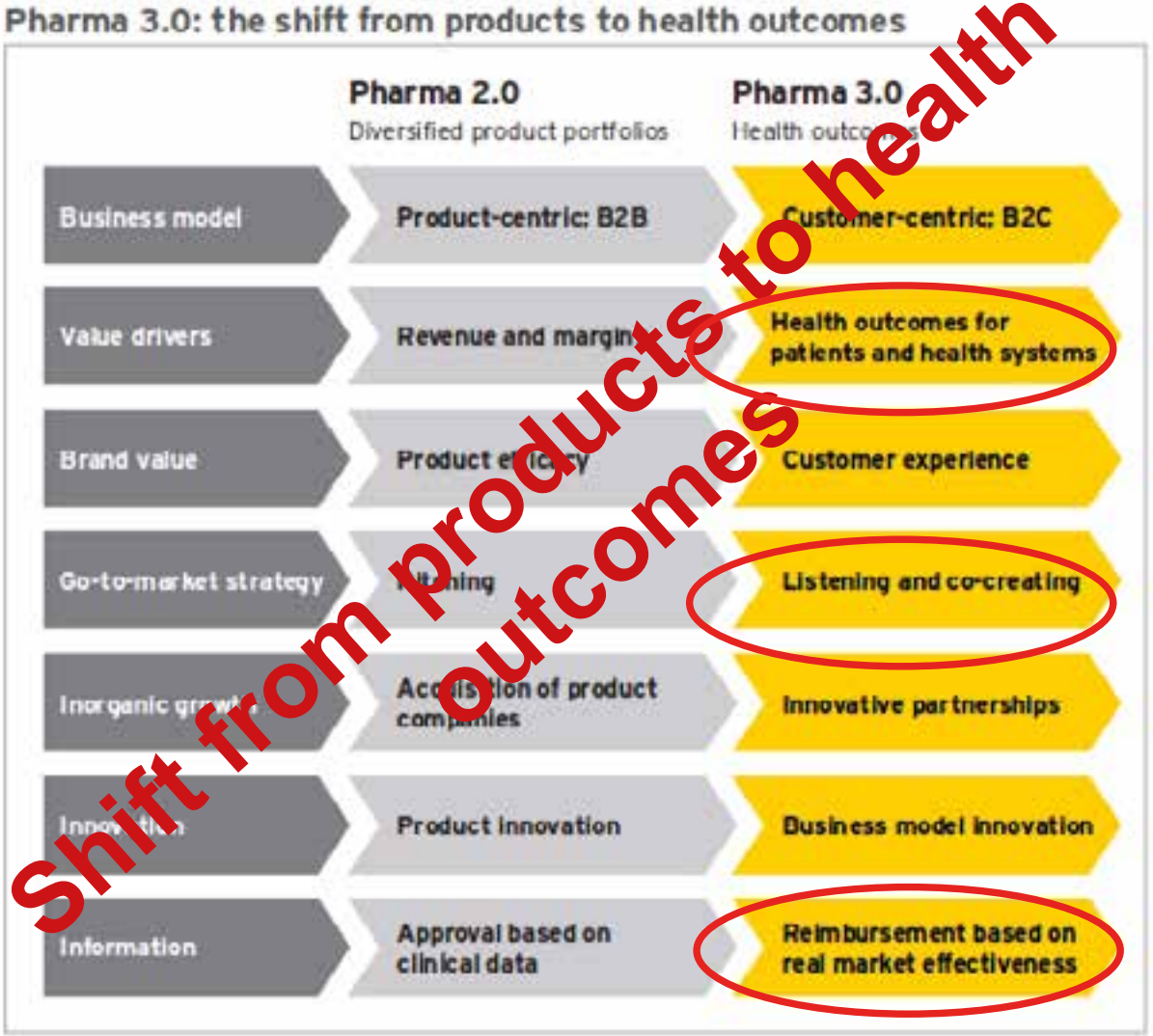

Source: Ernst & Young, Progressions: Building Pharma 3.0

Related work

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SCANBALT

ScanBalt

EUSBSR EU STRATEGY FOR THE BALTIC SEA REGION

Center for Integration of Medicine and Innovative Technology

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Related Work

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Center for Integration of Medicine and Innovative Technology

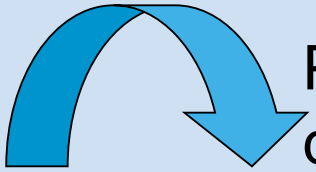
CIMIT accelerates the healthcare innovation cycle by facilitating collaboration among clinicians, healthcare managers, technologists, engineers and entrepreneurs through the development and implementation of novel products, services and procedures to improve patient care.

CIMIT AT–A–GLANCE

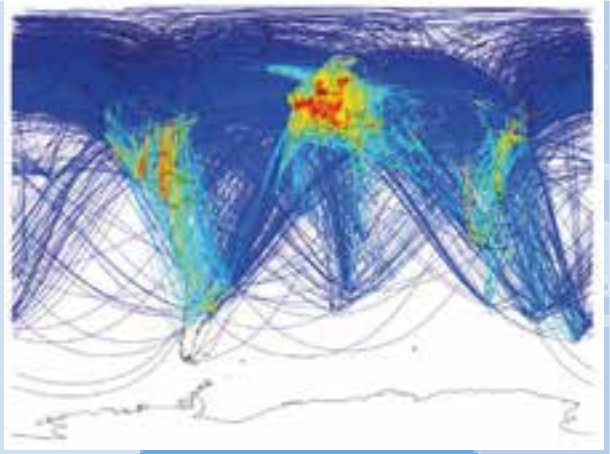
- Founded: 1998
- Member Institutions: 13
- Industry Partners: 60+
- Projects Funded: 550+
- Active Projects: 76
- Principal Investigators: 310+
- Peer-Reviewed Publications: 500+
- Invention Disclosures: 200+
- Patent Applications: 200+
- Patents Issued: 30+
- Licenses: 10+
- Companies Formed: 15+

Source: http://www.cimit.org

Conclusions



Product (service) development takes place at a global level

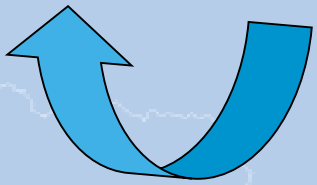


From „The lab is our world …“

Think global – act local

to „….the world is our lab!“

Health care delivery takes place at the regional level



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Conclusions

- *Focus on health outcomes*
- We need technical AND process AND organizational AND social innovation
- Focus on demand- and user-driven innovation
- View innovations as part of a holistic system
- From „smart specialisation“ to „smart implementation“
- We need „smart investment“ (taking the value into account and not only financial aspects)
- Creating shared value could be a good framework
- Collaboration is key in finding solutions for common challenges

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Conclusions cont.

Keep the balance in the „Ecosystem“ !
Focus on value!

move to an

evidence-based,

outcomes focused,

behaviour-driven

world

BioCon Valley®

Partners

- Göteborg University (SE)
- North Denmark Region (DK)
- Culminatum Innovation (FI)
- Entrepreneurship Development Centre for Biotechnology and Medicine (EE)
- BioCon Valley (GE)
- Turku Science Park (FI)
- InnoBaltica (PL)
- Institute of Biotechnology/Vilnius University (LT)
- ScanBalt (DK – Coordinator)
- 15 associated partners

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„The significant problems we face cannot be solved at the same level of thinking we were at when we created them“

Albert Einstein

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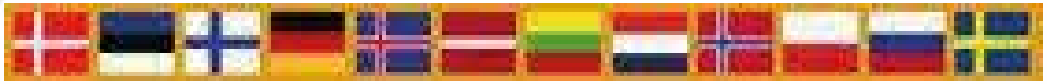


„It is hard to learn from experience,
But it is even harder not to learn from experience“

Anonymous

Tromsø, Norway, 27-28 March 2014

Thursday 27 March

1430-1800 WG meeting, including expert presentation by **Ms Pille Kink**, Standardisation Manager at the Estonian e-Health Foundation

Friday 28 March

0900-1115 National Centre for Telemedicine including expert presentation by **Ms Magne Nicolaisen, Ms Kirsten Eriksen, Mr Per Hasvold**

1115-1200 WG meeting and summing-up

The BSPC Working Group on Innovation in Social- and Health Care held its **second meeting** in Tromsø on 27-28 March 2014. The meeting unanimously elected Ms Olaug Bollestad, Norway, to succeed Raimonds Vējonis as Chair of the WG, since Vējonis had been appointed Minister of Defence of Latvia in January 2014. An opening expert presentation was provided by **Ms Pille Kink** from the Estonian e-Health Foundation. After the meeting, the WG made a study visit to the Norwegian Centre for Integrated Care and Telemedicine, where briefings were given on coordinated care and demographic challenges in rural areas, telemedicine innovation and implementation, flexible e-learning in healthcare, homecare and prevention, and barriers and legal aspects of cross-border telemedicine.

eHealth in Estonia

Pille Kink
Estonian E-Health Foundation

Facts about Estonia

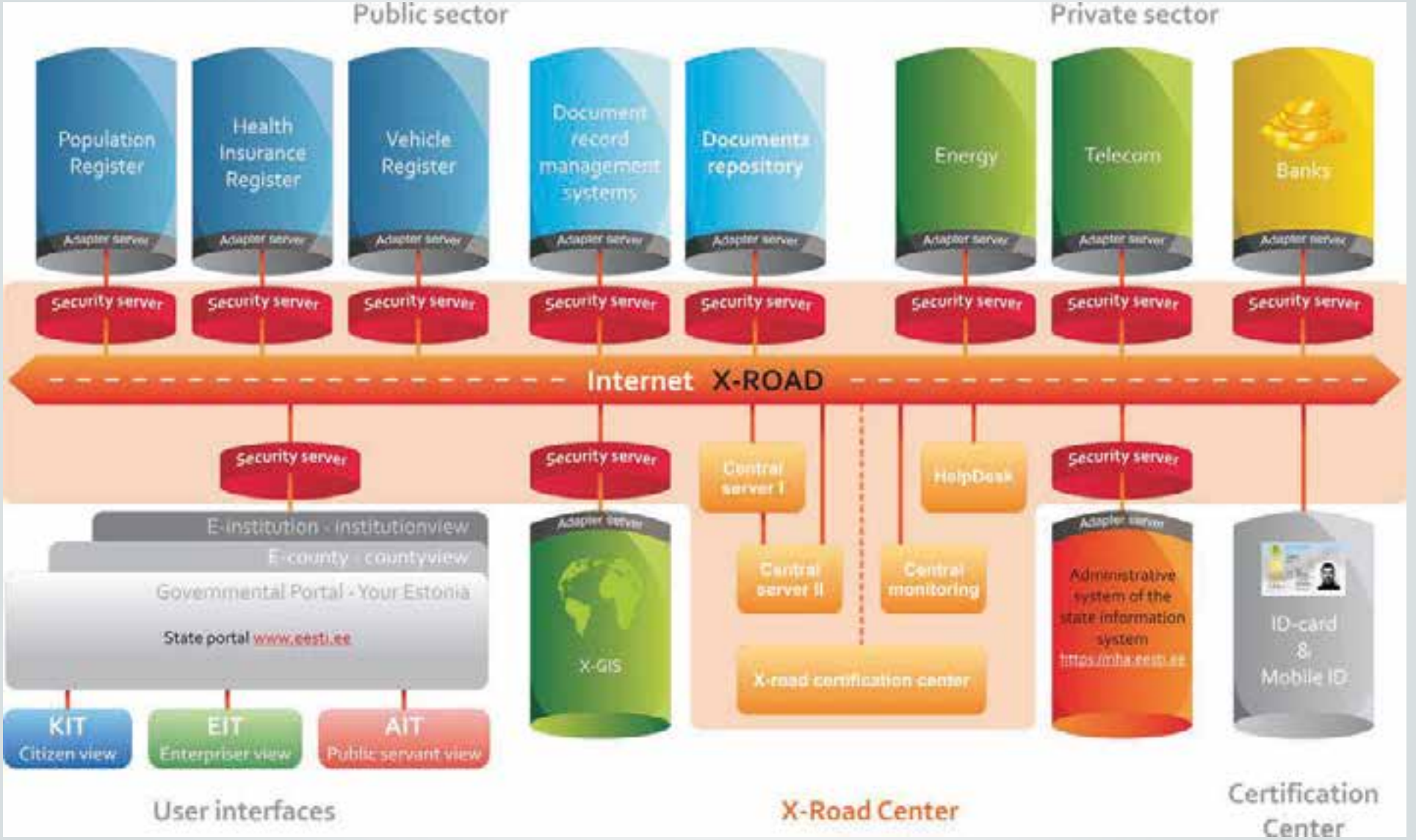
Estonia

45 227 km² area of Estonia
1.29 mio inhabitants

60 hospitals
464 GPs

Healthcare expenditures
5.9% from GDP 2011
6.3% from GDP 2012

Estonian information system platform

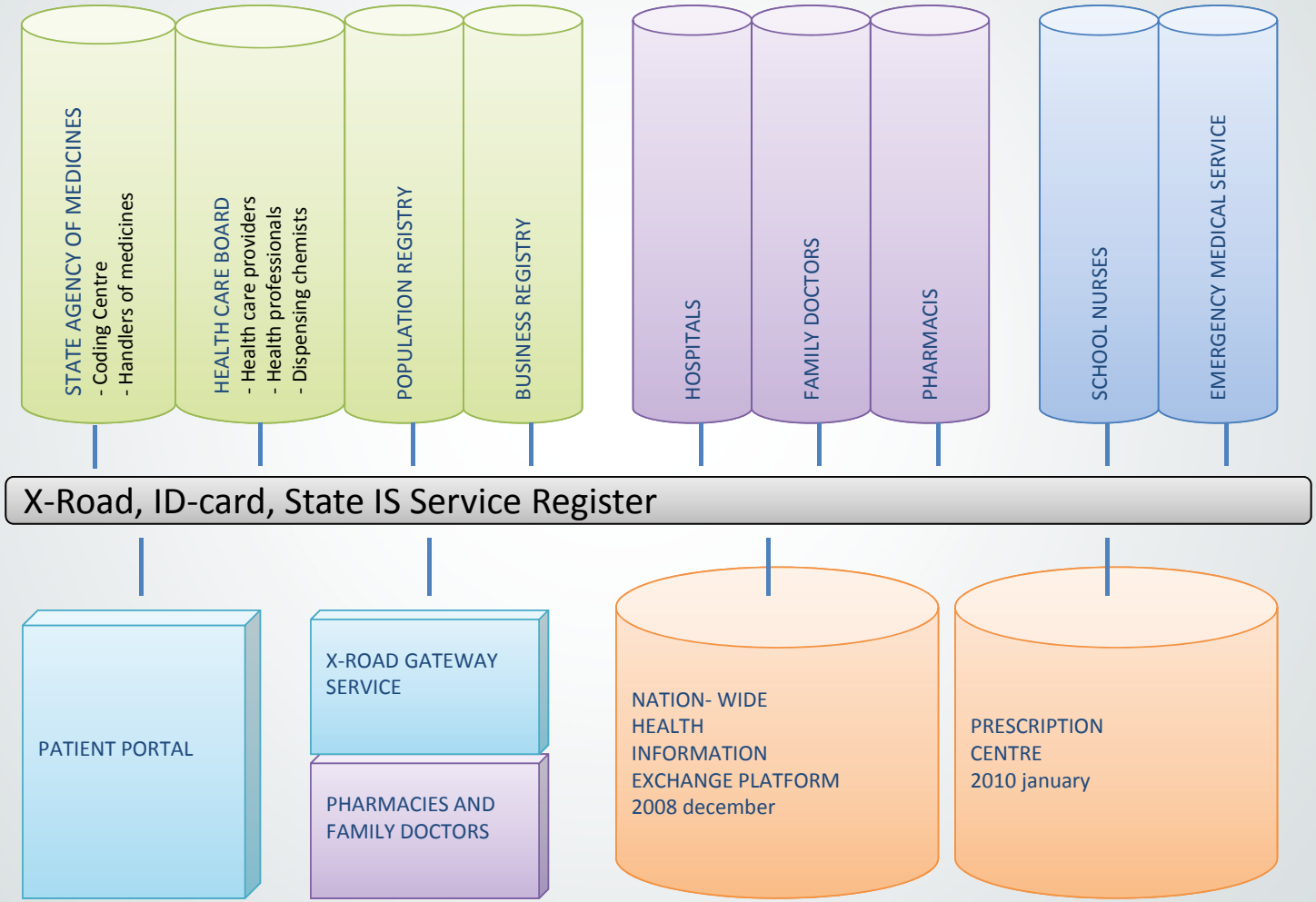


eHealth systems in Estonia

- Health Information System
- Digital Prescription
- Health Insurance Information System
- Administrative and Product Registries
- Public Health and Quality Registries
- Telemedicine Tools used in health sector
- Service providers information systems

4

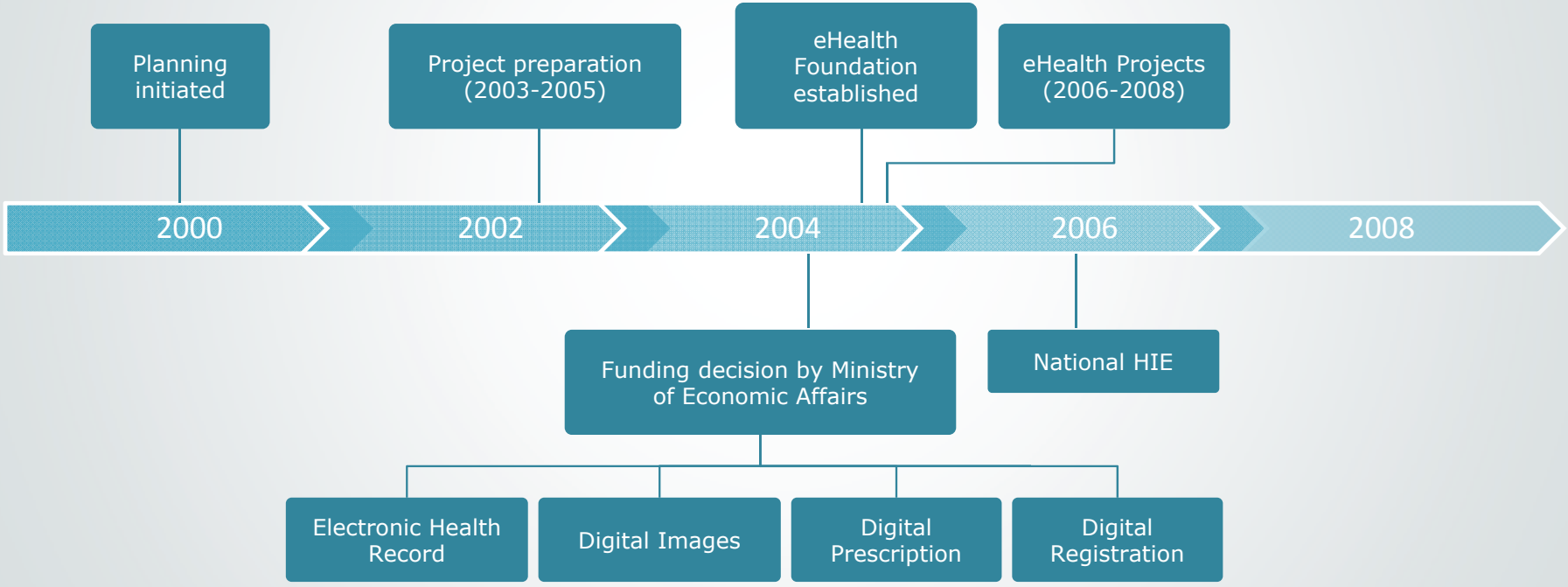
Architecture



5

Security and authentication

HIE platform history



Functionalities of health information system:

- Provide services to health care providers to simplify their every day work
- Provide health information to patients
- Central secure storage of health data

eHealth in numbers

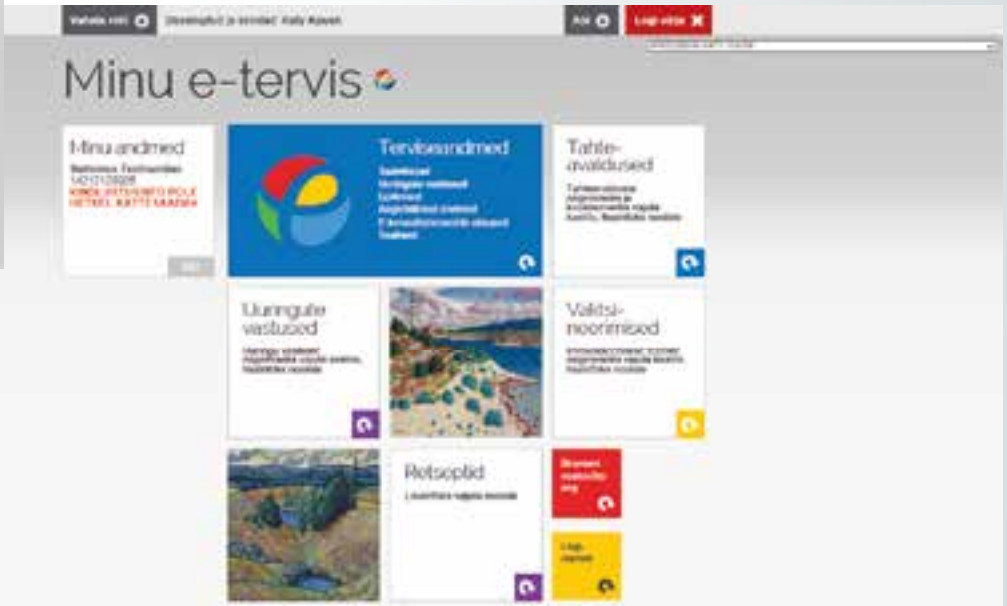
ePrescription covers 97% of issued prescriptions.

1.2 mio person have documents (93% of population) in central system

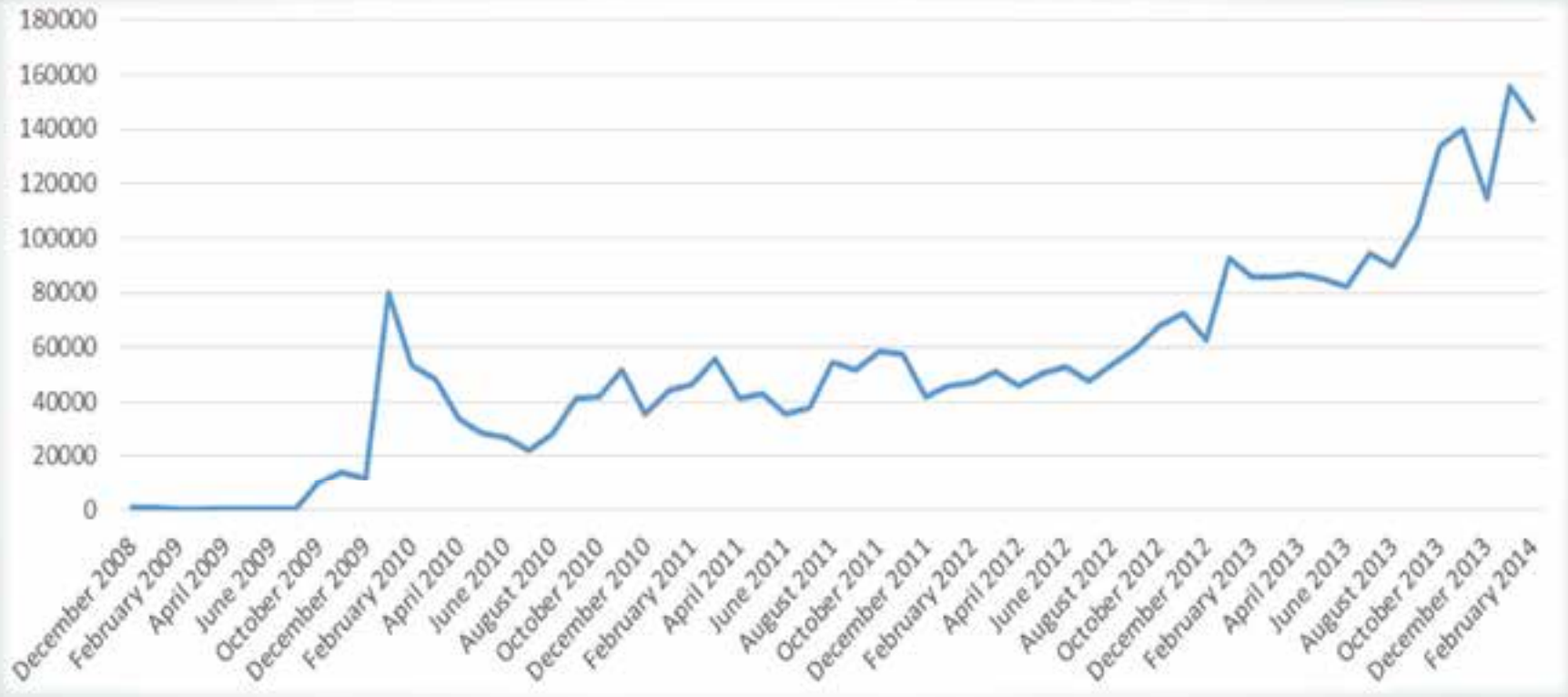
~ 97% of stationary case summaries have sent to the central DB

9

New Patient Portal released 01.07.2013



Number of patient queries



11

Possibilities for patient

In patient portal:

- View and print out medical documents sent by health care providers to the central system;
- View information about their general practitioners and validity of health insurance;
- Make informed consents;
- Provide general information about themselves for health care providers;
- Give authorisations for trustees;
- Mask data for trustees and health care providers;
- Monitor logs

Get useful information and read explanations

12

STANDARDS

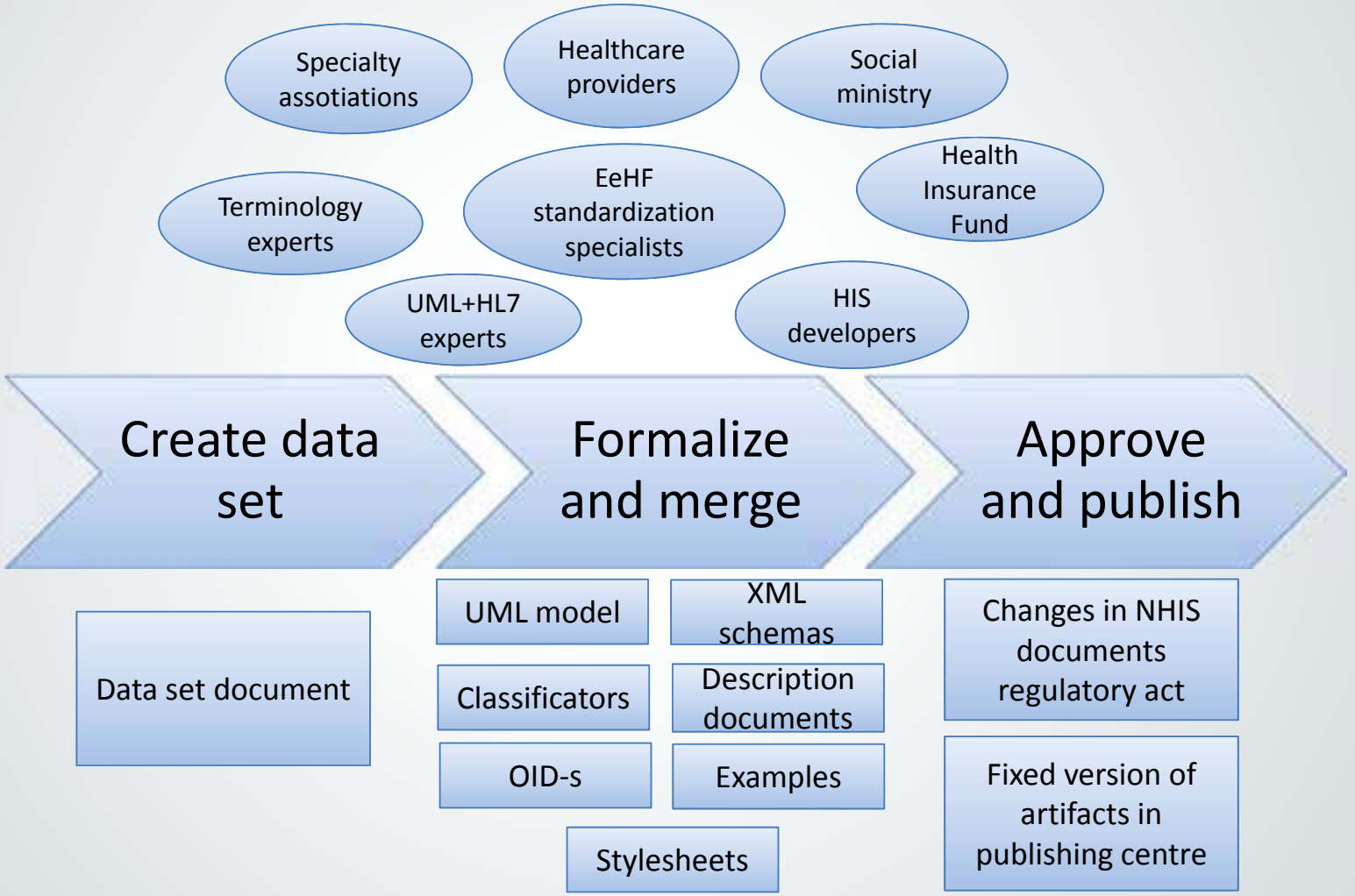
13

Standards

- HL7 and DICOM (Picture Archive)
- International classification: ICD-10, LOINC, NCSP, ATC
- Estonian eHealth's OID registry
- Local eHealth classificators
  - Published in publishing centre
  - Classificators are regulated by government act

14

Standardization process



15

Major architectural decisions of HIS

- Integration through Central system (Opt-out)
- HL7 v3 (extended)
- Documents are kept in XML format (HL7 CDA)
- All structured data fields have OID-s
- Only final versions of clinical documents are sent into central system
- Reuse of national infrastructure
  - ID card for authentication and digital signature
  - Xroad for secure communication

16

Benefits of eHealth Systems

- Greater efficiency
- Lower costs
- Quality of care
- Patient awareness about their health

17

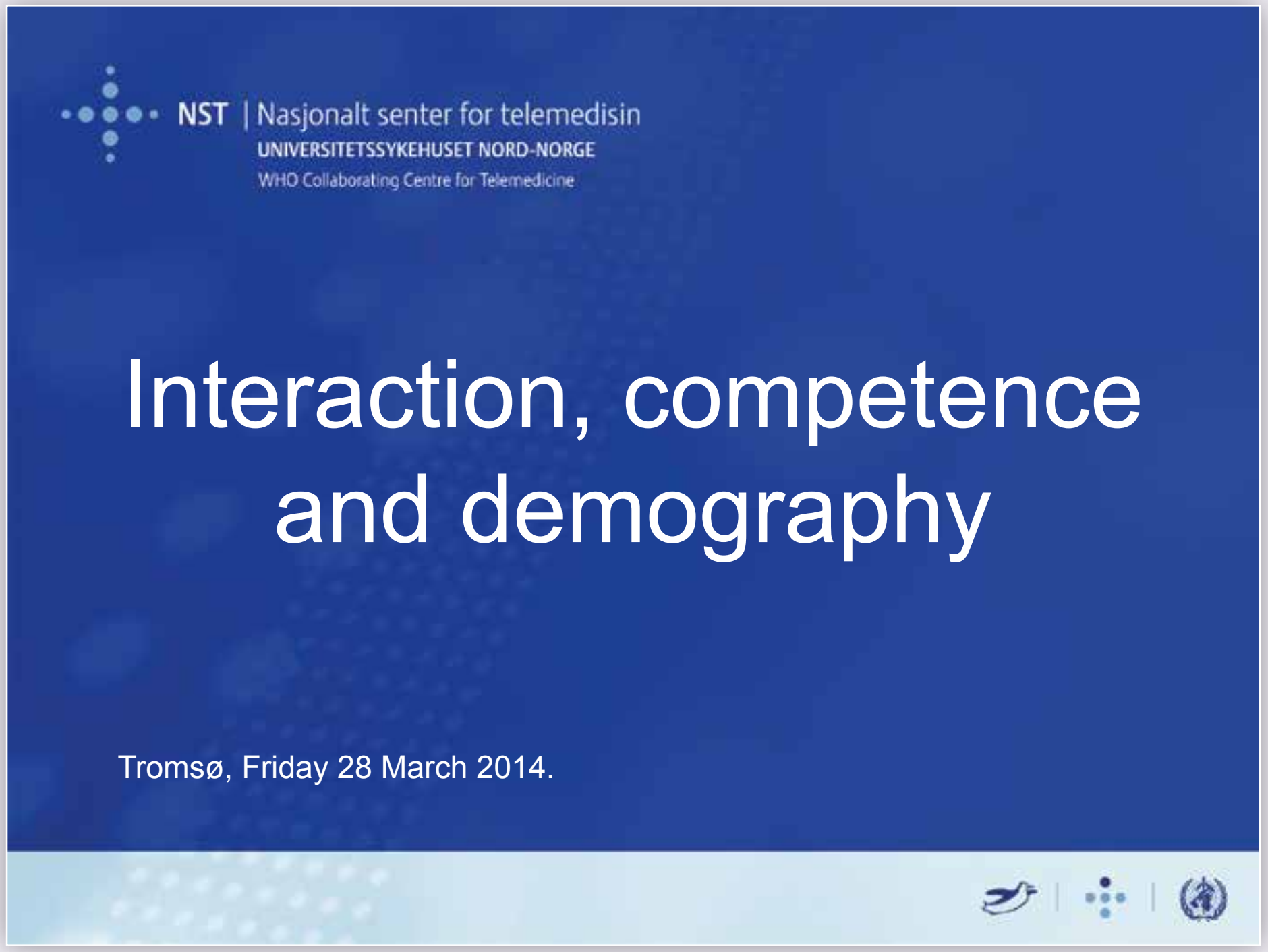

LEARNING
POINTS

- Resources were planned only for central development.
- Usability. Developing process has to include medical competence – users
- Data quality is important
  - Complete and quality data give value.
- Balance between security and usability
  - PIN for every document …

19

Thank you!

20


NST | Nasjonalt senter for telemedisin
UNIVERSITETSSYKEHUSET NORD-NORGE
WHO Collaborating Centre for Telemedicine
Interaction, competence and demography
Tromsø, Friday 28 March 2014.

What's important…?

- "We do as we are told"

Worlds best relay-team?

Practice...?

Are we good at this?

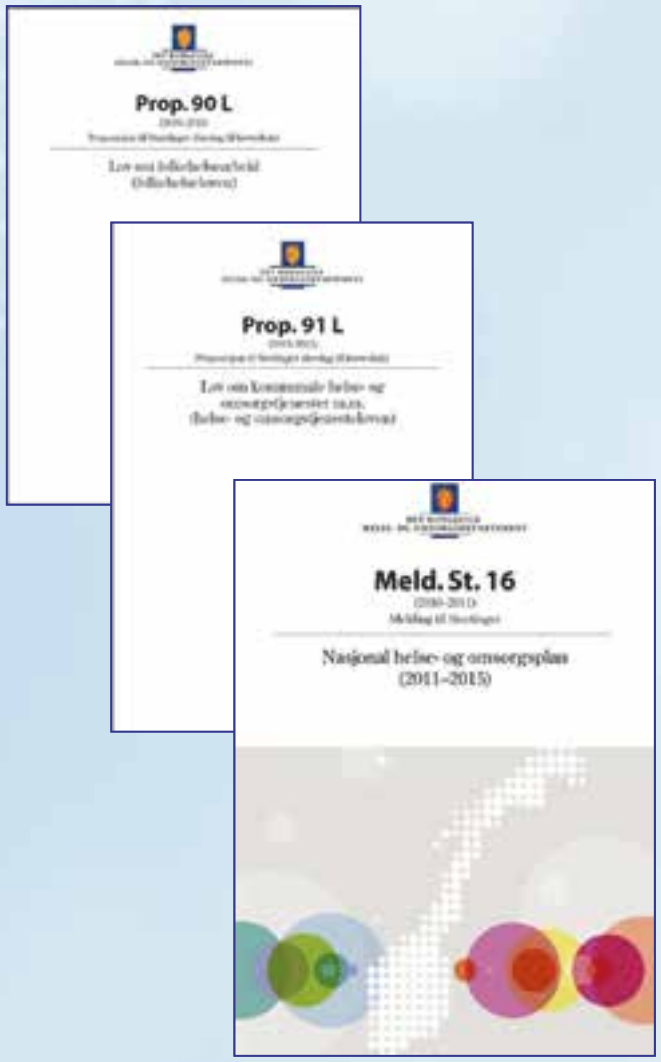
Predictability and quality


Når ingenting er helt som før.....

Ensure quality and sustainable development

Enighet om utfordringsbildet;

Vi må gjøre endringer!



Aging population

Demographic trends Troms

	År	2010	2012	2015	2020	2025	2030	
Troms		156 494		161 185		168 466	171 594	
Over 67		19 849		23 177		30 237	33 029	
% endring		12,6%		14,4%		18%	19,2%	

Example Tromsø

	År	2010	2012	2015	2020	2025	2030	
Tromsø		67 305		69 373		78 016	80 649	
Over 67		5 983		7 455		10 896	12 462	
% endring		8,9%		10,7%		14%	15,4%	

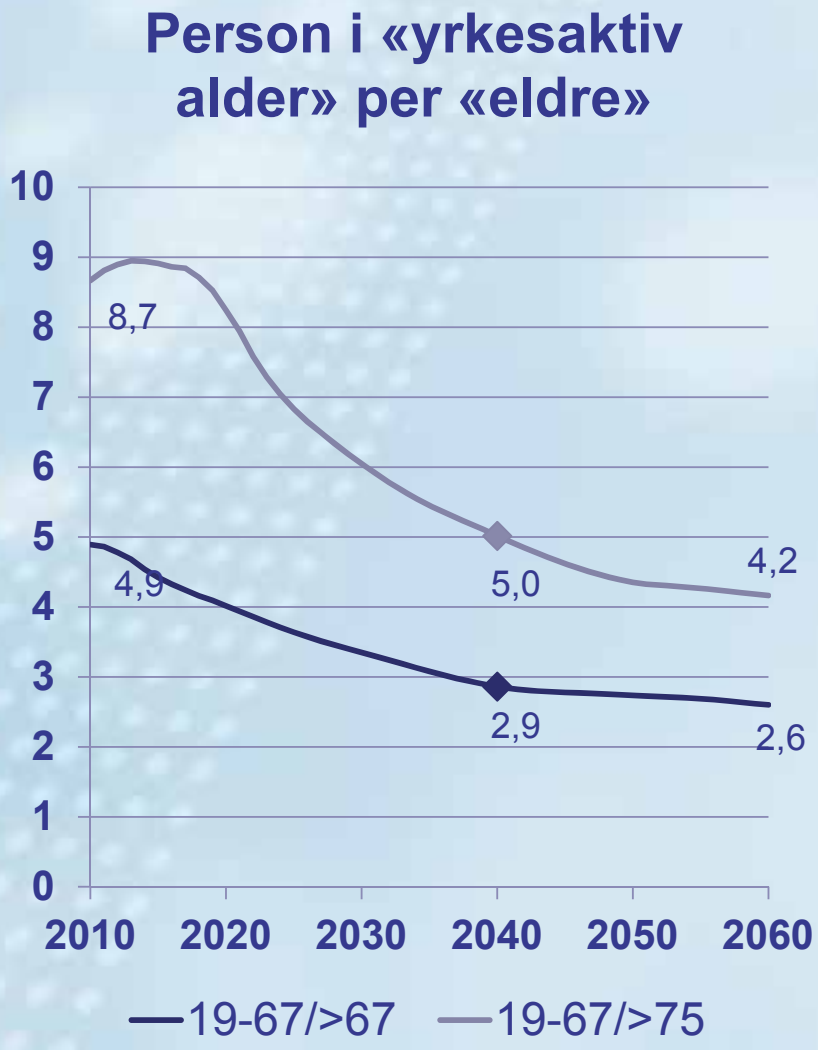
Example Ibestad

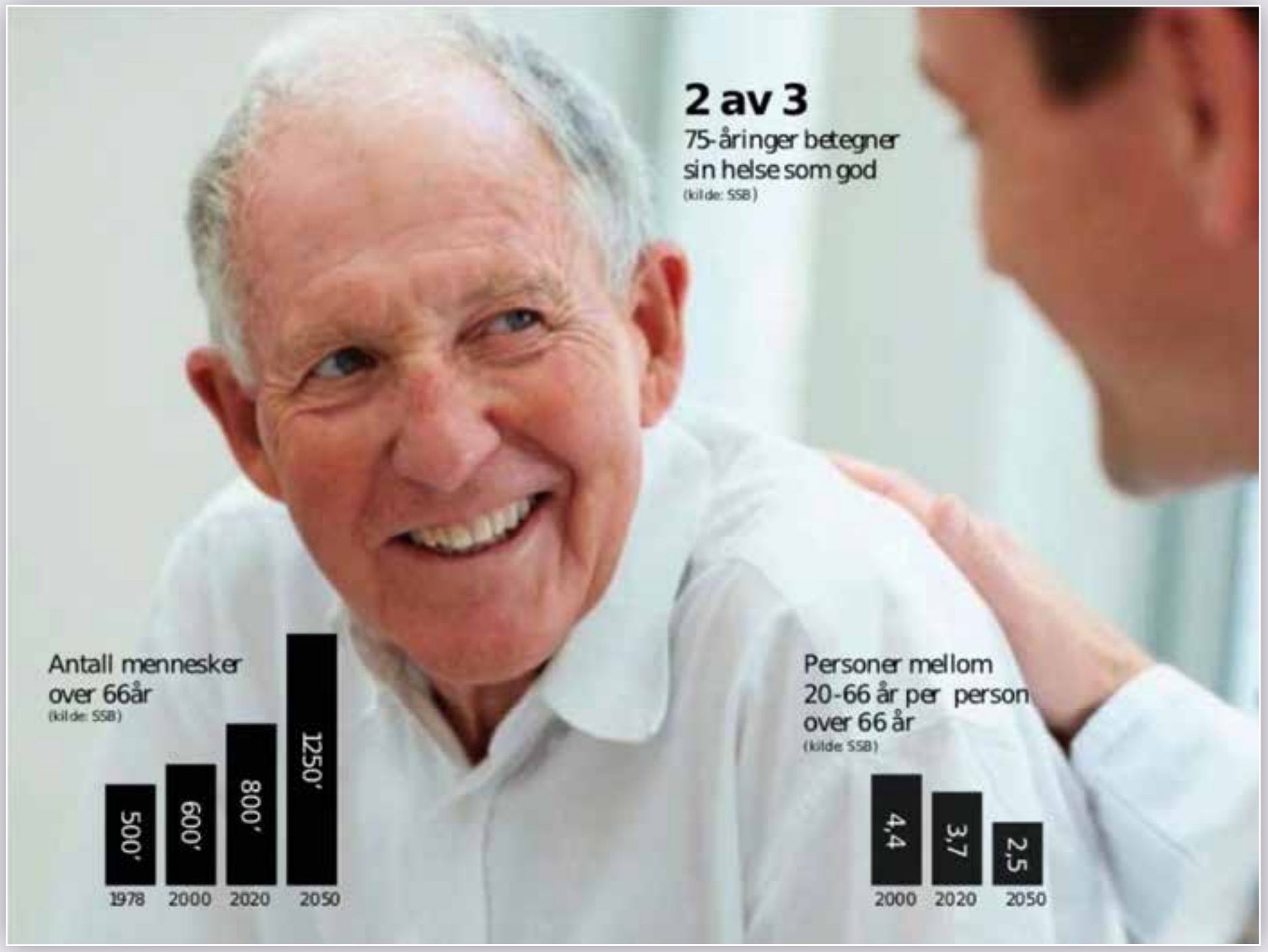
	År	2010	2015	2020	2025	2030		
Ibestad		1 408	1 237	1 087		886		
Over 67		359	362	375		358		
% endring		25%	29%	34%		40%		

Productivity and skills

- I dag går
  hver 6. elev
  fra ungdomsskolen inn i helse- og omsorgsarbeid
- Med samme nivå på tjenestetilbudet, vil vi i 2025 ha behov for at
  hver 4. elev
  fra ungdomsskolen blir helse- og sosialarbeider
- …. og i 2035 må
  hver 3. elev
  velge h/s utdanning….

Need for increase in society's workforce




2 av 3
75-åringer betegner sin helse som god
(kilde: SSB)
Antall mennesker over 66år
(kilde: SSB)
500'
600'
800'
1250'
1978
2000
2020
2050
Personer mellom 20-66 år per person over 66 år
(kilde SSB)
4,4
3,7
2,5
2000
2020
2050

self-management and prevention

Per Erlend Hasvold, MSc
Section Manager - Home-based services and personal health systems
per.hasvold@telemed.no
Norwegian Centre for Integrated Care and Telemedicine - NST
University Hospital of North Norway - UNN HF

challenges

- Government white-paper:
  - today every 6th child in secondary school take a health or care related education
  - in 2035 every 3rd child must get a health or care related education if we shall deliver the same services to the same parts of the population as today

this is not sustainable!

challenges

- a Danish colleague calculated the amount of time the worst COPD patients spent visiting health services: 0,02%
- i.e. more than 99,98% of the time seriously ill patients spend alone, making all critical decisions that will affect their health

challenges

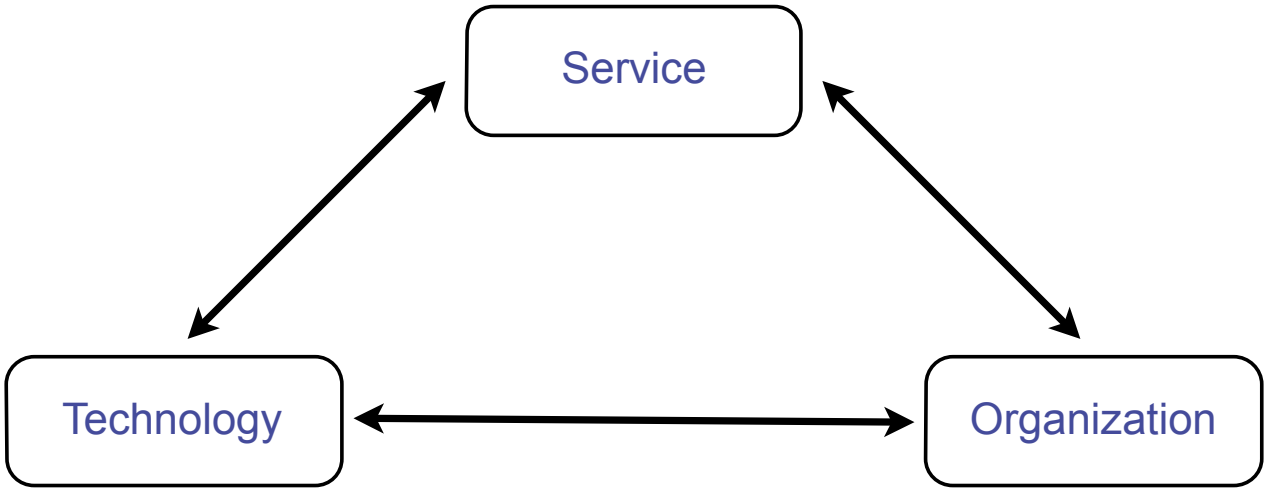
- healthcare organizations are a complex systems
- healthcare organizations characterized by professional roles and ethics, and high rate of ad-hoc decisions
- healthcare has been slow at making changes

our objectives

to find ways of applying technology:

- to deliver better care, using fewer resources
- to support self-management
- to motivate changes in lifestyle to a more healthy one
- to prevent secondary disease
- to reduce the risks leading to injury and health problems

a sociotechnical perspective



the diabetes diary

- result of 12 years of research
- examples: bluetooth interface for blood glucose meters; SMS service for parents of child with type 1 diabetes
- user involvement in all aspects of development
- focus on usability; supporting self-management
- current version is available for free at Google Play and App Store
- features mechanism for analyzing data to find similar situations; seeing trends and patterns
- future: tailoring; gamification; investigate gender differences

eRehabilitation

- current projects:
  - COPD patients receive treadmill, pulse-oxymeter, iPad - follow up by physiotherapist
  - post cardiac surgery rehabilitation, tailored support to encourage adherence to training
- we achieve better adherence and compliance, improvements in quality of life, reduction of readmissions to hospital

welfare technology

- participation in national networks on welfare technology
- support of projects on municipality level on smart homes for the frail
- use of virtual presence robot - the Giraf
- the serenity button: use of mHealth to connect the resources around the patient
- discuss aspects of welfare technology and possible consequences

mental health

- apply eHealth to create low threshold services to reach people with mild mental health problems
- create models of care that gives more citizen services with less use of resources

apps and mHealth

Fitbit.com

Whitings.com

apps

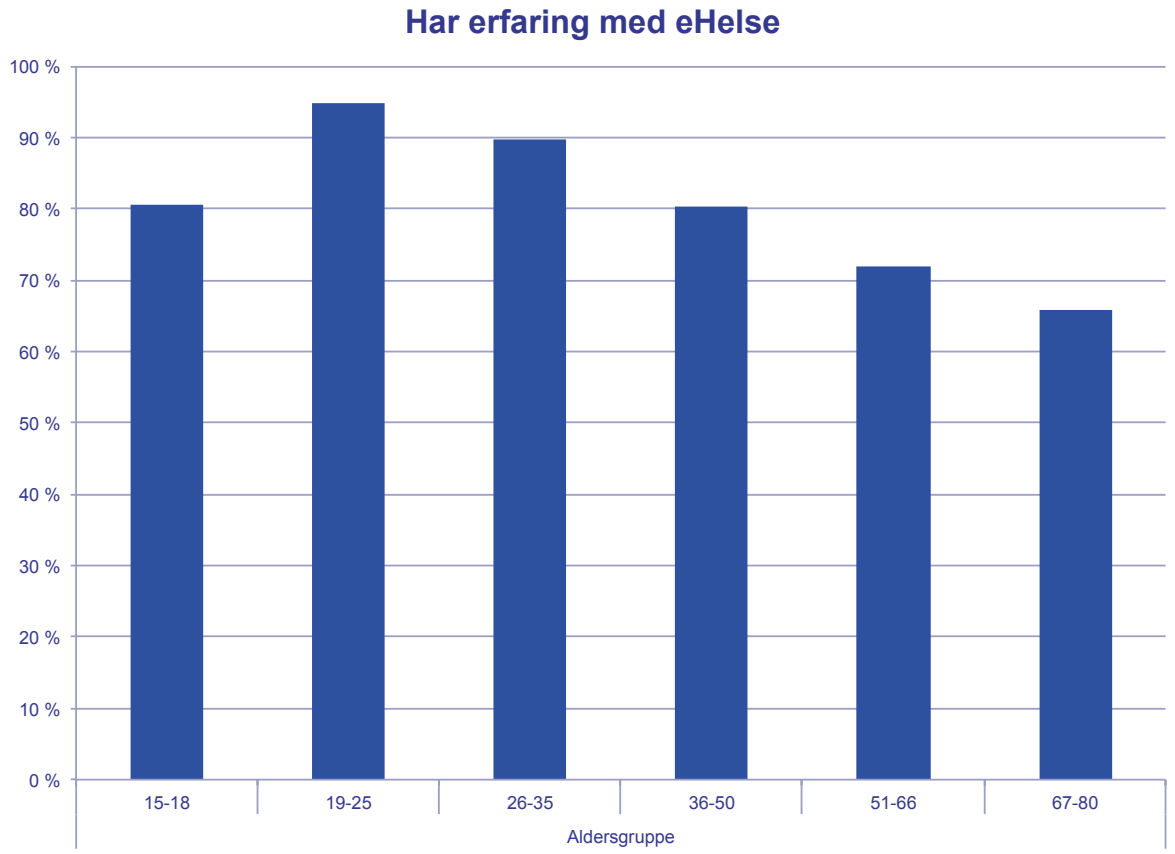
- apps are maturing
- ecosystems of apps
- integration with legacy systems
- advanced data analysis (in phone or online)
- dashboard interfaces
- tailoring

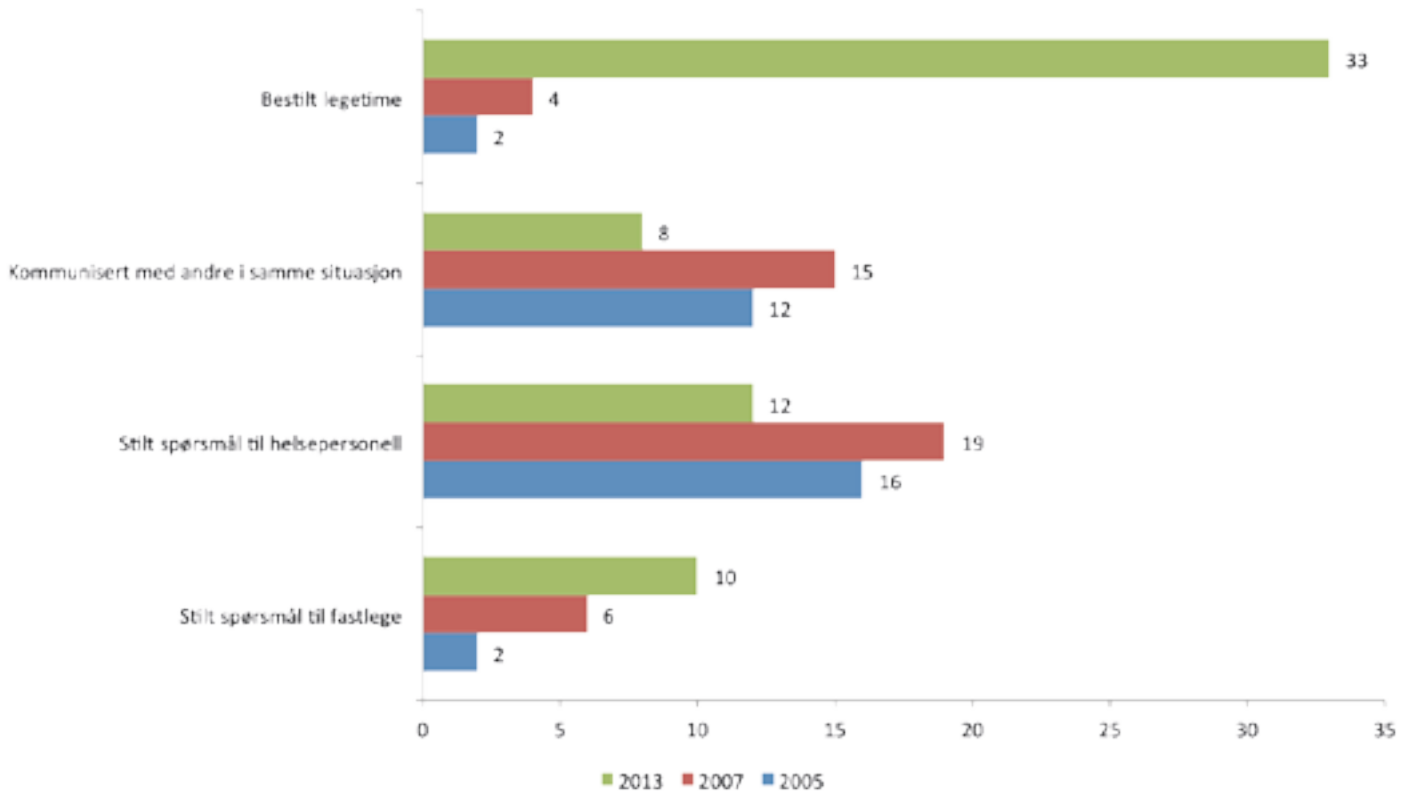
health information

- apps and devices collect data about the user - more than health professionals can deal with
- using big-data and multivariate analysis we turn huge amounts of data into useful information
- important in terms of bridging the personal health systems to the professional health information systems
- citizen services: erdusyk.no
- real-time dashboard for infections in the region: snow.telemed.no

eHealth trends

- national survey on use of eHealth and interaction with health care services through the net: 2000, 2001, 2003, 2005, 2007, 2013
- November 2013:
  - 26% has used a foreign eHealth service
  - 44% wants to be able to send email to GP
  - 48% are worried that information will not be available in an emergency situation
  - 41% are worried about health information privacy


Har erfaring med eHelse
100 %
90 %
80 %
70 %
60 %
50 %
40 %
30 %
20 %
10 %
0 %
15-18
19-25
26-35
36-50
51-66
67-80
Aldersgruppe


Bestilt legetime
33
4
2
Kommunisert med andre i samme situasjon
8
15
12
Stilt spørsmål til helsepersonell
12
19
16
Stilt spørsmål til fastlege
10
6
2
0
5
10
15
20
25
30
35
2013
2007
2005

tailored eHealth

- slutta.no smoking cessation - part of the national health portal
- tailoring: feedback and type of follow up depends on psychological profile - stratification of user types
- tailoring leads to better adherence and compliance - i.e. better outcomes

universal access

- privacy laws require use of BankID to log on to national portal helsenorge.no to access personal information and services
- however, if you are blind, you need someone to help you with the BankID code generator - i.e. the assistant has full access to the health information (as well as banking services)!
- mHealth is a challenge in terms of UA


Knowledge
Trust
Technology
Safety requires:
- Equipment must be made for the task
- Equipment must be well maintained
- Equipment must be used correctly

gaming and gamification

- gaming is used to award healthy behavior and to attract users to a health service
- gaming used for activating people and to measure cognitive performance - might be useful in diagnostic and monitoring
- gamification is to build in the factors that attract people to become active in games to make people adhere to lifestyle change programs, and to educate: e.g. sjekkdeg.no

thank you!

per.hasvold@telemed.no

Norwegian Centre for
Integrated Care and Telemedicine

NST

Flexible e-learning in healthcare

Kirsten Eriksen

Section Manager
helsekompetanse.no

kirsten.eriksen@telemed.no + 47 913 49 652


helsekompetanse.no
Finn e-læring
Videoforelesninger
Om oss
Blogg
Kontakt
Møteplassen for e-læring i helsetjenesten
LAG E-LÆRING
Videokonferanser | Søk i kurskatalog
Se film om e-læring
TROMSØ, 6. MAI 2014
Helsekompetanse 2014
Konferanse for deg som er opptatt av kompetansebygging i helsetjenesten
Les mer

E-learning platform

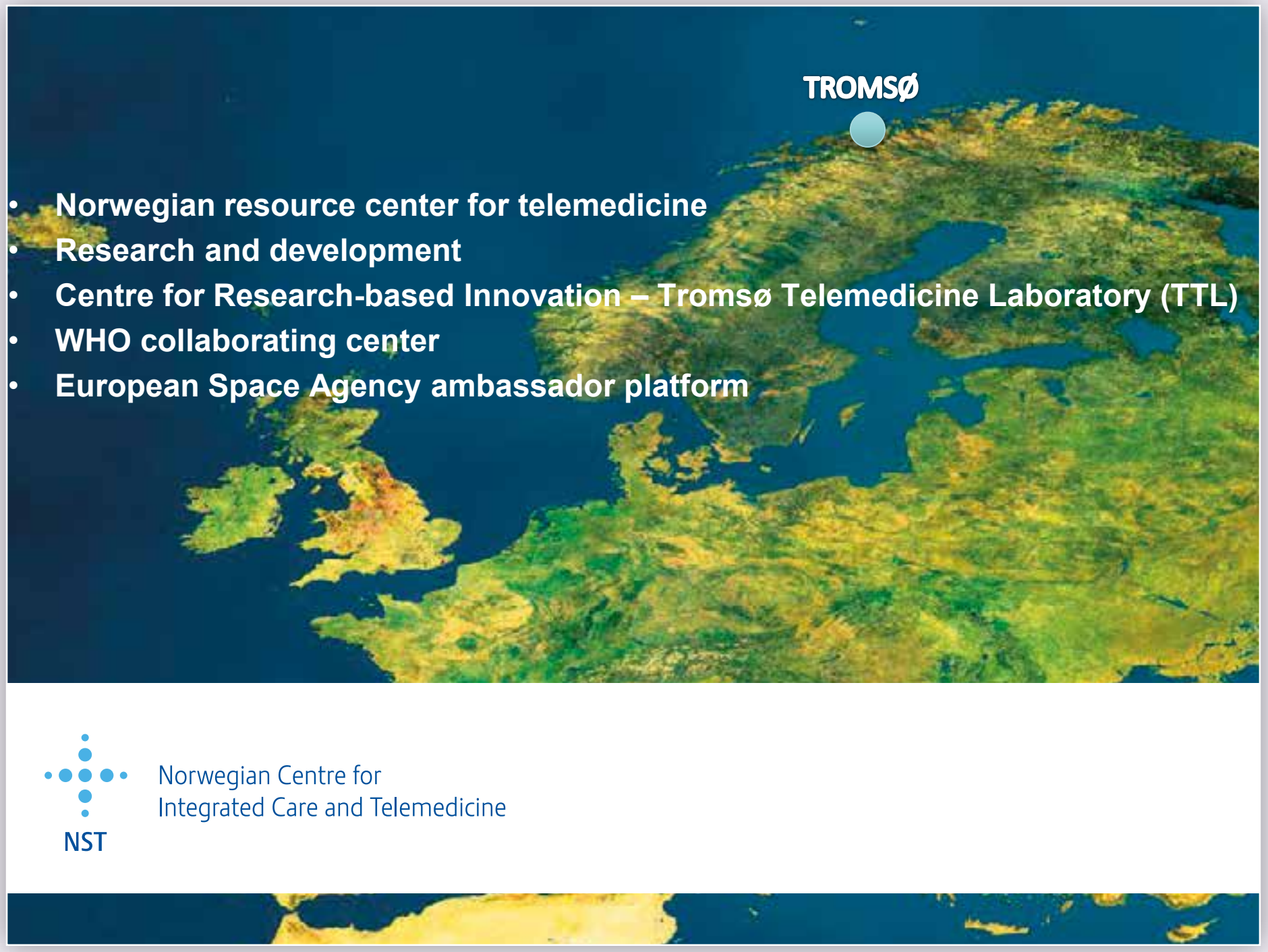
Content development

Advisory

Pedagogical structure

Support

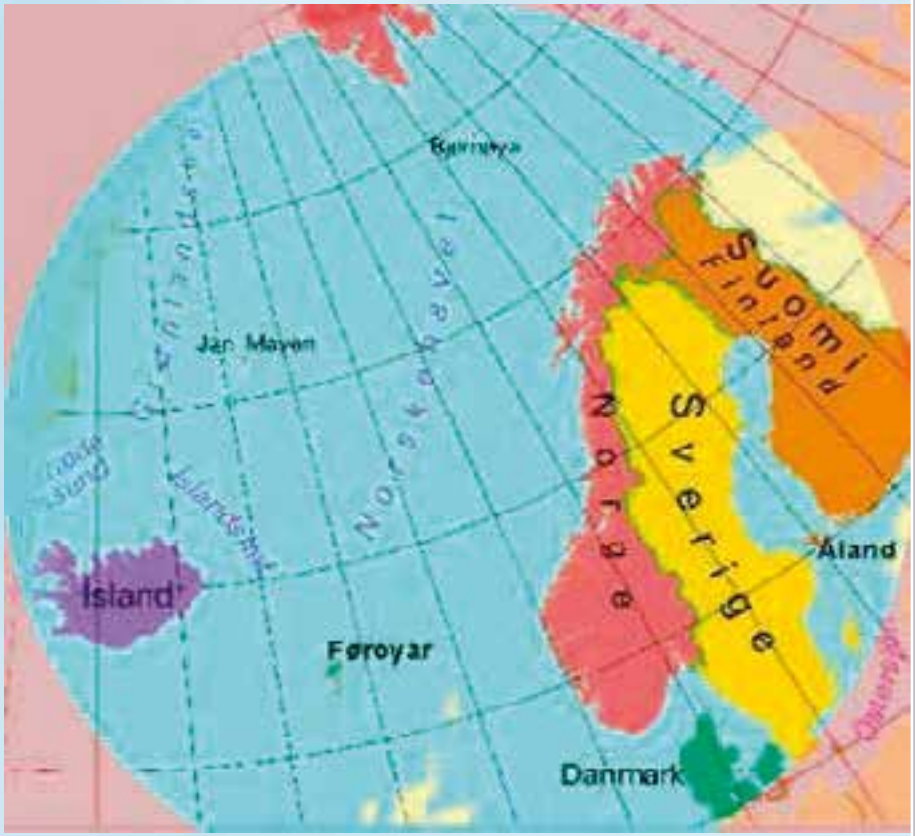
Technical development


TROMSØ
• Norwegian resource center for telemedicine
• Research and development
• Centre for Research-based Innovation – Tromsø Telemedicine Laboratory (TTL)
• WHO collaborating center
• European Space Agency ambassador platform
NST
Norwegian Centre for
Integrated Care and Telemedicine

Nordic competence network

Using VC - Disability:

Norway, Iceland, the Faroe Islands and Greenland, Denmark, Sweden



How to treath rare diseases

Nordic course portal

Dansk Suomi Íslenska Bokmål Svenska

norden

Nordens Velfærdscenter

Hem Kurser Kontakt oss Om

Velkommen til Nordens Välfärdscenter

START KURSET

Medical Peace Work

Welcome to the new Medical Peace Work website

Learn how war and human rights violations affect health.

Discover your special role as a health worker.

Speak out for the prevention of violence and promotion of peace.

As medical professionals we care for the life, health and wellbeing of our patients. Violence, weapons and war cause enormous suffering and misery, and endanger what is important for us.

It is therefore our professional responsibility to work towards the prevention of violence and the promotion of peace, human rights and human security.

Medical Peace Work is an emerging field of expertise in health work, violence prevention and peace building.

Medical Peace Work is a partnership of medical organizations and teaching institutions committed to the development of this new field of expertise.

Medical Peace Work is also seven online courses and a collection of teaching resources for medical peace education. You can find them here on this website.

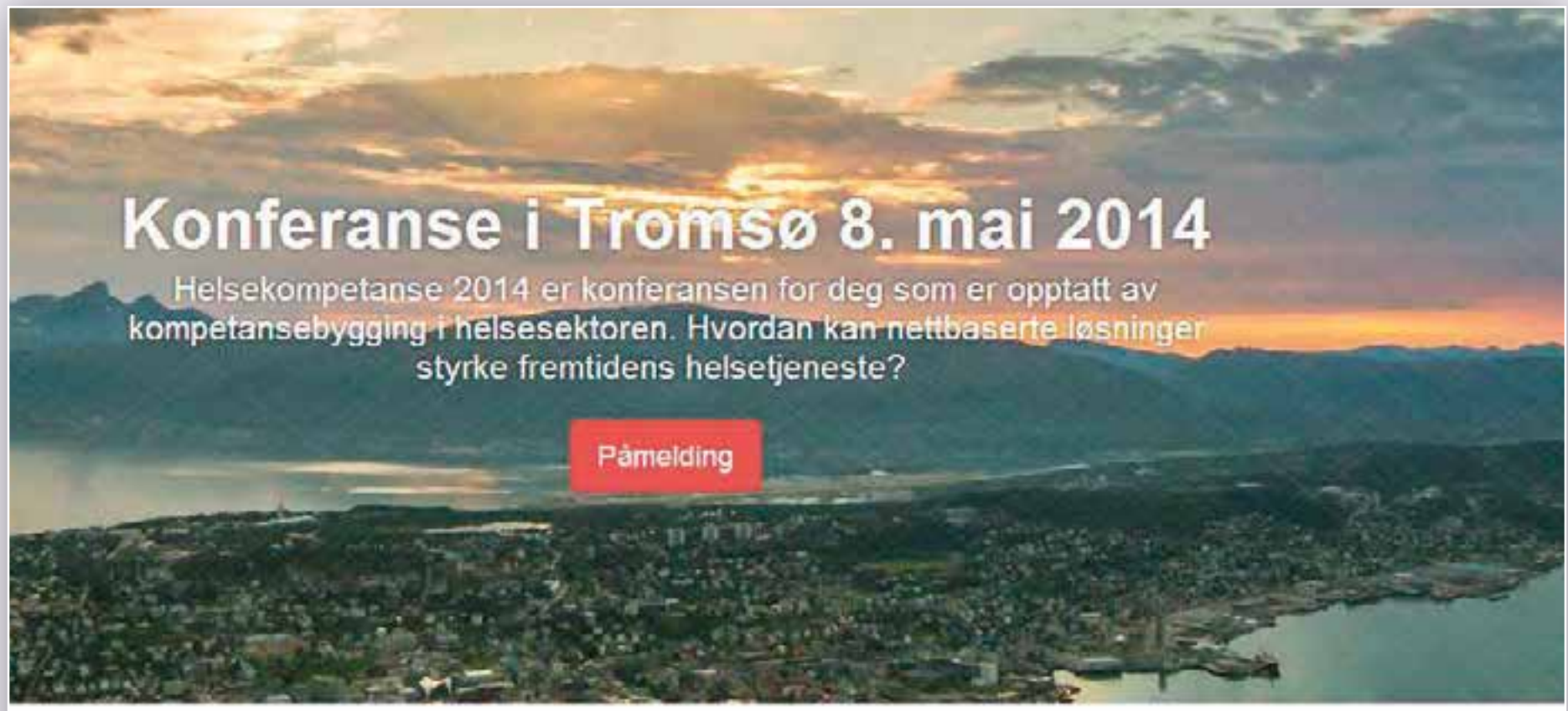
The role of physicians and other health workers in the preservation and promotion of peace is the

Latest news

- Call for Nomination: International Medical Peace Award 2014
- Elective module Peace, Health and Medical Work 2014 (10 ECTS, University of Tromsø, Norway)
- PEGASUS Conference in Toronto, May 2-4
- IPPNW World Congress 2014 in Kazakhstan, August 25-29
- The sucess of nonviolent civil resistance
- Drones: the physical and psychological implications of a global theatre of war
- MPW online courses accredited by Norwegian Medical Association


MEDICAL PEACE WORK
Iceland
Sverige
Norge
Suomi
Gulf of Bothnia
Eesti
Latvija
Lietuva
North Sea
United Kingdom
Ireland
Éire
Nederland
België
Belgique
Deutschland
Polska
Беларусь
Česká republika
Slovensko
Україна
Moldova
Magyarország
Celtic Sea
France
Bay of Biscay
Hrvatska
România
Србија
България
Italia
Tyrrhenian Sea
Black Sea
Georgia
Caspian Sea
Azerbaijan
Portugal
España
Ελλάς
Türkiye
Turkmenis

Global learning for local impact



Om konferansen

Det er et helsepolitisk mål at behandling og oppfølging skal foregå nærmest mulig den som har behov for helsehjelp. Dette gjør det viktigere enn noen gang å satse på kompetansebygging.

Helsekompetanse ved NST skal for fjerde gang arrangere konferanse hvor tema er læring, deling og kompetanseutfordringer i helsesektoren

Dette er møteplassen for helsearbeidere, ledere, brukerorganisasjoner, politikere, utdanningsinstitusjoner og kompetansemiljø som er opptatt a kompetansebygging i helsesektor

Birštonas, Lithuania, 19-20 June 2014

Thursday 19 June

1430-1800 Excursion

Friday 20 June

0900-1200 WG Meeting, including expert presentation by **Ms Nijolė Dirgінčienė**, Mayor of Birštonas and President of the Lithuanian Association of Resorts, and by **Ms Jurgita Kazlauskienė,** Vice President of European Spas Association (ESPA)

The BPSC Working Group on Innovation in Social- and Health Care convened its **third meeting** in Birštonas, Lithuania, on 19-20 June 2014. The meeting itself was preceded by an extensive study tour of the balneological and rehabilitational resort of Birštonas, with several sanatoriums and a wide range of high-quality recreational, rehabilitational and medical services (see www.visitbirstonas.lt). The WG meeting received initial greetings from the Mayor of Birštonas, **Ms Nijole Dirginciene**, who is also President of the Lithuanian Association of Resorts. Her introduction was followed by a presentation on The Role of Resorts in the Baltic Health Tourism Sector by **Ms Jurgita Kazlauskiene**, Vice President of the European Spas Association. The WG meeting primarily engaged in deliberations over the WG Mid-Way Report, to be presented to the 23rd BSPC in Olsztyn on 24-26 August 2014, and its first set of political recommendations.

Role of the Resorts in the Baltic Tourism Sector

JURGITA KAZLAUSKIENĖ

Vice President of European Spas Association (ESPA)

Content

I. The Role of the Spas in Europe.
II. Trends in Health and Spa tourism.
III. Potentials of Baltic Spa product.
IV. Stakeholders of Lithuanian Spa Sector.

The role of the Spa and Health Tourism in Europe

3

- 1.400 spa communities and health resorts in Europe;
- The industry employs direct and indirectly 750.000 people;
- Annual turnover of 45 billion euro;
- Europe wide 180 million overnights.

More than Tourism: Spas and Health Resorts in Europe – Centres for Health

Spas and Health Resorts in Europe – Centres for Health

- Spas and health resorts - health centers with a high quality and complex value chain;
- Spas and health resorts in rural areas - health centers for the local population;
- Increasing life expectancy and economic consequences of demographic change;
- National healthcare systems in Europe are required to ensure good health services for the population;
- Cross border healthcare directive.

1. A natural remedy „of the soil, the sea or the climate
2. Physicians in the community or in the health facility aquainted how to use the remedies in therapies
3. A place / hall to get the remedies
4. Places for therapies (clinics, hotels, physical therapy with local remedies)
5. House for the guests (communication, information, health training)
6. A park, forest, walking trails
7. Places for sport activities, kineso - therapy
8. Places for cultural activities

The use of natural remedies on site (of the soil, the sea or the climate)

The knowledge about the bioclimatic conditions

The special medical knowledge how to use the local natural remedies

Good air quality, drinking water quality

No stress due to noise, dangers, contamination

…. a „small paradise“

This USP should be more emphasized in future!

The misuse of the term Spa

- Today we must recognize, that we have an improper use of the term “spa”
- We learn terms like day spas, urban spas, city spas and cruise spas
  – when we will have night spas?
- Thanks to the Americans too hair spas and teen spas are trendy
  – for me baby spas are still missing!
- The bottom line in this “new spa world” is, that local natural remedies were separated from the spas.

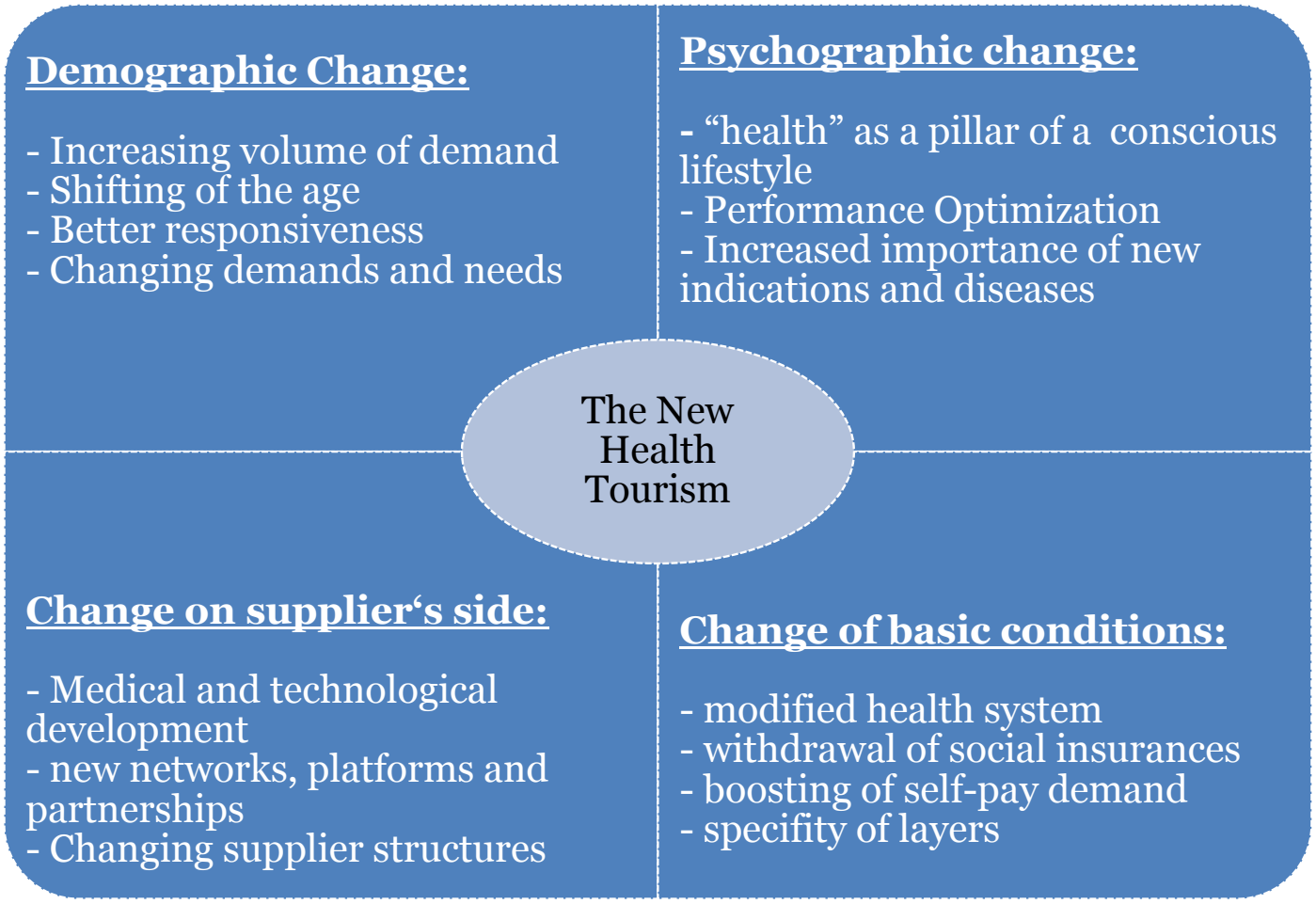
Consequences

Consequences from this situation should be a clear and simple positioning of our spas and health resorts in Europe in two ways:

- ✓ First! There must be local natural remedy/ies at the place and
- ✓ Second! The communities/facilities (e.g. Balnearios, Medispas) must have a medical background.

II. Trends in Health and Spa tourism. The demand of Baltic Spa product.

II. Influences in market development of „New Health Tourism



Šaltinis: p. Claudia Wager, Generalinė direktorė, FIT *REISEN* GmbH

II.Megatrends

New Lifestyle

- Slow down one's life
- Recover one's balance
- Looking for a new way of living

Health

- Improve and maintain health gets more important
- Higher willingness to invest in the own health

Relaxing and Recreation

- Enjoying peace and quiet
- Feeling relaxed, healthy and beautiful
- Being active

Demographic Changes

- Number of Best Agers increases
- Best Agers nowadays are experts in travelling
- Affinity to wellness and health care

The future of the market is determined by four megatrends

12

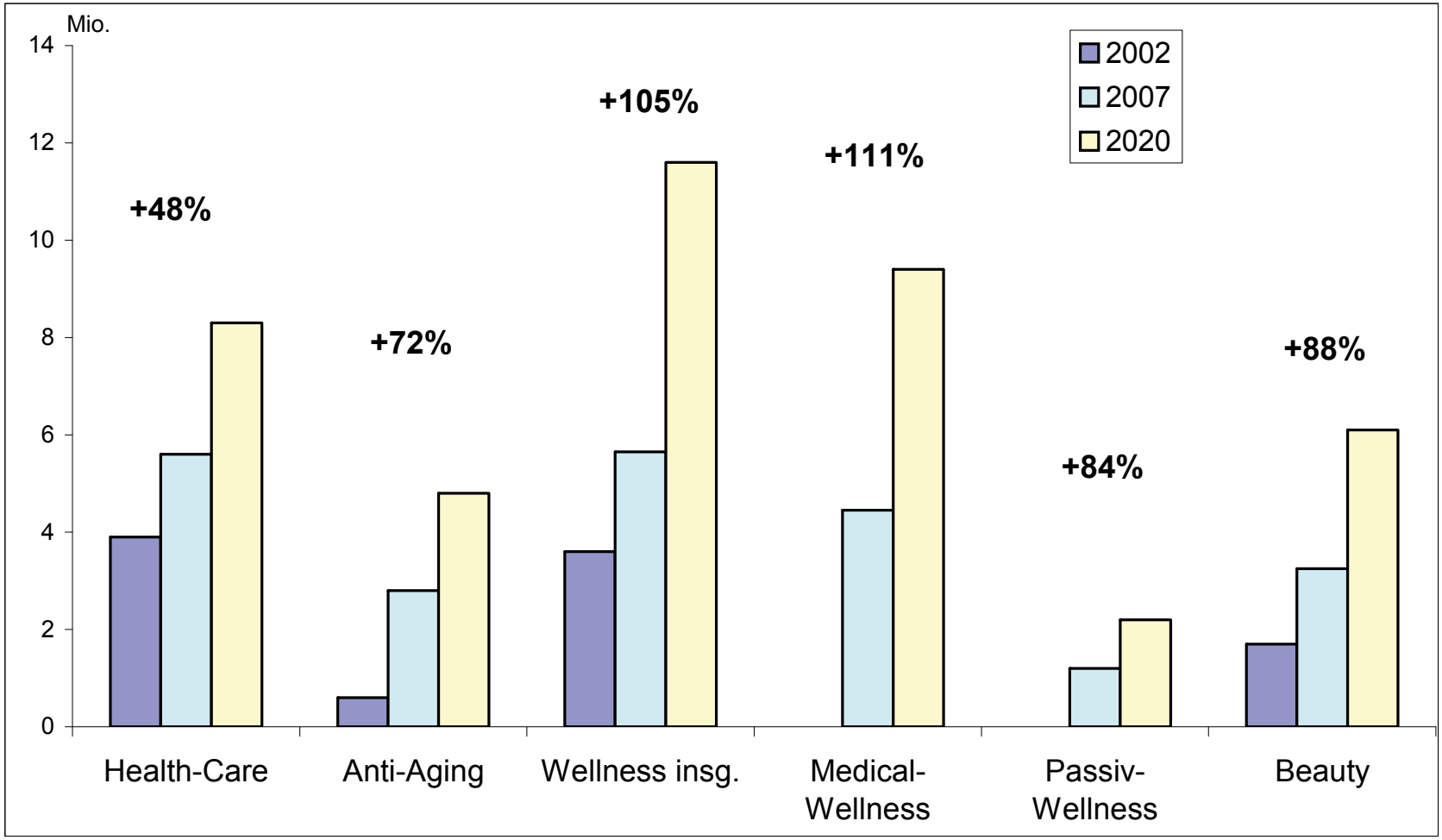
Šaltinis: p. Claudia Wager, Generalinė direktorė, FIT *REISEN* GmbH

Spa and Health Tourism Trends

13

- Shorter stays like one week, even in the traditional spas;
- Price is the most important indicator;
- All inclusive;
- Wellness – Ayurveda is still in the trend – 3 overnights;
- Individual services and value for money is the main point for the decision where to go;
- Slimming cure, Detox, Yoga, Anti-Stress stays are highly demanded.

Future Health Tourism market: forecast 2020



Quelle: IFF: Gesundheitsstudie 2020; Veränderungswerte berechnet von 2007 auf 2020.

III. The potential of the Baltic Spa product

CLASSIFICATION OF HEALT TOURISM (LT)

SVEIKATOS TURIZMAS
(*Health & Wellness Tourism*)

SVEIKATINIMO TURIZMAS arba MEDICINOS TURIZMAS (*Medical Tourism*)

*MEDICINOS TURIZMAS (Medical Tourism)			ODONTO-LOGIJOS TURIZMAS (Dental Tourism)	SLAUGOS IR GLOBOS TURIZMAS (Nursing & Caring Turism)
DIAGNOSTI-KOS IR SVEIKATOS IŠTYRIMO TURIZMAS (Diagnostic & Health Check-Up Tourism)	REABILITA CIJOS TURIZMAS (Rehabilita-tion tourism	MEDICININIS SPA TURIZMAS (SANATORI-NIS GYDYMAS) (Medical SPA Tourism)		

SVEIKATINGUMO TURIZMAS (*Wellness Tourism*)

SVEIKATN GUMO SPA TURIZMAS (Wellness)	GROŽIO TURIZMAS (Beauty)	FITNESO TURIZMAS (Sport & Fitness)	SVEIKATOS ŠVIETIMO TURIZMAS (Halth Education)	SVEIKOS MITYBOS TURIZMAS (Healthy Nutrition)


Baltic Spas one of the bests in Europe!!!


BIRŠTONAS


DRUSKININKAI

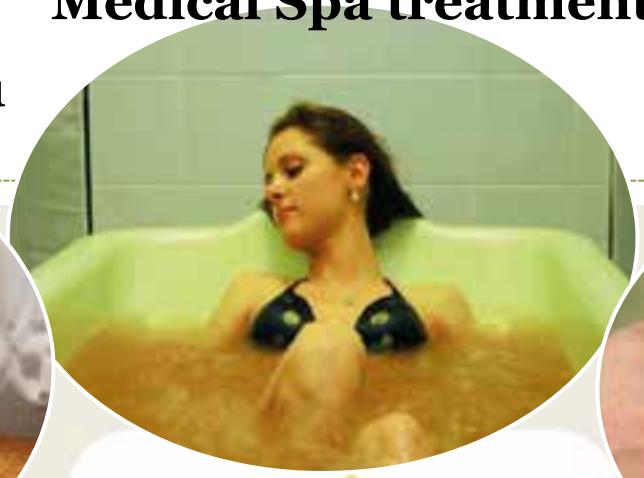

PALANGA


NERINGA

Recreational areas

Medical Spa treatment

Conference bureau



wellness

LIETUVOS
KURORTŲ ASOCIACIJA

sports & fitness

leisure

Family vacations

Traditions more than 200 years

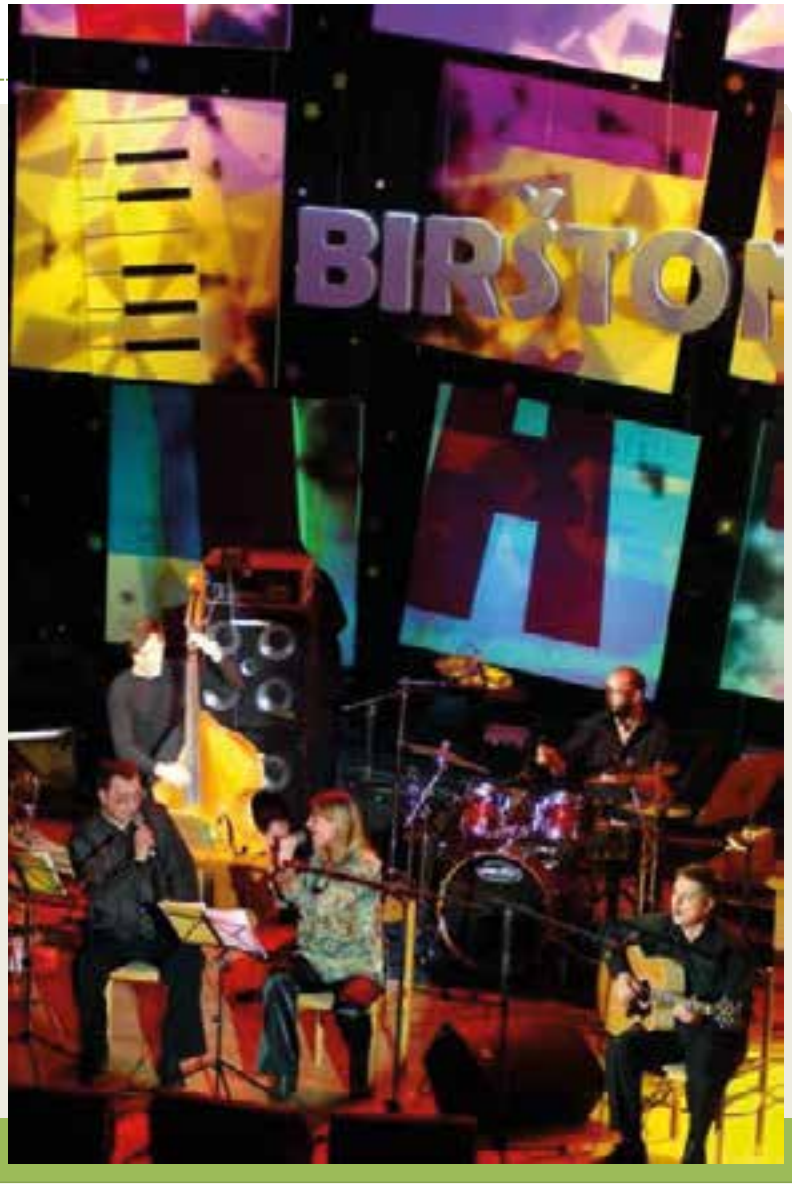
La plage. à Polonga.

Eco-Fit

A places worth visiting!


UNESCO WORLD HERITAGE

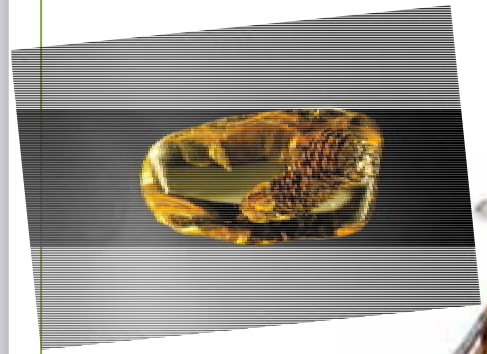
Traditional festivals of art and music



Traditional food + Ecological and green products

Baltic Amber in Tourism

Why is the Baltic Amber unique?



- Found on the shore of the Baltic Sea;
- 50 million years old;
- Three elements are hidden in it: air, water and earth;
- Contains 8% of amber acid that has healing properties;
- Protects against a bad eye;
- Relieves pain, strengthens the immune system, helps to cope with common colds;
- Is used to manufacture fascinating jewellery;
- Is used in SPA's and in foods.

Use of the Baltic Amber

Amber Jewellery
Amber in Culinary
Amber in Cosmetics
Amber in Design
Amber in Medicine

IV. Stakeholders of Lithuanian Spa sector

SPA & WELLNESS RESORTS
LEISURE AND RECREATIONAL SPAS
SPORT & FITNESS SERVICES
BEAUTY TREATMENTS

I. Stakeholders of Lithuanian Spa sector

- MEDICAL SPAS, SPA CLINICS, REHABILITATION CENTRES, DAY TIME SPA CENTRES, HOTEL SPA CENTRES, HEALTH CENTRES, etc.
- MEDICAL SPA CENTRES – a licensed institutions, whose main goal is to provide medical care and rehabilitation services, using natural local remedies: mineral water, therapeutic mud, climate, Baltic sea water. The personnel working there have a medical background.

I. Stakeholders of Lithuanian Spa sector

• Number of Medical Spas	22
• Number of staff	2 799
• Number of rooms	2 867
• Number fo places	over 6 thous.
• Annual turnover	more than 206 mln.Lt.
• Overnights per year	1 271 185
• Guests per year	113 179
	30 % - foreign guests.

2010 m. IV ketvirčio ir 2011 m. trijų pirmųjų ketvirčių duomenys. Lietuvos statistikos departamentas

I. Stakeholders of Lithuanian Spa sector

- The average of accomodation 70%
  - Lithuanian 76%
  - Foreign guests 24%
- The average income (per person) 1 398 Lt
- The average length of stay 11,88 day
  - Lithuanian 11,03 day
  - Foreign guests 15,24 day

  - Hotels 1,91 day

- Šaltinis: Medicinos turizmo galimybių analizė, 2012 m.

Lithuanian medical Spa & wellness product

- medical (health) SPA procedures, a wide choice of services, authenticity (amber therapy, herb therapy and so on.)
- Natural local remedies (mineral water and therapeutic mud, sea water, climate);
- doctors' consultations;
- qualified medical personnel;
- relatively large number of accommodation;
- good value for money;
- a good geographical location, the attractiveness of the Russian and Scandinavian markets;
- Program length: 2-21 day;
- Price per day: starts from 130,- LT (37 EUR);
- Activities: Aero tourism, bicycle, water tourism, skiing, water entertainment, bicycle, Nordic walking, yoga, entertainment clubs, catering services, etc.

Medical Spa treatment

Natural local remedies

- Mineral Water
- Therapeutic Mud
- Climate
- Local Herbs
- Baltic sea (water, sand and sun)
- Amber Therapy

Traditions and new technologies

Mineral water baths

SPA & wellness programs

Active sports

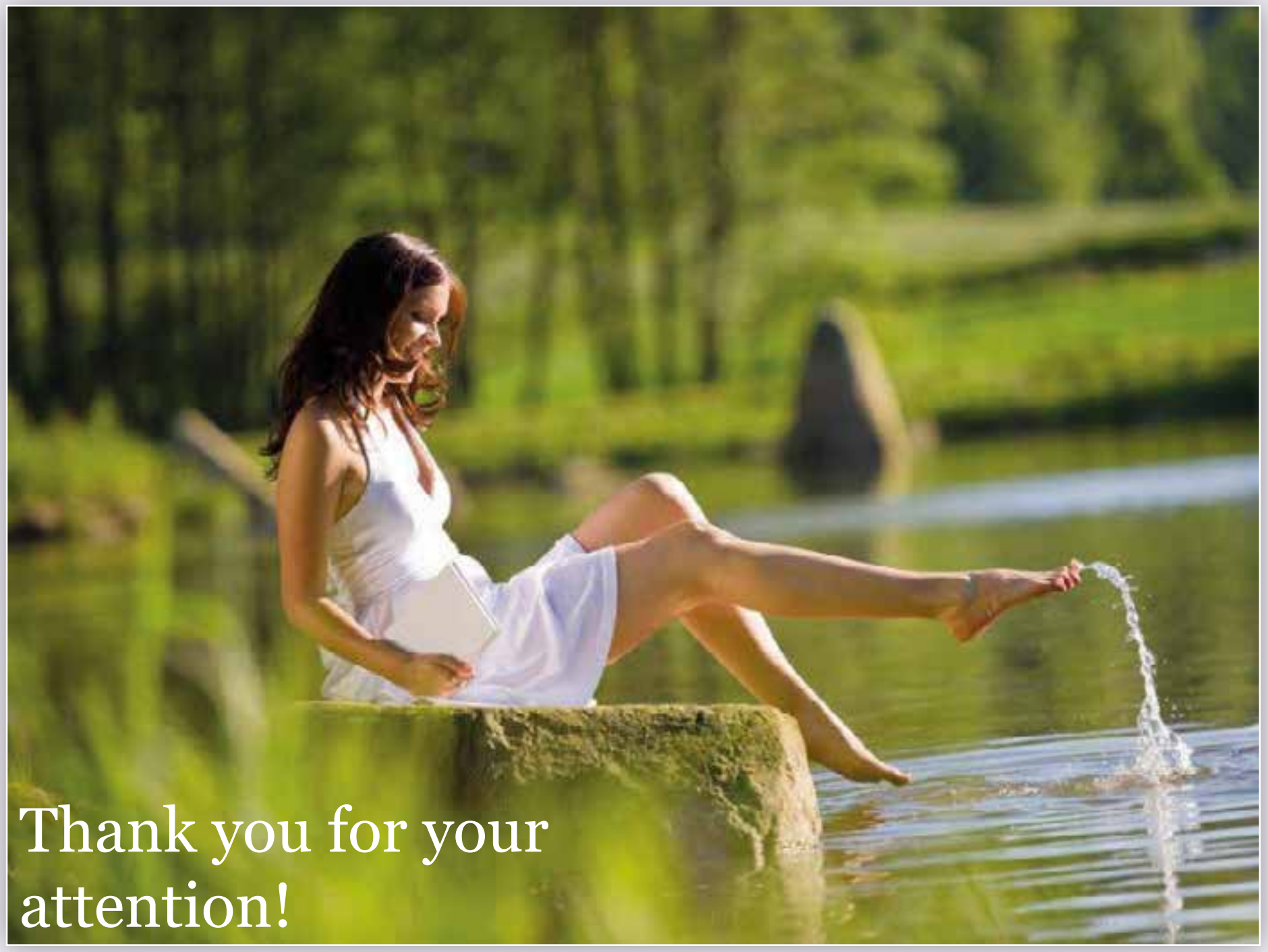

Cycling routes
Total in Lithuania: more than 770 km
More the 450 km in Lithuanian Resorts
SSDD

Activities all year round

Responsibility for our lives

Recognizing that one of the main goals of the EU-policies will be the prevention of the people in the EU - the spas and health resorts in Europe should more emphasize their role as ***competence centres for health and prevention****.*

We should underline that our spas are "lighthouses" mostly situated on the country side of the regions in the EU.


Thank you for your attention!

Copenhagen, Denmark, 13-14 November 2014

Thursday 13 November

1430-1730 Study visit to Steno Diabetes Centre – focus on lifestyle-related diseases / diabetes and innovation

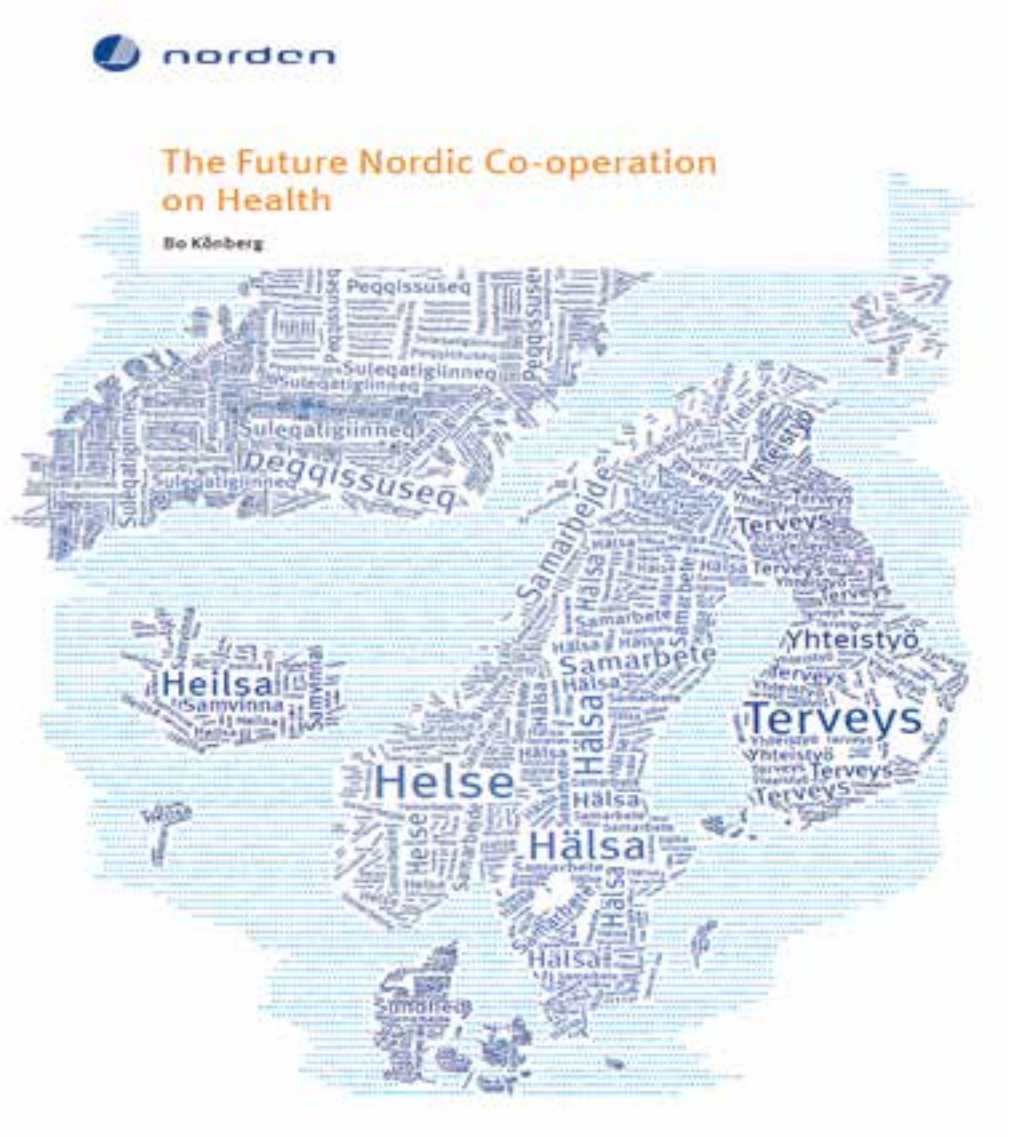
Friday 14 November

0930-1015 Meeting with Hospital Solutions Director for Northeast Europe, **Mr Vincent Giele, Medtronic** – focus on innovation and cooperation between the public and private sector

1030-1115 Meeting with former Swedish minister, **Mr Bo Könberg**, on his report on closer healthcare cooperation in the Nordic countries

1130-1300 WG meeting

The BSPC Working Group on Innovation in Social- and Health Care held its **fourth meeting** in Copenhagen on 13-14 November 2014. The meeting itself was preceded by a visit to Steno Diabetes Center with the focus on lifestyle-related diseases/diabetes and innovation. Steno Center is a world-leading institution within diabetes care and prevention. It is owned by Novo Nordisk AS, and is a non-profit organisation working in partnership with the Danish healthcare system. The Working Group meeting started with a presentation by **Vincent Giele,** Hospital Solutions Director for Northeast Europe in Medtronic. Medtronic is the world's largest medical technology company, offering innovative therapies to fulfil a mission of alleviating pain, restoring health and extending life. Their medical therapies treat cardiac and vascular diseases, diabetes, and neurological and musculoskeletal conditions. The second expert presentation was given by former Swedish minister, **Bo Könberg**, on his report on closer healthcare cooperation in the Nordic countries over the next 5-10 years. The report was submitted on 11 June 2014 and it contains 14 proposals.



norden

Nordic Council of Ministers

14 tangible proposals for future co-operation on health in the Nordic region

Bo Könberg

BSPC
Copenhagen

14.November 2014

Increase in longevity

- During the last century Nordic longevity has increased with more than 25 Years
- And those years are healthy years!

Life expectancy

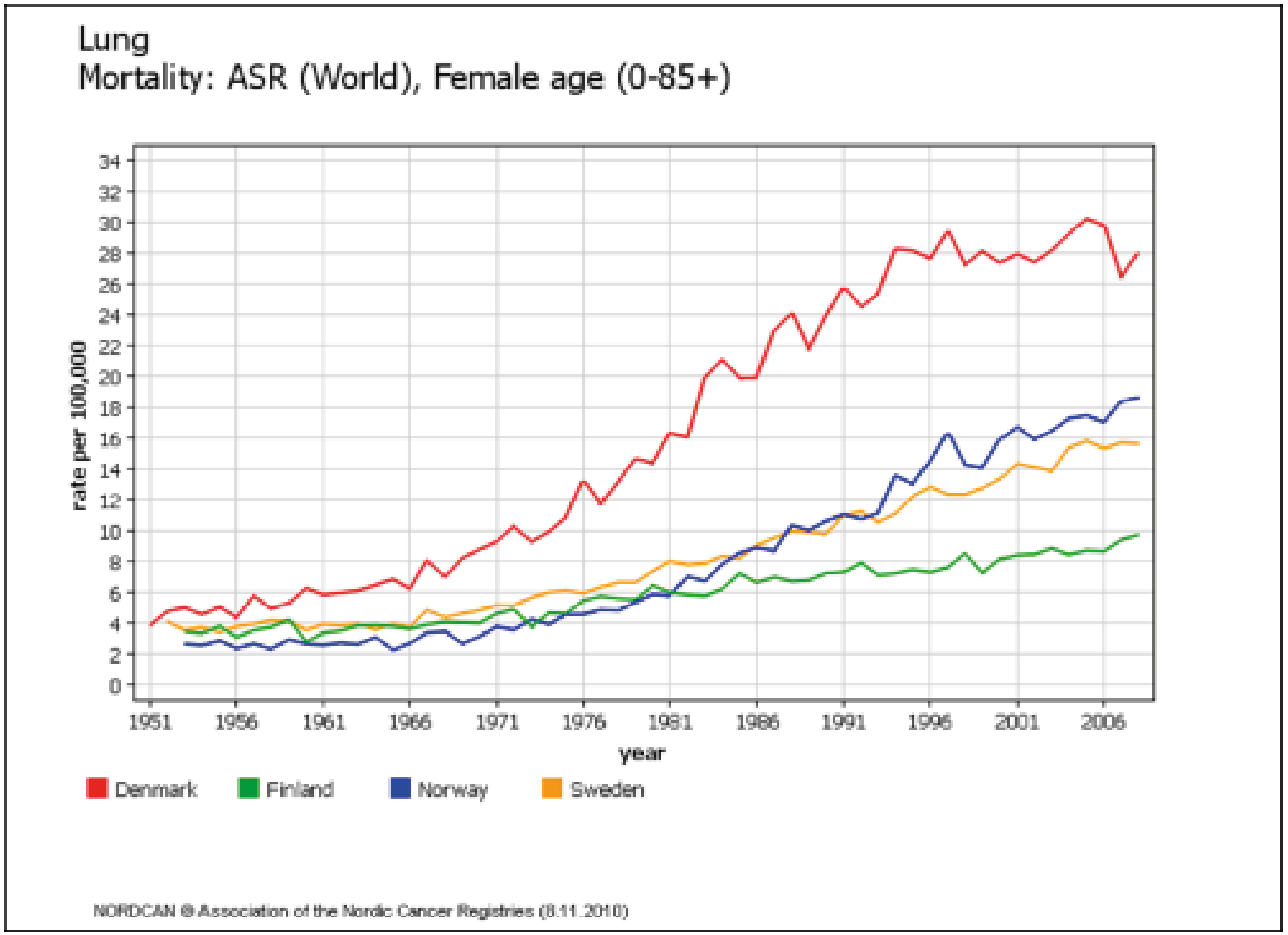
(years)

	2012	Increase (yrs) 1960–2012*
Iceland	82.9	9
Sweden	81.7	9
Norway	81.5	8
Finland	80.6	12
Denmark	80.1	8
Nordic average	81.4	9

Data: World Bank 2012
*rounded to the nearest whole number

16

Lungcancer


Lung
Mortality: ASR (World), Female age (0-85+)
rate per 100,000
0
2
4
6
8
10
12
14
16
18
20
22
24
26
28
30
32
34
1951
1956
1961
1966
1971
1976
1981
1986
1991
1996
2001
2006
year
Denmark
Finland
Norway
Sweden
NORDCAN © Association of the Nordic Cancer Registries (8.11.2010)

1. Vigorous measures against growing antibiotic resistance

2. Strong co-operation on highly-specialised treatment

3. Set up network on rare diagnoses

4. Set up a virtual centre for register-based research

5. Greater co-operation on initiatives to improve public health

6. Public health policy platform to reduce inequality in health

7. Patient mobility in the Nordic region

8. Greater co-operation on welfare technology

9. Greater co-operation on e-Health

10. Greater co-operation in the psychiatric field

11. Greater mandate for co-operation in health preparedness

12. Greater pharmaceutical co-operation to increase cost-effectiveness and safety

13. New exchange of officials

14. Co-operation on national experts in the EU Commission

Proposal 2: Highly-specialised treatment

- Set up a Nordic review group at high level for highly-specialised treatments, with the aim of holding regular dialogue between the countries on the needs and opportunities for co-operation initiatives.

Proposal 3: Rare diagnoses

- Set up a Nordic network for co-operation on rare diagnoses to strengthen existing and new joint initiatives, and to improve coordination of these.

Proposal 4: Register-based research

- Strengthen research co-operation regarding data registers, biobanks and clinical intervention studies.
- Introduce a model for mutual recognition of ethical reviews of Nordic research projects.
- Set up a Nordic virtual centre for register-based research.

Proposals 5 and 6: Public health

- Increased co-operation on public health
- Increase the exchange of information on public health
- Set up a public health policy platform for developing proposals

Proposal 7: Patient mobility within the Nordic region.

- Evaluate the effects, on patients, of the Nordic countries' recently-adopted implementation of the EU patient mobility directive.
- Try to extend the right to care in another Nordic country.

Proposal 8: Welfare technology

- Strenghtened Co-operation on Welfare Technology

Proposal 9: E-health

- Extended co-operation on e-health
- Co-operation on e-prescriptions
- Create a Nordic health library online
- Develop a Nordic search tool "My patient"

Proposal 12:

Extended Nordic pharmaceutical co-operation

- Greater exchange of experiences on the conditions and prices with purchases
- Extend the exchange of experiences on implementation of new drugs

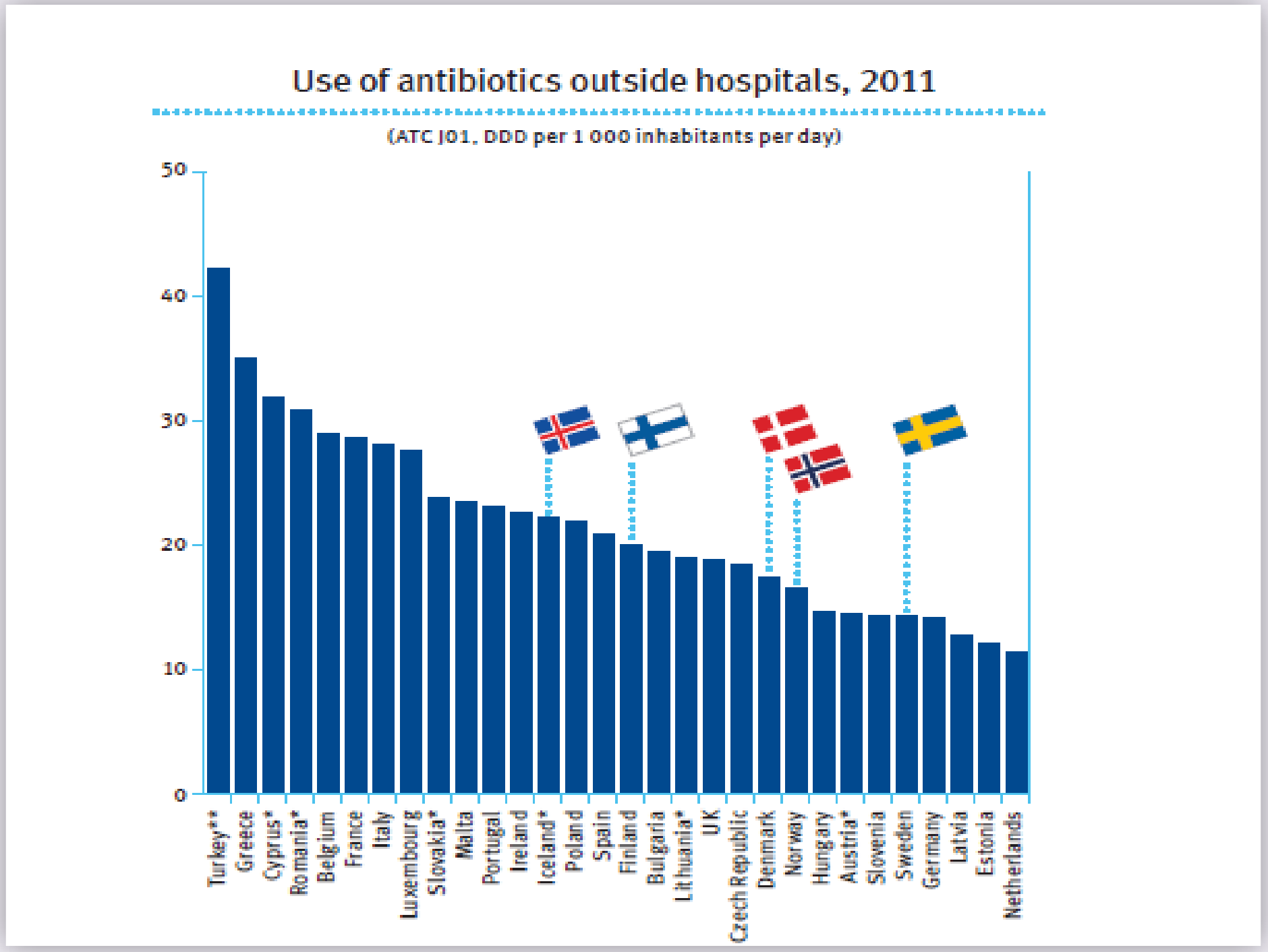
Proposal 12:

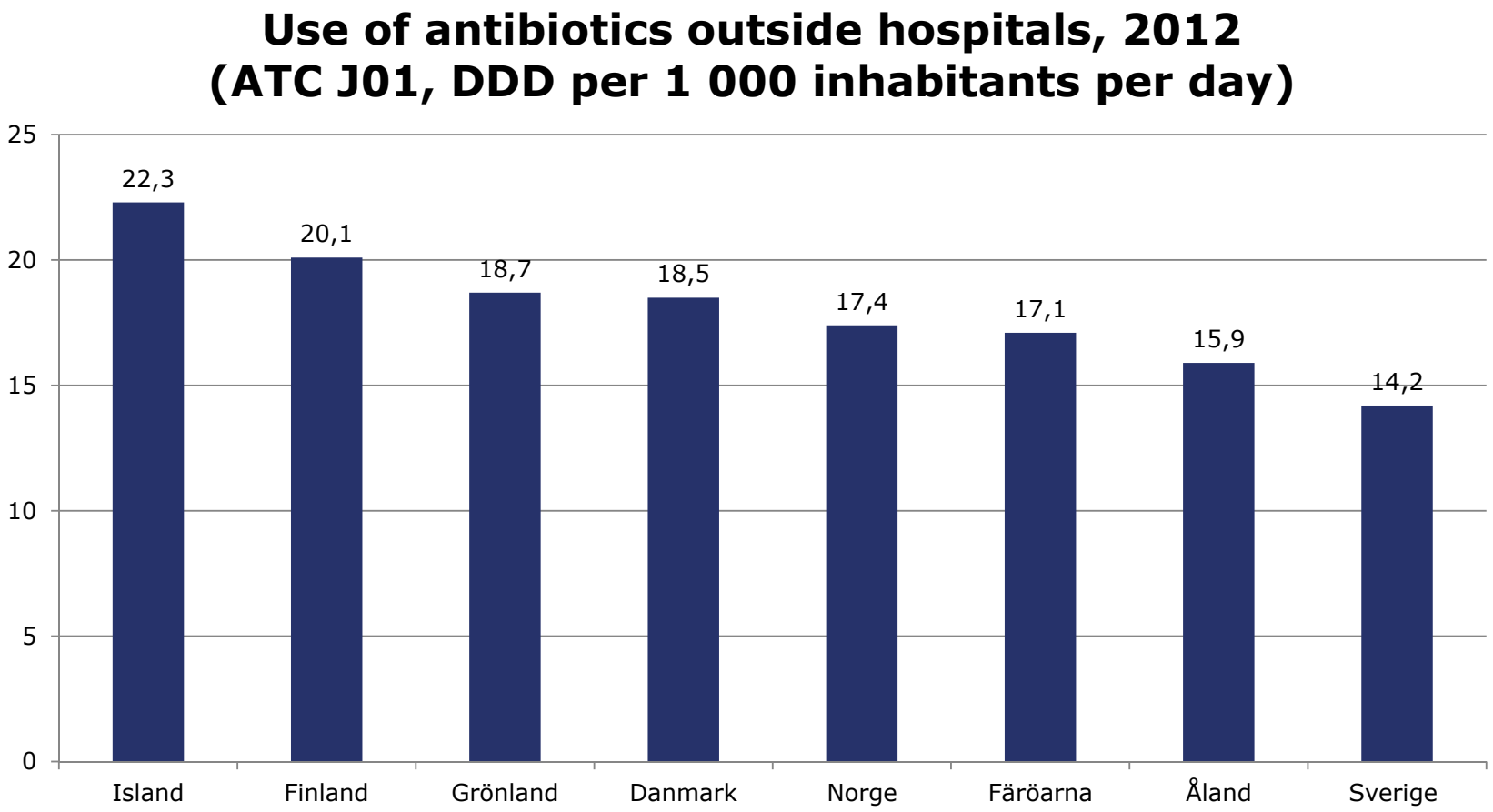
Extended Nordic pharmaceutical co-operation

- Greater exchange of experiences on the conditions and prices with purchases
- Extend the exchange of experiences on implementation of new drugs

Proposal 1: The decrease in antibiotic resistance

- The first invention was in 1930
- Up to 1970, twenty new antibiotics were developed
- Between 1970 and 1987, two new antibiotics were developed
- Since then no new ones!
- This year some 50 000 persons in Europe and North America will die due to the increased reistance

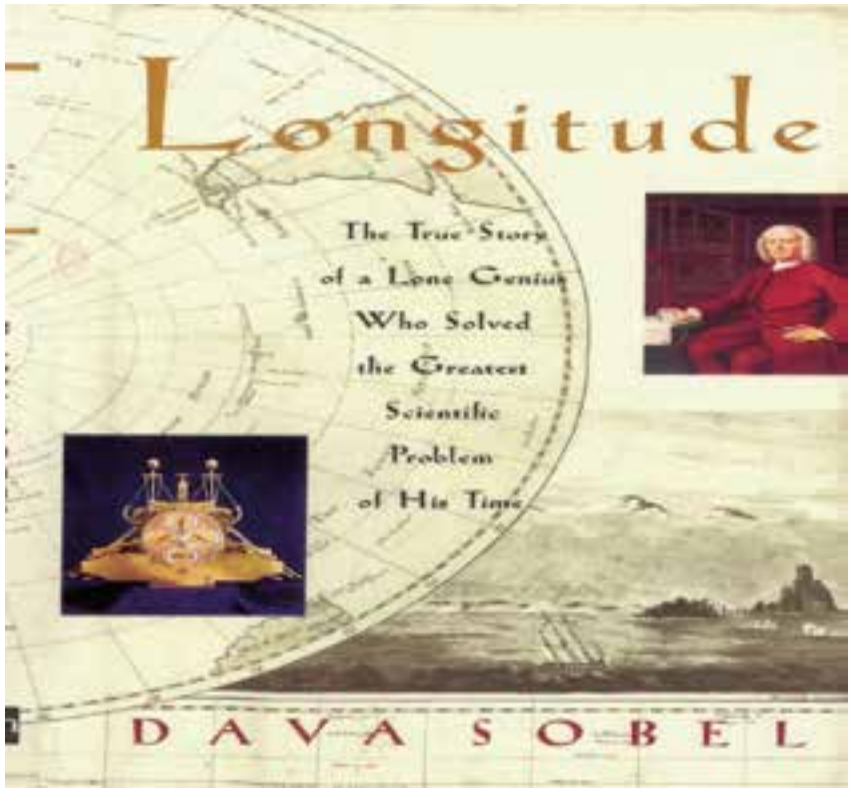

Use of antibiotics outside hospitals, 2011
(ATC J01, DDD per 1 000 inhabitants per day)
50
40
30
20
10
0
Turkey**
Greece
Cyprus*
Romania*
Belgium
France
Italy
Luxembourg
Slovakia*
Malta
Portugal
Ireland
Iceland*
Poland
Spain
Finland
Bulgaria
Lithuania*
UK
Czech Republic
Denmark
Norway
Hungary
Austria*
Slovenia
Sweden
Germany
Latvia
Estonia
Netherlands


Use of antibiotics outside hospitals, 2012
(ATC J01, DDD per 1 000 inhabitants per day)
25
20
15
10
5
0
22,3
20,1
18,7
18,5
17,4
17,1
15,9
14,2
Island
Finland
Grönland
Danmark
Norge
Färöarna
Åland
Sverige

Concerted Nordic action against antibiotic resistance

- Reduce consumption of antibiotics in the Nordic region to the lowest European level within five years.
- All countries in the world to adopt plans to reduce use of antibiotics.
- Prescription requirement in countries with developed health systems.
- Abolish bonus payments to doctors and veterinary surgeons.
- Major initiative (SEK 75 billion from rich countries for five years, of which 2.5 billion from the Nordic region) to strengthen systems and rewards for developing new antibiotics.

Longitude, by Dava Sobel



Actions since this spring

- April:
  WHO warns of "the risks for a world without antibiotics"

- May:
  WHO:s General Assembly orders the development of an action plan for next spring

- June:
  A British commitee proposes a Longitude Prize of 10 million pounds for the development of a new antiobiotic

- September:
  President Obama orders an action plan for next spring
  and
  EU’s Veterinary Committee proposes a ban for veterinary bonuses on prescriptions of antibiotics

"The next supermodel"


The report is part of the Nordic Council of Ministers programme, Sustainable Nordic Welfare
www.norden.org/welfare

norden

Nordic Council of Ministers

The report can be downloaded from

www.norden.org/en/publications/publikationer/2014-731

(Language versions: Swedish, Finnish, Icelandic and English)

Steno Diabetes Center

Baltic area
Parliamentary visit

13 November 2014

Martin Ridderstråle,
Vice president and
Head of Patient Care

steno
diabetes center

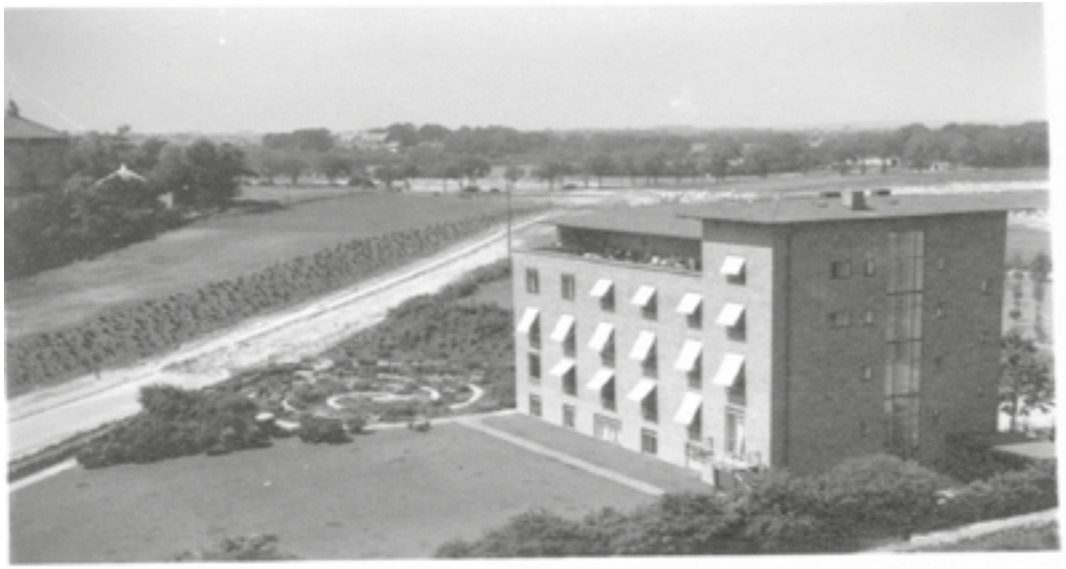
Agenda

14.30 Presentation of Steno Diabetes Center and Patient Care by VP Martin Ridderstråle
- Private – Public partnership
- Research and educational activities
- Effectiveness and outcomes of diabetes management

15.40 Presentation of Health Promotion Research by VP Bjarne Bruun-Jensen
- Putting the patient in the centre in patient education
- Community-based diabetes prevention

16.10 Discussion and question session

17.00 End of meeting or small tour of the Campus



Founded in 1932 to improve clinical care of patients and to understand diabetes

steno

Four major areas at Steno

- Research
- Health Promotion Research
- Patient Care
- Education

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Steno Research

- Pathophysiology
- Systems Medicine
- Complications
- Epidemiology

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Our vision is to become leaders in diabetes care and translational research with focus on early disease and prevention

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Public Private Partnership

Strategic Alliances

Why collaborate?

- Denmark is a little country (Population of 5 million)
- Allows us to concentrate on our competitive advantage
- Develop competencies that may be even more widely relevant
- Allows us to foster linkages which expand collaboration
- Assist in developing an influence over policy
- Increased mobility of scientists / Talent attraction

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Patient Care

Patient Care

A unique public-private partnership

- Collaborative Clinical Care for 5600 patients
- Screening for and treating Complications
- Team-based care delivery
- Education of patients
- One-stop shop

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Diabetes Complications

Microvascular

Leading cause of blindness in working age adults

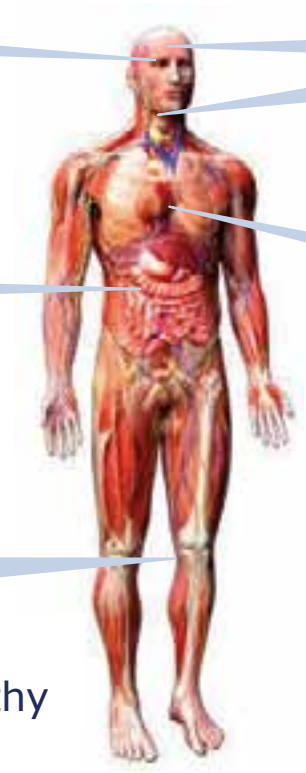
Diabetic Retinopathy

Diabetic Nephropathy

Leading cause of end-stage renal disease

Diabetic Neuropathy

Leading cause of non-traumatic lower extremity amputations



Macrovascular

Stroke

Cardiovascular Disease

2 to 4 fold increase in cardiovascular mortality and stroke

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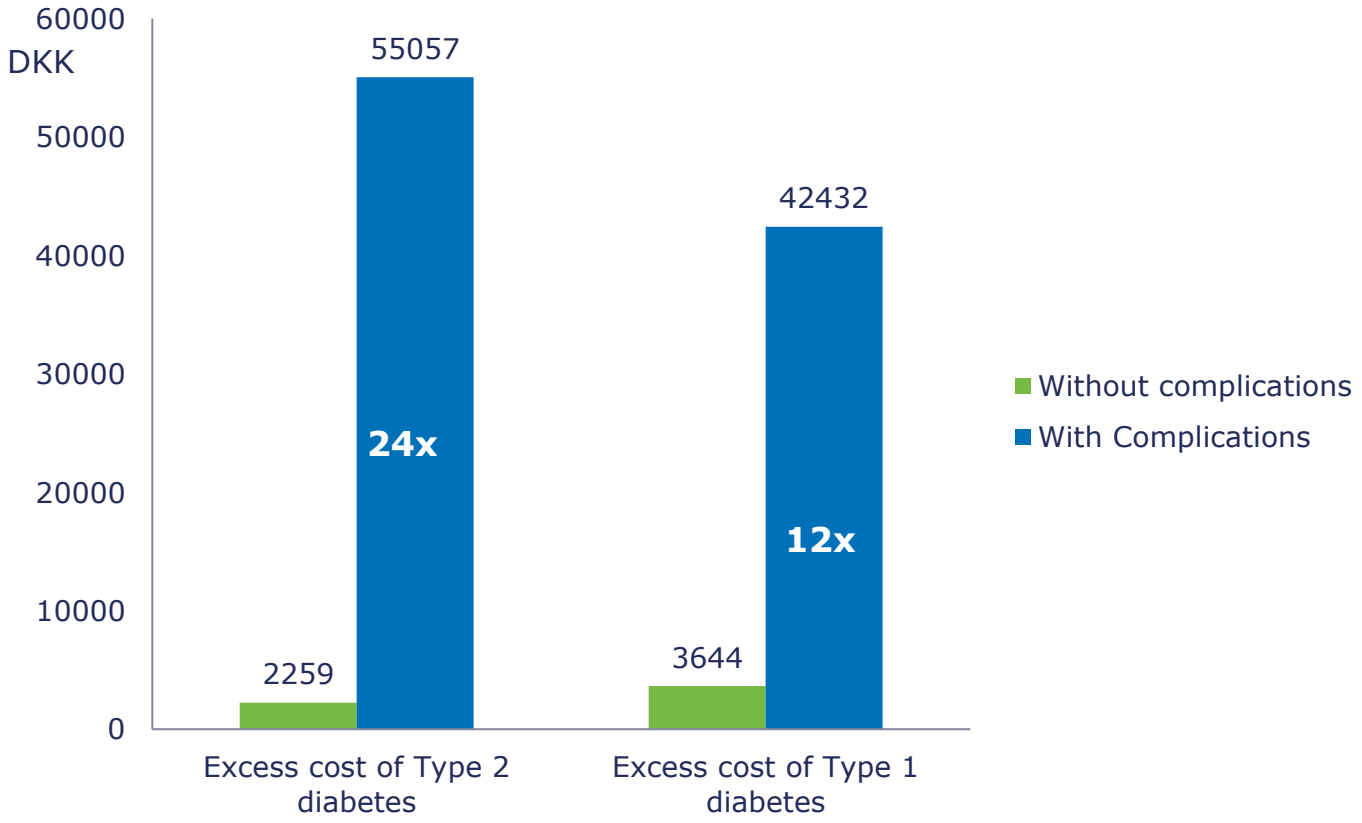
Costs of complications: The Helsinki Study

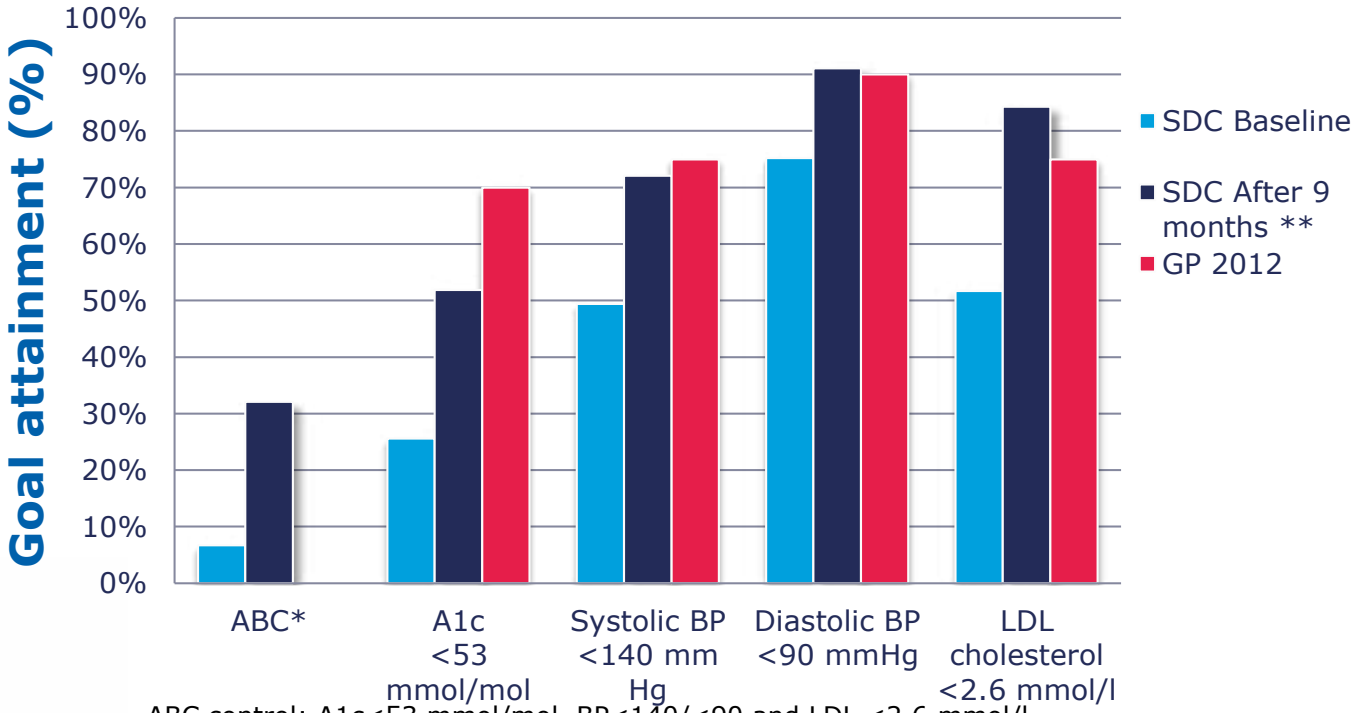


Patient Care

The HbA_{1c} level has never been this low – Type 1 Diabetes

Patient Care

The HbA_{1c} level has never been this low – Type 2 Diabetes

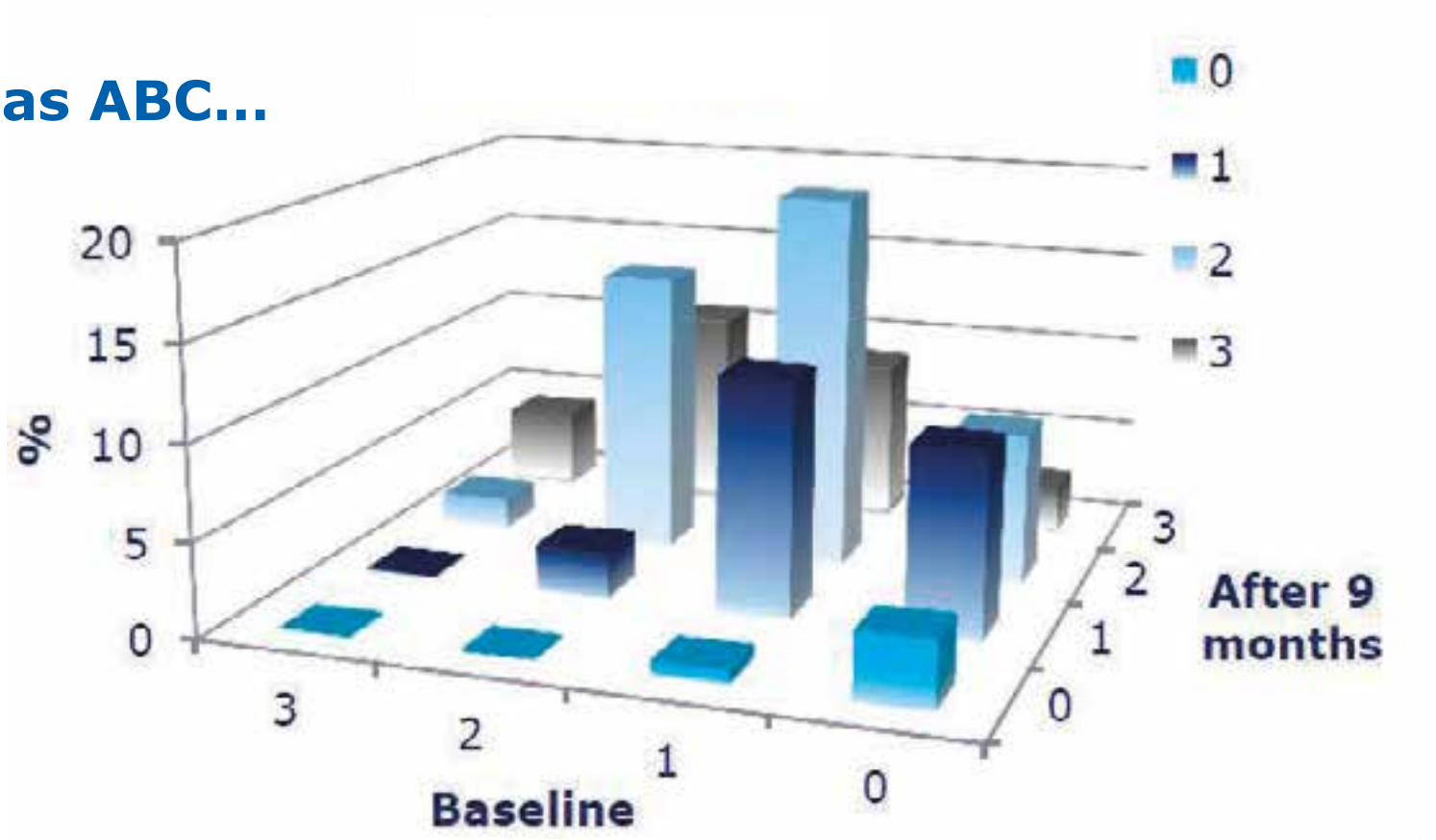


ABC control: A1c<53 mmol/mol, BP<140/<90 and LDL <2.6 mmol/l.
Data from GP not available. ** p<.0001.

EASD 2014

Patient Care

As easy as ABC…



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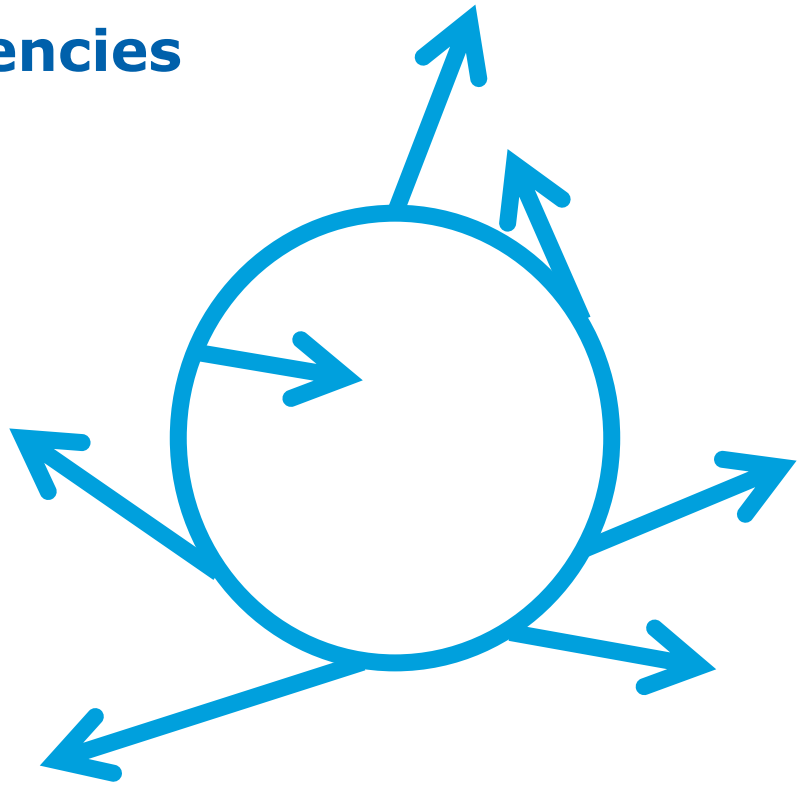
Safai N et al. EASD 2014

Patient Care

Aligning competencies



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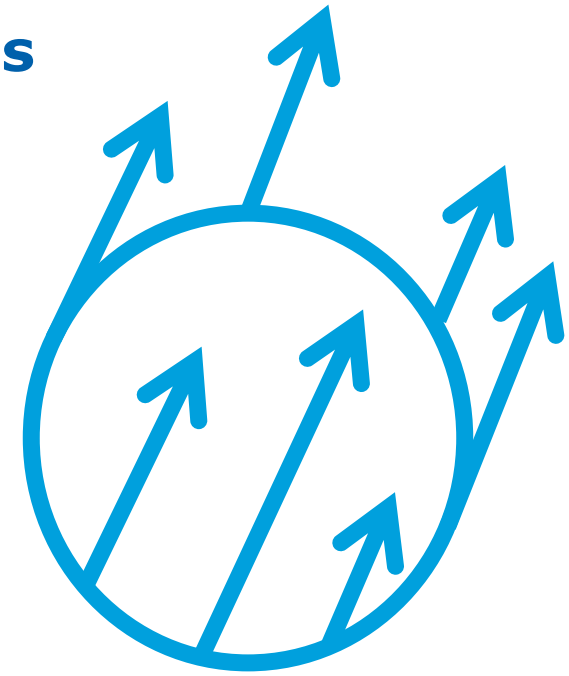
Patient Care

Aligning competencies



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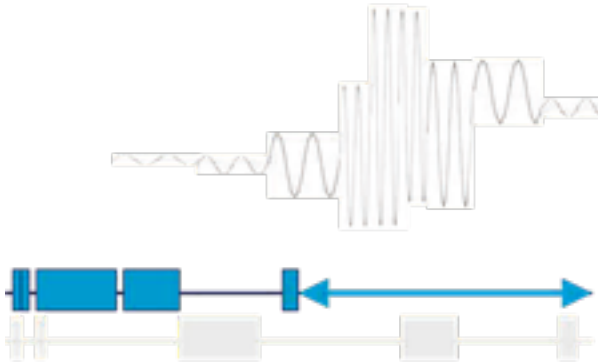
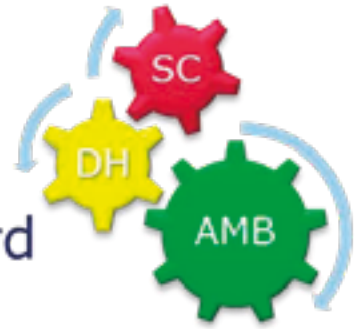
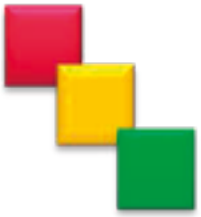
Patient Care

Innovating Diabetes Care Delivery



1. Even flow
2. Common standard
3. Deviations
4. Measure & Visualize
5. Daily meetings
6. Continuous improvements





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Patient Care

DAGENS
Medicin

Steno Patient Center vinder Den Gyldne Skalpel

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Patient Care

Patient Care

Innovating Diabetes Care Delivery

Documentation

"Den Gyldne Skalpel 2014"

IKAS Akkreditering 2014

ISO Akkreditering 2014

Sundhedsstyrelsens tilsynsbesøg 2014

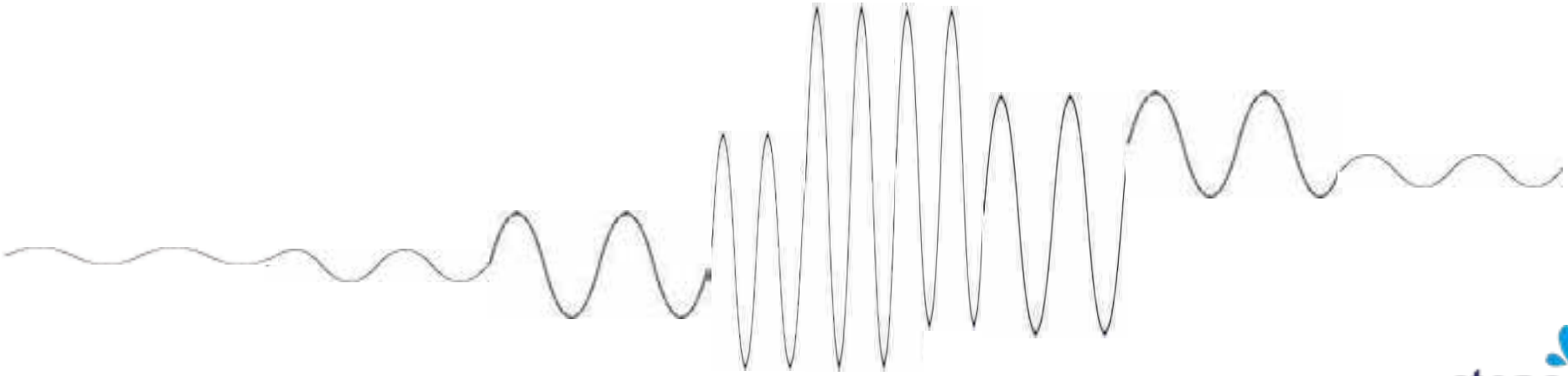
Patient Care

Creating a value adding even flow

Ambulatory

Day Hospital

Specialist Ambulatory



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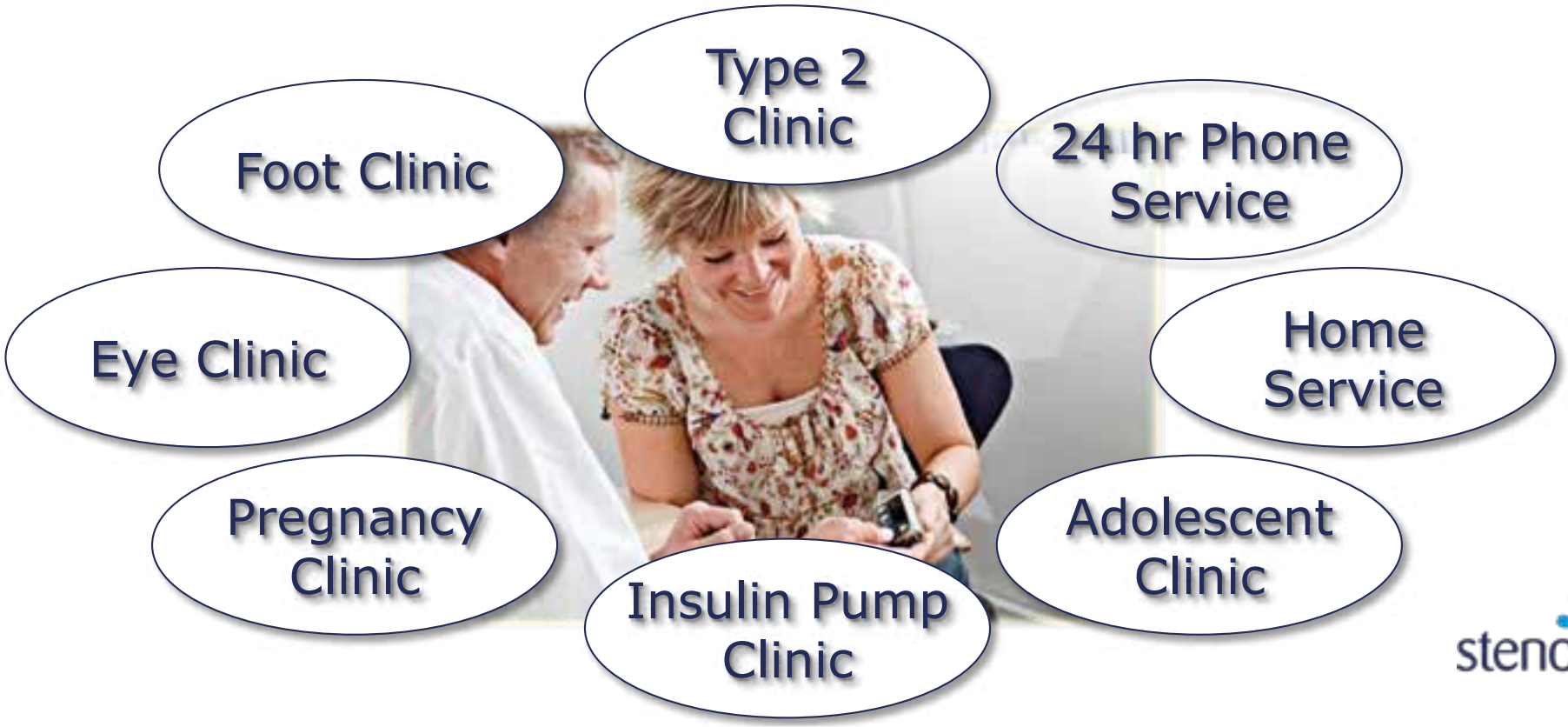
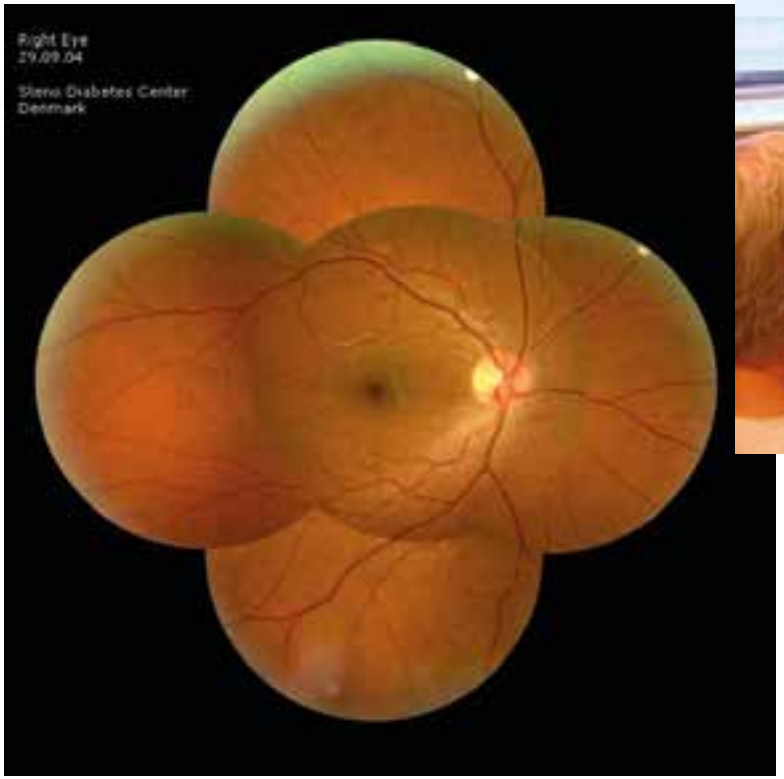
Patient Care

Special attention to special needs



Patient Care

Special attention to special needs



Eye Clinic

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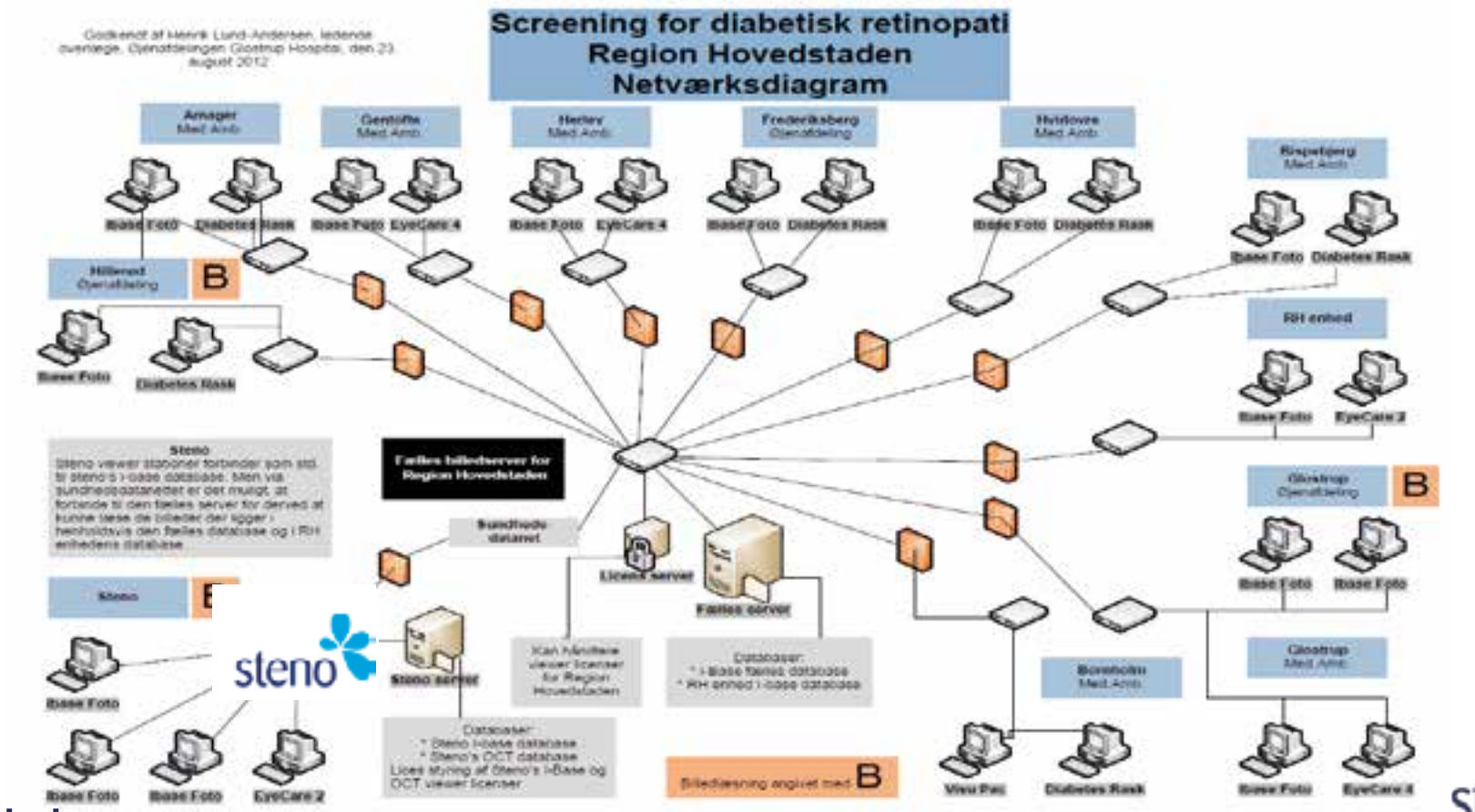
Patient Care



Eye Clinic

Patient Care

Special attention to special needs

- Three podiatrists
- Orthopedic consultant weekly
- Assessments of risk patients
- Orthopedic foot ware
- Treatment of ulcers
- Observation, examination and education

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Patient Care

Foot Therapist of the Year!

Steno Research - Epidemiology

Reduction in Diabetes Morbidities

DIABETICMedicine

DOI: 10.1111/dme.12320

Short Report: Complications

Reduced incidence of lower-extremity amputations in a Danish diabetes population from 2000 to 2011

M. E. Jørgensen, T. P. Almdal and K. Færch

Steno Diabetes Center, Gentofte, Denmark

Accepted 18 September 2013

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Steno Research - Epidemiology

Reduction in Diabetes Morbidities

	T1 diabetes	T2 diabetes
Cardiovascular Disease	- 12 %	- 30 %
Major amputations	**-70 %**	**- 82 %**
Severe retinopathy	- 18 %	-34 %

Steno Research - Epidemiology

Reduction in Diabetes Mortality

JCEM ONLINE

Brief Report—Endocrine Care

Improved Survival Among Patients With Complicated Type 2 Diabetes in Denmark: A Prospective Study (2002–2010)

Kristine Færch, Bendix Carstensen, Thomas Peter Almdal, and Marit Eika Jørgensen

Steno Diabetes Center, DK-2820 Gentofte, Denmark

J Clin Endocrinol Metab, April 2014, 99(4):E642–E646

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Steno Research - Epidemiology

Reduction in Diabetes Mortality

	T1D	T1D without nephropathy	T2D	Non-DM (DK)
Men	4.6 %	8.6 %	5.1 %	2.5 %
Women	2.5 %	3.5 %	2.6 %	1.8 %

Published: Diabetologia, 16 August 2013
Time trends in mortality rates in type 1 diabetes from 2002 to 2011,
Marit E. Jørgensen, Thomas P. Almdal and Bendix Carstensen

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Patient Care

Patient Satisfaction

DAGENS Medicin

DANMARKS BEDSTE HOSPITAL

Nyheder | Videnskab | Almen praksis | Karriere | Blogs | Opinion | Agenda | Uddannelse | Bøger | Annoncer | Job

Opdateret 29.11.2013 *Danmarks Bedste Hospital: 2013*

Steno er diabetespatienternes darling

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Patient Care

Patient Satisfaction

"Safe taking home"

"Good overall impression"

"Informed about life style"

Innovating Diabetes Care

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Innovating Diabetes Care

Innovating Diabetes Care

European Diabetes Technology Course

New diabetes technology course certifies health professionals

By Philip Munch, 20 October 2014

This week Steno collaborated with the Diabetes Technology Society to educate health professionals at the European Diabetes Technology Course in Copenhagen. The Diabetes Technology Society, a leading American organisation, saw the need for a certified diabetes technology clinician programme in Europe a couple of years ago.

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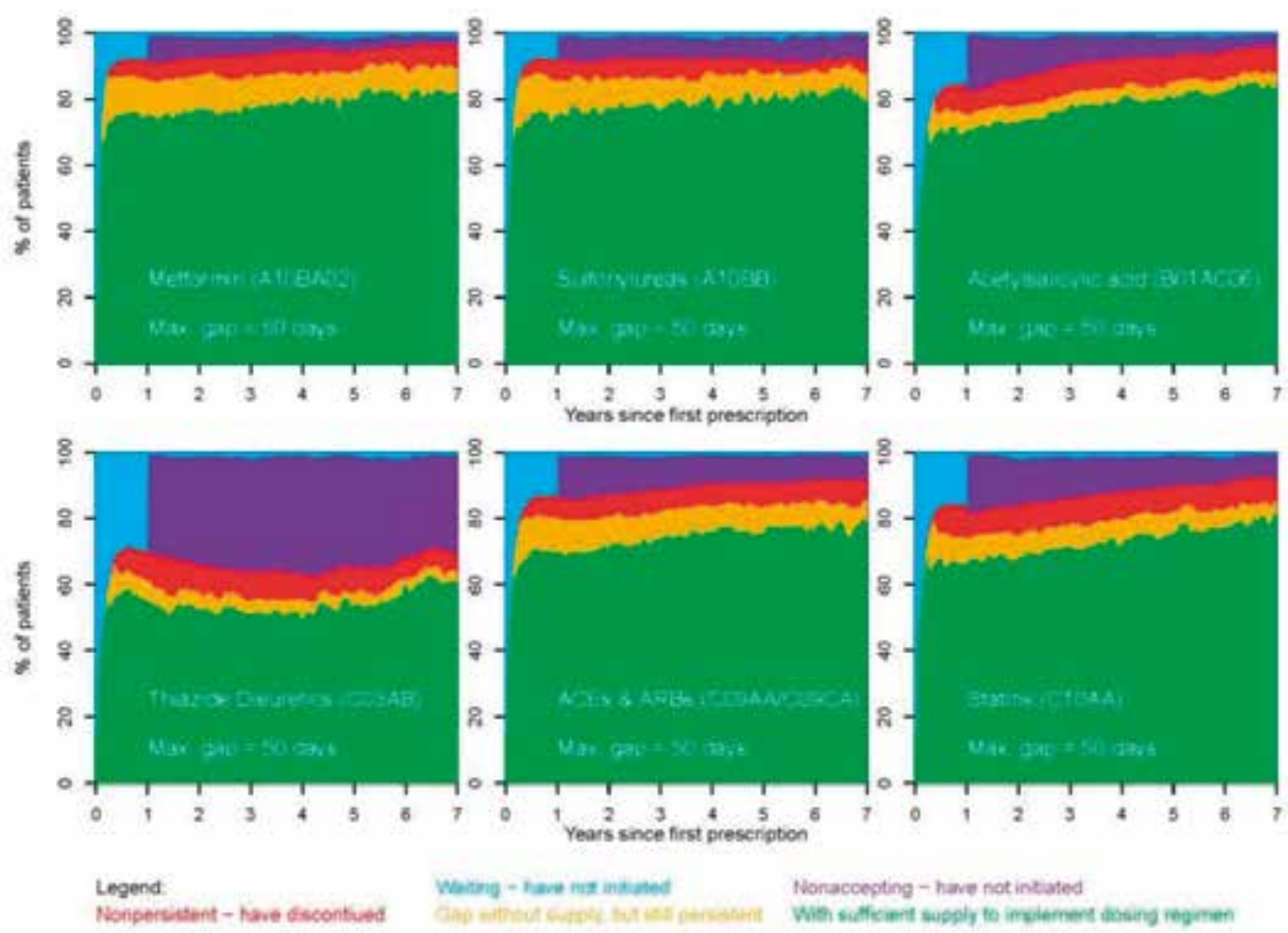
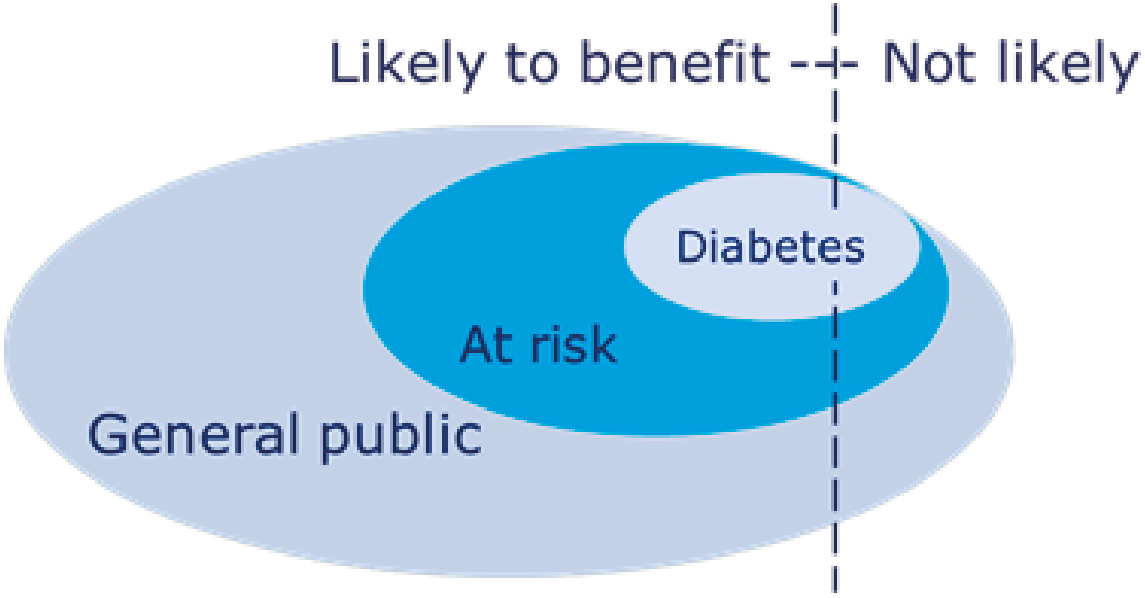
Steno Research - Epidemiology



Innovating Diabetes Care

LifeLab – personalising evidence based medicine



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Innovating Diabetes Care

Healthy person ⇄ Pre-diab. ⇄ Diabetes ⇄ Complicated

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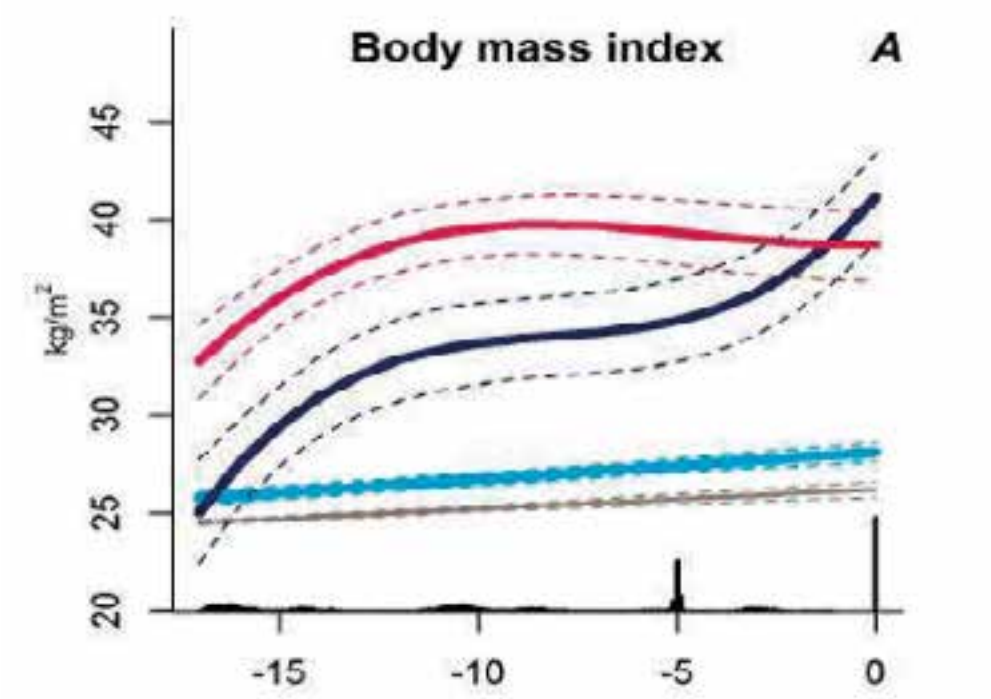
Steno Research - Epidemiology

The Addition-Pro Study: Progression to diabetes

Screening status 2001-2006	ADDITION-PRO Follow-up 2009-1011														
	Non-classifiable		NGT		iIFG		iIGT		IFG+IGT		SDM		KDM		Total
	n	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Low risk	11	5.7	149	**76.8**	18	**9.3**	5	**2.6**	3	**1.6**	5	**2.6**	3	**1.6**	**194**
Normoglycaemia	21	1.9	741	**67.4**	109	**9.9**	77	**7.0**	52	**4.7**	60	**5.5**	40	**3.6**	**1100**
iIFG	0	0	101	**28.0**	84	**23.3**	13	**3.6**	29	**8.0**	29	**8.0**	105	**29.1**	**361**
iIGT	3	1.2	60	**23.5**	13	**5.1**	39	**13.3**	36	**14.1**	37	**14.5**	67	**26.2**	**255**
IFG+IGT	3	1.6	20	**10.9**	8	**4.3**	11	**6.0**	22	**12.0**	25	**13.7**	94	**51.4**	**183**
	38		1071		232		145		142		156		309		**2093**

Steno Research - Epidemiology

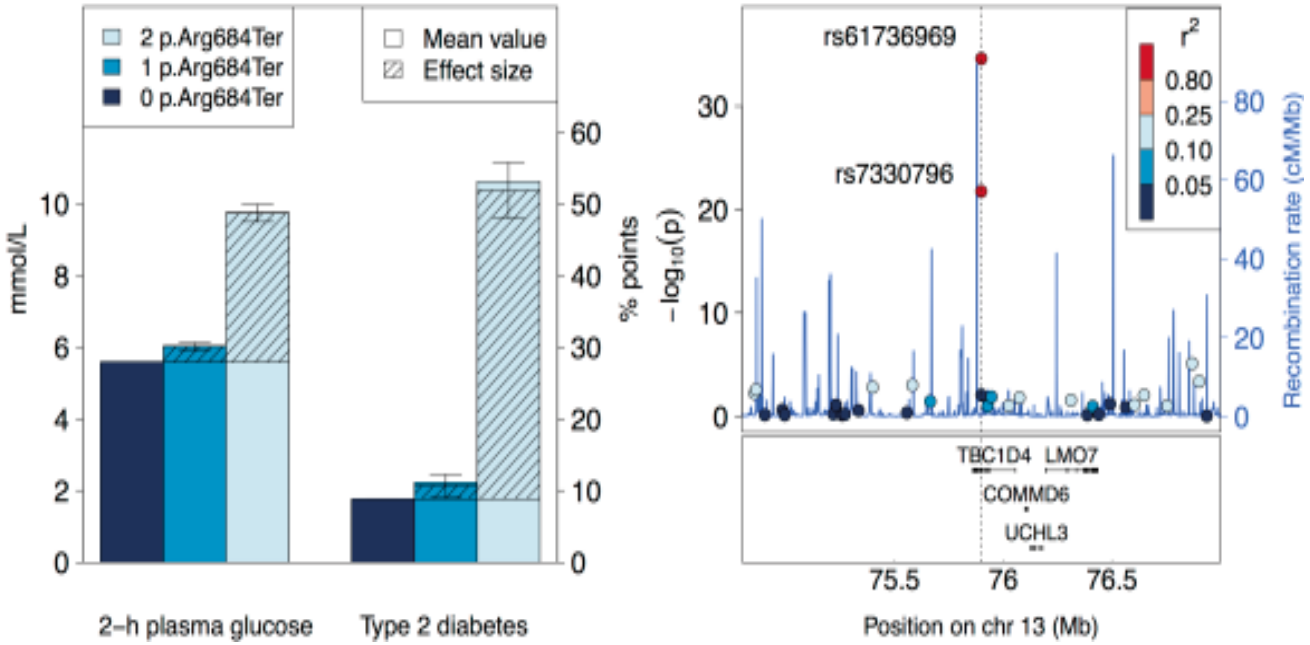
Whitehall II study: *Latent class trajectory analysis*



Vistisen et al. PLOS Medicine 2014

Steno Research - Epidemiology

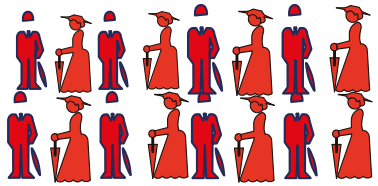
Greenland studies: *genetic risk*



Moltke et al. Nature 2014

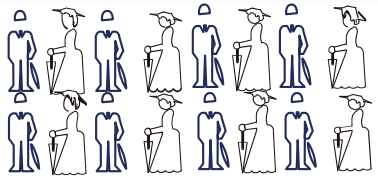
Steno Research - Pathophysiology

Early complications



Duration 5-15 years

No major complications



Duration >30 years

PROLONG

– protective genes in diabetic complications and longevity

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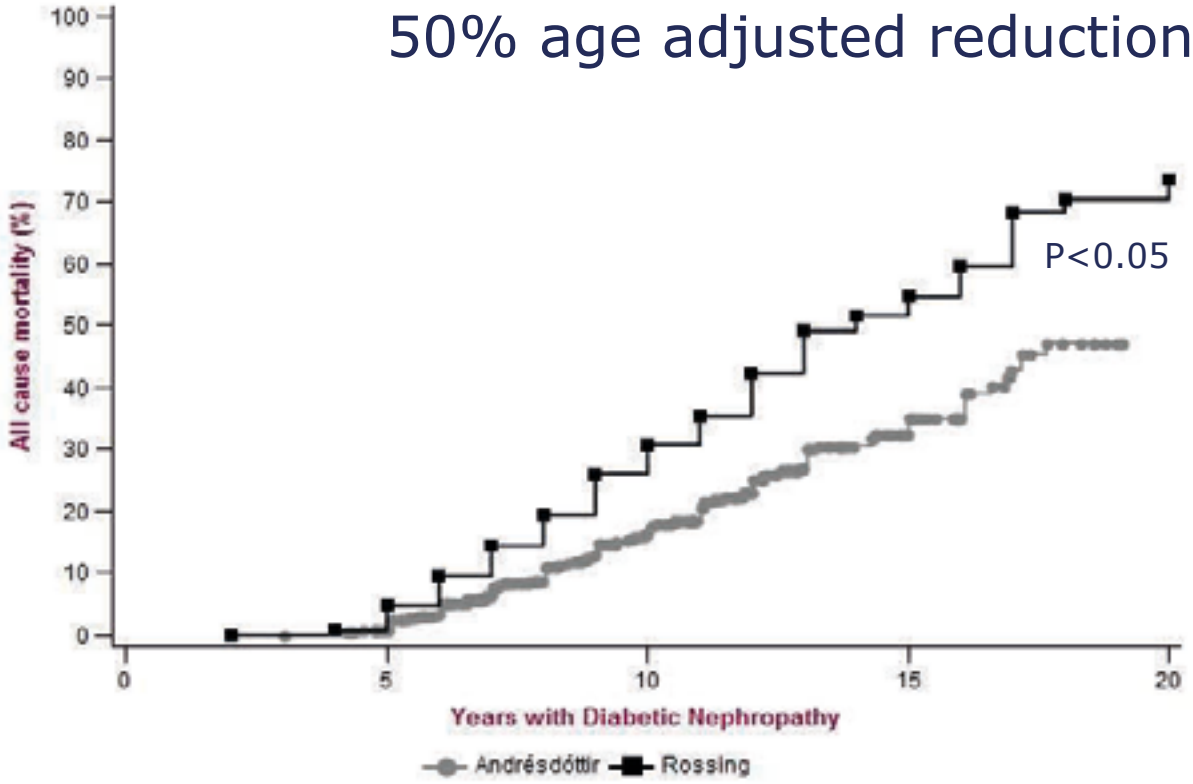
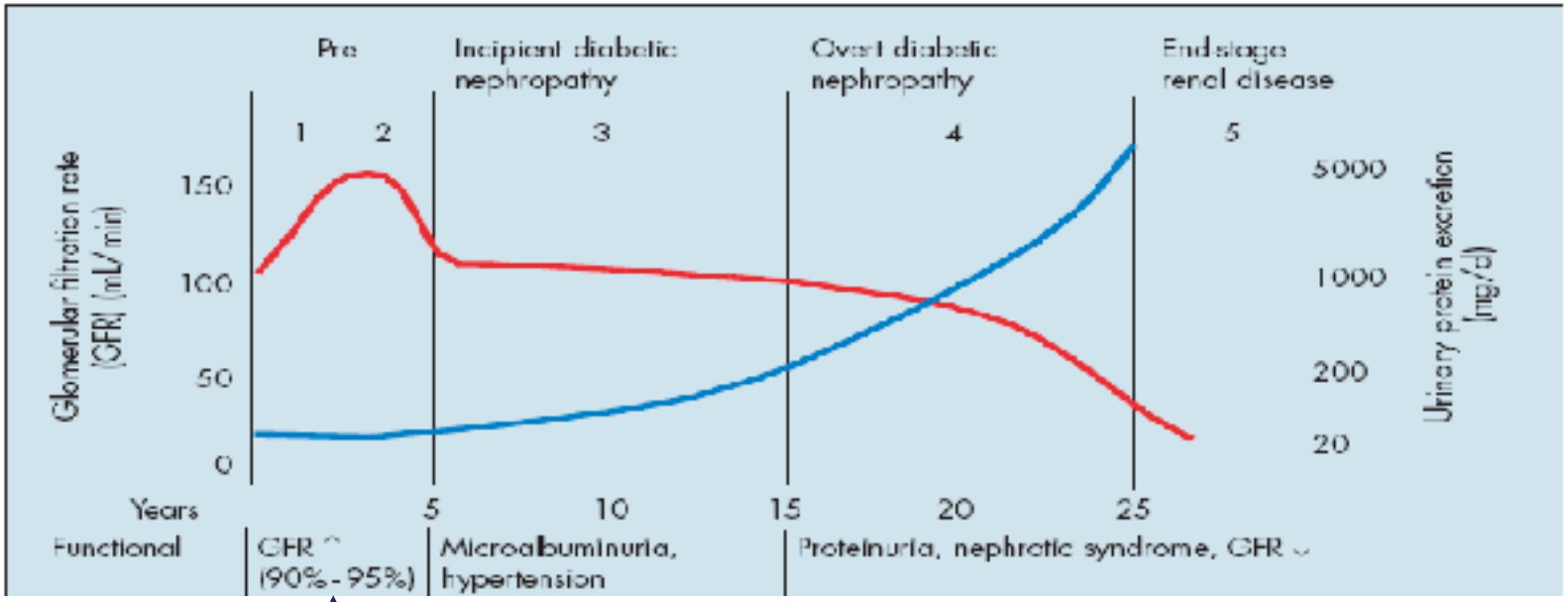
Steno Research - Complications

50% age adjusted reduction in mortality



G Andrésdóttir *et al Diabetes Care, 2014cJun;37(6):1660-7*

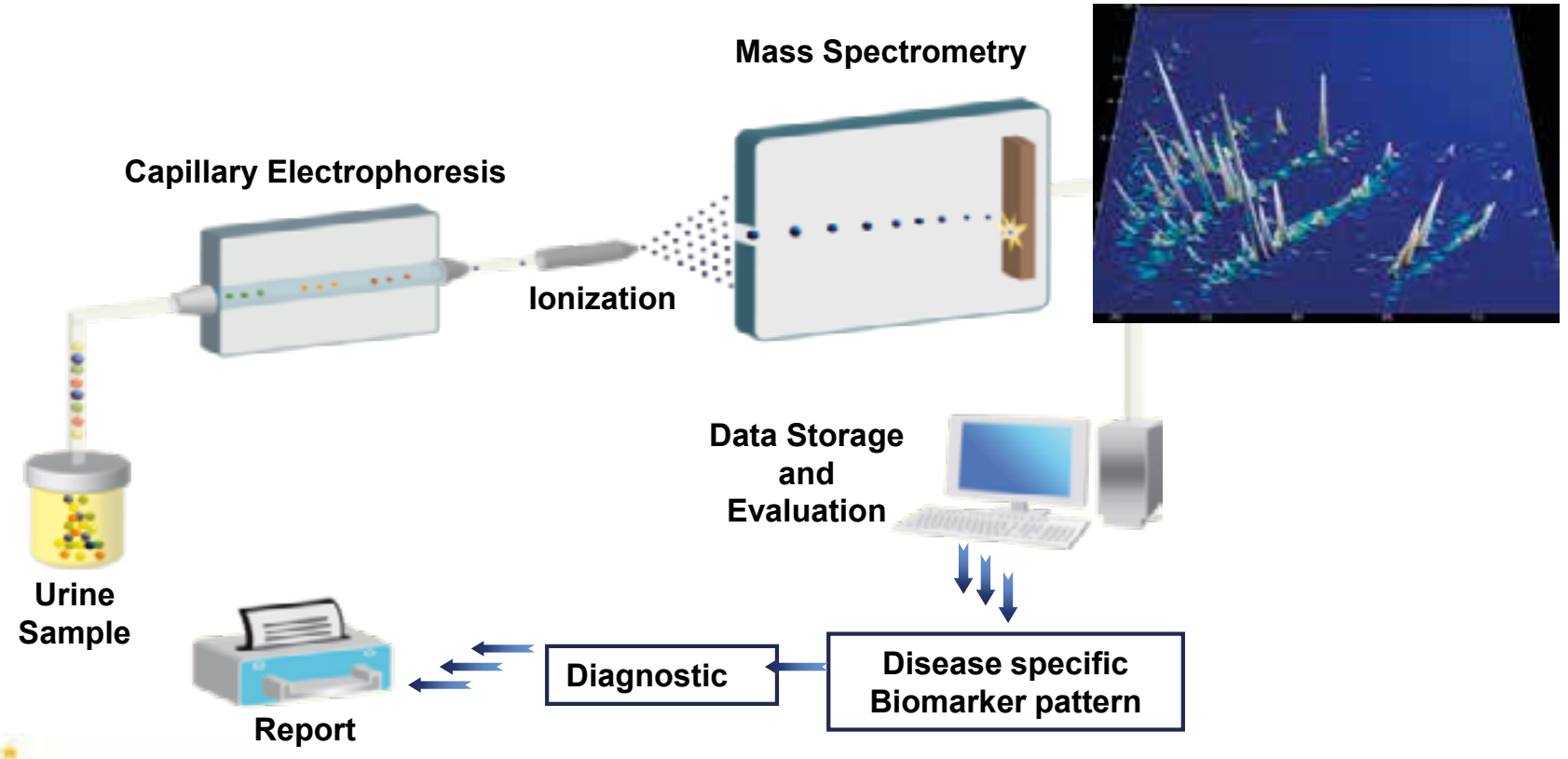
Steno Research - Complications



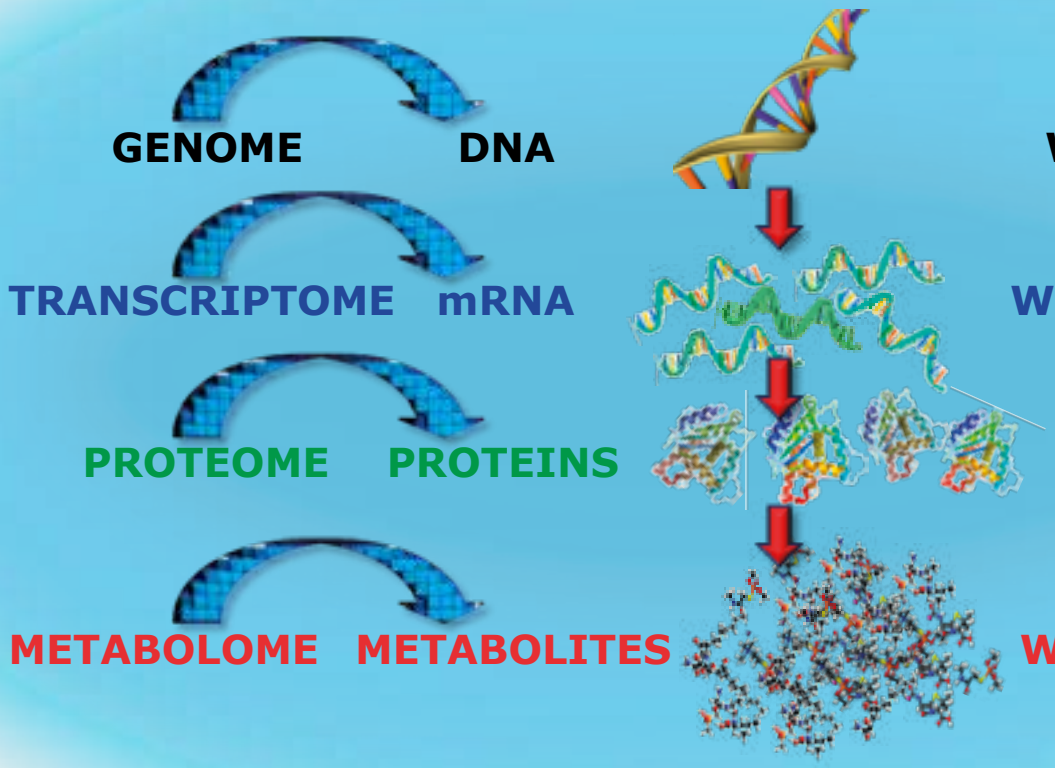
Existing markers

New marker
Early and robust

Steno Research - Complications



OMICS: from genes to metabolites



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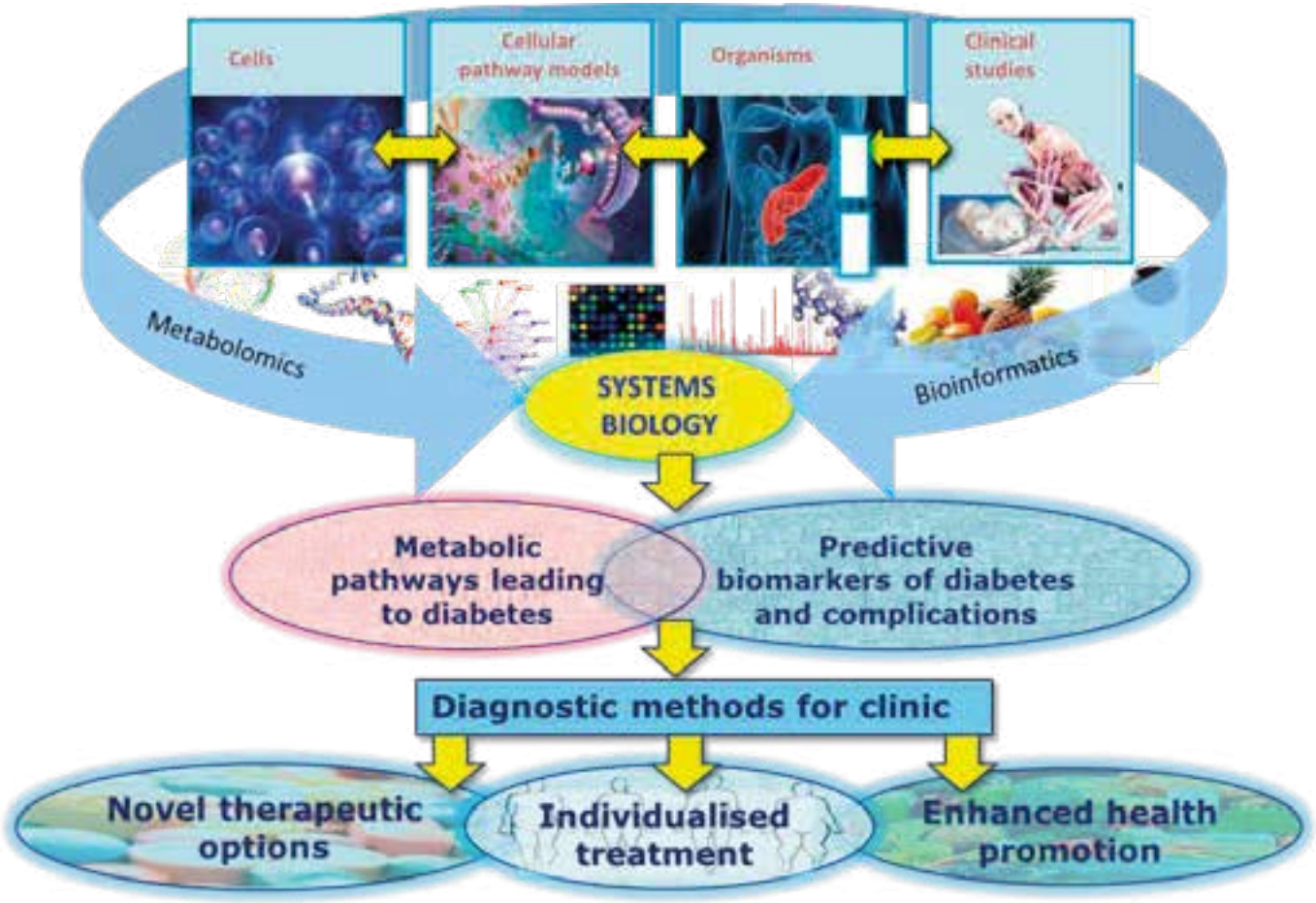
Steno Research – Systems Medicine



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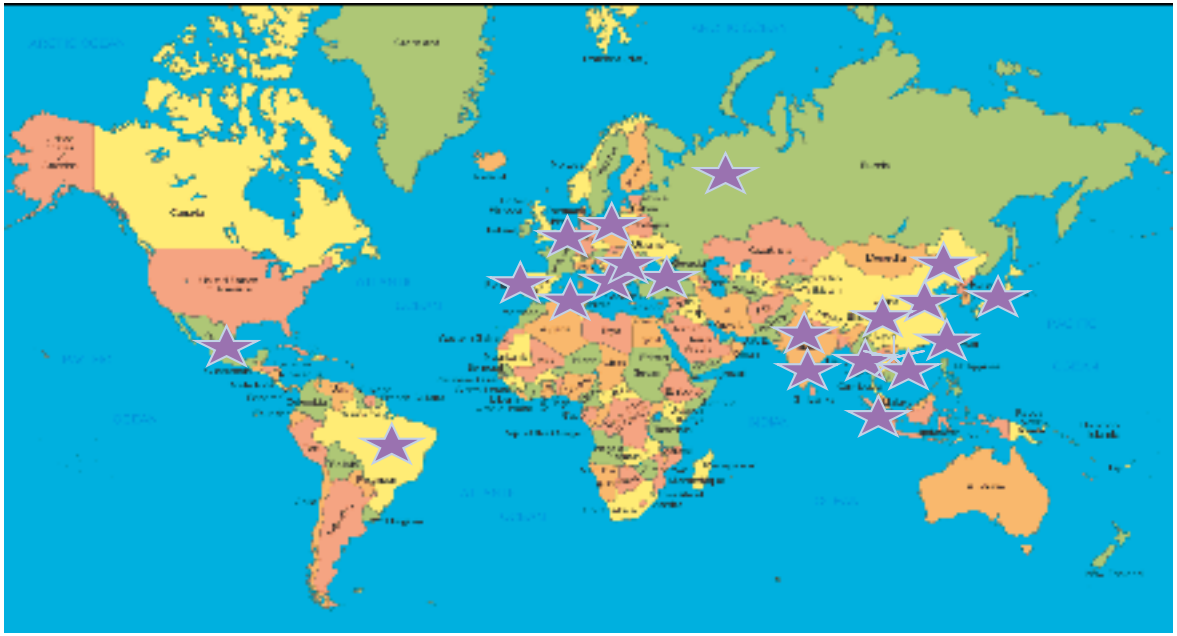
Education

Since 2000, the STAR programme has been the central education platform

- The goal of the programme is to increase knowledge about diabetes in developing countries
- Courses are taught in China, India, the Middle East, South-East Asia and Latin America
- More than 8,000 HCPs have been trained through the STAR programme
- The programme is funded by the Novo Nordisk Foundation



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With the REACH programme, Education aims to significantly scale up training of HCPs

- The REACH programme will target approximately 9,200 HCPs annually, corresponding to reaching 500,000 patients per day

Steno Diabetes Center REACH Programme

- Diabetes education for HCPs, training trainers
- Combines face-to-face training with e-learning
- Starts in South-East Asia and extends to Latin America
- Creates a new network of Steno satellites

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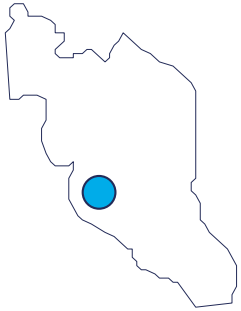
The SDC satellite will teach doctors and HCPs in Malaysia and nearby countries

Malaysia Satellite



- Kuala Lumpur
- Satellite can also serve nearby countries

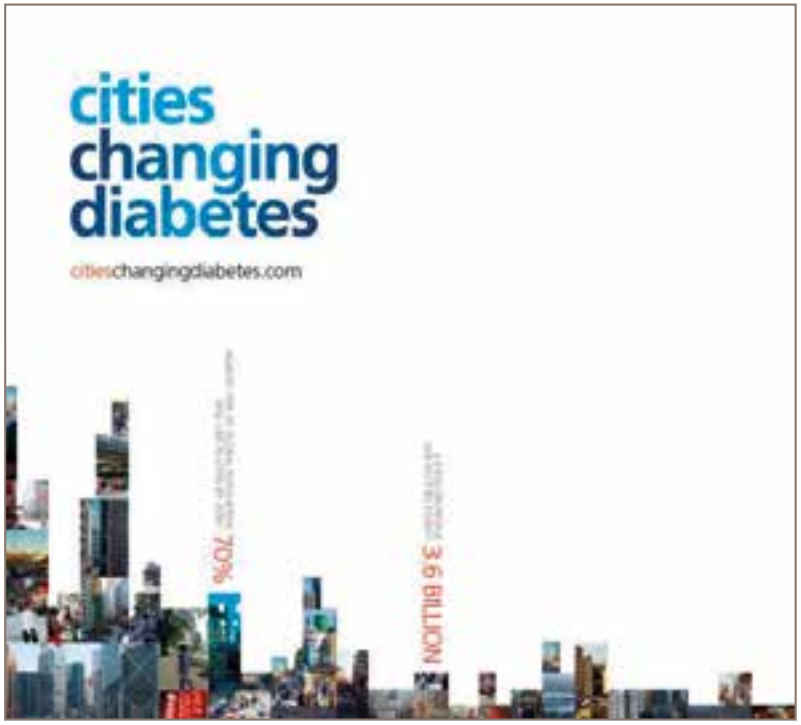
Target group

- Doctors
- HCPs

Partners

- Ministry of Health
- Academic institution

Steno as global partner in Cities Changing Diabetes



"We will find solutions that will make a real difference for people with diabetes and those who are at risk"

- Steno becomes global partner in Novo Nordisk's Cities Changing Diabetes project together with UCL
- We support the project with our experience and expertise in fields such as
  - Education
  - Epidemiology
  - Health Promotion
- The aim of the project is in line with our vision and strategy to strengthen focus on prevention and diabetes care

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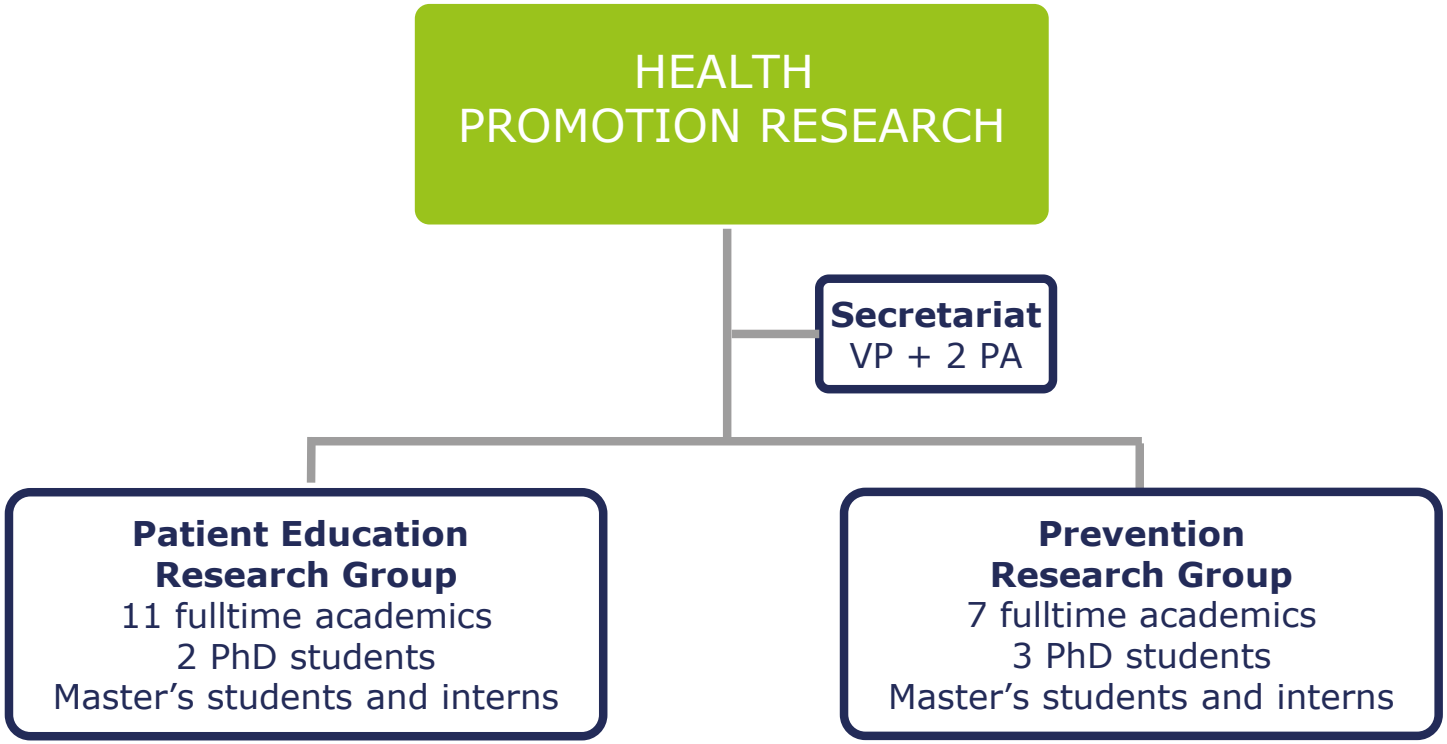
Health Promotion Research

Head and professor Bjarne Bruun Jensen

Health Promotion Research



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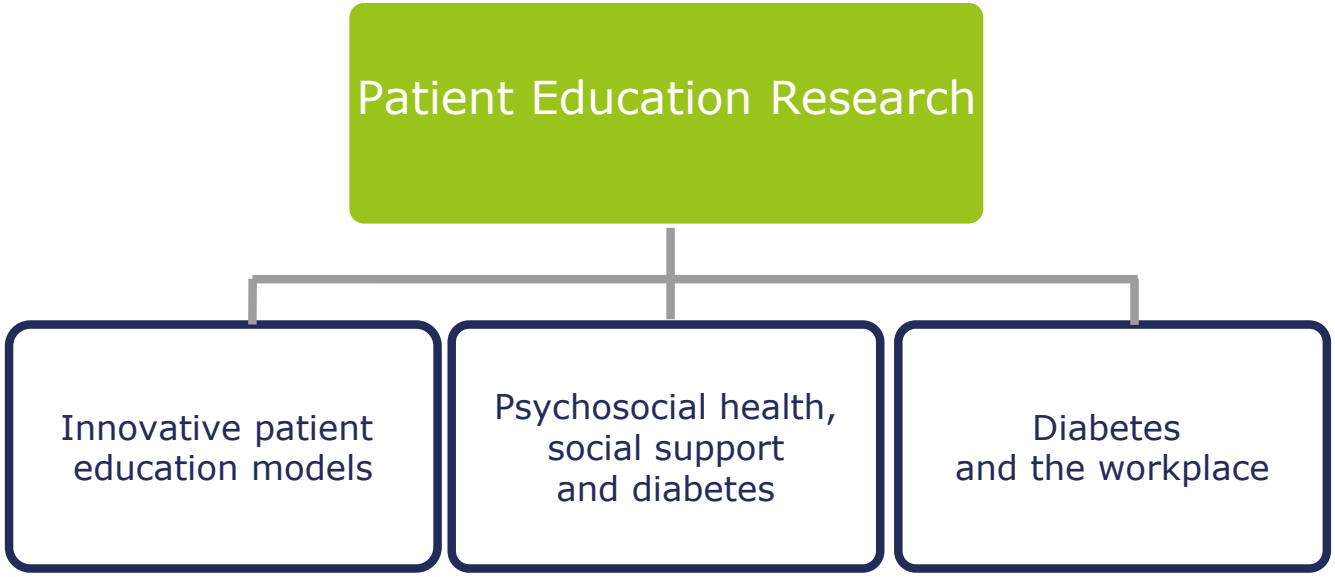
Patient Education Research Group



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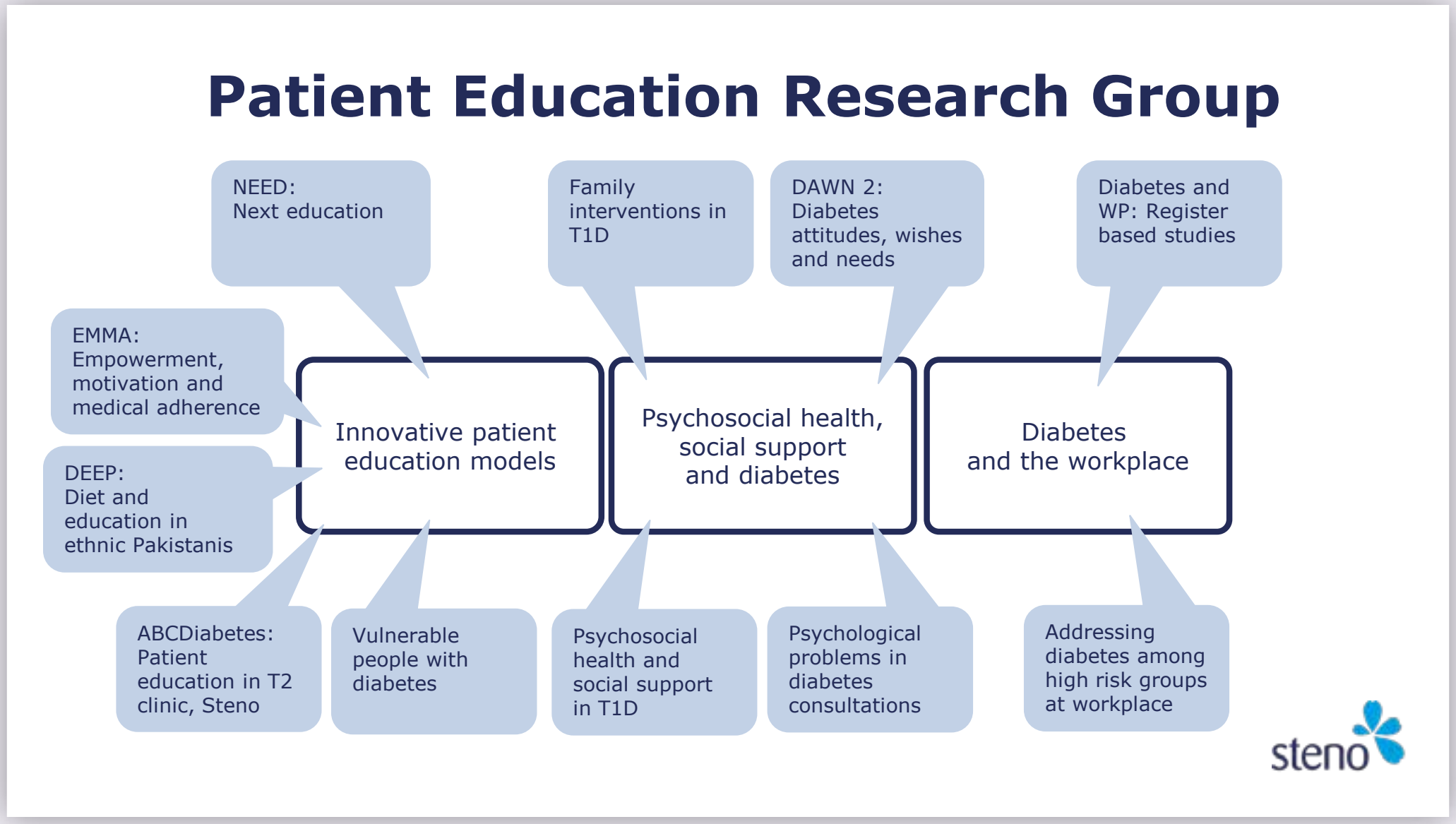
Patient Education Research Group
NEED: Next education
Family interventions in T1D
DAWN 2: Diabetes attitudes, wishes and needs
Diabetes and WP: Register based studies
EMMA: Empowerment, motivation and medical adherence
DEEP: Diet and education in ethnic Pakistanis
Innovative patient education models
Psychosocial health, social support and diabetes
Diabetes and the workplace
ABCDiabetes: Patient education in T2 clinic, Steno
Vulnerable people with diabetes
Psychosocial health and social support in T1D
Psychological problems in diabetes consultations
Addressing diabetes among high risk groups at workplace
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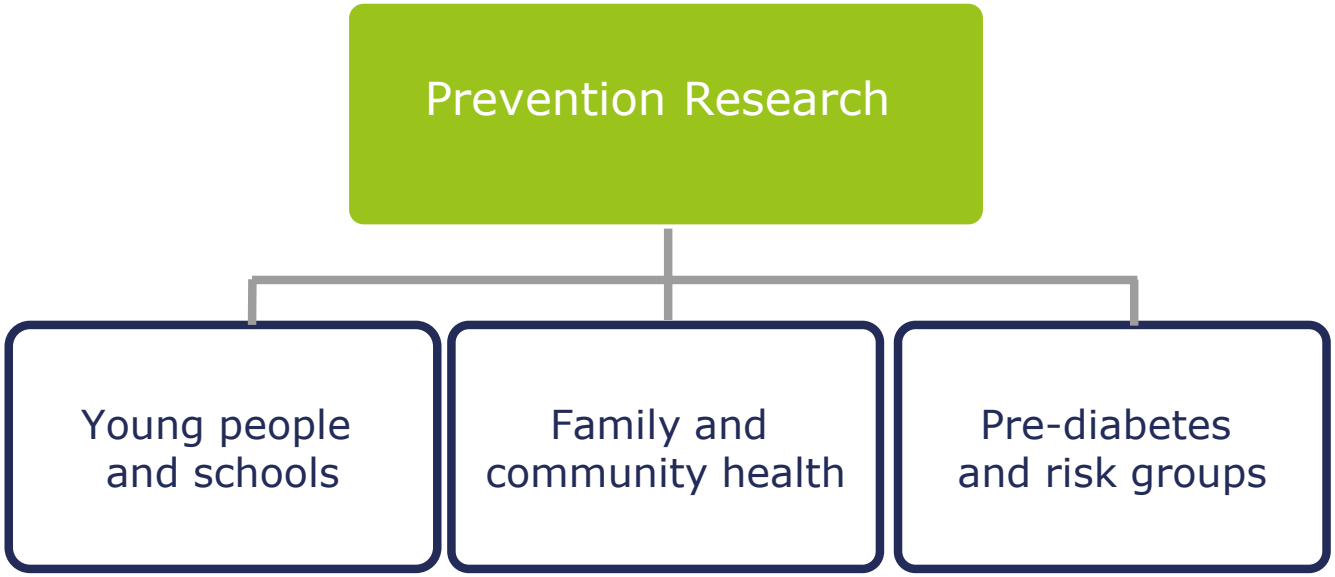
Prevention Research Group



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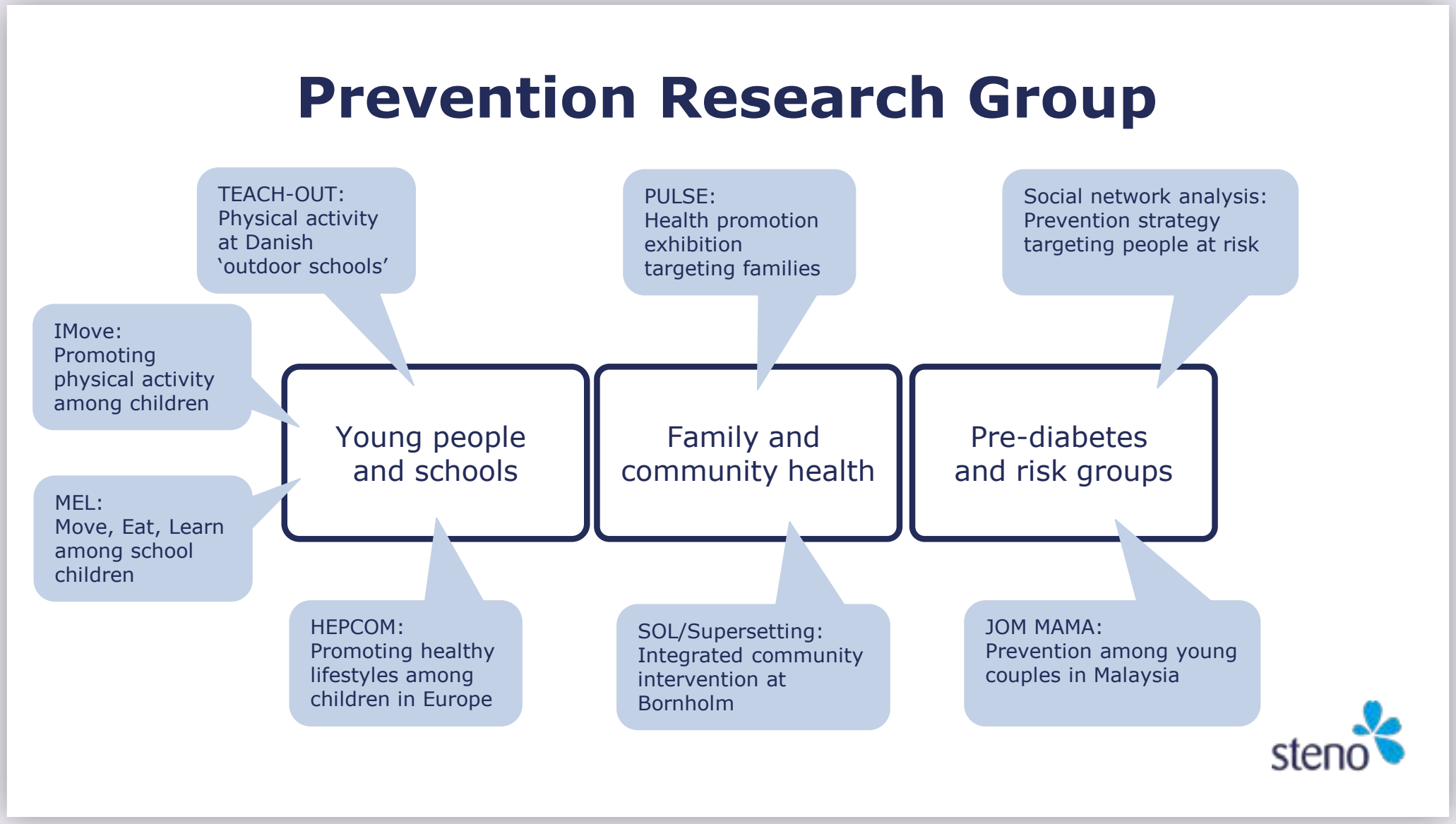
Prevention Research Group
TEACH-OUT: Physical activity at Danish 'outdoor schools'
PULSE: Health promotion exhibition targeting families
Social network analysis: Prevention strategy targeting people at risk
IMove: Promoting physical activity among children
MEL: Move, Eat, Learn among school children
Young people and schools
Family and community health
Pre-diabetes and risk groups
HEPCOM: Promoting healthy lifestyles among children in Europe
SOL/Supersetting: Integrated community intervention at Bornholm
JOM MAMA: Prevention among young couples in Malaysia
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Profile with innovation in focus: "2+3+5"

Field: Two focus ***areas***

- Patient education and Prevention

R & D: Three ***criteria***

- Practice-orientation, Interdisciplinarity & Collaboration

Intervention Paradigm: Five guiding ***principles***

- Participation and active involvement of the target group
- Positive and broad concept of health
- Action competence and empowerment
- A 'Settings' perspective
- Equity in health

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NEED: Next Education

NEED: Next Education - feasibility study

Background

- Participation and dialogue are core values in patient education
- A participatory approach is a challenge for professionals

Objective

- to examine if the toolbox enhances participation and dialogue both among patients and between patients and educators

Design

- 45+ different settings throughout DK were involved
- Questionnaire about educator experiences (n=432)
- Observation of education sessions (n=19)
- In-depth interviews with educators (n=18)

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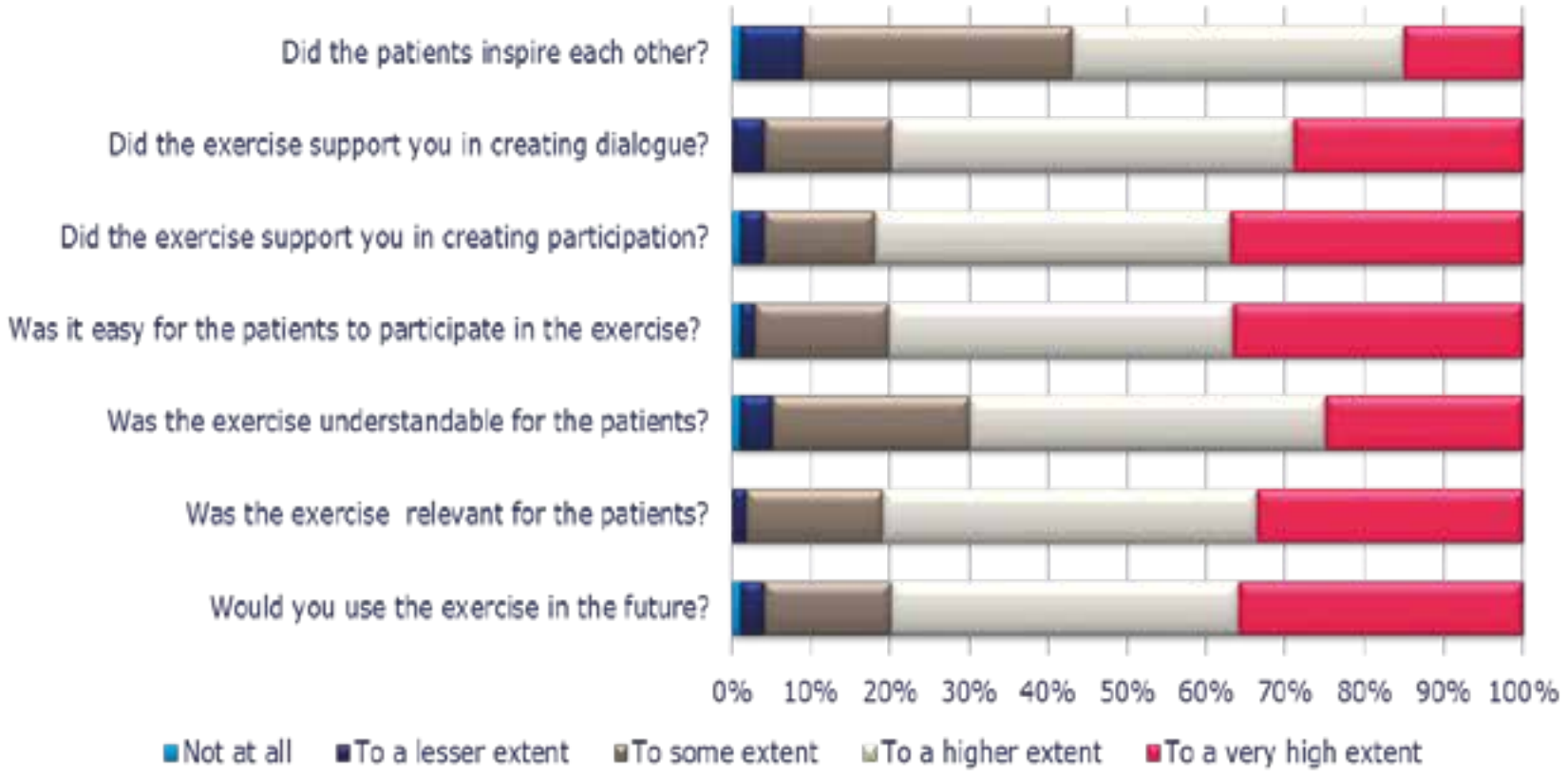
NEED: Next Education - feasibility study

Some results from questionnaires n:432



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NEED: Next Education - feasibility study

Four categories emerged

- Icebreaker (educators and patients less shy/nervous)
- Patient centeredness (patients defining the starting point)
- Group interactivity (patients feeling inspired by each other)
- Flexibility (enable educators to include new themes and tools)

Conclusion

- Toolkit efficient in facilitating participation and dialogue

Next step

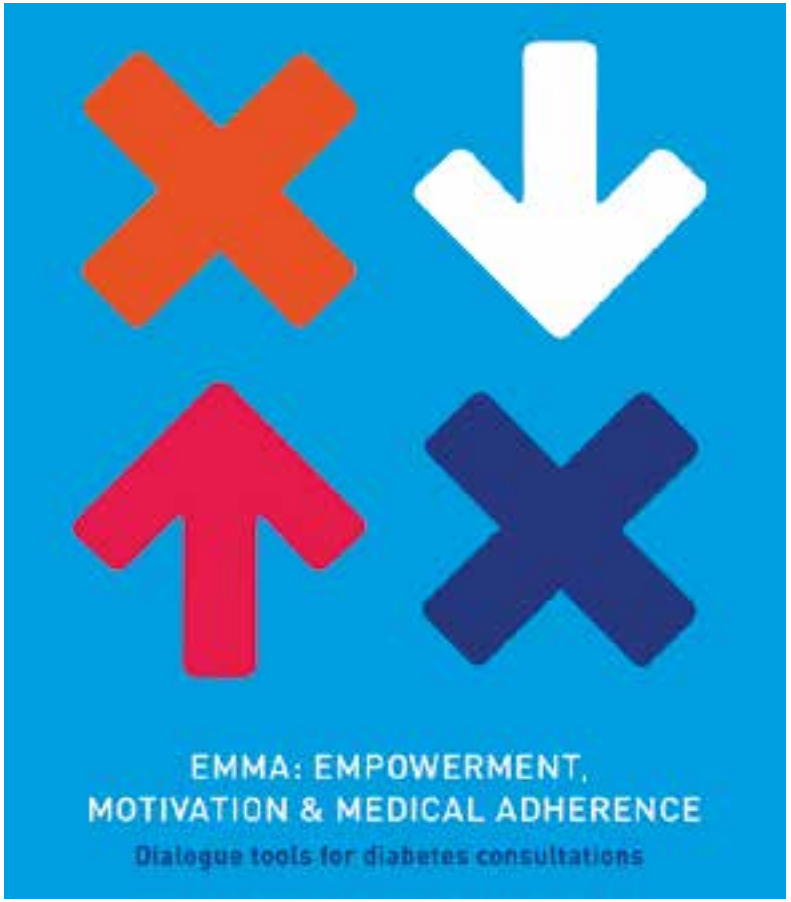
- Effect evaluation (2014/2015)

EMMA study at Steno

EMMA: Empowerment, Motivation & Medical Adherence - Dialogue tools for diabetes consultations

Start at Steno:

- EMMA training 1½ day, Sept./Oct. 2014
- Participants - 3 nurses and 1 physician
- EMMA in outpatient – fidelity/feasibility
- RCT (n=270) + qualitative evaluation



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Tools for vulnerable people with diabetes

- Grant from Danish Ministry of Health
- With Danish Diabetes Association and Region of Southern Denmark
- Feasibility test finalised (80 HCPs)
  - Questionnaires
  - Observations
  - Interviews
- Data analysis ongoing

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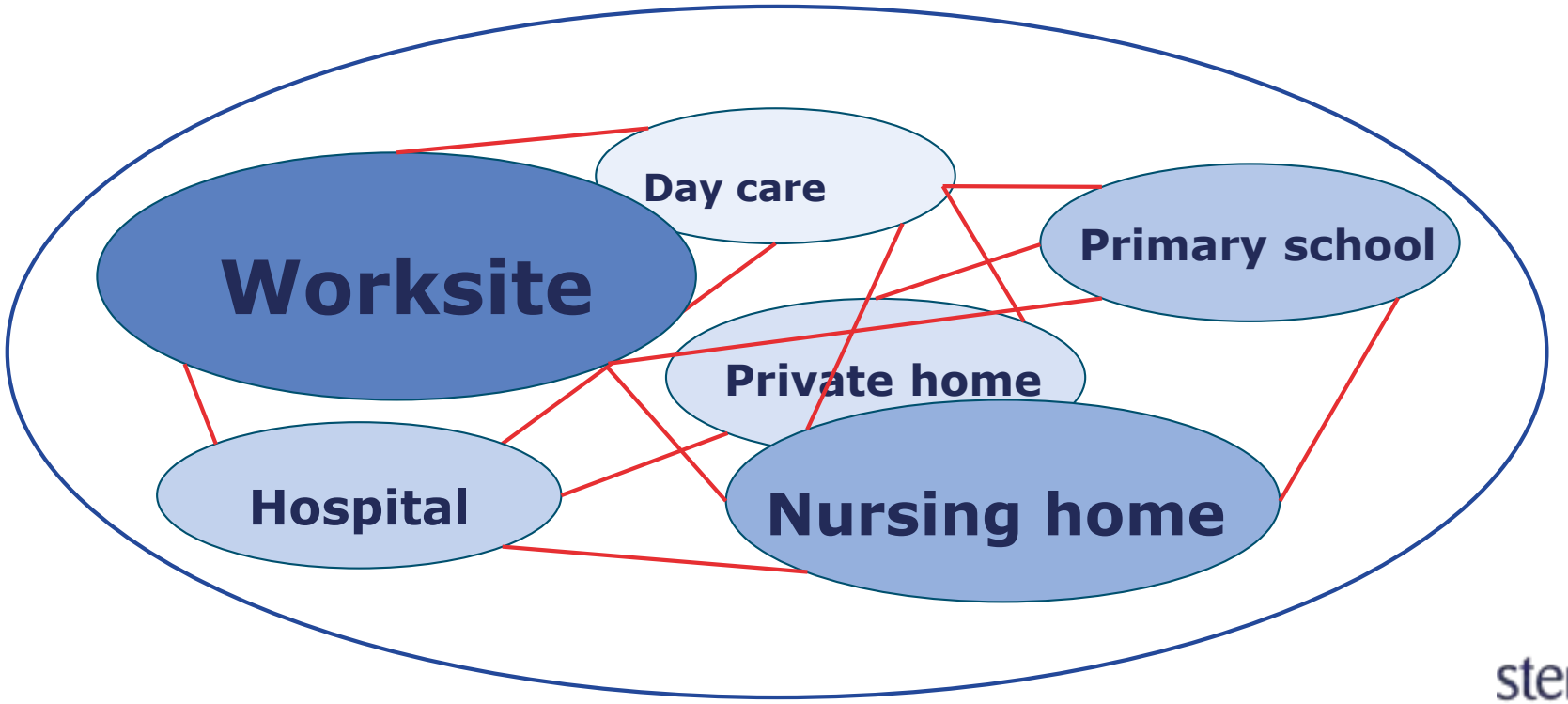
The 'Supersetting' approach - a community prevention approach

The 'Supersetting' approach



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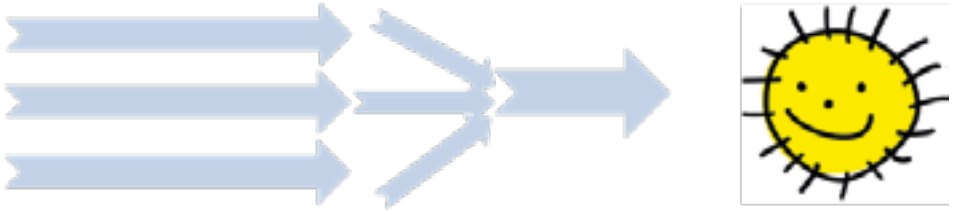
SUPERSETTING: BORNHOLM

Aim: To improve health and quality of life for families with small children

The intervention aims at facilitating synergy between:

- Schools and daycare institutions
- Media: Local TV (TV2 Bornholm)
- Supermarkets



Action research and co-creation

Outcomes: local ownership, TV-watching, selling of healthy products, knowledge and attitudes etc.

Control: Odsherred Municipality

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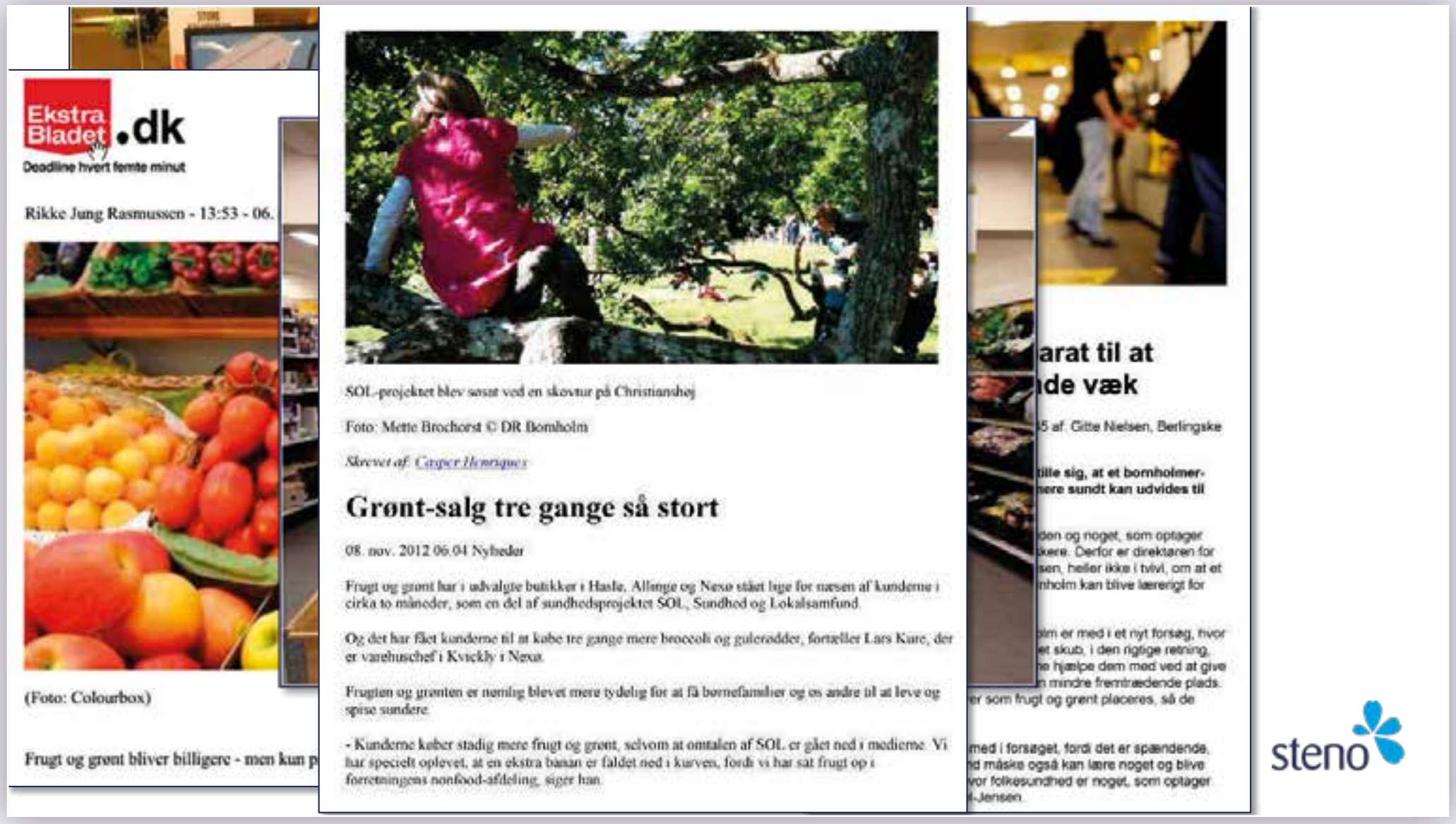

Ekstra Bladet .dk
Deadline hvert femte minut

Rikke Jung Rasmussen - 13:53 - 06.

(Foto: Colourbox)

Frugt og grønt bliver billigere - men kun p

SOL-projektet blev sæsat ved en skovtur på Christianshøj

Foto: Mette Brochorst © DR Bornholm

Skrevet af: Casper Henriques

Grønt-salg tre gange så stort

08. nov. 2012 06.04 Nyheder

Frugt og grønt har i udvalgte butikker i Hasle, Allinge og Nexø stået lige for næsen af kunderne i cirka to måneder, som en del af sundhedsprojektet SOL, Sundhed og Lokalsamfund.

Og det har fået kunderne til at købe tre gange mere broccoli og gulerødder, fortæller Lars Kure, der er varehuschef i Kvickly i Nexø.

Frugten og grønten er nemlig blevet mere tydelig for at få børnefamilier og os andre til at leve og spise sundere.

- Kunderne køber stadig mere frugt og grønt, selvom at omtalen af SOL er gået ned i medierne. Vi har specielt oplevet, at en ekstra banan er faldet ned i kurven, fordi vi har sat frugt op i forretningens nonfood-afdeling, siger han.

arat til at
de væk

5 af: Gitte Nielsen, Berlingske

tte sig, at et bornholmer-
ere sundt kan udvides til

den og noget, som optager
kere. Derfor er direktøren for
sen, heller ikke i tvivl, om at et
nholm kan blive lærerigt for

im er med i et nyt forsøg, hvor
et skub, i den rigtige retning,
e hjælpe dem med ved at give
n mindre fremtrædende plads.
er som frugt og grønt placeres, så de

med i forsøget, fordi det er spændende,
d måske også kan lære noget og blive
vor folkesundhed er noget, som optager
-Jensen.

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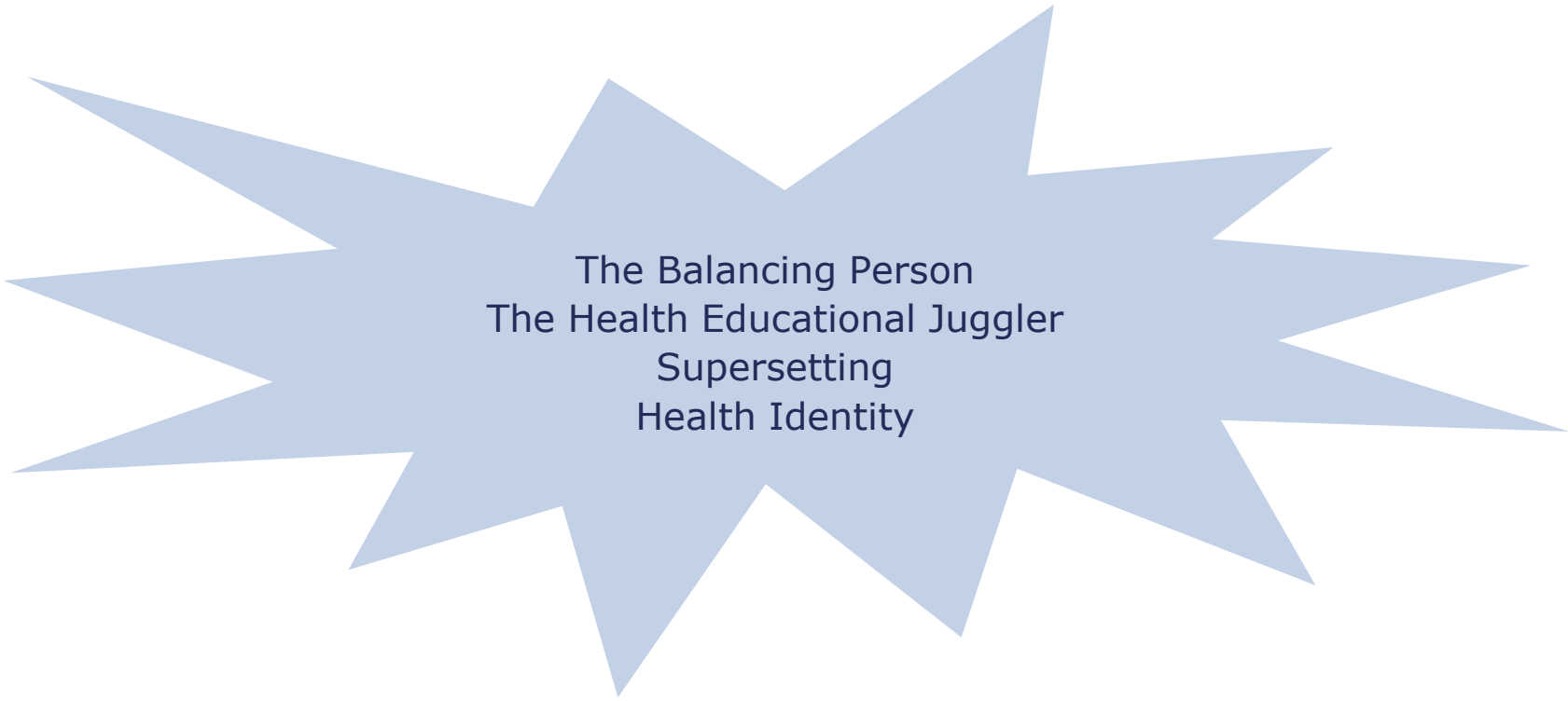
Examples of new Health Promotion concepts



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Health Promotion Research

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Thank you!

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Levanger, Norway, 5-6 March 2015

Thursday 5 March

1615-1900 Study visit of Nord-Trøndelag Health Study Facilities

Friday 6 March

0900-0915 Welcome by municipal director in Levanger and Innherred, **Mr Jon Ketil Vongraven**
Presentation of all participants

0915-0950 Health in all policies in a local context. The Municipal Master Plan as a strategic tool to promote public health and health equity by **Ms Dina von Heimburg**, Public Health Co-ordinator in Innherred district.

0950-1030 Enabling inhabitants to cope with everyday life. Presentation of a municipal sector plan for health and welfare services by **Mr Jon Ketil Vongraven**, health director in Levanger municipality.

1045-1115 Presentation of Norwegian Competence Centre for Arts and Health in Levanger, director **Mr Odd Håpnes**

The BSPC Working Group on Innovation in Social and Health Care (BSPC WG ISHC) also had a **study trip to the HUNT research institution** on 5-6 March 2015. The Nord-Trøndelag Health Study (The HUNT Study) is one of the largest health studies ever performed. It is a unique database of personal and family medical histories collected during three intensive studies. The fundamental strategy is to earn and maintain the confidence of the population we work in and with as is necessary for any successful population study. This strategy has been successful and has resulted in extraordinarily high participation rates. There is enthusiastic public and political support for HUNT and for the HUNT Research Centre. This has created a good basis for further health surveys in the county and an excellent research environment. The WG also visited Levanger municipality to hear about the municipal sector's plan for health and welfare services, the Municipal Master Plan as a strategic tool to promote public health and health equity, and the new Norwegian Competence Centre for Arts and Health. Levanger aims to include the health perspective in all local policies.

Livskvalitet og vekst

Health in all policies in a local context

The Municipal Master Plan as a strategic tool to promote public health and health equity

Dina von Heimburg, Public Health Coordinator in Innherred samkommune (joint municipality)

1

WHO Healty Cities

- Euro Healthy Cities network
- National network in Norway
- Verdal and Levanger are proud members

- «Laboratory»: Develop and share «best practice» of public health work at the local and regional level.

Seminar in Estonia 2014

Study trip to Poland 2015

UCL Institute of Health Equity

UCL

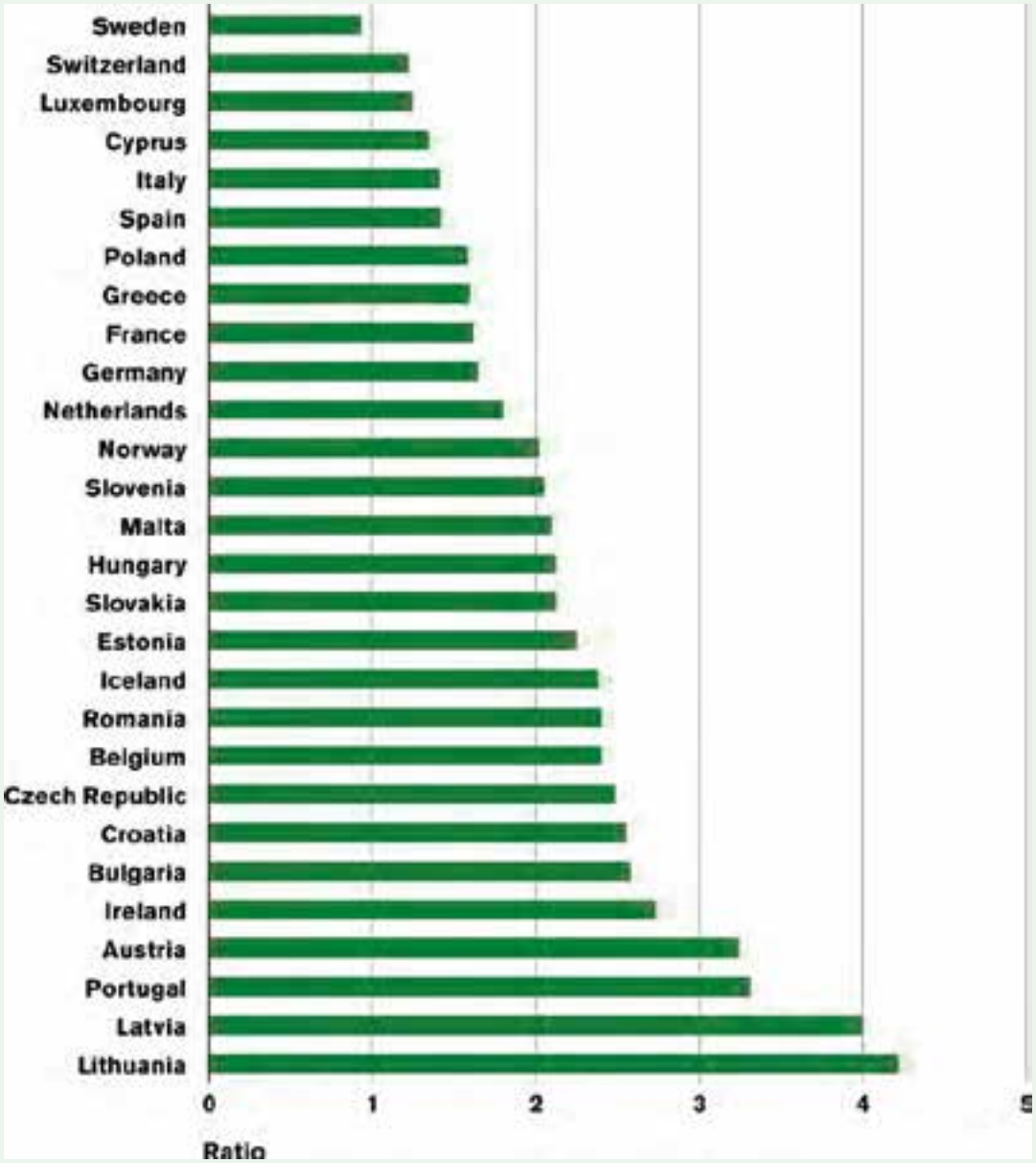
Review of social determinants and the health divide in the WHO European Region

Professor Peter Goldblatt, UCL,
Presentation in Levanger 2014

UCL Institute of Health Equity

UCL

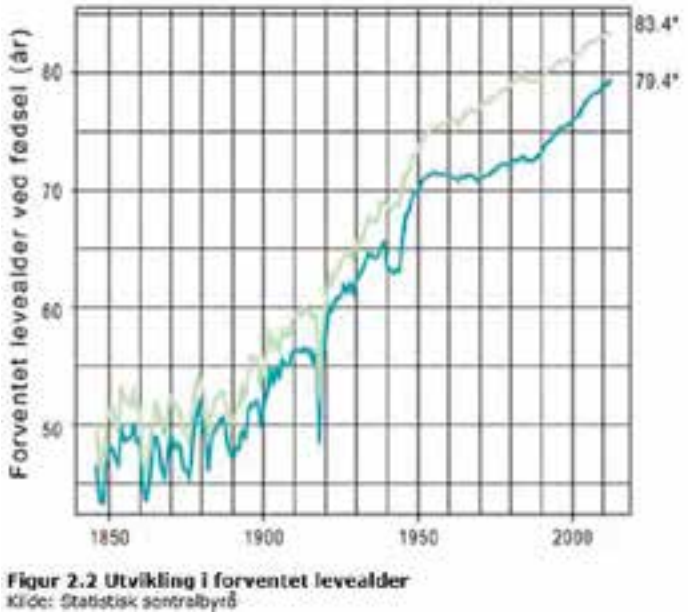
Ratio of poor health among people with primary-level education (level 1) to poor health among those with basic tertiary education (level 5) in selected European Region countries, 2010



Source: EU–SILC

Public health in Norway

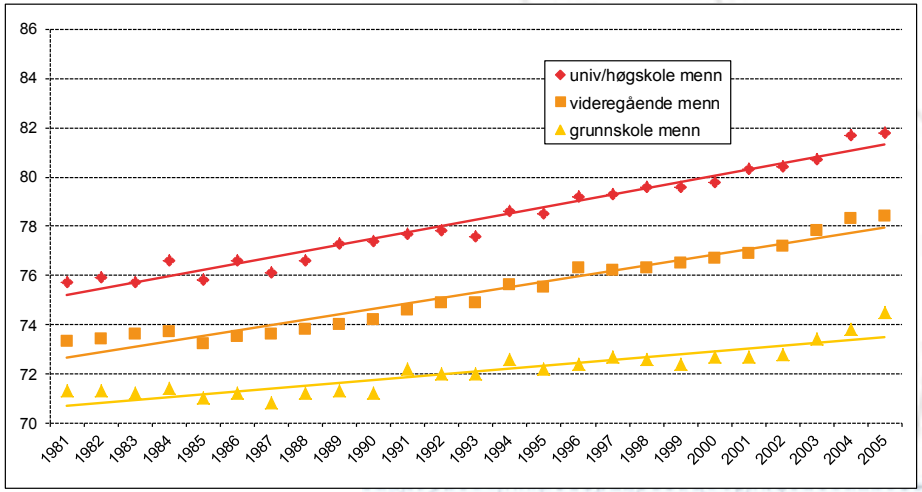
In general, Norwegians have good health, but we still face major challenges….



Figur 2.2 Utvikling i forventet levealder
Kilde: Statistisk sentralbyrå

1. Social inequalities in health is increasing
2. Demographical changes in the population
3. Changes in lifestyle caused by societal structures
4. NCD's and mental health

Life expectancy – men by educational level

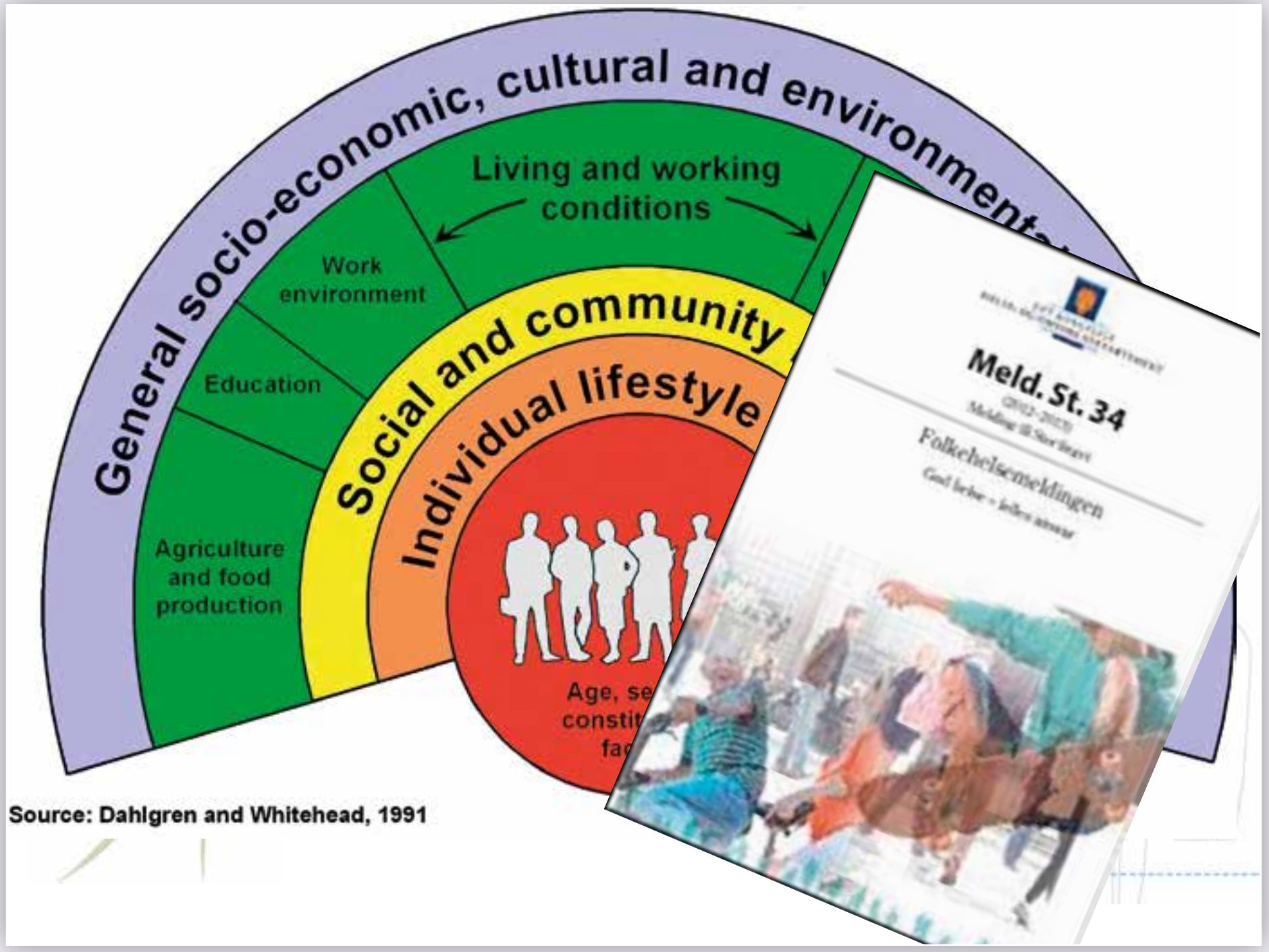


7

The «new» Public Health Act

- New challenges in public health
- Previous legislation had not worked out as intended
- «Bottom up» - public health advocacy from municipalities and counties
- The *coordination health reform of 2012* points out the need for strengthening health promotion and early prevention in order to facilitate a sustainable development – locally, nationally and internationally

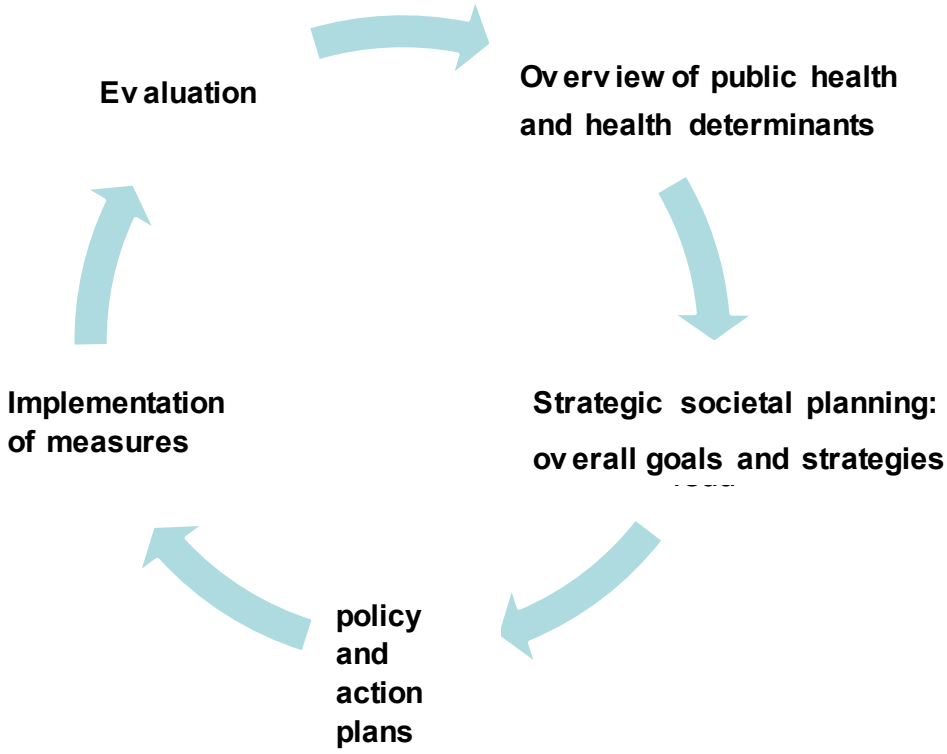
8


General socio-economic, cultural and environmental
Living and working conditions
Work environment
Education
Agriculture and food production
Social and community
Individual lifestyle
Age, se
consti
fa
Source: Dahlgren and Whitehead, 1991
Meld. St. 34
Folkehelsemeldingen

Empowering communities through The Public Health Act

Main objective:

Societal development in order to promote public health and reduce health inequalities



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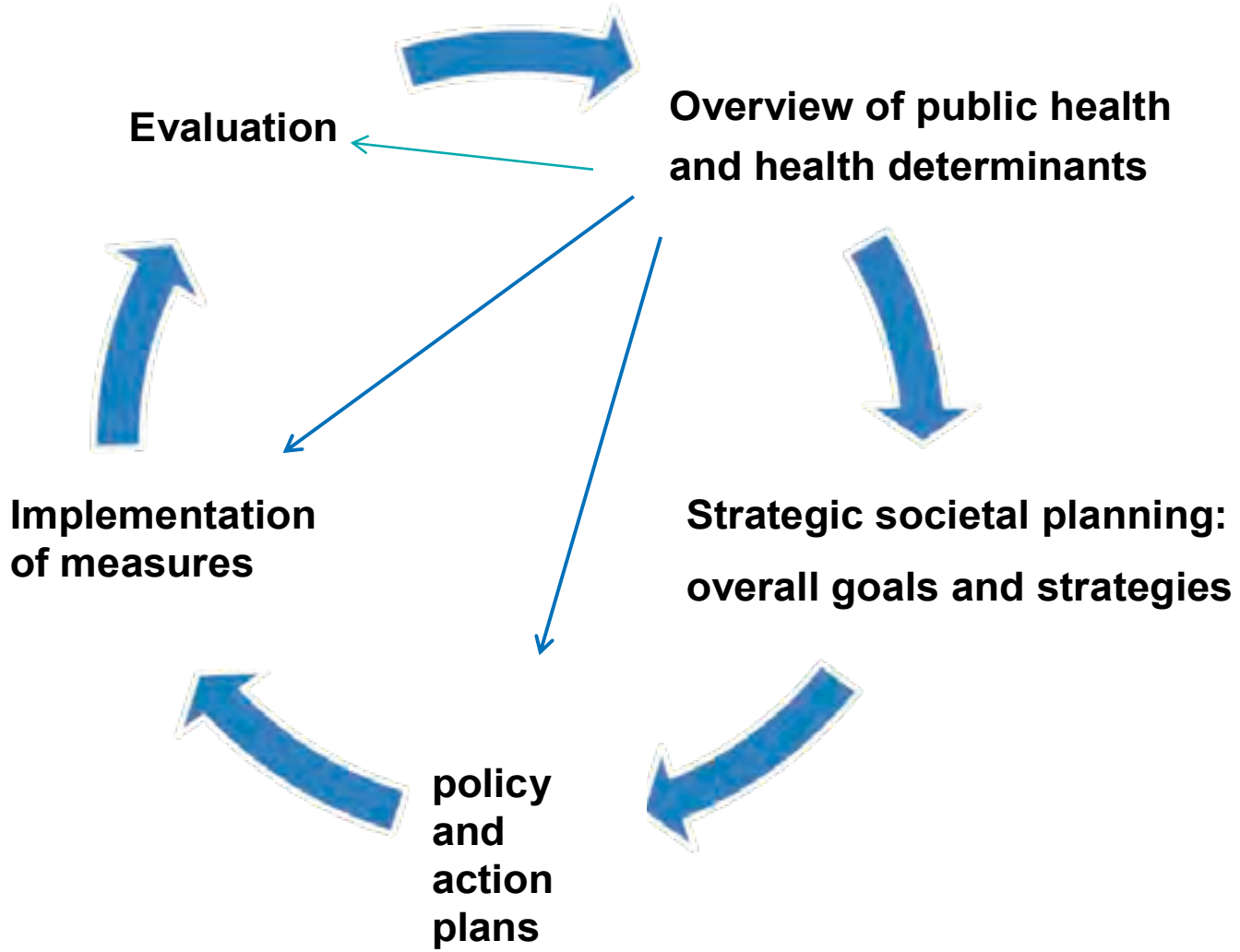

Evaluation
Overview of public health and health determinants
Implementation of measures
Strategic societal planning: overall goals and strategies
policy and action plans

Underpinning principles – Public Health Act

1. ***Health equity:*** Health inequities arise from the societal conditions in which people are born, grow, live, work and age – the social determinants of health. Social inequities in health form a pattern of a gradient throughout society. Levelling up the gradient by action on the social determinants of health is a core public health objective. A fair distribution of societal resources is good public health policy.

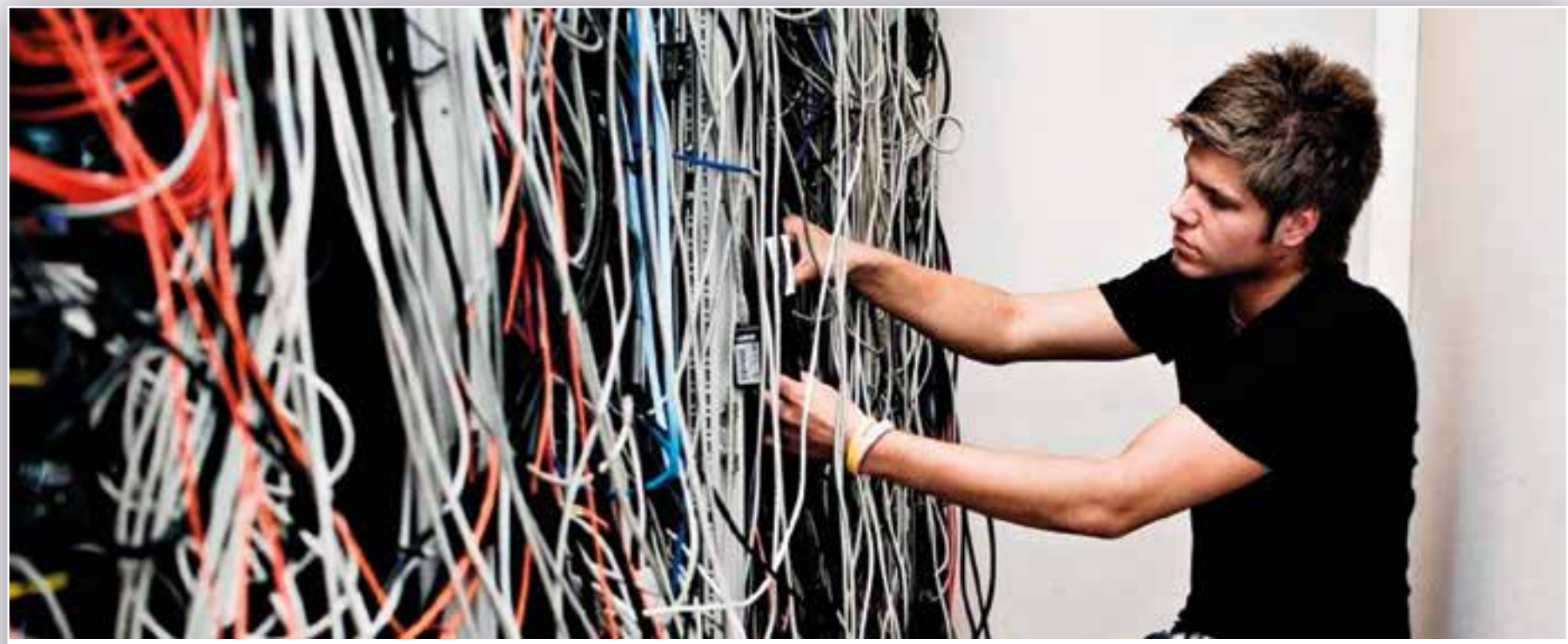
2. ***Health in all policies:*** Equitable health systems are important to public health, but health inequities arise from societal factors beyond health care. Impact on health must be considered when policies and action are developed and implemented in all sectors. Joined up governance and intersectoral action is key to reduce health inequities.

Principles of public health cont.

3. ***Sustainable development:*** Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs. Public health work need to be based on a long term perspective

4. ***Precautionary principle:*** If an action or policy has a suspected risk of causing harm to the public or to the environment, the absence of scientific consensus that the action or policy is harmful, cannot justify postponed action to prevent such harm

5. ***Participation:*** Public health work is about transparent, inclusive processes with participation by multiple stakeholders. Promotion of participation of civil society is key to good public health policy development



Health promotion requires systematic wiring

However, organizing tons of wires to get the machinery working, is not an easy task…

14

3 Main messages from Verdal and Levanger:

- Public Health Strategy = Municipal Master Plan.
  A holistic approach to HiAP.
- Local knowledge and research-based arguments have been extremely important
- Sufficient anchoring in the political and administrative leadership has been crucial to success.

15

… Verdal and Levanger try our very best to fulfill the systematic public health circle….

Central principles in Verdal and Levanger:

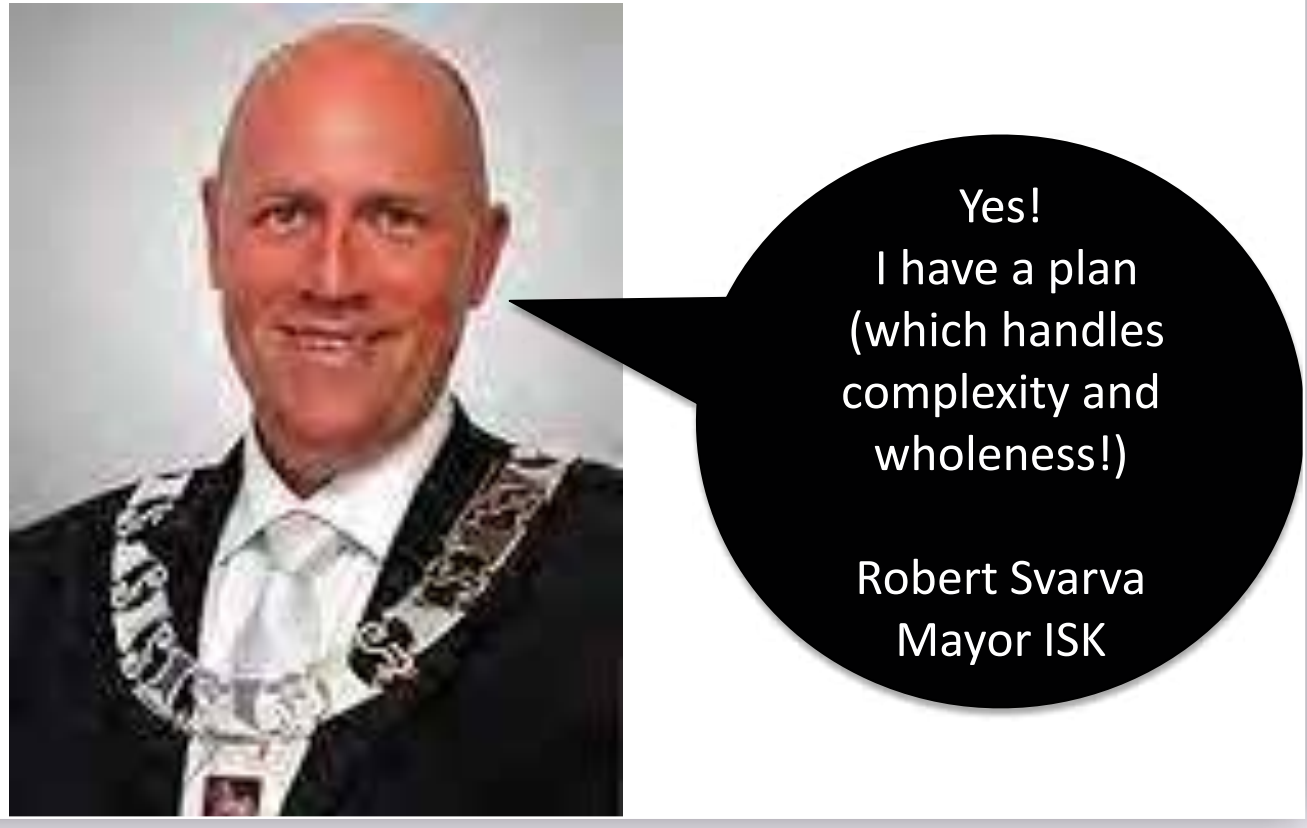
- Public health and equity are political choices. The Mayors are our «public health leaders», and the chief of administration and all the rest of us support them in this task.

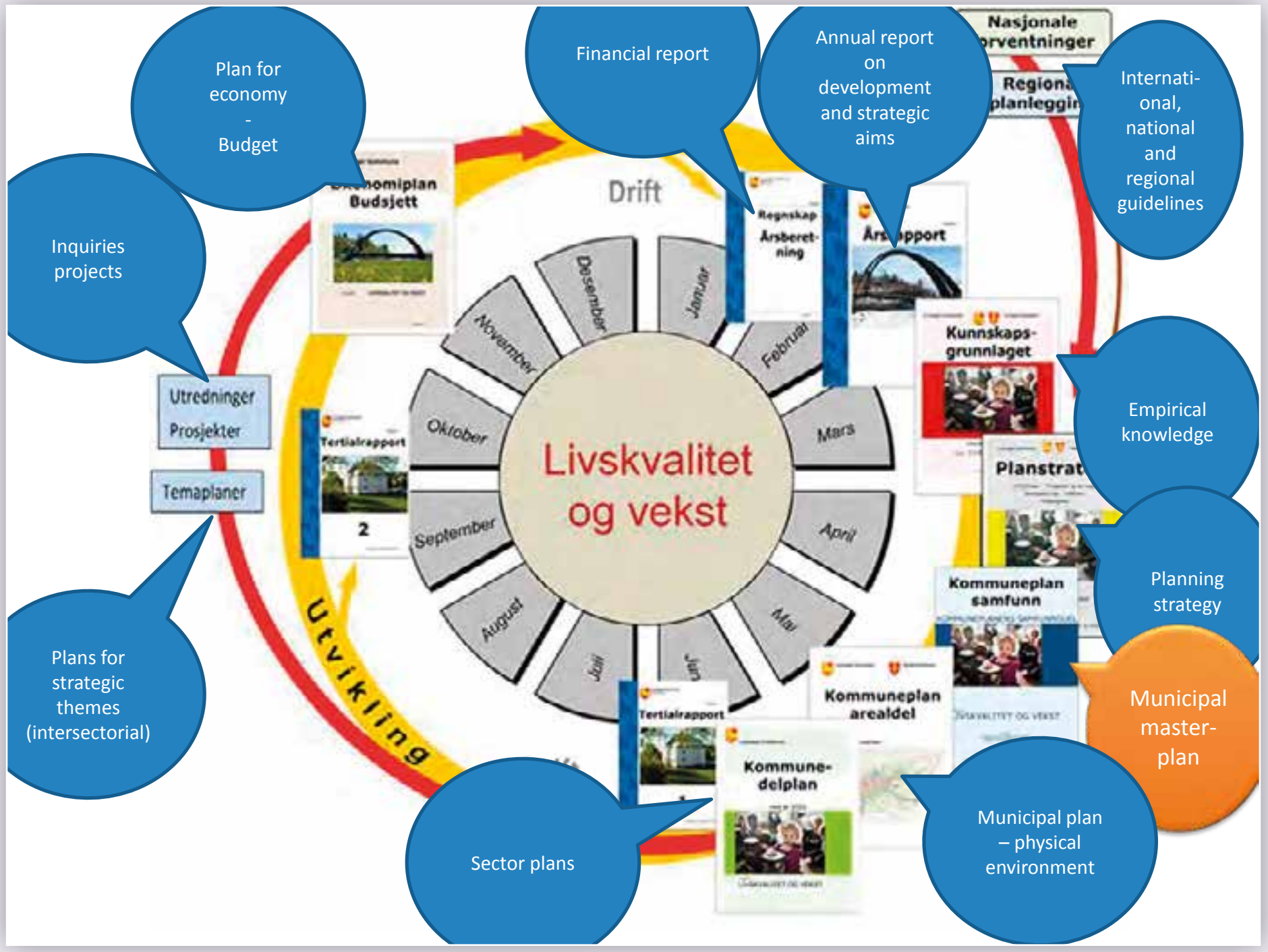
- We develop our work through processes anchored within the municipality organization prior to loosely connected projects.

- Strategic development of services and communities with a focus on overall planning, co-creation and leadership

17

…Policy and governance must be conducted on the basis of procedures that unites knowledge, goals, strategies, actions and priorities, so that we can deal with a complex world …

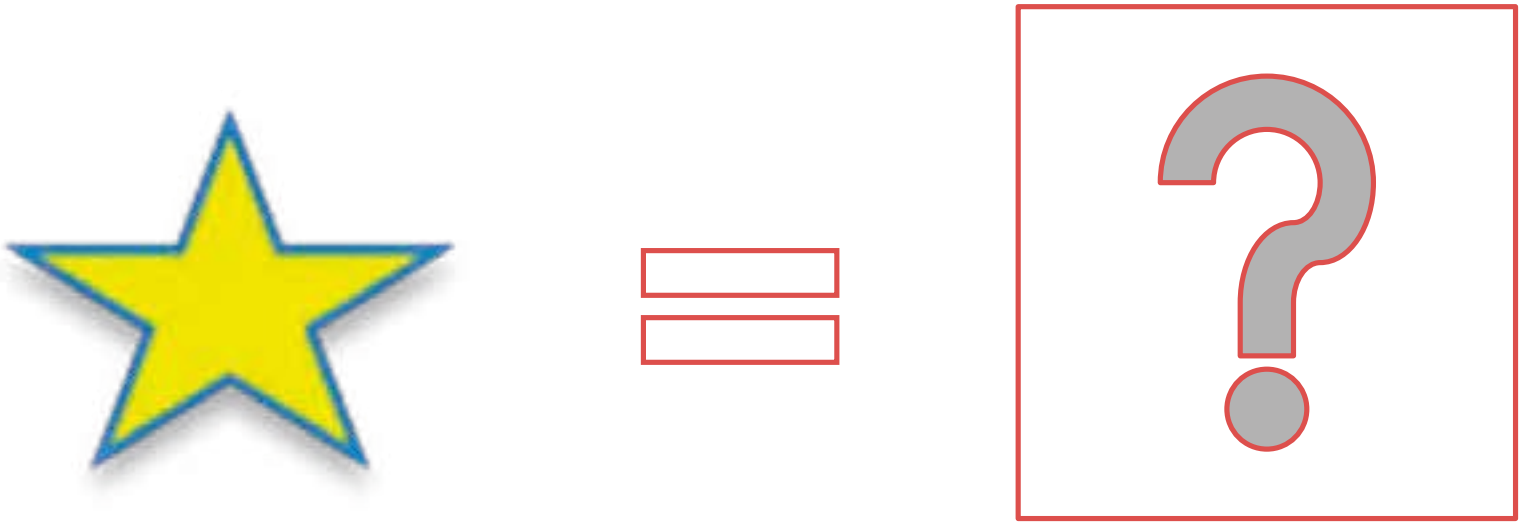



Plan for economy - Budget
Financial report
Annual report on development and strategic aims
Nasjonale
Regional planlegging
Internati-onal, national and regional guidelines
Inquiries projects
Drift
Budsjett
Regnskap
Årsberet-ning
Årsrapport
Kunnskaps-grunnlaget
Empirical knowledge
Utredninger
Prosjekter
Temaplaner
Tertialrapport
2
Livskvalitet og vekst
Planstrat
Kommuneplan samfunn
Planning strategy
Plans for strategic themes (intersectorial)
Utvikling
Kommuneplan arealdel
Tertialrapport
Kommune-delplan
Municipal master-plan
Sector plans
Municipal plan – physical environment
Januar
Februar
Mars
April
Mai
Juni
Juli
August
September
Oktober
November
Desember

Municipal plan – public health strategy

Process 2014


Municipality of Levanger
Municipality of Verdal
Municipal Masterplan 2015-2030
Vision: Quality of life and growth
sustainable societies - a good start and coping throughout the lifespan - generous and robust life environments



22

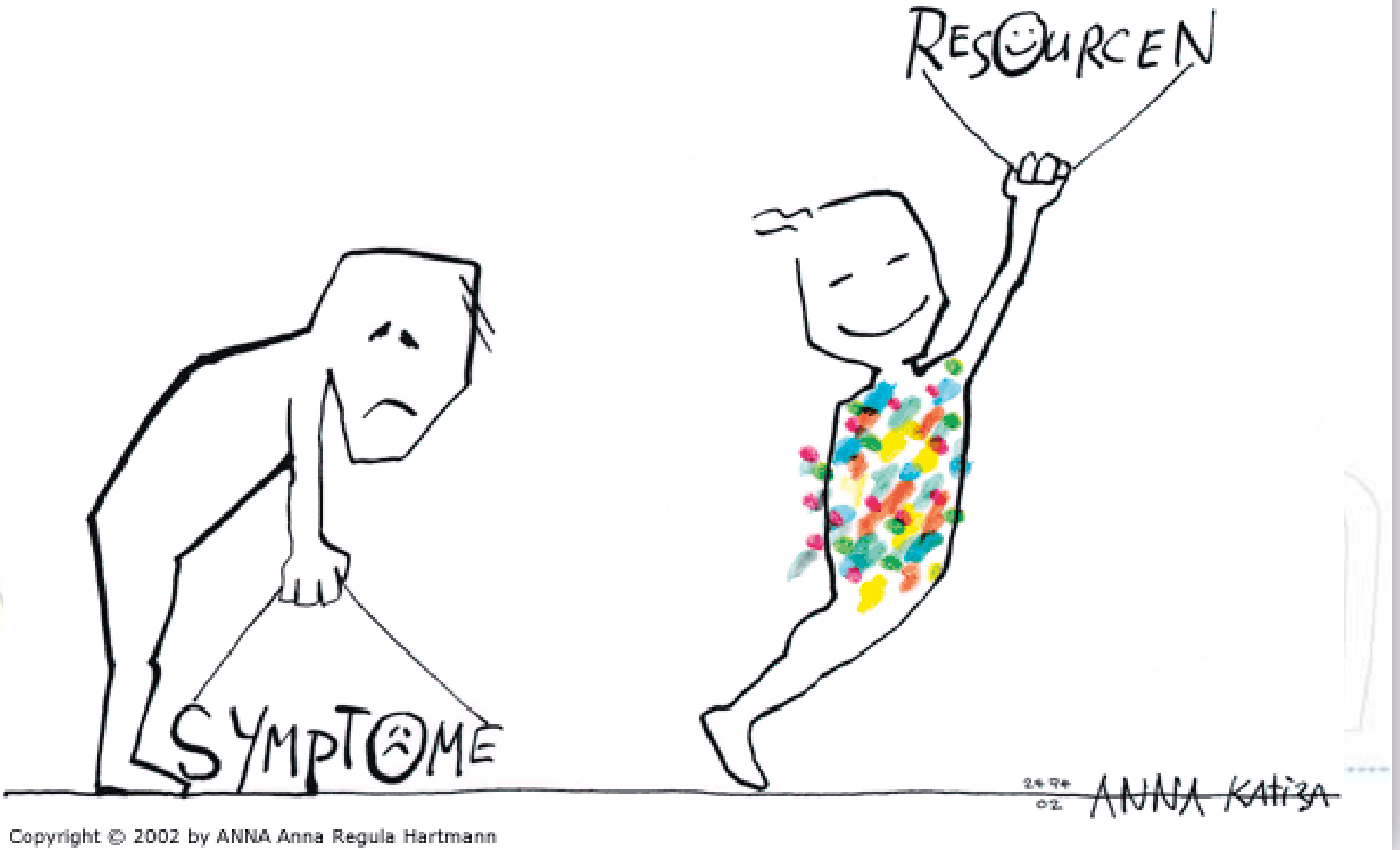
What are we really planning for??

Health in All Policies!

24


OTTAWA CHARTER
FOR HEALTH PROMOTION
1986
• STRENGTHEN COMMUNITY ACTION
• DEVELOP PERSONAL SKILLS
• ENABLE
• MEDIATE
• ADVOCATE
• BUILD HEALTHY PUBLIC POLICY
• CREATE SUPPORTIVE ENVIRONMENTS
• REORIENT HEALTH SERVICES

Redefine our perspectives: What creates health, well-being and resilience?



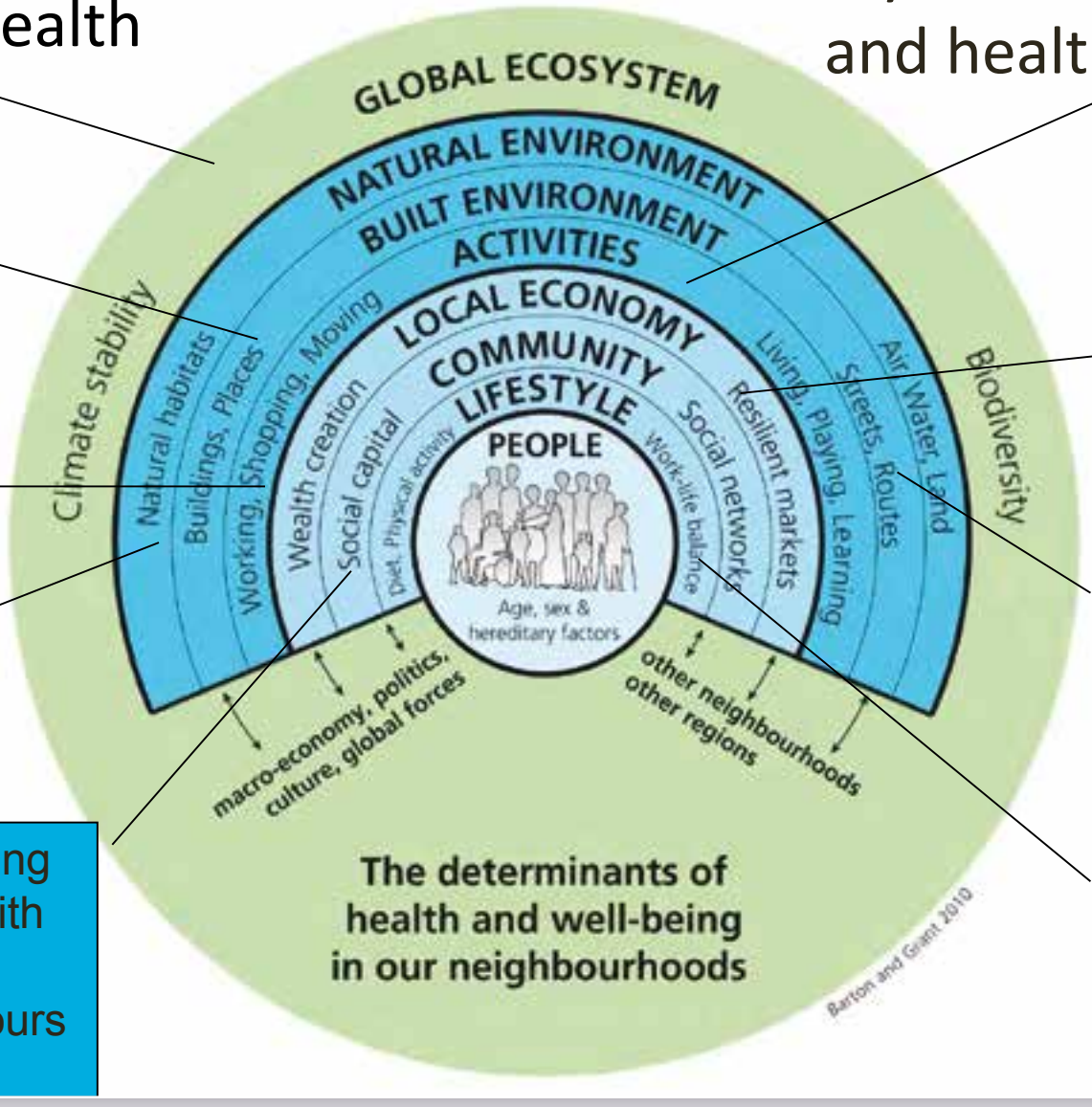
Mike Grady, UCL/Marmot review team, 2014)

What enhances my wellbeing and health

- Recycling facilities
- Green spaces that I can use
- Affordable healthy food
- Affordable transport
- Spending time with my neighbours

What is detrimental to my wellbeing and health

- Lack of interesting activities in winter
- Poor local job prospects
- Poor street lighting and uneven pathways
- Soaring fuel bills and poor insulation

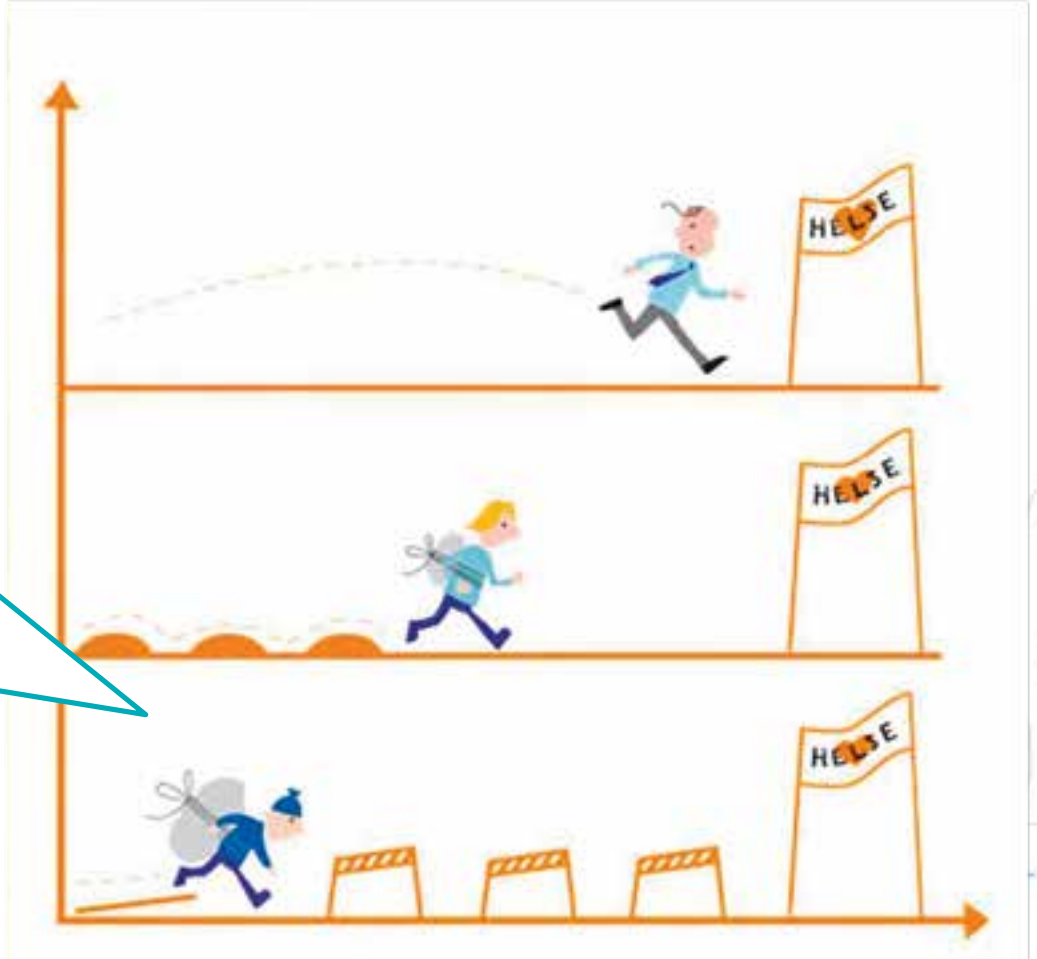


Half full or half empty?

http://www.abcdinstitute.org

Social inequalities in health is unfair and unavoidable

I can get strong and resilient by carrying this burden, but it basically depends on my social conditions, and if I learn proper tecniques to carry these stones on my back…

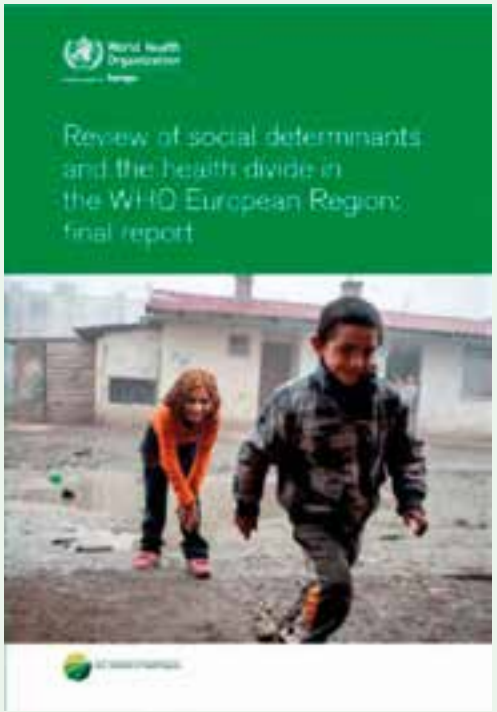


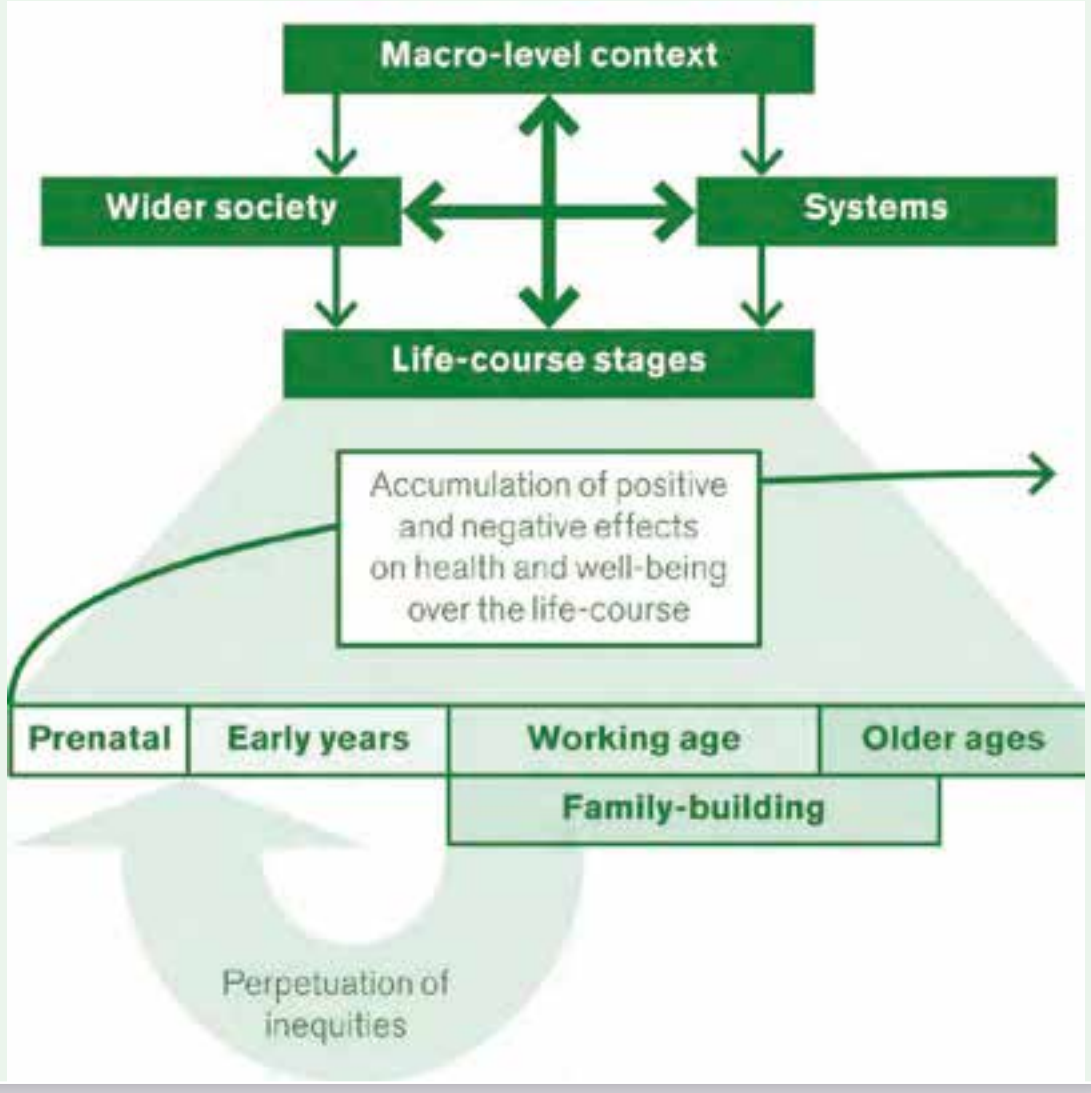
29

UCL Institute of Health Equity

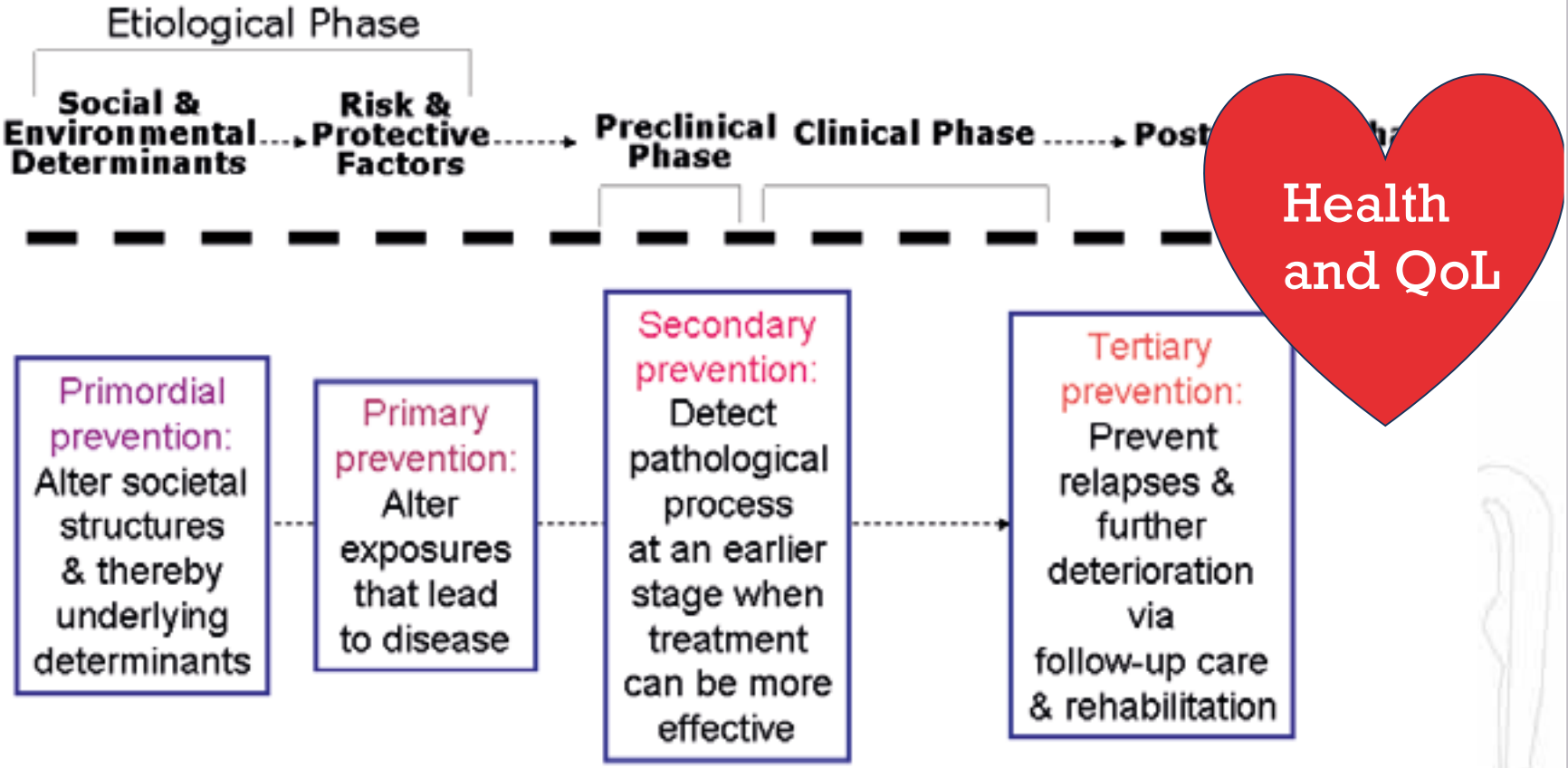
UCL

Life course and generational perspective





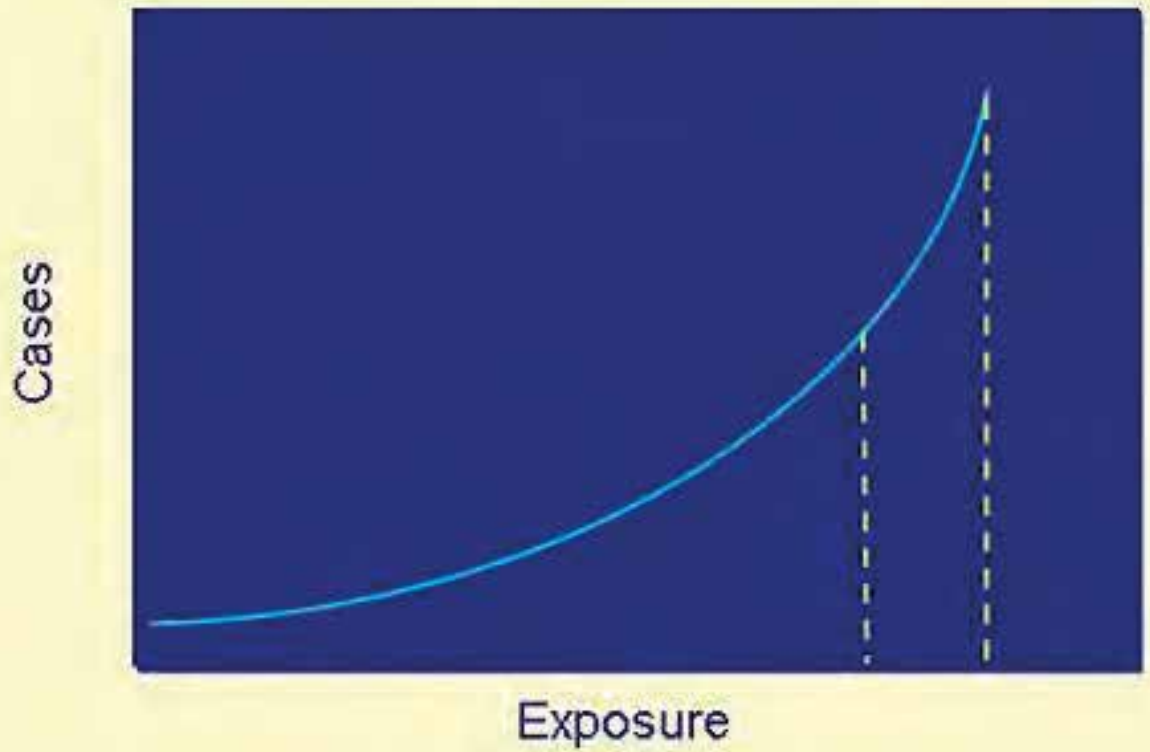
Clinical Course of a Disease, linked to prevention stages



31

Rose G (1985). Sick individuals and sick populations.

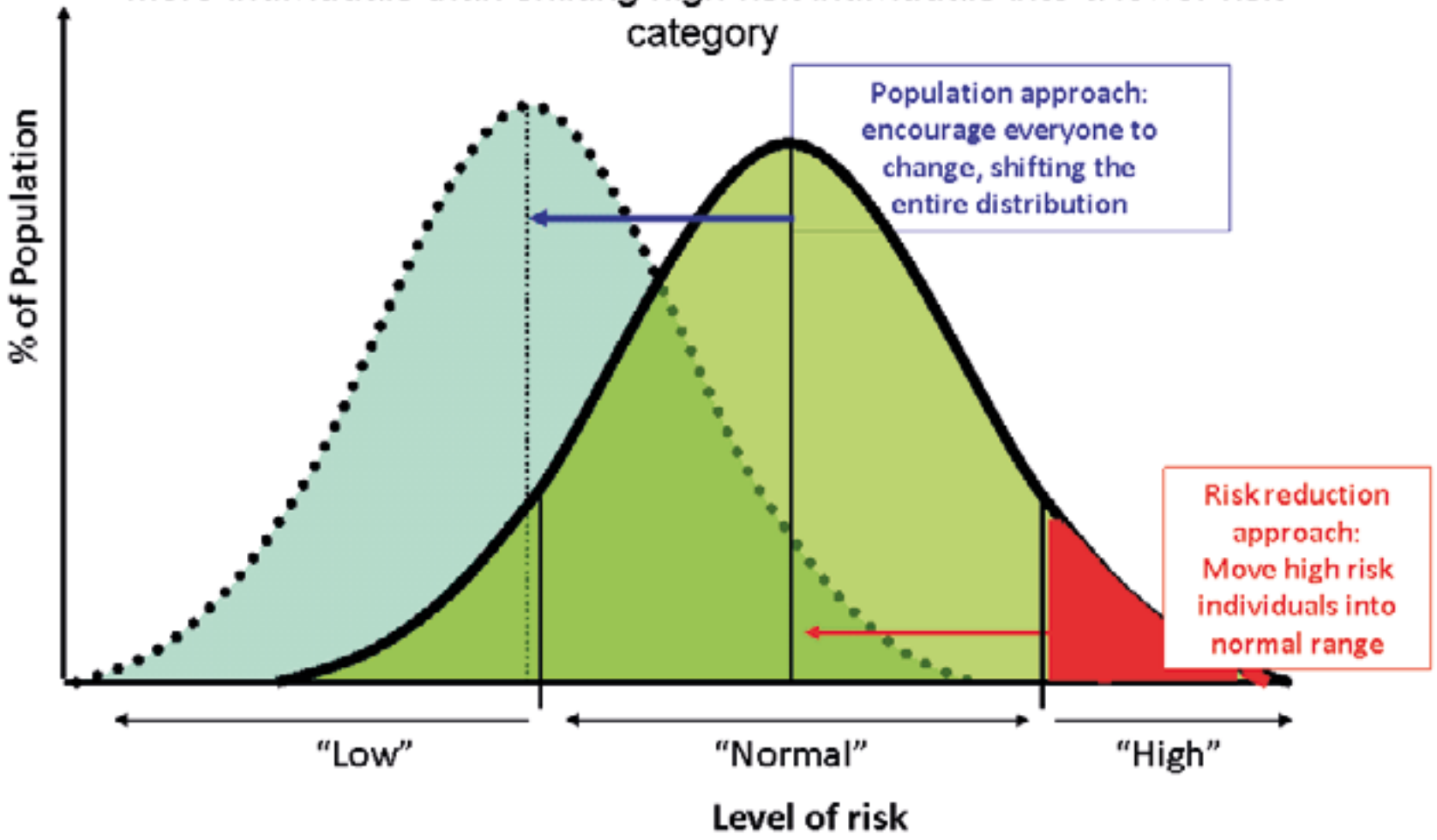
The Prevention Paradox



A large number exposed to a small risk generate more cases than a small number exposed to a large risk

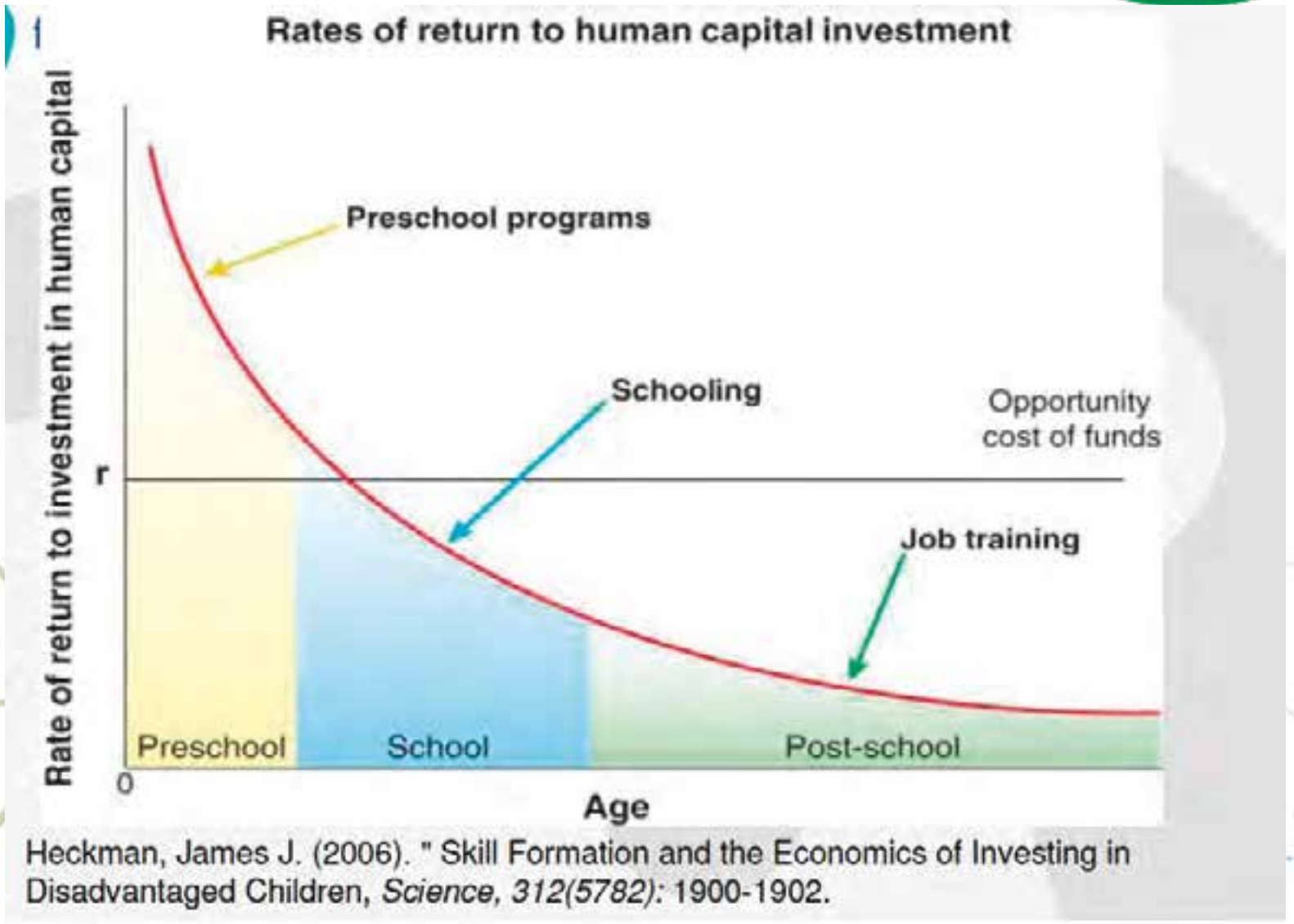
The Bell-Curve Shift in Populations

Shifting the whole population into a lower risk category benefits more individuals than shifting high risk individuals into a lower risk category

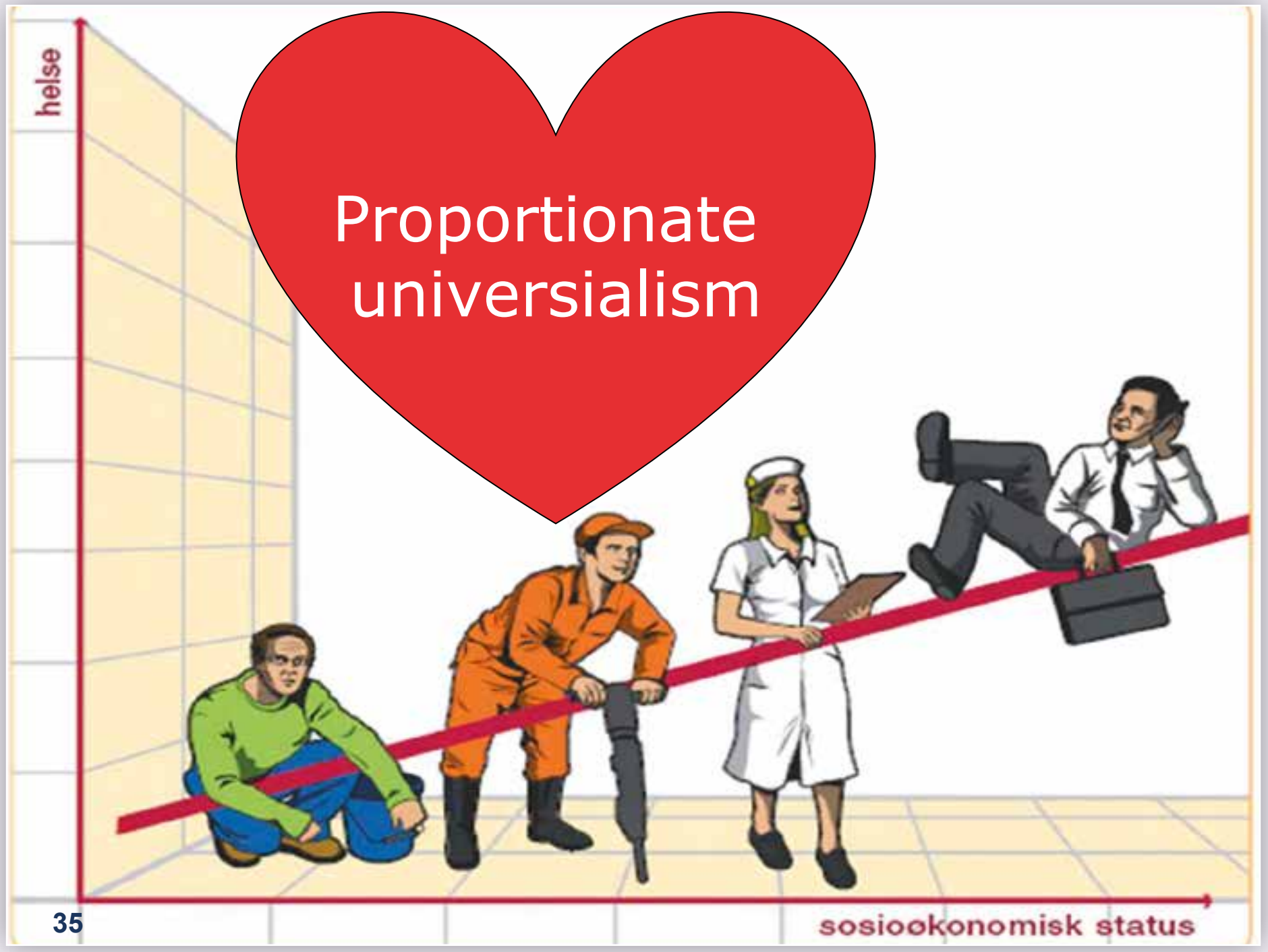


Source: Rose G. Sick Individuals and sick populations. *Int J Epidemiol.* 1985; 12:32-38.

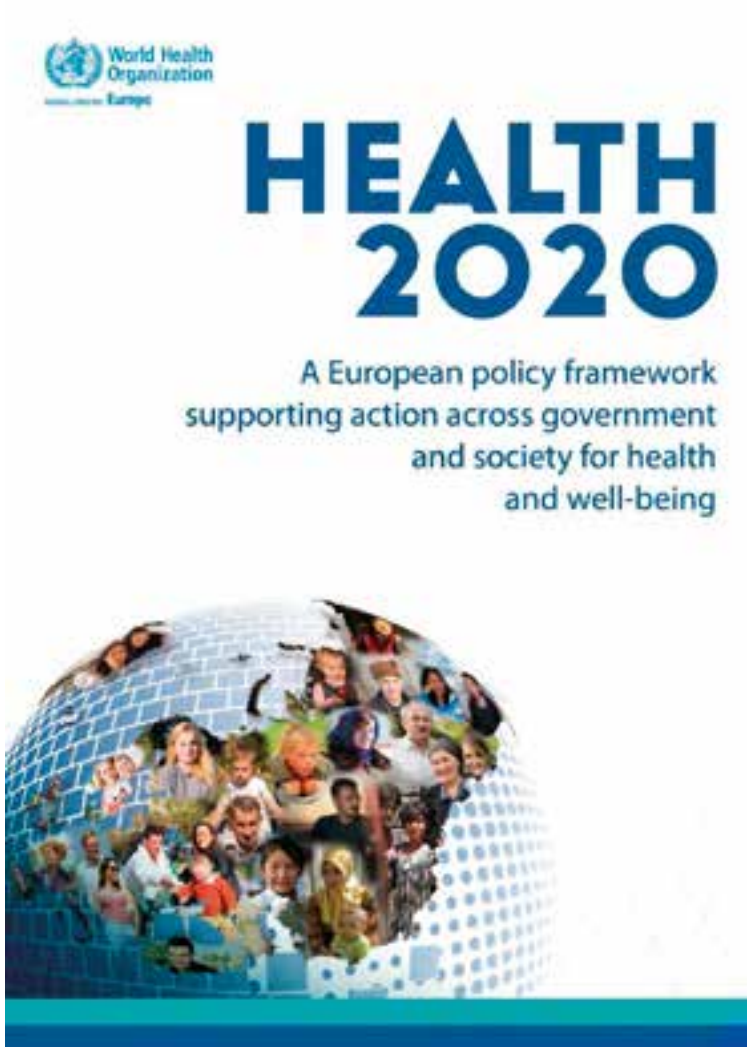
Early Childhood = investment



Heckman, James J. (2006). " Skill Formation and the Economics of Investing in Disadvantaged Children, *Science, 312(5782):* 1900-1902.


helse
Proportionate universialism
35
sosiookonomisk status

WHO Health 2020



Health 2020 recognizes that successful governments can achieve real improvements in health if they work across government to fulfill two linked strategic objectives:

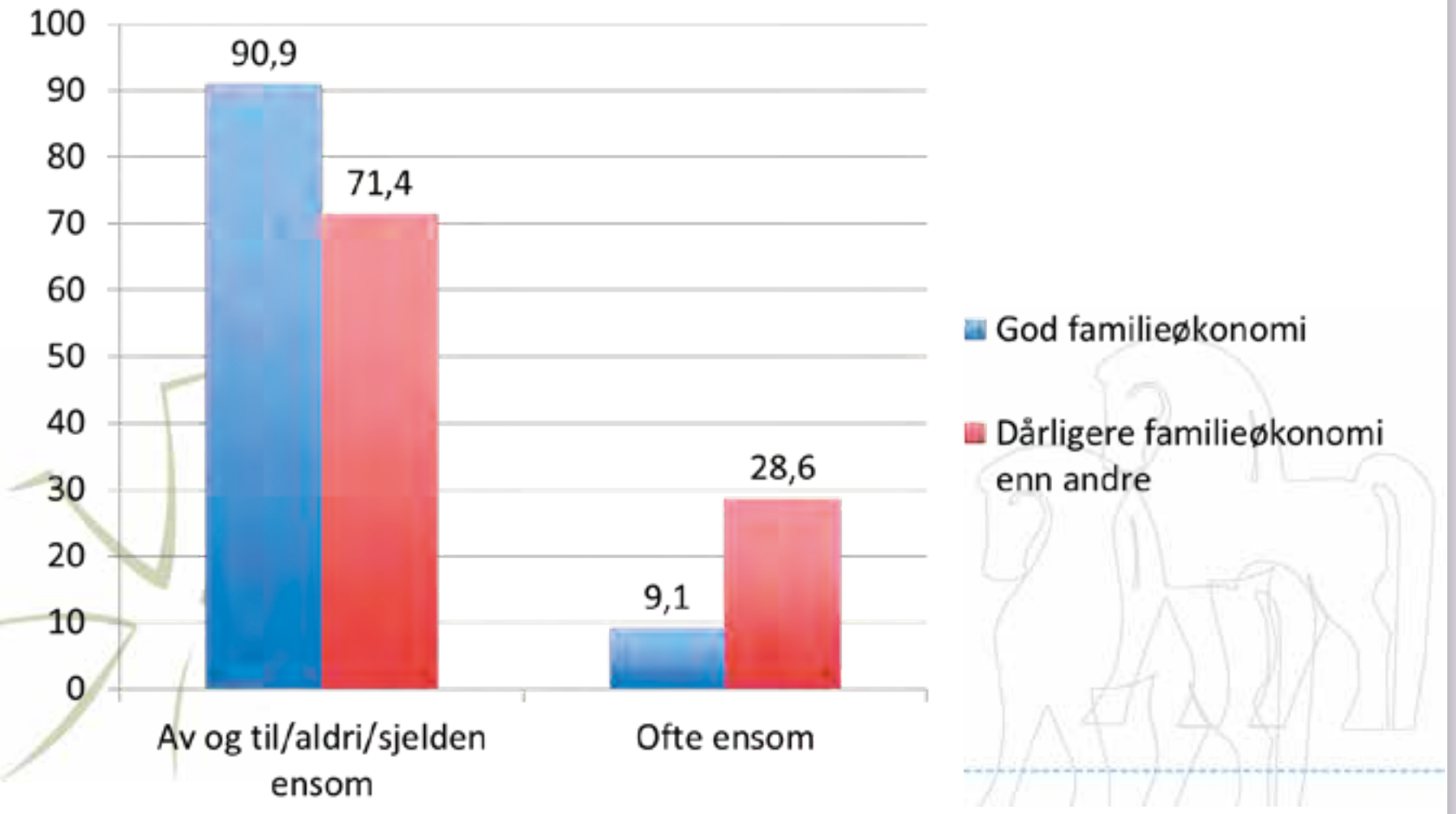
- ***improving health for all and reducing health inequalities***
- ***improving leadership and participatory governance for health.***

The Trondheim Declaration (2014): Fair distribution of health and well-being - a political choice

Helsedirektoratet

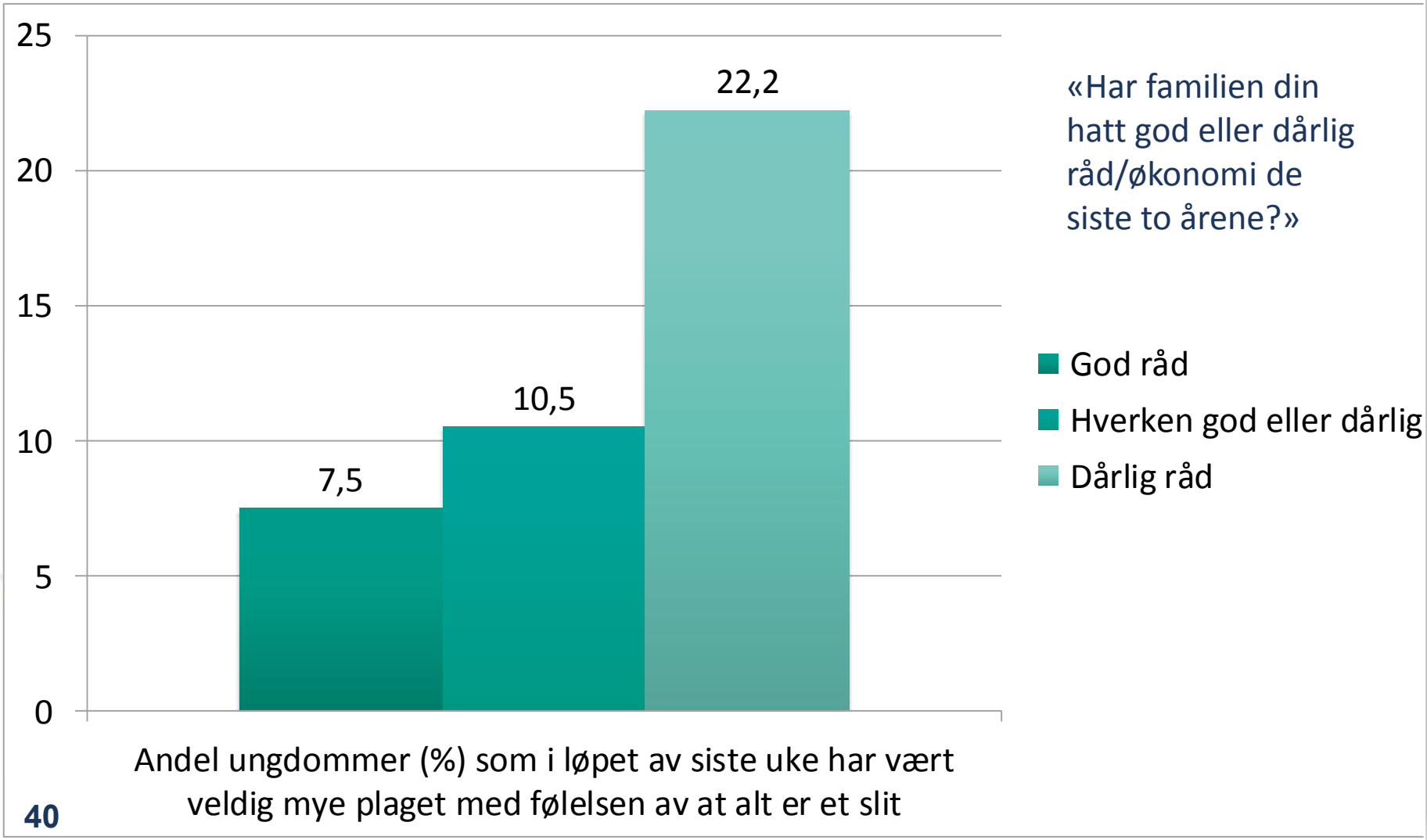
Local empirical data on population health and determinants

UNG-HUNT 3: Social inequalities – loneliness amongst youth in Levanger



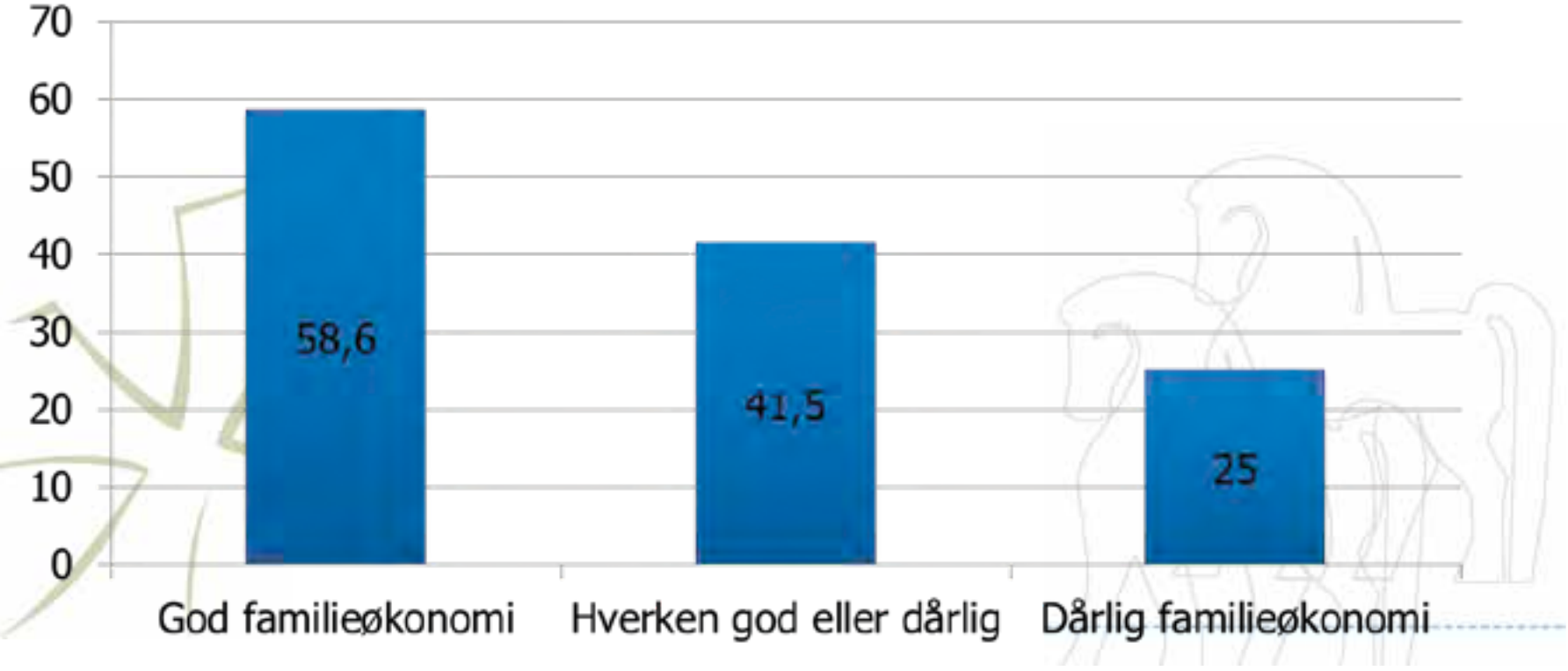
Ungdata 2012 – Levanger

«feels like everything is a struggle» - Family economic resources



40

Ungdata Verdal 2013
Percentage of young people who thrive very well in the community – family economy



Paradigm shift???

FROM DISEASE PREVENTION TO SOCIETAL DEVELOPMENT!

42

The power of definitions and «framing»

We chose the definition of health provided by Peter F. Hjort as the basis for the development of our goals and strategies:

"Good health is what a person has when he has the ability and the capacity to cope with and adapt to life's inevitable difficulties and day-to-day requirements."

43

Definitions and perspectives provided in the MMP

We shall therefore focus our work on community development that promotes public health and reduces social inequalities in health and conditions of life. The focus on the residents will give everyone the opportunity to participate in the community regardless of age, gender, orientation, social and cultural background and disability. Public health is affected by all social sectors, as shown in Figure 1. That is why public health strategy is woven like a red thread through the entire local government plan, in which quality of life, health and control are key concepts.

We have chosen the definition of health[1] provided by Peter F. Hjort as the basis for our goals and strategies for the community: "Good health is what a person has when he has the ability and the capacity to cope with and adapt to life's inevitable difficulties and day-to-day requirements."

What affects health and quality of life?

The factors affecting quality of life and health may be presented in a causal chain that stretches from the general community situation to the characteristics of the individuals. This is illustrated in Figure 1[2].

Although social networks and living habits have a more immediate impact on health and quality of life, they are also greatly affected by underlying factors in which all the social sectors play an important role.

We must therefore consider the consequences for health, quality of life and a fair distribution of the conditions of life in everything we do.

Figure 1 Public health is affected by all sectors

Page 4 in the Municipal Master Plan

44


ORGANIZING +
MOBILIZING
=
SOLUTION

Creating solutions together

«Health in all policies»

Process 2014

Planning strategy 2013-2016

Holistic solutions – Municipal plans

Health | Childhood | Culture | Buisiness | City Centre

GUIDELINES
VALUES
KNOWLEDGE

Revision of public health strategy

Developement of services and local community

Defining perspectives

Existing municipal plans


Municipality of Levanger
Municipality of Verdal
Municipal Masterplan 2015-2030
Vision: Quality of life and growth
sustainable societies - a good start and coping throughout the lifespan - generous and robust life environments

GOALS

We are working to achieve the following objectives:

- Our municipalities are good communities to live in for a whole lifetime, and everyone feel as a valued part of the community
- All children must be given the best possible start in life
- All the inhabitants feel secure, they have control of their everyday life and they have added several active years of life with good health and well-being
- Our municipalities are a force for development in a sustainable and robust part of Central Norway

societies, B) give priority to a good

ing environments. The blue text boxes

A) E

- Prior
- Prioritis
- Ensuring th ens' needs
- Arranging for a ss world and increased food production
- Taking still clearer resp climate challenges
- Mobilising local community resources through transparency, the involvement of citizens and collaboration and alliances with knowledge institutions, business, the cultural and the voluntary sector and public players
- Ensuring holistic solutions, coordinated work processes and future-oriented and knowledge-based services
- Reconciling policy and service provision through binding, coherent and economically sustainable planning
- Contribute to a sustainable development in the region with emphasis on infrastructure, business and cooperation with other municipalities


...We need to evaluate our efforts ...
eval
Nasjonale forventninger
Regional planlegging
Societal analysis
Drift
Økonomiplan Budsjett
Regnskap Årsberet-ning
Årsrapport
Kunnskaps-grunnlaget
Planstrategi
Kommuneplan samfunn
Kommuneplan arealdel
Kommune-delplan
Tertialrapport 1
Tertialrapport 2
Utredninger
Prosjekter
Temaplaner
Januar
Februar
Mars
April
Mai
Juni
Juli
August
September
Oktober
November
Desember
Livskvalitet og vekst
utviklingsevaluering

INDICATORS AND PERFORMANCE REVIEW

The target indicators shown below are ass for the assessment of the results in the annual report. The assessment is performed in the light of the ipal objectives and is intended to give an indication of whether the development is in line with them. Where pos assessment must be based on a breakdown by geography, age, gender and social status. It must presupp bition for the situation to be improved for all and for inequality to be reduced.

- Life Expectancy (Public Health Institute of
- Self-reported health and quality of life (
- Years of life with good health (HUNT4)
- Access to trusted friends/networks w
- Participation in further education (Co
- Long-term unemployment (Nav)
- Disability (Nav)
- Households with persistent p
- Participation in cultural activit
- Physical activity (bicycling and
- Infrastructure for walking and bic
- Traffic (number of passengers us
- Civil Index (The Civil Survey)
- Democracy Index (The Civil Surv
- The Municipal Barometer (Munici
- Source Separation (Innherred Renovati
- The Industrial Index (Central Industrial Orga
- Commercial Institutions (Innovation Norway)
- Net and gross operating profit as a percentage of operating reve accounts)
- Provision reserve as a percentage of operating income (Municipal accounts)

A lot of public health-related indicators!

Where possible, the assessment must be sorted by geography, age, gender and social status. Ambition: improve situation for all and reduce inequality

Direct links between strategies, measures and (joint) budgeting

8.3 Driftstiltak

Strategier i Kommuneplanens samfunnsdel			Tiltak	Kostnad (mill. kr.)					Finansiering av helårsvirkning		
Sikre en bærekraftig politikk	Prioritere en god start og mestring hele livet	Skape rause og robuste livsmiljøer		2015	2016	2017	2018	2019 -2022	Omlegging drift	Ekstern finans.	Nye midler i økonomi-planen
Strategi 1: **Forebyggende, tidlig og tverrfaglig innsats**											
x	x		Styrking av ordinær opplæring gjennom kompetanseutvikling, bevisstgjøring av lærere.	X	X	X	X	X	X		
	x		Økt pedagogtetthet. Statlig satsing i to av ungdomsskolene våre (2013 – 16).	X	X					X	
x			Realisere Familiens hus.	X	X	X	X	X	X		
x	x		Styrke skolehelsetjenesten opp mot nasjonal norm (Helsedir. IS-1798).	X	X	X	X	X		X	X
x	x		Etablere to 100%-stillinger for kommunepsykologer	X	X	X	X	X		I 2015	Fra 2016

...With a little help from our friends....

Vital to reach out for help (to our friends) in order to create the skills, the willingness and the abilities needed to implement and evaluate HiAP efforts and effects of interventions.

- People, neighbourhoods, NGOs, public and private organizations and businesses everyone that might contribute in the local community
- The Norwegian Healthy Cities Network (WHO)
- Partnership with University College of London/Marmot Review Team
- HUNT, University College of Nord Trøndelag, local hospital (HNT), KS, NT County government, National centre of arts and health
- Other local, regional, national and international resources

SUNNE KOMMUNER

54

«How can it be organized?»

Process 2014

Planning strategy 2013-2016

GUIDELINES
VALUES
KNOWLEDGE

Holistic solutions – Municipal plans

Health | Childhood | Culture | Buisiness | City Centre

Revision of public health strategy

Developement of services and local community

Defining perspectives

Existing municipal plans

3 Main messages from Verdal and Levanger:

- Public Health Strategy = Municipal Master Plan.
  A holistic approach to HiAP.
- Local knowledge and research-based arguments have been extremely important
- Sufficient anchoring in the political and administrative leadership has been crucial to success.

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UCL Institute of Health Equity

UCL

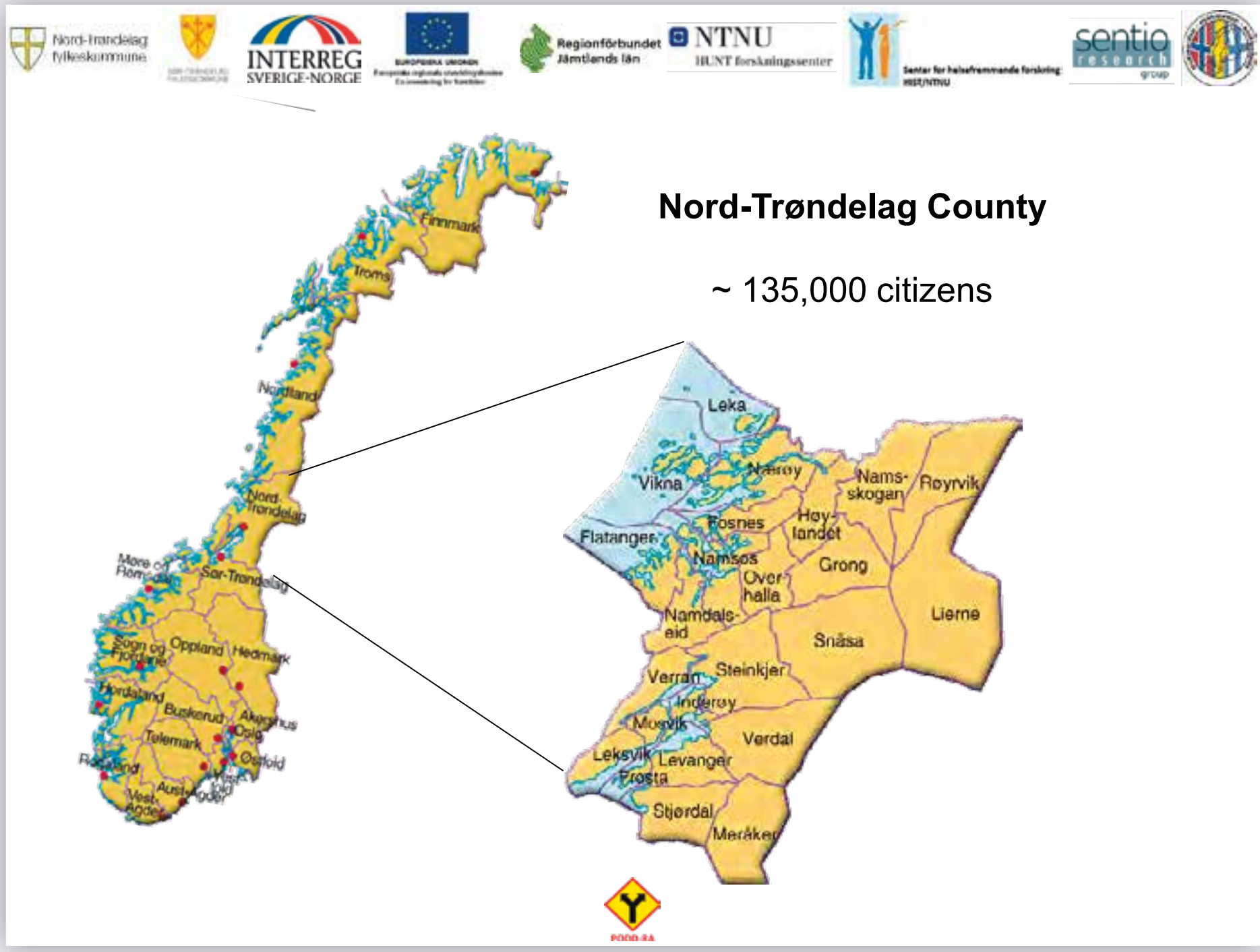
Thank you for listening!!

Contact information:

Email: dihe@innherred-samkommune.no

Phone: +47 93043714

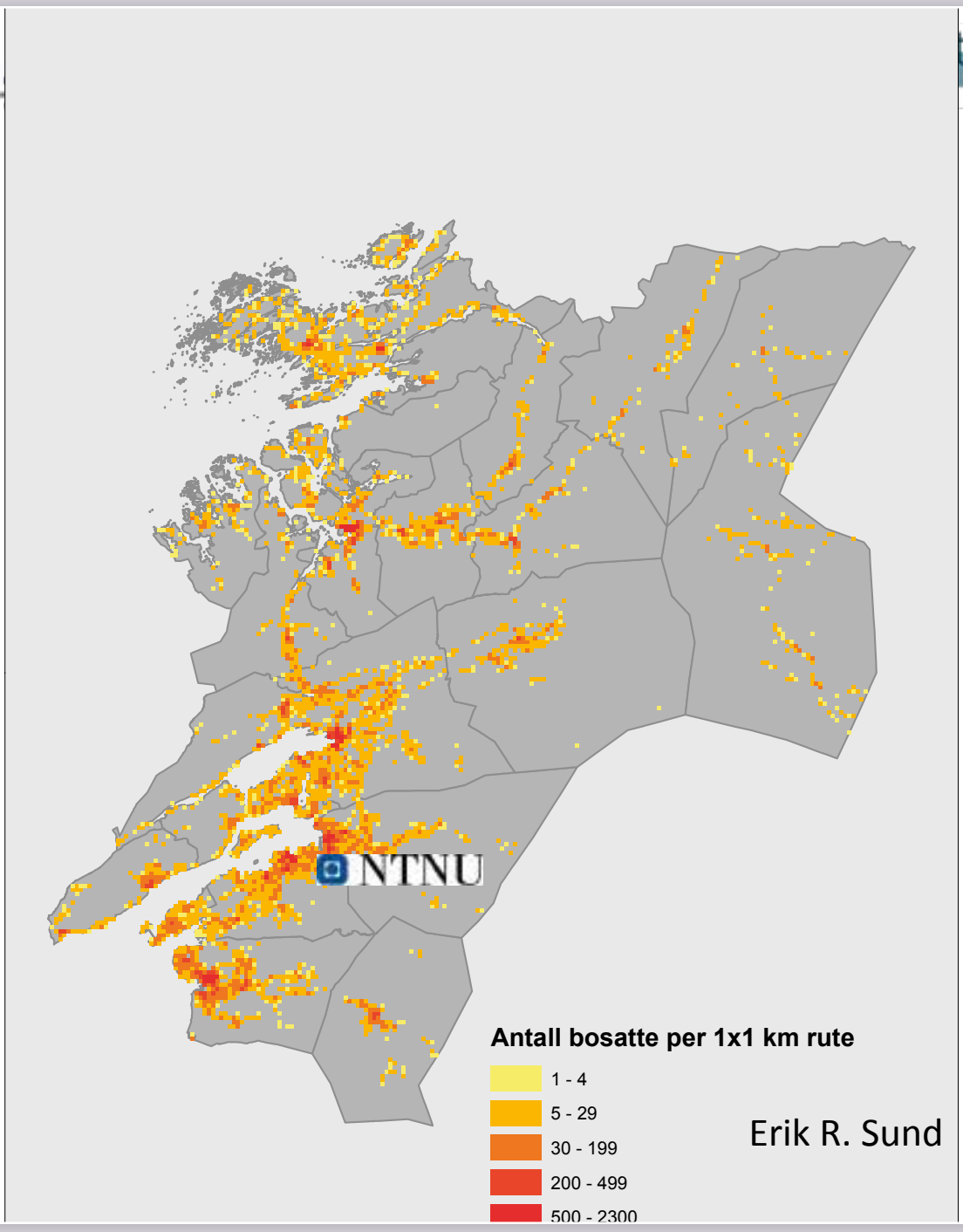
The HUNT Study

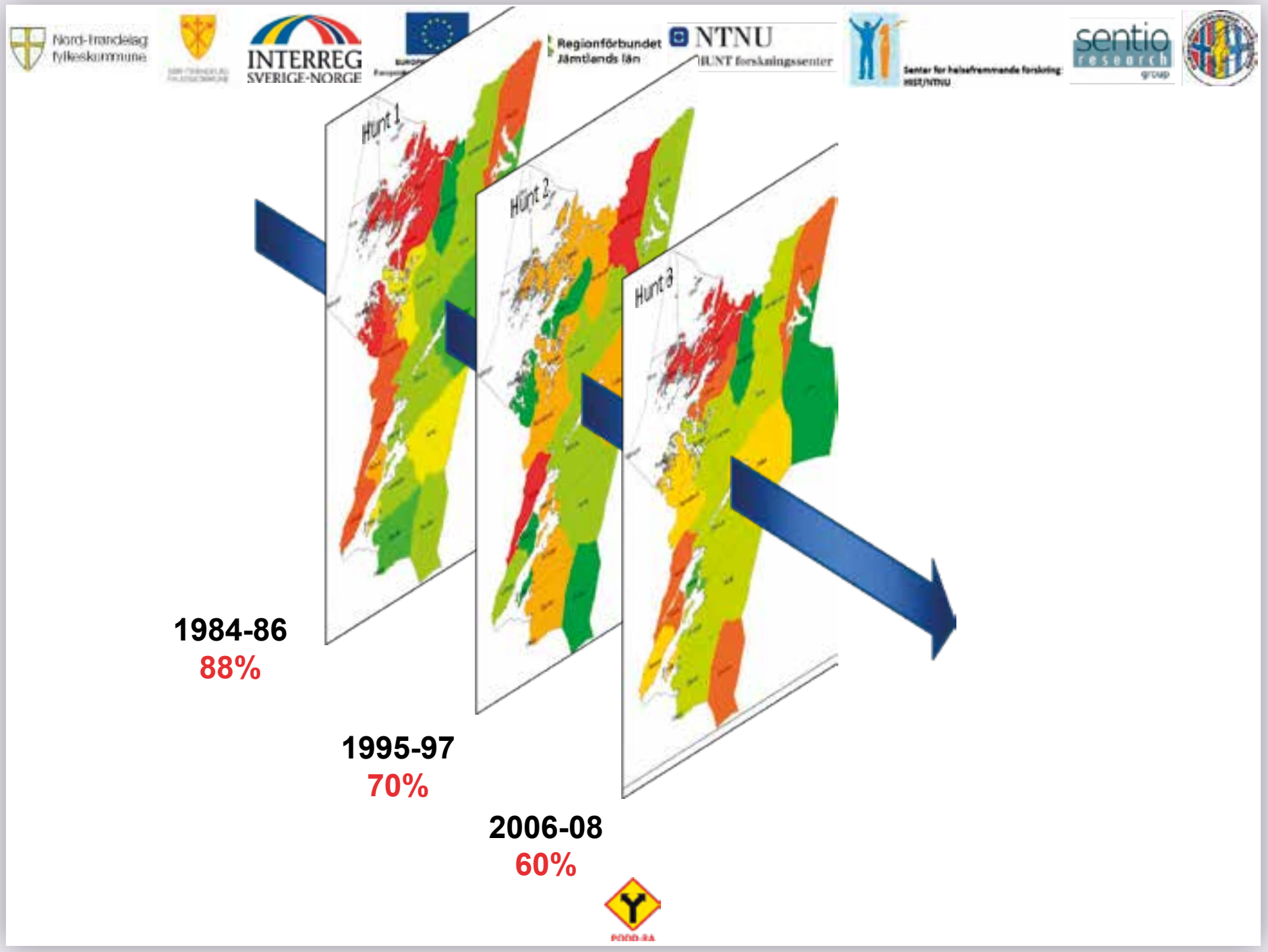

Nord-Trøndelag County
~ 135,000 citizens
Finnmark
Troms
Nordland
Nord-Trøndelag
Sør-Trøndelag
Oppland
Hedmark
Buskerud
Telemark
Østfold
Leka
Vikna
Nærøy
Nams-skogan
Røyrvik
Flatanger
Fosnes
Høy-landet
Namsos
Grong
Over-hallа
Namdals-eid
Lierne
Snåsa
Verran
Steinkjer
Inderøy
Mosvik
Verdal
Leksvik
Levanger
Frosta
Stjørdal
Meråker

Nord-Trøndelag fylkeskommune

INTERREG SVERIGE-NORGE

Where people live




Nord-Trøndelag fylkeskommune
INTERREG SVERIGE-NORGE
Regionförbundet Jämtlands län
NTNU
sentio research group
Hunt 1
Hunt 2
Hunt 3
1984-86
88%
1995-97
70%
2006-08
60%

Nord-Trøndelag fylkeskommune

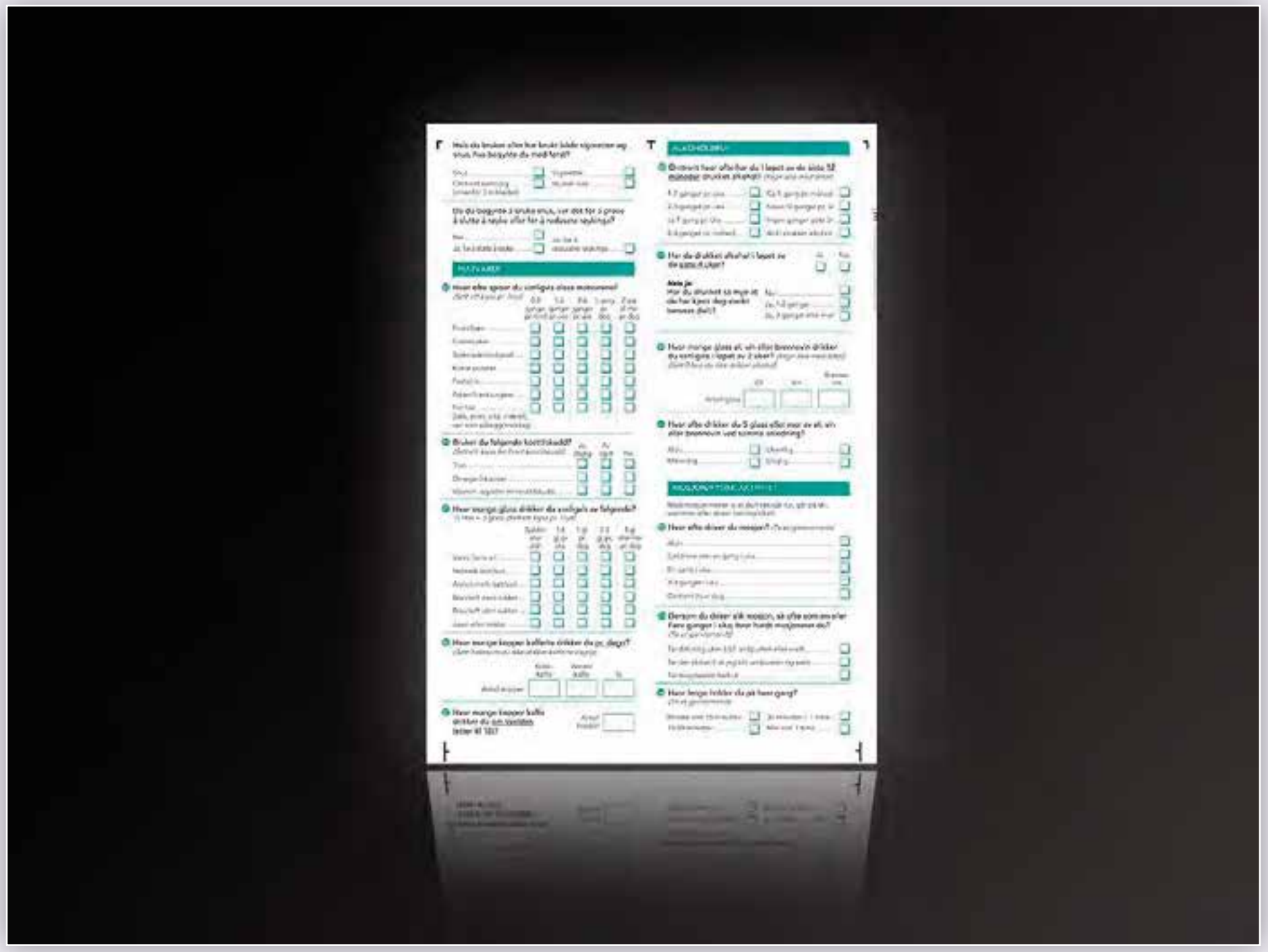
INTERREG SVERIGE-NORGE

EUROPEISKA UNIONEN

Region Jämtland

Health data from 120,000 individuals


Measuring health




hunt 3
hunt 3
23 municipalities

NTNU
HUNT forskningssenter

Senter for helsefremmende forskning
HIST/NTNU

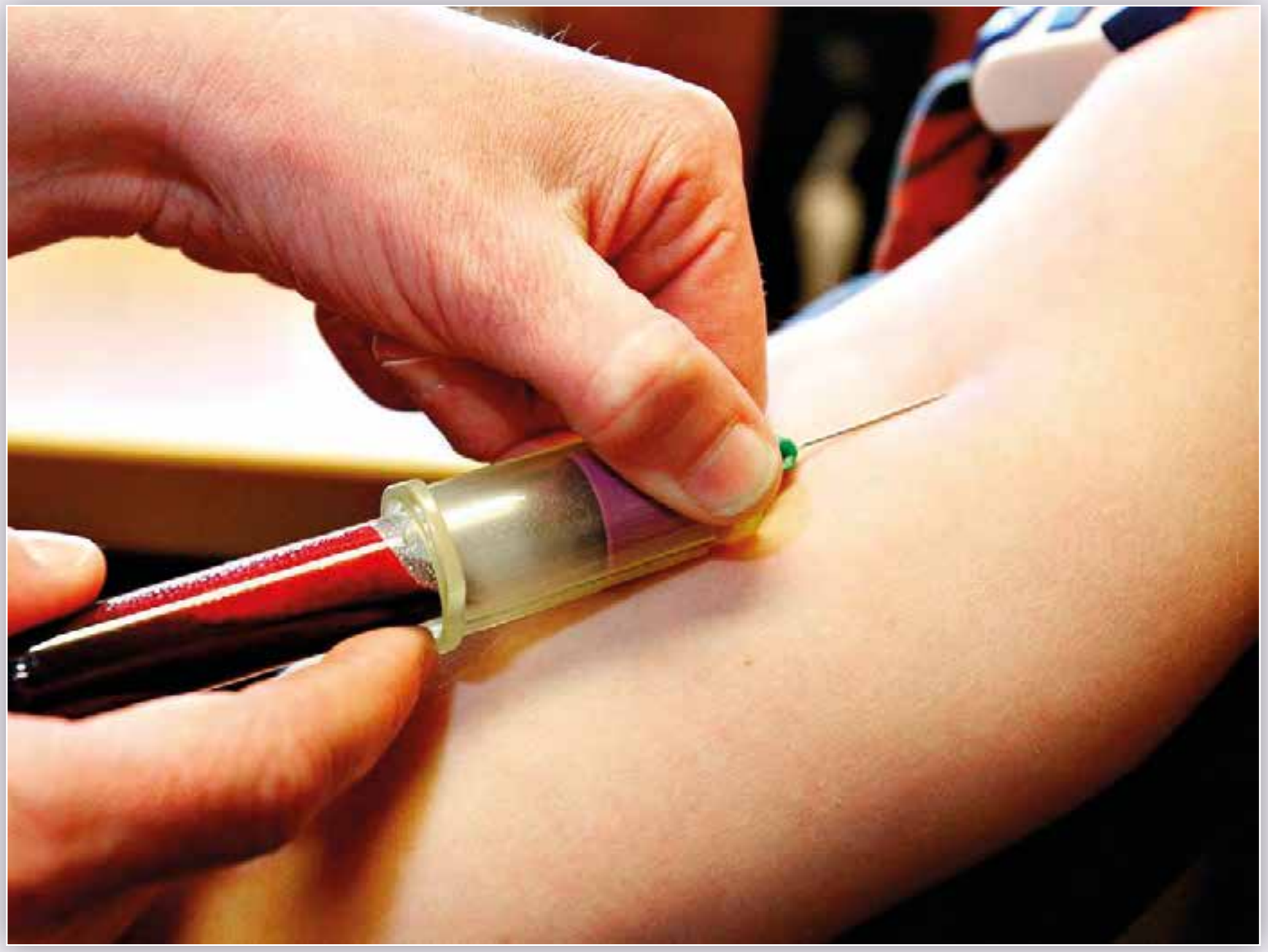
sentio research group

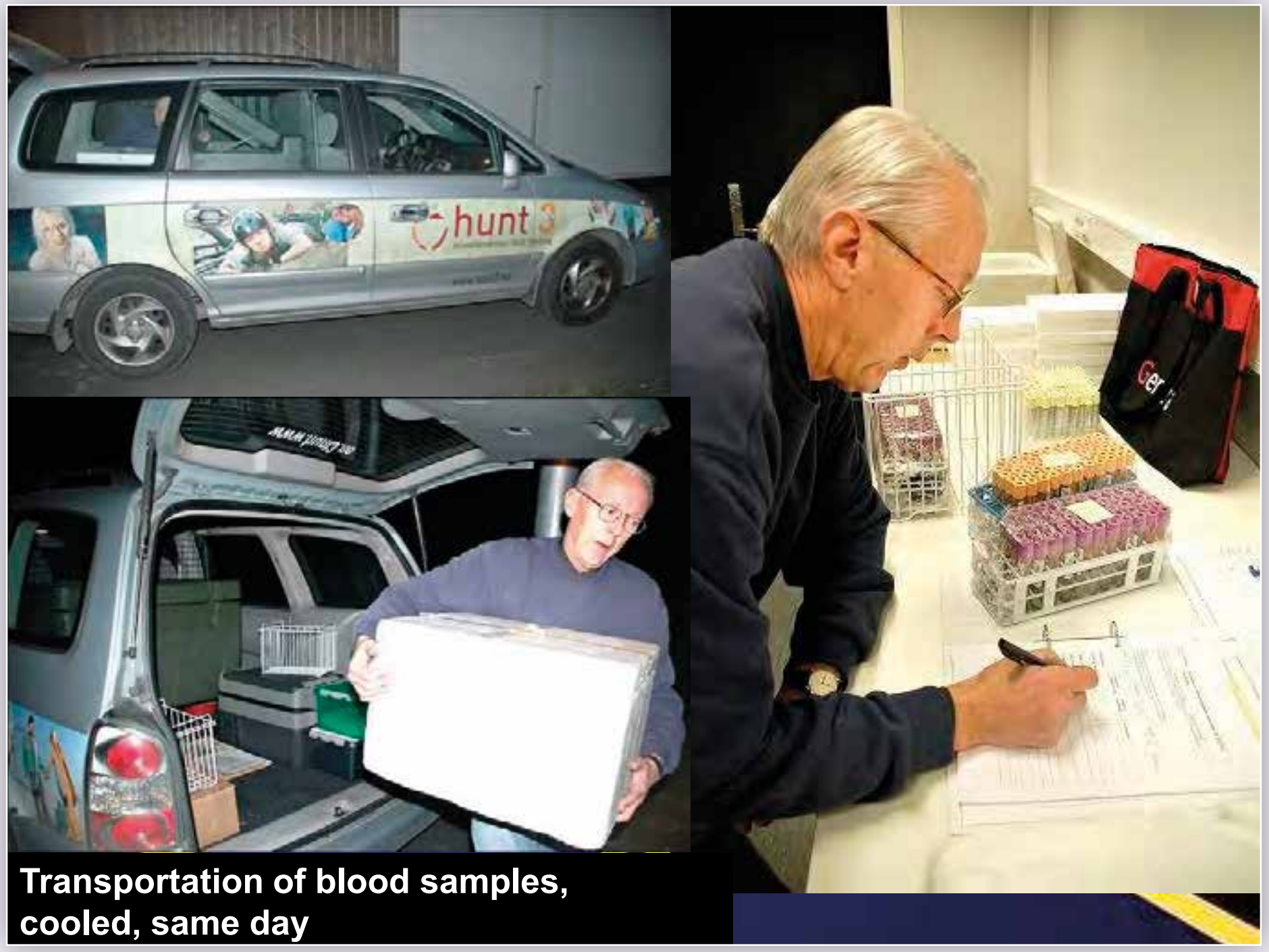
Height, weight

Blood pressure

Lung function


Bone scan
LUNAR
ADVANCE

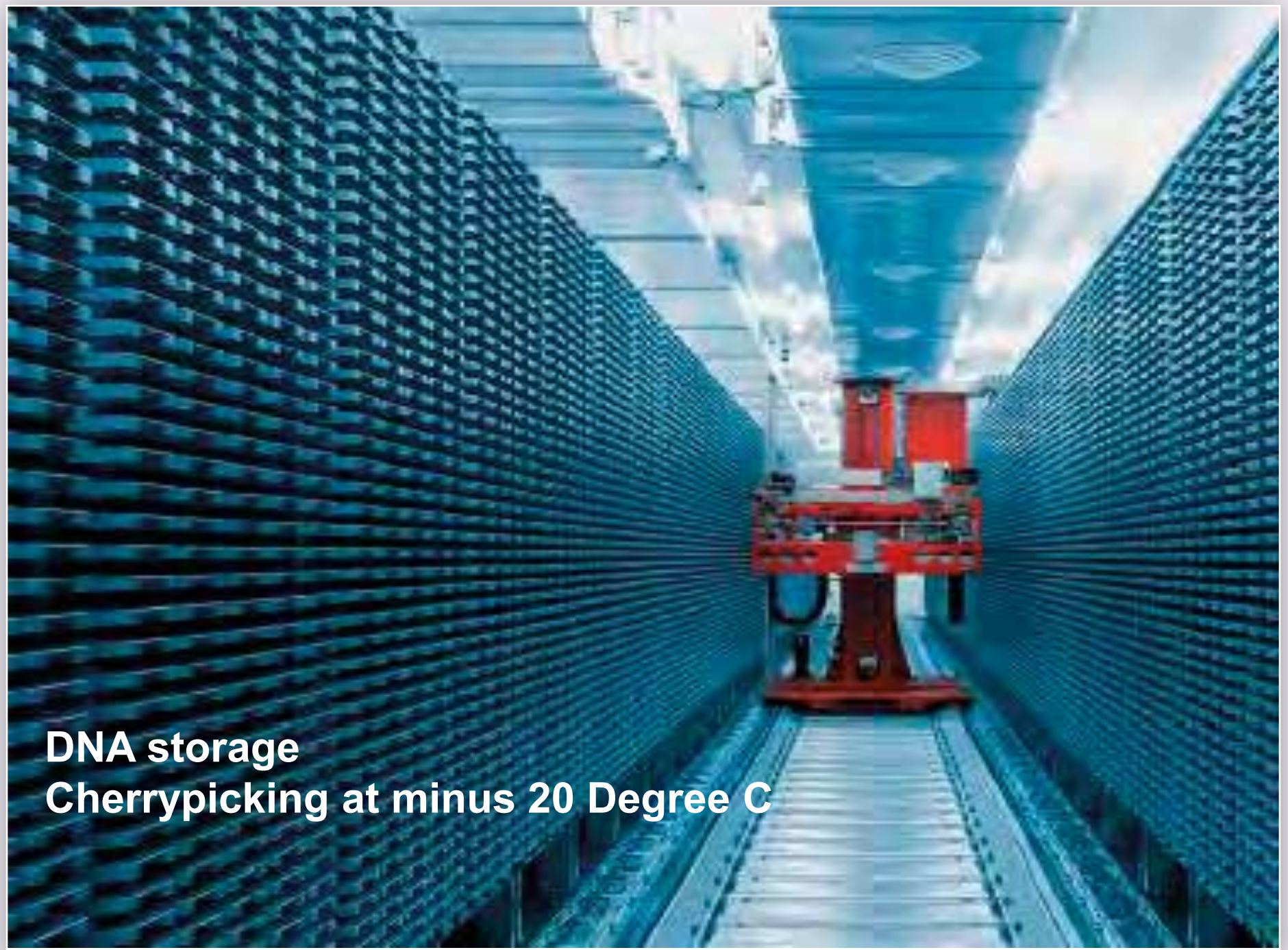



hunt
Transportation of blood samples,
cooled, same day

HUNT Research Centre,

Nord-Trøndelag

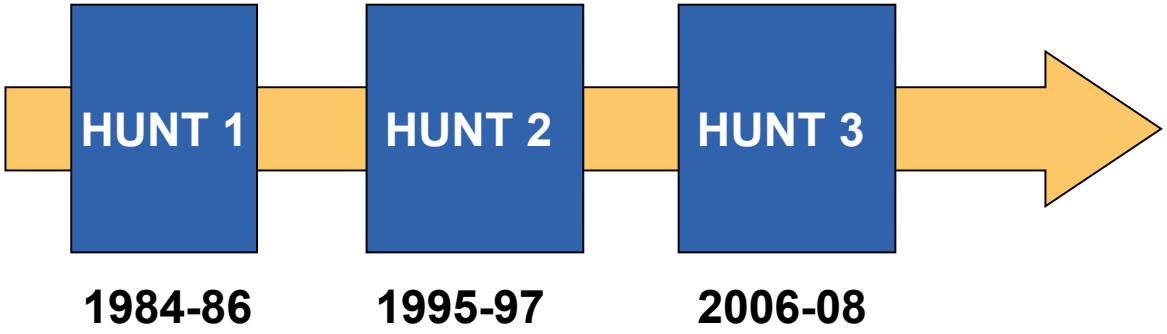

HUNT 3:
30 small tubes per person


DNA storage
Cherrypicking at minus 20 Degree C

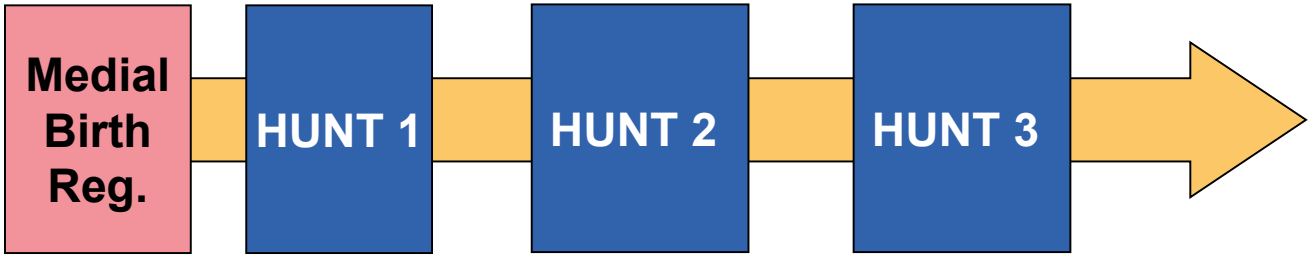
Cryo tubes at - 196°C


STATEBOURNE
biosystem 80

DNA-extraction
Genotyping



Key:
The 11-digit personal identification number



Key:

The 11-digit personal identification number

REGISTRIES

- Cause of death
- Cancer
- Family register
- Drug prescriptions
- Stroke
- Myocardial infarction
- Venous trombosis
- Dementia
- Multiple sclerosis
- Bipolar
- Scizofrenia

Nord-Trøndelag fylkeskommune

INTERREG SVERIGE-NORGE

Regionförbundet Jämtlands län

NTNU IRUNT forskningssenter

Scientific papers:

~ 60-70 each year

Totally ~ 700

130 PhD degrees

Nord-Trøndelag fylkeskommune

INTERREG SVERIGE-NORGE

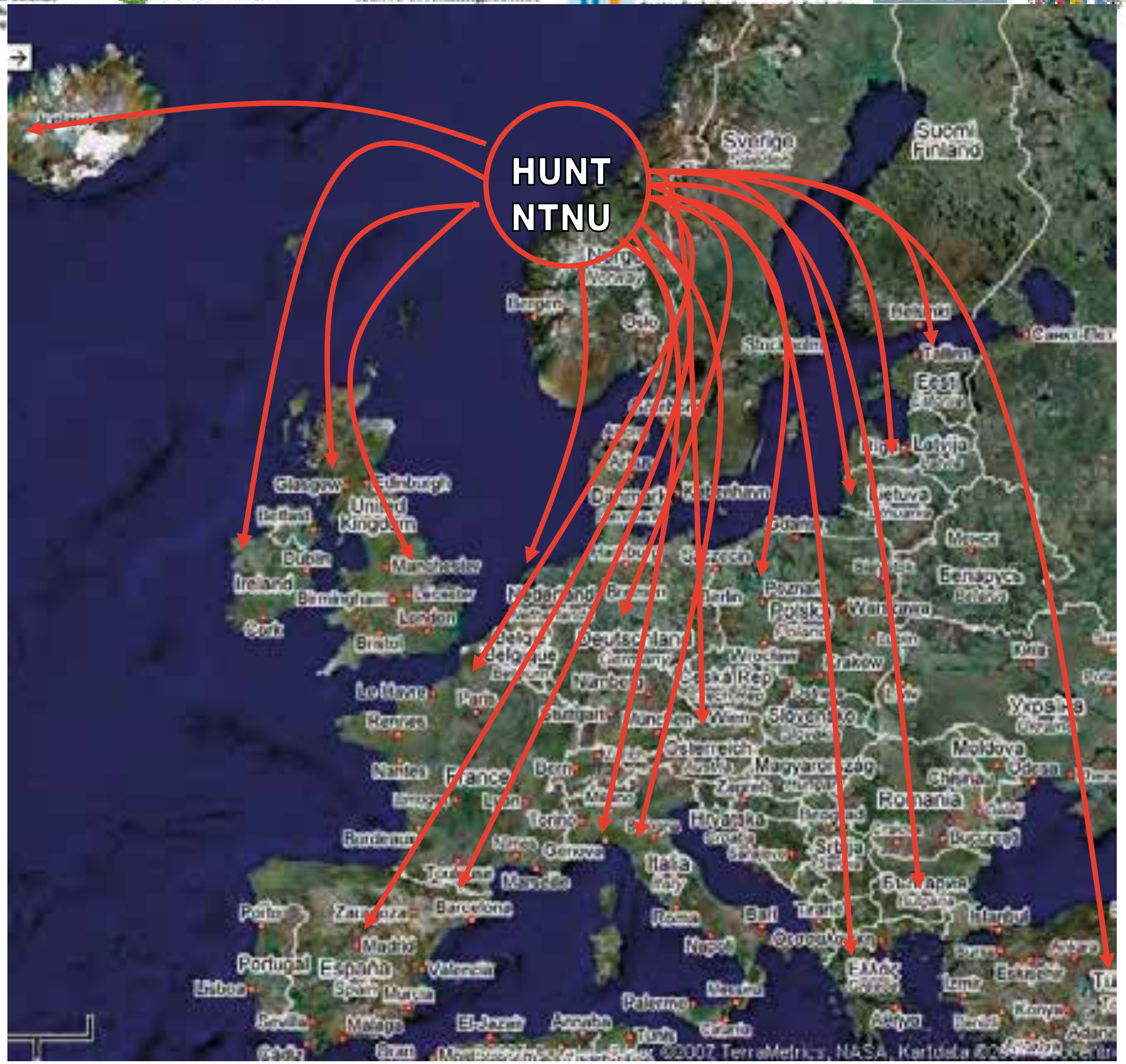
Regionförbundet Jämtlands län

NTNU

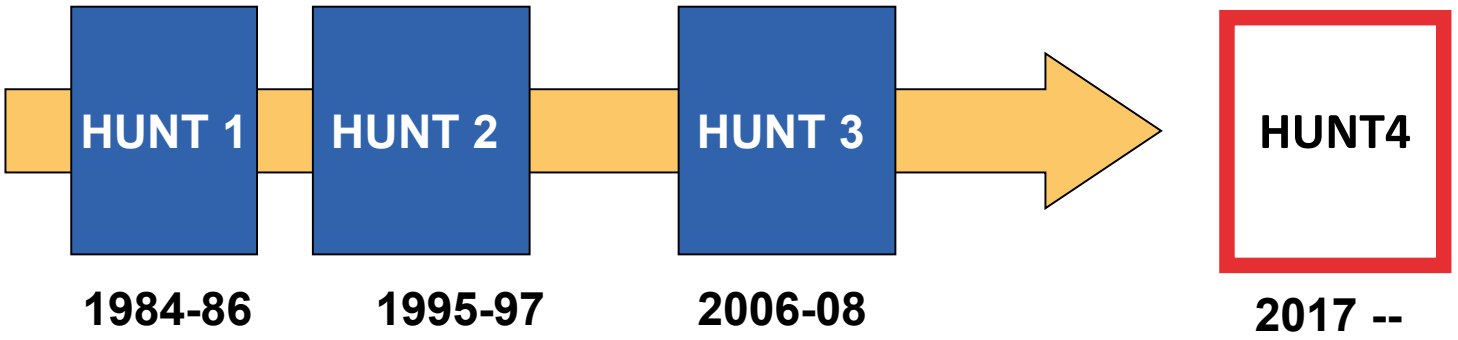
HUNT forskningssenter

sentio research

European collaboration



FOOD-RA


HUNT 1
HUNT 2
HUNT 3
HUNT4
1984-86
1995-97
2006-08
2017 --

Political support

The Norwegian government

The County Council

The 23 municipalities

TRUST

Viking spirit

Nord-Trøndelag fylkeskommune

INTERREG SVERIGE-NORGE

Regionförbundet Jämtlands län

NTNU HUNT forskningssenter

Senter for helsefremmende forskning HUNT/NTNU

sentio research group

The aim:

Longer -
and better life

http://www.ntnu.no/hunt

The Nord-Trøndelag Health Study (HUNT)

HUNT is one of the largest and most comprehensive population-based health surveys ever performed. HUNT is a unique databank of personal and family medical histories, clinical measurements, exposure variables and biological material collected in three consecutive studies from 1984–2008. In total, more than 100,000 persons from the County of Nord-Trøndelag in Norway have participated.

HUNT collaborates with national and international research groups on some of the most important health challenges facing our world today, such as diabetes, cancer, musculoskeletal disease, mental illness, migraine, prostate problems, urinary incontinence, reproduction, weight and cardiovascular disease.

Built on trust

The fundamental strategy of HUNT is to earn and maintain the confidence of the population we work in and with. This strategy has been successful and has resulted in extraordinarily high participation rates. There is enthusiastic public and political support for HUNT and for the HUNT Research Centre. This has created a good basis for further health surveys in the County and an excellent research environment.

Extensive data

The HUNT studies have compiled extensive medical, lifestyle and environmental data associated with each biological sample, comprising in total about 800 exposure variables and nearly 3000 different variables per individual. These datasets allow for prospective correlations to be made between genetic, epigenetic, lifestyle, environmental and health/disease profiles. Through an individual personal identifier (PIN) linkage to registries at the national level can be established to access additional information. Participants have provided very detailed information through the HUNT surveys. This has been validated in several studies based on HUNT data and has greatly contributed to the overall value of the HUNT Biobank for research projects.

The Nord-Trøndelag Health Study, HUNT

Contact information

HUNT Research Centre is part of the Faculty of Medicine at the Norwegian University of Science and Technology (NTNU), Trondheim, Norway. HUNT Research Centre is located in Verdal in the County of Nord-Trøndelag.

Read more: **www.hunt.ntnu.no**

Tel: +47 74 07 51 80
Fax: +47 74 07 51 81
E-mail: hunt@medisin.ntnu.no

Director HUNT study:
Ass. Professor Steinar Krokstad
E-mail: Steinar.Krokstad@ntnu.no

Director HUNT biobank:
Professor Kristian Hveem
E-mail: Kristian.Hveem@ntnu.no

Selected publications

Close to 500 publications and 40 PhD's, based on HUNT data, are an important part of our scientific output.

Dale AC, Vatten LJ, Nilsen TI, Midthjell K, Wiseth R. Secular decline in mortality from coronary heart disease in adults with diabetes mellitus: cohort study. BMJ. 2008 Jul 1;337:a236.

Rayjean J. Hung, James D. McKay, Valerie Gaborieau, et al. A genome-wide association study identifies a susceptibility locus for lung cancer encompassing nicotine acetylcholine receptor subunit genes at 15q25. Nature. 2008 Apr 3;452(7187):633-7

Eleftheria Zeggini, Laura J Scott, Richa Saxena, Benjamin F Voight, Jonathan L Marchini Tianle Hu, Paul IW de Bakker et al . Metanalysis of genome-wide association data and large-scale replication identifies additional new susceptibility loci for type 2 diabetes. Nature Genetics 40, 638 - 645 (2008). Published online: 30 March 2008

Johansson S, Raeder H, Eide S, Midthjell K, Hveem K, Sovik O, Molven A, Njølstad P. Studies in 3,523 Norwegians (HUNT2) and Meta-Analysis in 11,571 Subjects Indicate that Variants in the HNF4A P2 Region are Associated with Type 2 Diabetes in Scandinavians. Diabetes. 2007 Dec;56(12):3112-7.

Hallan S, Astor B, Romundstad S, Aasarød K, Kvenild K, Coresh J. Association of kidney function and albuminuria with cardiovascular mortality in older vs younger individuals: The HUNT II Study. Arch Intern Med. 2007 Dec 10;167(22):2490-6.

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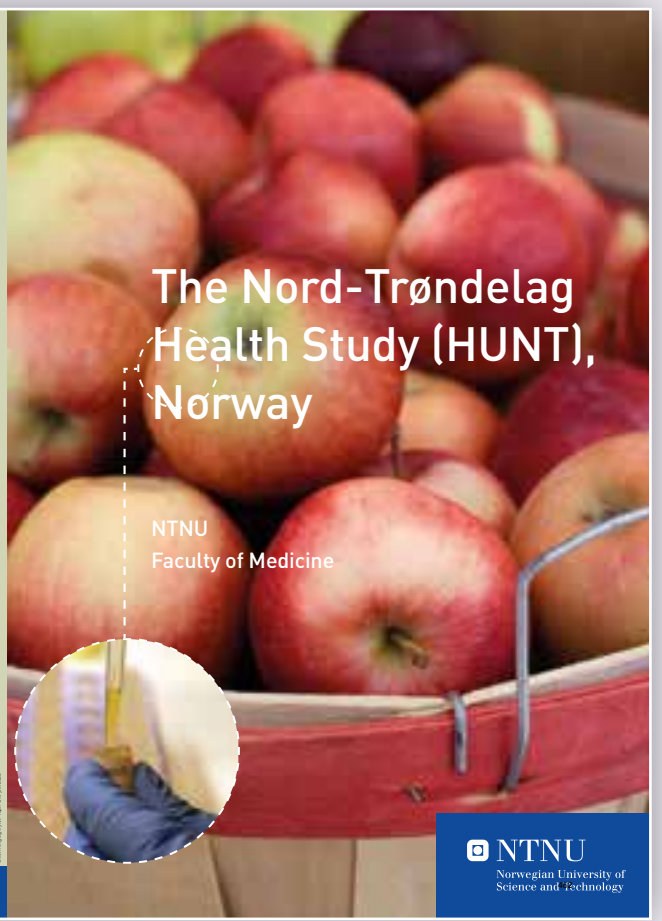
HUNT Biobank in Levanger

www.hunt.ntnu.no



The Nord-Trøndelag Health Study (HUNT), Norway

NTNU
Faculty of Medicine

NTNU
Norwegian University of Science and Technology

HUNT 1-2-3

In 1984, a population-based health study was launched in the central Norwegian region of Nord-Trøndelag. The study was intended to stimulate epidemiological research and to provide a new basis for clinical and preventive medicine projects. The study was named the HUNT Study.

The County of Nord-Trøndelag has a scattered rural population of about 130,000, which can be characterized as stable and homogeneous. Urban centres are small, with fewer than 25,000 inhabitants, and the population is served by two well-established local hospitals. To date, three surveys have been completed.

The **HUNT1** study (1984–1986) recruited 75,000 participants above 20 years of age, with no upper age limit. The participation rate was 88 %, a remarkable result in national and international terms. The survey was based on questionnaires and clinical examination, a capillary glucose test was taken, but no biological samples were stored.

The **HUNT2** study (1995–1997) comprised 74,000 participants, once again achieving a very high participation rate of 72 %. The age group between 13 and 19 was included in a sub-study called *YoungHUNT*. In addition to questionnaires and clinical examination, 65,000 blood samples (serum, whole blood) were collected from all participants aged 20 or older, resulting in the current collection of purified DNA material.

The **HUNT3** study (2006–2008) was completed in June 2008 with a attendance rate of close to 60 %, comprising about 60,000 participants, including the YoungHUNT sub-study. The study introduced a strict protocol for collection, sample handling and storing of blood samples, thus ensuring biological samples of optimal quality.

Covering more than 20 years
HUNT offers unique opportunities for longitudinal studies, given that 46,000 individuals participated in both HUNT1 and HUNT2, covering a period of 10 years. Of these, 27,000 have also participated in HUNT3, allowing for 20 years of longitudinal follow-up. In HUNT 3, 37,000 of the participants in HUNT2 were re-examined.

The combination of health data and biological material with a very large number of other exposure variables, is ideal for studies of interactions between genetic variation, lifestyle and environmental factors. The value of HUNT lies also in the possibility of linking to well-classified phenotypic information sources, such as local and national disease registries.

The homogeneous and stable population of Nord-Trøndelag in Norway is a unique source of health information and biological material

YoungHUNT: In 1995, YoungHUNT was established covering the age group from 13 to 19 with a attendance rate of 90 % of the invited.

HUNT Biobank and the National CONOR Biobank

HUNT Biobank is one of the most modern and extensive international biobanks, storing whole blood and DNA from 200,000 individuals, serum and plasma samples from more than 100,000 individuals as well as urine, RNA tubes, cells, buffy coat and Na-heparin tubes for environmental analysis for as many as 50,000 individuals.

All bio-specimens from the HUNT surveys are collected, processed and stored at the HUNT Biobank in Levanger, which was officially opened in March 2007. The Biobank is a new laboratory and storage facility (2000 m²) specially designed for the purpose and equipped with state-of-the-art infrastructure, including a fully automated DNA storage facility, in which all samples are stored at the appropriate temperature.

The National CONOR Biobank is located on the same site, where it serves as a central research repository for DNA samples from all the largest Norwegian health surveys. These make up "the Cohorts of Norway" (CONOR), which include samples from more than 200,000 individuals.

International collaboration and ongoing studies
The HUNT databank provides data on a large number of diseases observed in the general population. The data have been utilized in more than 250 ongoing or completed research projects, with particular emphasis on major disease areas such as diabetes type 2, cardiovascular, kidney and pulmonary disease, and bone density - as well as in studies on urine incontinence, haemochromatosis, reflux disease/dyspepsia, thyroid disease, headache and skeletomuscular complaints, anxiety and depression.

HUNT is an integral part of several EU projects in the Sixth and the Seventh Framework Programme and its role in EU-funded health research is expected to be further extended in years to come. HUNT also participates in major collaborative transatlantic projects funded by the National Institutes of Health (NIH) and the National Cancer Institute (NCI).

HUNT has cooperated actively with the UK Biobank, on the basis of a bilateral national agreement signed in 2005, including the development of integrated solutions for data management and automated sample handling.

In 2007, NTNU and the International Agency for Research on Cancer (IARC/WHO) signed a memorandum of understanding promoting cancer research, based on HUNT studies.

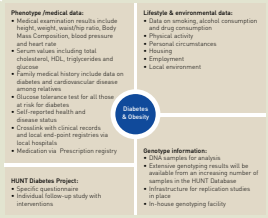
HUNT Biobank is also collaborating with partners in India to establish population-based health cohorts and biobanks.

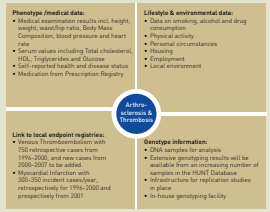
HUNT Biosciences Ltd

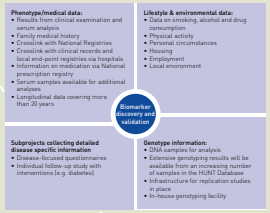
HUNT Biosciences Ltd is the commercial arm of the HUNT Biobank and CONOR. HUNT Biosciences was established in 2007 in order to offer a professional interface with industry and facilitate commercial use of HUNT data, without compromising the trust of the donor population. HUNT Biosciences is publicly owned, and any profits made by the company will be returned to the community as a financial basis for further research.

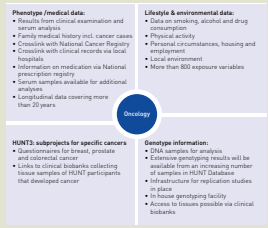
Contact information: Neptunveien 1, N-7650 Verdal, Norway. Tel: + 47 74 07 51 80 Fax: +47 74 07 51 81 www.hunt.ntnu.no

HUNT phenotype, genotype and environmental data support R&D for major disease areas such as:









Tampere, Finland, 16-17 March 2015

Monday 16 March

1700-1915 WG meeting, including expert presentations by **Ms Auli Pölönen**, Coordination Manager, M.Sc., Clinical Nutritionist, Pirkanmaa Hospital District, Prevention of Diabetes and Cardiovascular Diseases, and **Ms Maarit Varjonen-Toivonen**, Chief Physician, Centre of General Practice, Pirkanmaa Hospital District

Tuesday 17 March

0900-0930 Brief introduction and words of welcome by **Mr Rauno Ihalainen**, Director of Pirkanmaa Hospital District

0930-1030 Visit to the Vaccine Research Center accompanied by **Ms Vesna Blažević**, Head of Laboratory and **Mr Heikki Hyöty**, Professor

The BSPC Working Group on Innovation in Social and Health Care (BSPC WG ISHC) held its **fifth meeting** in Tampere on 16-17 March 2015. The meeting itself was preceded by a study tour of the Vaccine Research Centre and the Tampere University Central Hospital. The Working Group was briefed by **Auli Pölönen**, Clinical Nutritionist at Pirkanmaa Hospital District, on the Prevention of Diabetes and Cardiovascular Diseases. The second briefing was given by **Maarit Varjonen-Toivonen**, Chief Physician at the Centre of General Practice in Pirkanmaa Hospital District, on electronic reporting linked to Operations Planning & Budgeting on the Communal Level. At Tampere University Hospital the WG members received a briefing on the hospital and were then informed about diabetes research and vaccine development against type 1 diabetes by **Vesna Blažević**, Head of Laboratory, and **Heikki Hyöty**, Professor at Tampere University Hospital.

Electronic reporting linked to Operations Planning & Budgeting on the Communal Level

Ms Maarit Varjonen-Toivonen
Chief Physician, Primary Health Care

Pirkanmaa
Hospital District

Introduction

- About organization
- Background to the development of electric welfare report
- Presentation of the electric welfare report
- Linkage to Planning and Budgeting on the Communal level

Tampere University Hospital`s special responsibility area

- 4 hospital districts
- 31 health centres

Tampere University Hospital's special responsibility area

- Pirkanmaa Hospital District (PSHP)
- Southern Ostrobothnia Hospital District (EPSHP)
- Häme Proper Hospital District (KHSHP)
- Joint Municipal Authority for Social and Healthcare Services in Päijät-Häme (PHSOTEY)

Helsinki University Hospital's special responsibility area

Kuopio University Hospital's special responsibility area

Oulu University Hospital's special responsibility area

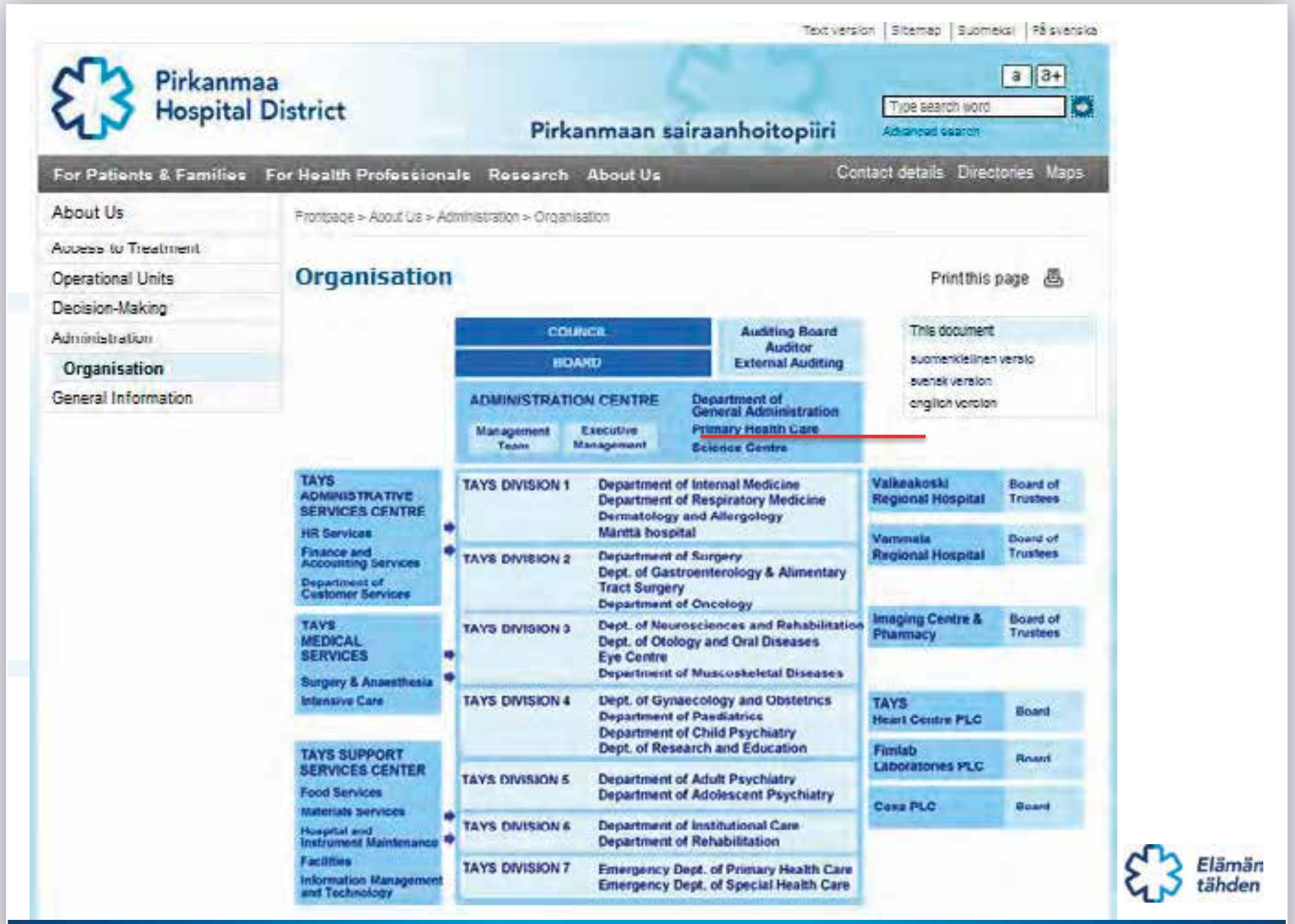
Turku University Hospital's special responsibility area

Elämän tähden

Member municipalities and facilities in 2013

- Tampere University Hospital
  - Tampere Central Hospital
  - Pitkäniemi Hospital, Nokia
  - Ylinen Healthcare and Rehabilitation Centre, Ylöjärvi
  - Mänttä Hospital, Mänttä-Vilppula
  - Lahti Radiotherapy Unit
- Valkeakoski Regional Hospital
  - Kaivanto Hospital, Kangasala
- Vammala Regional Hospital, Sastamala

Elämän tähden


Text version | Sitemap | Suomeksi | På svenska
Pirkanmaa Hospital District
Pirkanmaan sairaanhoitopiiri
a a+
Type search word
Advanced search
For Patients & Families
For Health Professionals
Research
About Us
Contact details
Directories
Maps
About Us
Access to Treatment
Operational Units
Decision-Making
Administration
Organisation
General Information
Frontpage > About Us > Administration > Organisation
Organisation
Print this page
COUNCIL
BOARD
Auditing Board
Auditor
External Auditing
This document
suomenkielinen versio
svensk version
english version
ADMINISTRATION CENTRE
Management Team
Executive Management
Department of General Administration
Primary Health Care
Science Centre
TAYS ADMINISTRATIVE SERVICES CENTRE
HR Services
Finance and Accounting Services
Department of Customer Services
TAYS MEDICAL SERVICES
Surgery & Anaesthesia
Intensive Care
TAYS SUPPORT SERVICES CENTER
Food Services
Materials services
Hospital and Instrument Maintenance
Facilities
Information Management and Technology
TAYS DIVISION 1
Department of Internal Medicine
Department of Respiratory Medicine
Dermatology and Allergology
Mänttä hospital
TAYS DIVISION 2
Department of Surgery
Dept. of Gastroenterology & Alimentary Tract Surgery
Department of Oncology
TAYS DIVISION 3
Dept. of Neurosciences and Rehabilitation
Dept. of Otology and Oral Diseases
Eye Centre
Department of Musculoskeletal Diseases
TAYS DIVISION 4
Dept. of Gynaecology and Obstetrics
Department of Paediatrics
Department of Child Psychiatry
Dept. of Research and Education
TAYS DIVISION 5
Department of Adult Psychiatry
Department of Adolescent Psychiatry
TAYS DIVISION 6
Department of Institutional Care
Department of Rehabilitation
TAYS DIVISION 7
Emergency Dept. of Primary Health Care
Emergency Dept. of Special Health Care
Valkeakoski Regional Hospital
Board of Trustees
Vammala Regional Hospital
Board of Trustees
Imaging Centre & Pharmacy
Board of Trustees
TAYS Heart Centre PLC
Board
Finlab Laboratories PLC
Board
Casa PLC
Board
Elämän tähden

Primary Health Care

- Chief Physician, Head of Centre Ms Doris Holmberg-Marttila
- Chief Physician (30 %), Professor of General Practice Ms Elise Kosunen
- Chief Physician, coordination of Health Promotion Ms Maarit Varjonen-Toivonen
- Expert Physician Mr Mika Palvanen
- Expert nurse Ms Leena Kuusisto
- Expert nurse Ms Riitta Salunen
- Secretary Ms Teija Kvist-Sulin

Elämän tähden

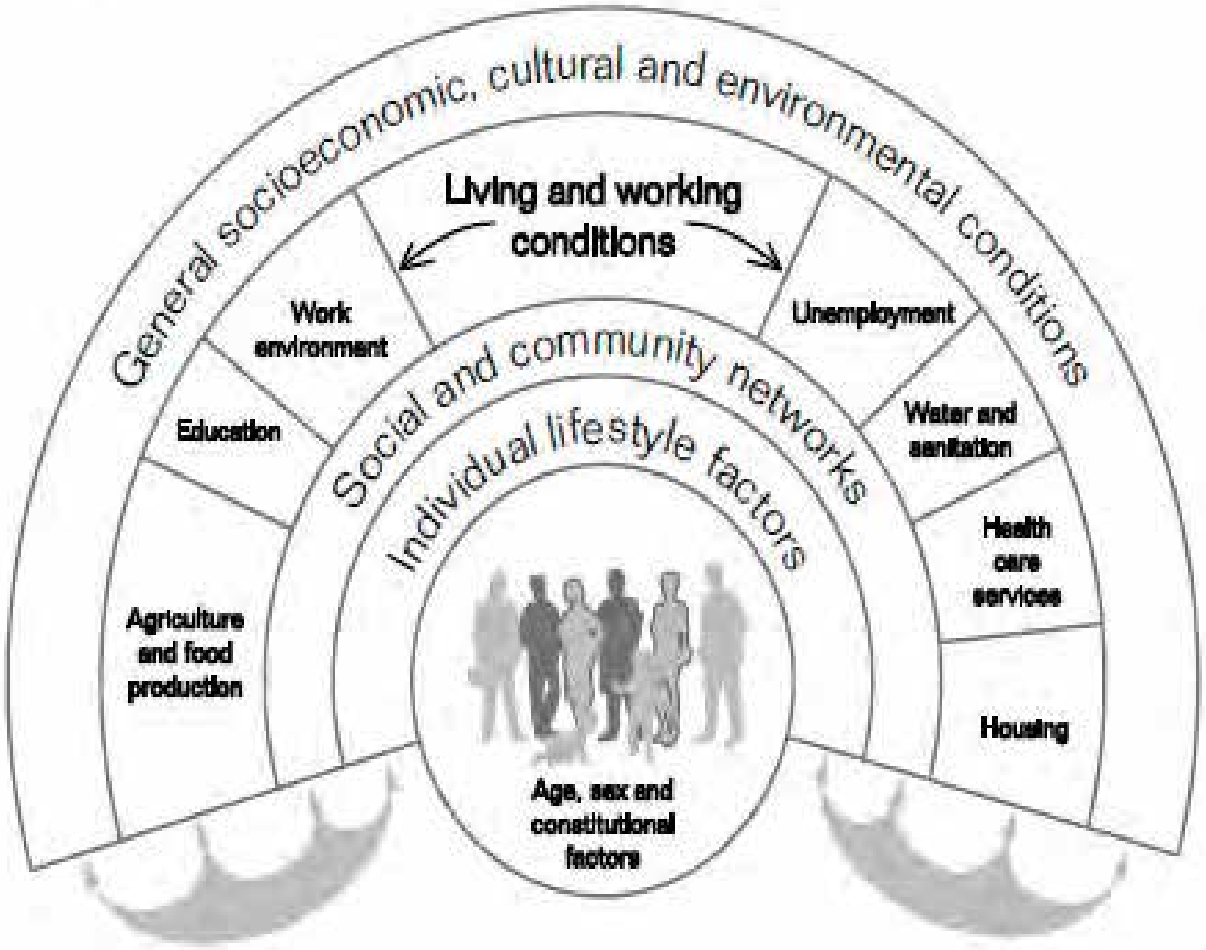
The Ottawa Charter for Health Promotion, 1986

Definition of ”Health Promotion”

- Health promotion policy and management
- Living environments
- Cooperation and participation
- Competencies
- Services
- Monitoring and assessment of health promotion

Elämän tähden

Fig. 3. The main determinants of health



Source: Dahlgren & Whitehead (4).

Elämän tähden

Health in all Policies, 2006

- During the first Finnish presidency of the EU in 1999, a council resolution was adopted to ensure health protection in all policies and activities of the EU
- HiAP was launched more specifically in the EU during the second Finnish EU Presidency in 2006
- HiAP was made one of the key principles in EU health strategy

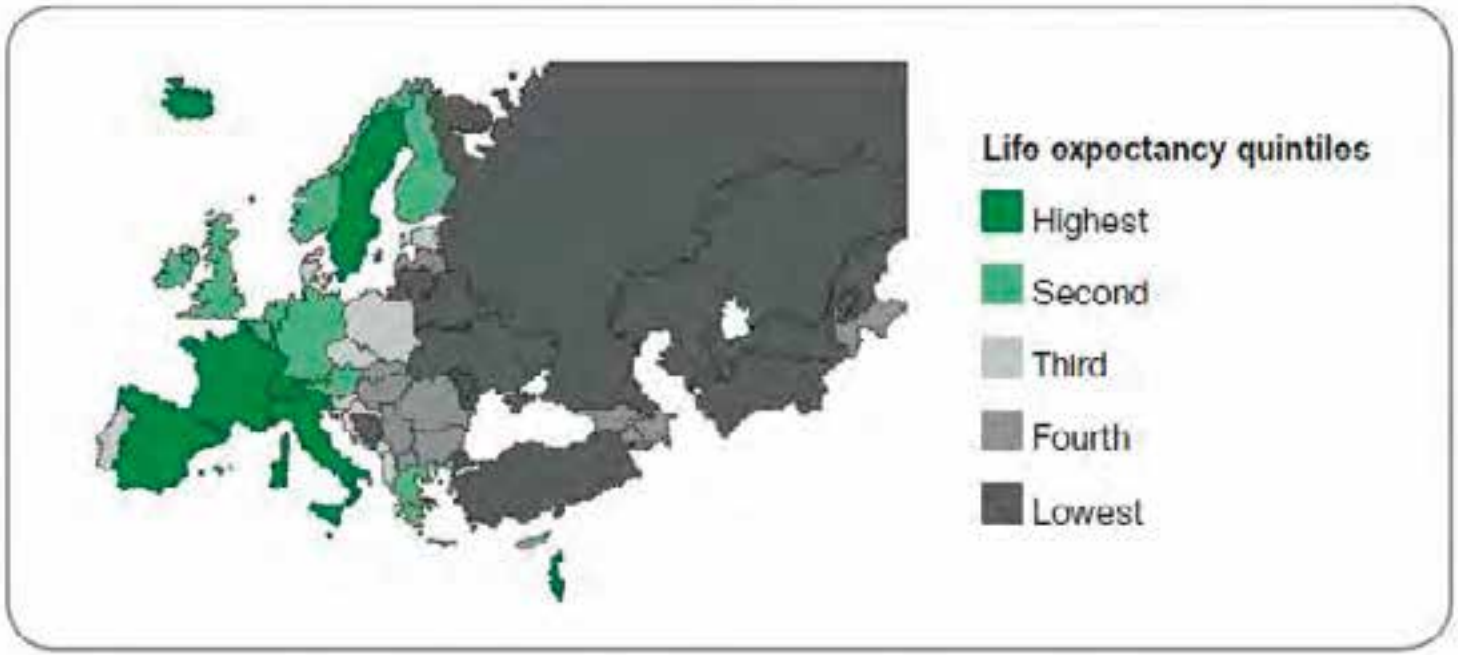
- Finland
  - The Finnish Government programme 2007 ->
  - The Health Care Act 2010: requires municipalities to prepare and discuss reports on their population groups' well-being and health and their major determinants within discussions of municipalities' strategic plans.

Elämän tähden

Health inequities in Europe

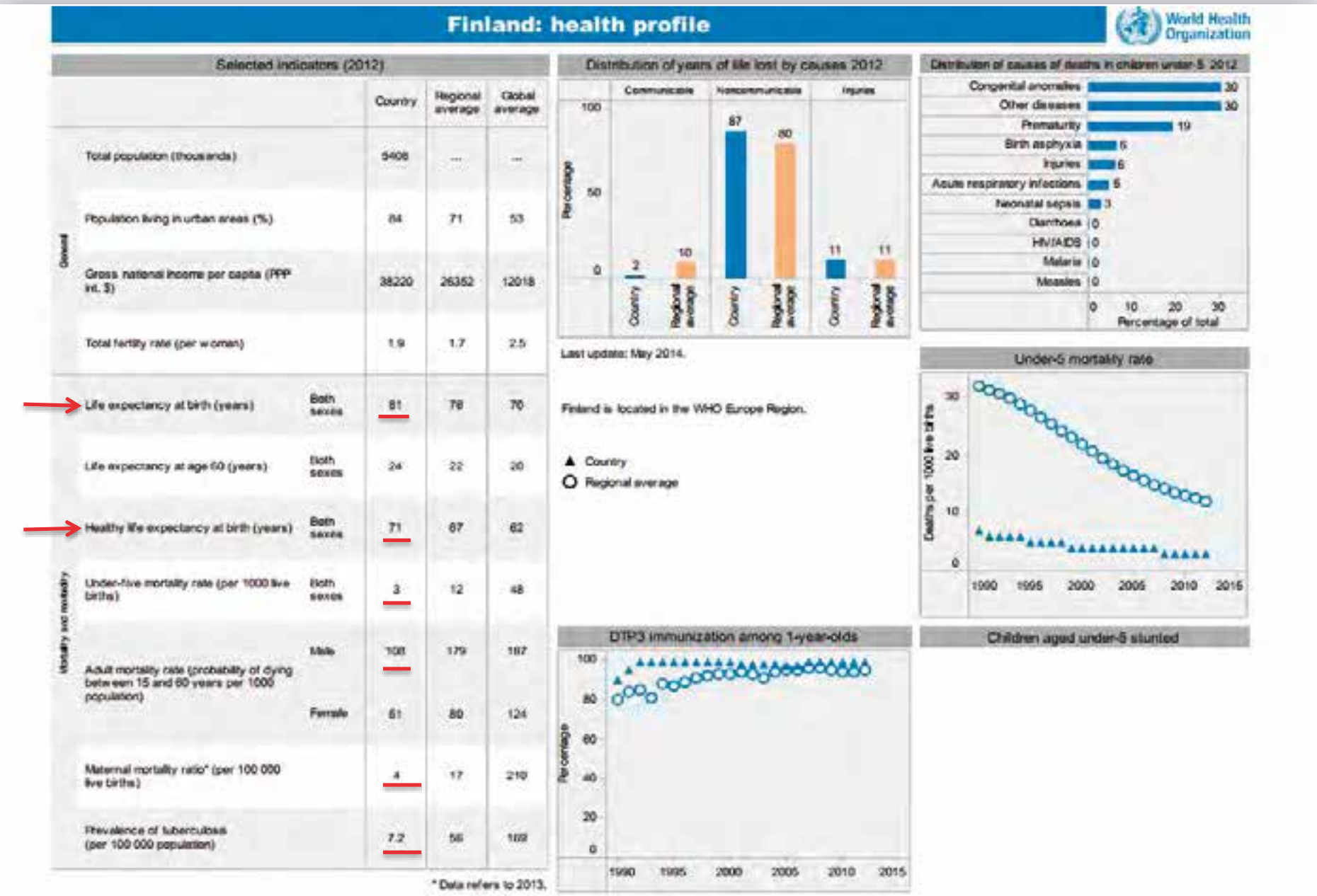
Fig. 1 shows the extent to which health varies between the countries in the WHO European Region; that is, the so-called health divide. The gap in life expectancy between the highest and the lowest countries is 17 years for men and 12 years for women.

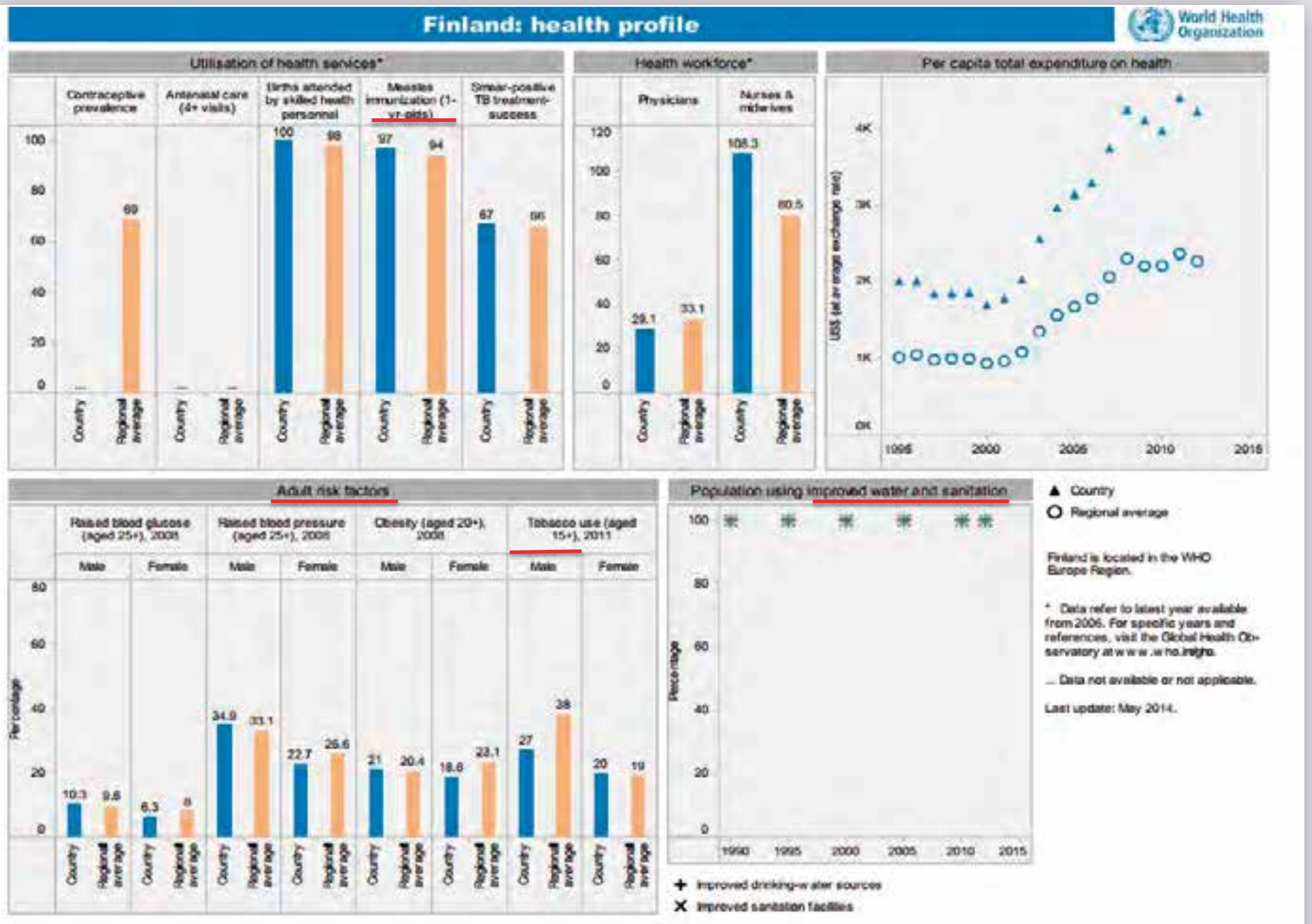
Fig. 1. Life expectancy in countries of the WHO European Region, 2010

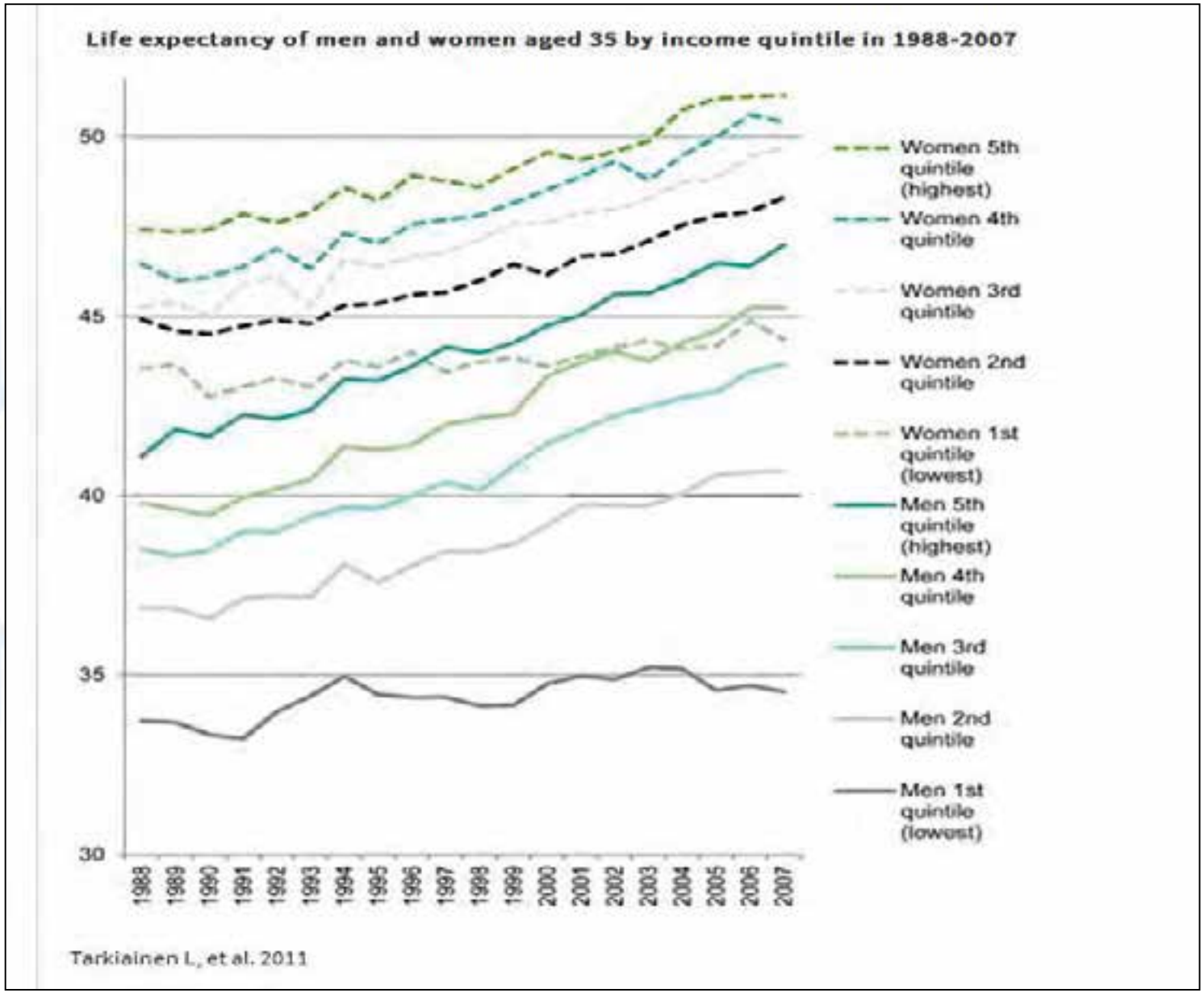


Source: WHO Regional Office for Europe *(3)*.

Elämän tähden

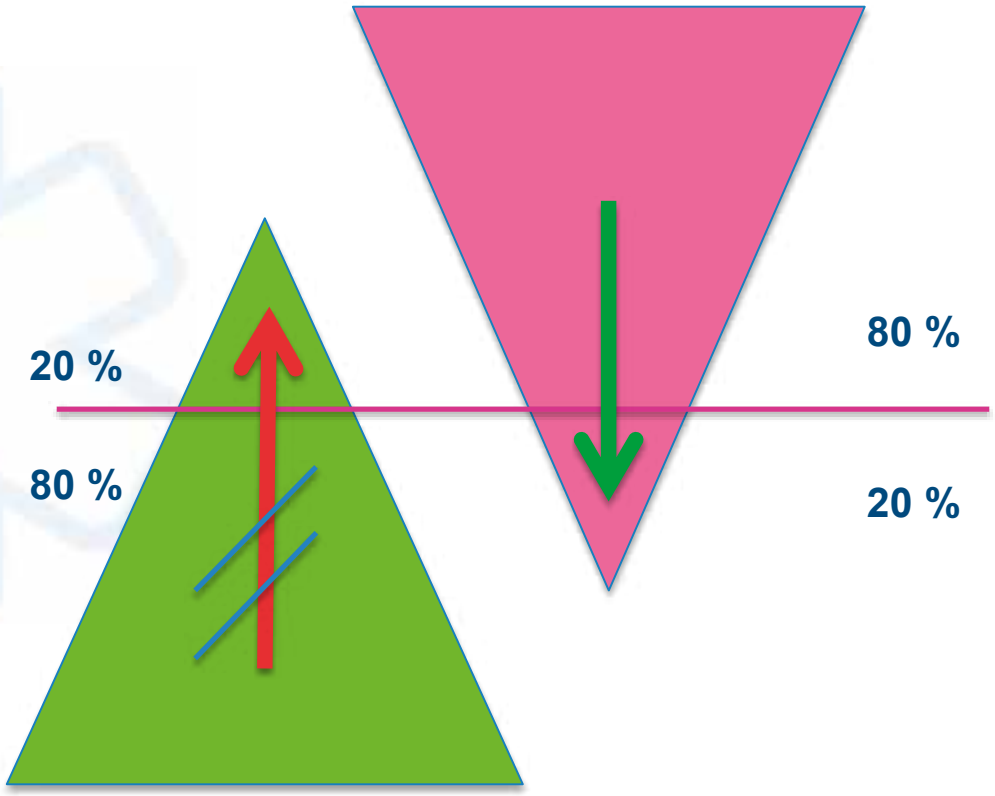

Finland: health profile
World Health Organization
Selected indicators (2012)
Country
Regional average
Global average
General
Total population (thousands)
5408
...
...
Population living in urban areas (%)
84
71
53
Gross national income per capita (PPP int. $)
38220
26352
12018
Total fertility rate (per woman)
1.9
1.7
2.5
Mortality and morbidity
Life expectancy at birth (years)
Both sexes
81
78
70
Life expectancy at age 60 (years)
Both sexes
24
22
20
Healthy life expectancy at birth (years)
Both sexes
71
67
62
Under-five mortality rate (per 1000 live births)
Both sexes
3
12
48
Adult mortality rate (probability of dying between 15 and 60 years per 1000 population)
Male
108
179
187
Female
61
80
124
Maternal mortality ratio* (per 100 000 live births)
4
17
210
Prevalence of tuberculosis (per 100 000 population)
7.2
56
169
* Data refers to 2013.
Distribution of years of life lost by causes 2012
Communicable
Noncommunicable
Injuries
Percentage
Country
Regional average
Last update: May 2014.
Finland is located in the WHO Europe Region.
Country
Regional average
Distribution of causes of deaths in children under-5 2012
Congenital anomalies 30
Other diseases 30
Prematurity 19
Birth asphyxia 6
Injuries 6
Acute respiratory infections 5
Neonatal sepsis 3
Diarrhoea 0
HIV/AIDS 0
Malaria 0
Measles 0
Percentage of total
Under-5 mortality rate
Deaths per 1000 live births
DTP3 immunization among 1-year-olds
Children aged under-5 stunted


Finland: health profile
World Health Organization
Utilisation of health services*
Contraceptive prevalence
Antenatal care (4+ visits)
Births attended by skilled health personnel
Measles immunization (1-yr-olds)
Smear-positive TB treatment-success
Country
Regional average
Health workforce*
Physicians
Nurses & midwives
Per capita total expenditure on health
US$ (at average exchange rate)
Adult risk factors
Raised blood glucose (aged 25+), 2008
Raised blood pressure (aged 25+), 2008
Obesity (aged 20+), 2008
Tobacco use (aged 15+), 2011
Male
Female
Percentage
Population using improved water and sanitation
Country
Regional average
Finland is located in the WHO Europe Region.
* Data refer to latest year available from 2006. For specific years and references, visit the Global Health Observatory at www.who.int/gho.
... Data not available or not applicable.
Last update: May 2014.
Improved drinking-water sources
Improved sanitation facilities


Life expectancy of men and women aged 35 by income quintile in 1988-2007
50
45
40
35
30
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
Women 5th quintile (highest)
Women 4th quintile
Women 3rd quintile
Women 2nd quintile
Women 1st quintile (lowest)
Men 5th quintile (highest)
Men 4th quintile
Men 3rd quintile
Men 2nd quintile
Men 1st quintile (lowest)
Tarkiainen L, et al. 2011

[THL 25.2.2015]

Reducing Health Inequalities



TIME

24 h/ day
= 8 760h/ 365 days

Meeting health care professionals
(example of person with many health problems)
- **physician 20min / week**
- **nurses 40 min/ week**

= 52h/ 365 days

= 0,006 % / 8 760h

The rest of the patient takes care of himself

Elämän tähden

The Health Care Act 1.5.2011 (1326/2010): new issues

Consideration of effects on health and welfare (11 §)

When planning and making decisions, local authorities and joint municipal authorities for hospital districts **shall assess and take into consideration any effects that their decisions may have on the health and social welfare of residents.**

Health and welfare promotion by local authorities (12 §)

* Local authorities **shall monitor the health and welfare** of their residents and any underlying factors per population group
* **Reports on the health and welfare** of residents as well as any measures taken shall be produced for the city or municipal council **once a year**
* A more **comprehensive review on welfare** shall be produced for the city or municipal council **once during each term of office.**
* **In their strategic plans**, local authorities shall identify **objectives for health and welfare promotion** by making use of local welfare and health indicators.
* Local authorities **shall assign coordinators for health and welfare promotion**.
* The **various local authority departments shall work together in health and welfare promotion**.
* Local **authorities shall cooperate with other** public organizations based in the local authority as well as with private enterprises and non-profit organizations

Elämän tähden

National Development Programme for Social Welfare and Health Care (Kaste)

- A strategic steering tool that is used to manage and reform social and health policy. Kaste I 2008 – 2012, Kaste II 2012 – 2015
- The Kaste Programme implements the Government Programme and the Strategy of the Ministry of Social Affairs and Health. The Government renewd the programme 2 January 2012.
- The targets of the Kaste programme are that
  1. Inequalities in wellbeing and health will be reduced
  2. Social welfare and health care structures and services will be organised in a client-oriented and economically sustainable way

Elämän tähden

KASTE: sub-programmes

1. Inequalities in wellbeing and health will be reduced

- Inclusion, wellbeing and health for risk groups
- More effective services for children, young and families with children
- Improved services for older people

2. Social welfare and health care structures and services will be organised in a client-oriented and economically sustainable way

- A new service structure and more effective primary services
- Information and data systems in support of clients and professionals
- Management will support the service structure and wellbeing at work

Electronic welfare report

Support for local strategic management

Kaste programme 2008 – 2011

Kanerva-Kaste -> ”TEHO-tool”

TerPS (The Healthy Northern Finland)

-> welfare report: cross-functional welfare leadership and political decision-making of local authorities.

Electric welfare report 0.1
Electric welfare report 0.2

Kaste programme 2012 – 2015

TerPS2 (2012 – 2014)

Electric welfare report 0.3

Suomen Kuntaliitto (the Association of Finnish Local and Regional Authorities)

-> 2014 -> Publication of new releases (0.4) summer 2015

Elämän tähden

Commonness of use of the electronic welfare report

www.hyvinvointikertomus.fi

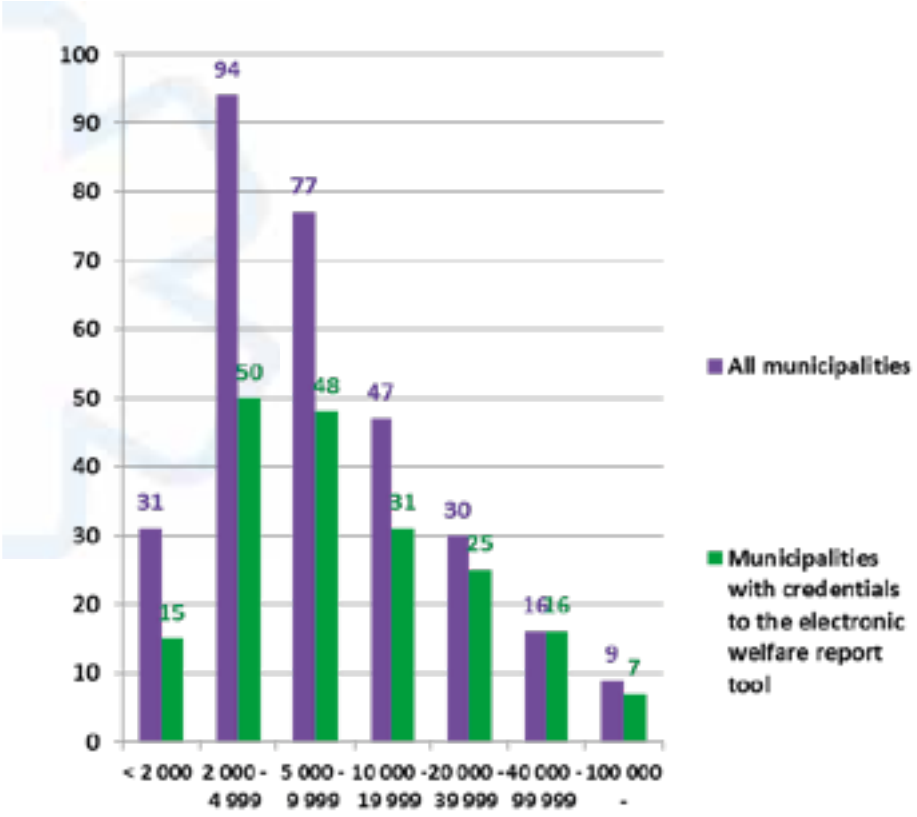
Over 250 local authorities are **implementing** the tool.

Local and Regional Government Finland

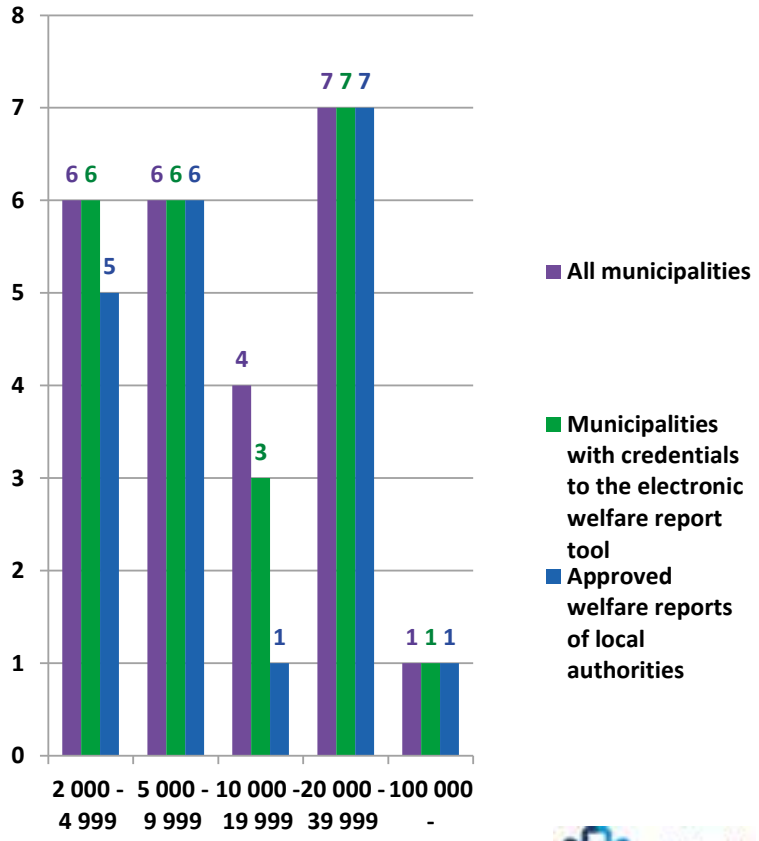
Elämän tähden

Municipalities with credentials to the electronic welfare report tool

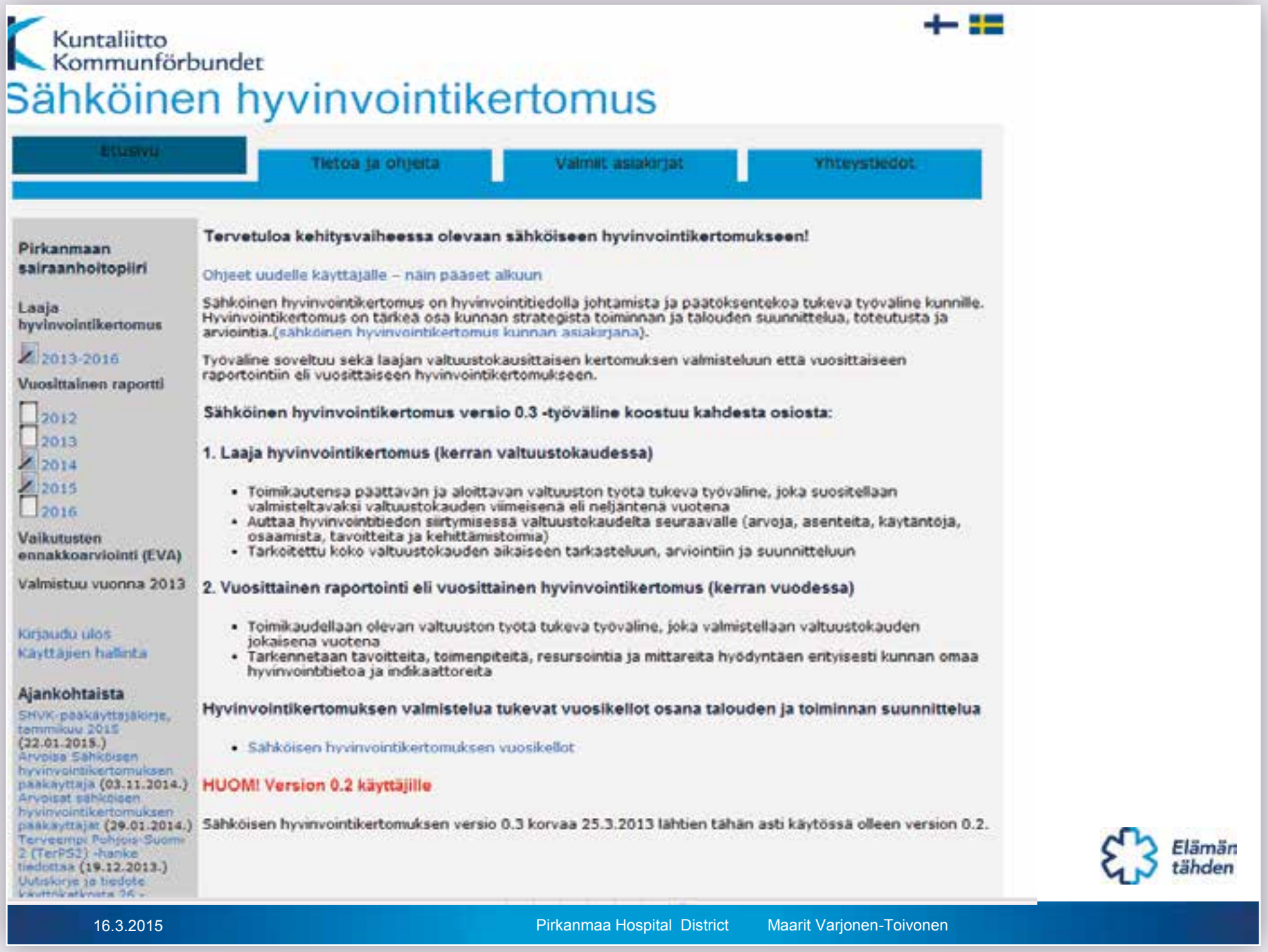
Finland

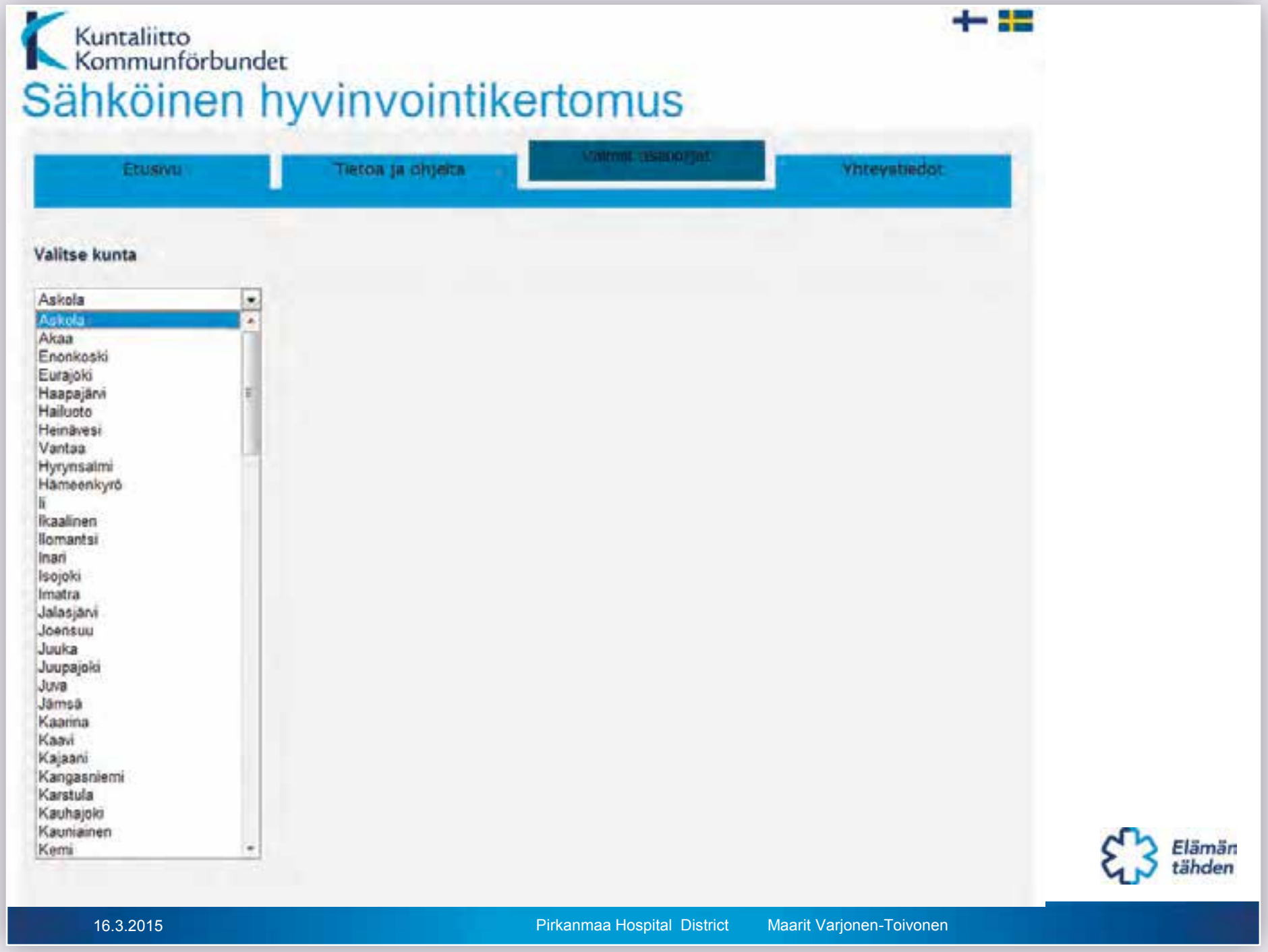


Pirkanmaa



the number of inhabitants in the municipality


Kuntaliitto
Kommunförbundet
Sähköinen hyvinvointikertomus
Etusivu
Tietoa ja ohjeita
Valmiit asiakirjat
Yhteystiedot
Pirkanmaan sairaanhoitopiiri
Laaja hyvinvointikertomus
2013-2016
Vuosittainen raportti
2012
2013
2014
2015
2016
Vaikutusten ennakkoarviointi (EVA)
Valmistuu vuonna 2013
Kirjaudu ulos
Käyttäjien hallinta
Ajankohtaista
SHVK-pääkäyttäjäkirje, tammikuu 2015 (22.01.2015.)
Arvoisa Sähköisen hyvinvointikertomuksen pääkäyttäjä (03.11.2014.)
Arvoisat sähköisen hyvinvointikertomuksen pääkäyttäjät (29.01.2014.)
Terveempi Pohjois-Suomi 2 (TerPS2) -hanke tiedottaa (19.12.2013.)
Tervetuloa kehitysvaiheessa olevaan sähköiseen hyvinvointikertomukseen!
Ohjeet uudelle käyttäjälle – näin pääset alkuun
Sähköinen hyvinvointikertomus on hyvinvointitiedolla johtamista ja päätöksentekoa tukeva työväline kunnille. Hyvinvointikertomus on tärkeä osa kunnan strategista toiminnan ja talouden suunnittelua, toteutusta ja arviointia.(sähköinen hyvinvointikertomus kunnan asiakirjana).
Työväline soveltuu sekä laajan valtuustokausittaisen kertomuksen valmisteluun että vuosittaiseen raportointiin eli vuosittaiseen hyvinvointikertomukseen.
Sähköinen hyvinvointikertomus versio 0.3 -työväline koostuu kahdesta osiosta:
1. Laaja hyvinvointikertomus (kerran valtuustokaudessa)
Toimikautensa päättävän ja aloittavan valtuuston työtä tukeva työväline, joka suositellaan valmisteltavaksi valtuustokauden viimeisenä eli neljäntenä vuotena
Auttaa hyvinvointitiedon siirtymisessä valtuustokaudelta seuraavalle (arvoja, asenteita, käytäntöjä, osaamista, tavoitteita ja kehittämistoimia)
Tarkoitettu koko valtuustokauden aikaiseen tarkasteluun, arviointiin ja suunnitteluun
2. Vuosittainen raportointi eli vuosittainen hyvinvointikertomus (kerran vuodessa)
Toimikaudellaan olevan valtuuston työtä tukeva työväline, joka valmistellaan valtuustokauden jokaisena vuotena
Tarkennetaan tavoitteita, toimenpiteitä, resursointia ja mittareita hyödyntäen erityisesti kunnan omaa hyvinvointitietoa ja indikaattoreita
Hyvinvointikertomuksen valmistelua tukevat vuosikellot osana talouden ja toiminnan suunnittelua
Sähköisen hyvinvointikertomuksen vuosikellot
HUOM! Version 0.2 käyttäjille
Sähköisen hyvinvointikertomuksen versio 0.3 korvaa 25.3.2013 lähtien tähän asti käytössä olleen version 0.2.
Elämän tähden
16.3.2015
Pirkanmaa Hospital District
Maarit Varjonen-Toivonen


Kuntaliitto
Kommunförbundet
Sähköinen hyvinvointikertomus
Etusivu
Tietoa ja ohjeita
Yhteystiedot
Valitse kunta
Askola
Askola
Akaa
Enonkoski
Eurajoki
Haapajärvi
Hailuoto
Heinävesi
Vantaa
Hyrynsalmi
Hämeenkyrö
Ii
Ikaalinen
Ilomantsi
Inari
Isojoki
Imatra
Jalasjärvi
Joensuu
Juuka
Juupajoki
Juva
Jämsä
Kaarina
Kaavi
Kajaani
Kangasniemi
Karstula
Kauhajoki
Kauniainen
Kemi
Elämän tähden
16.3.2015
Pirkanmaa Hospital District
Maarit Varjonen-Toivonen

Welfare report (The comprehensive review on welfare)

Part One: The evaluation of the ending council term

1. The evaluation of wellness information and measures
   - Indicators, Summary, Conclusions
2. The central doctrines to the next municipal council office

Part two: Planning of the future council term

3. Priorities of the municipal strategy
4. Plans and programs that support health and welfare promotion
   - National, Municipal, Regional
5. Plan for health promotion and wellbeing during the council office

Priorities and target for development	Goals	Measures and responsible parties	Resources	Assessment tools

6. Approved as a part of operating and financial plan of the municipal

Elämän tähden


Pohjois-Pirkanmaan sairaanhoitopiiri
KASTE
Elämän tähden
muutos
Indicators of the electric welfare report 0.3
Version 0.3 indikaattoreiden viitekehys
Themes of wellbeing
Hyvinvoinnin ulottuvuudet (teemat)
Lifespan
Elämänkaariajattelu
Inclusion and influence
A. Osallisuus & vaikuttaminen
Quality of life
B. Elämänlaatu
C. Henkinen hyvinvointi
Mental well-being
D. Terveys & toimintakyky
Health and functional capacity
E. Turvallisuus
Safety
F. Opiskelu & työ
Study and work
G. Tasa-arvo & oikeudenmukaisuus
Equality and fairness
H. Asuminen & ympäristö
Housing and environment
I. Toimeentulo
Livelihood
J. Kuntalaisten palvelut
Residents services
All age groups
2. Kaikki ikäryhmät
Children, young teens, families with children
3. Lapset, varhaisnuoret & lapsiperheet
1. Kunnan rakenteet, talous ja elinvoima
Municipal structures, budgets, vitality of the municipal
Adolescents and young adults
4. Nuoret ja nuoret aikuiset
People of working age
5. Työikäiset
6. Ikäihmiset
Elderly
81
16.3.2015
Pirkanmaa Hospital District
Maarit Varjonen-Toivonen

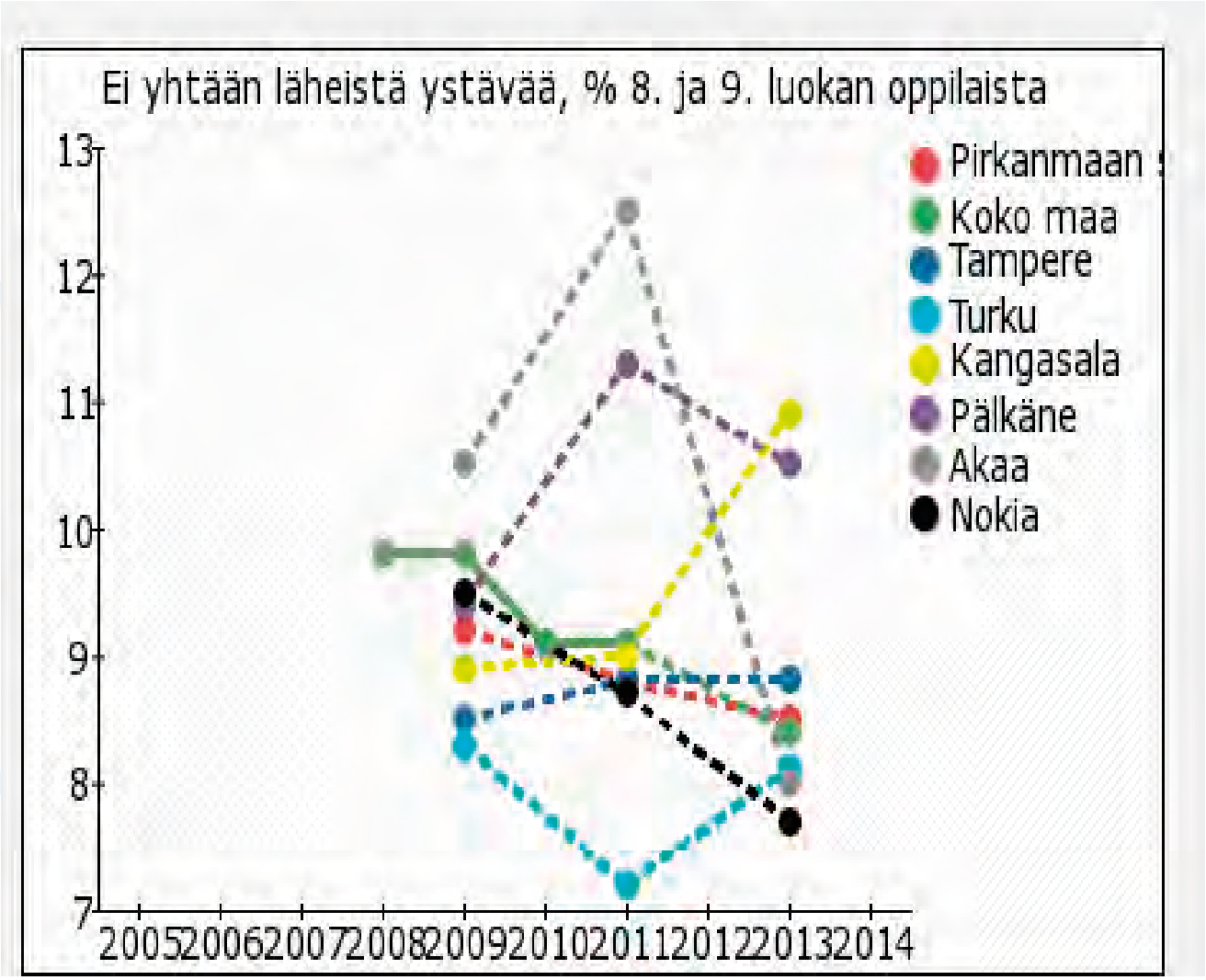
Paketti 3: Lapset, varhaisnuoret ja lapsiperheet

V1 = Koko maa
V2 = Tampere
V3 = Turku
V4 = Kangasala
V5 = Pälkäne
V6 = Akaa
V7 = Nokia
V8 = Mänttä-Vilppula
V9 = Kihnio
V10 = Helsinki

Year of information in Sotkanet

Teema	Perusindikaattori	Pirkanmaan sairaanhoitopiiri		V1 Koko	V2 Tamp	V3 Turk	V4 Kang	V5 Pälk	V6 Akaa	V7 Noki	V8 Mänt	V9 Kihn	V10 Hels
		Arvo	Muutos										
Elämänlaatu	Ei yhtään läheistä ystävää, % 8. ja 9. luokan oppilaista (2013) Info	8,5	←→	8,4	8,8	8,1	10,9	10,5	8	7,7	8,6	-	8,6
Henkinen hyvinvointi	Keskivaikea tai vaikea masentuneisuus, % 8. ja 9. luokan oppilaista (2014) Info	-	???	-	-	-	-	-	-	-	-	-	-
Terveys ja toimintakyky	Kokee terveydentilansa keskinkertaiseksi tai huonoksi, % 8. ja 9. luokan oppilaista (2013) Info	15	↓	15,9	14,6	14,8	14,3	24	19,1	14,4	15	-	14,4
Turvallisuus	Vanhemmuuden puutetta, % 8. ja 9.luokan oppilaista (2013) Info	17,9	↓↓↓	18,6	17	17,9	18,7	25,8	18,6	18,7	20,2	-	18
Asuminen ja ympäristö	Ahtaasti asuvat lapsiasuntokunnat, % kaikista lapsiasuntokunnista (2013) Info	29	←→	29,3	31,5	33,4	23,9	30,6	30	28	26,5	41,1	35,2
Toimeentulo	Lasten pienituloisuusaste (2012) Info	14,1	↓	14,3	18,9	21,1	8,7	13,3	10,9	10,1	14,8	20,9	16,8
Kuntalaisten palvelut	Kasvatus- ja perheneuvonnan asiakkaat vuoden aikana / 1000 alle 18-vuotiasta (2013) Info	82	←→	74,2	61,1	101	138,4	102,3	82,4	117,7	38,9	97,4	75,1

Elämän tähden



Sotkanet:
"Has no close friends, as % of all pupils in 8th and 9th year of comprehensive school "

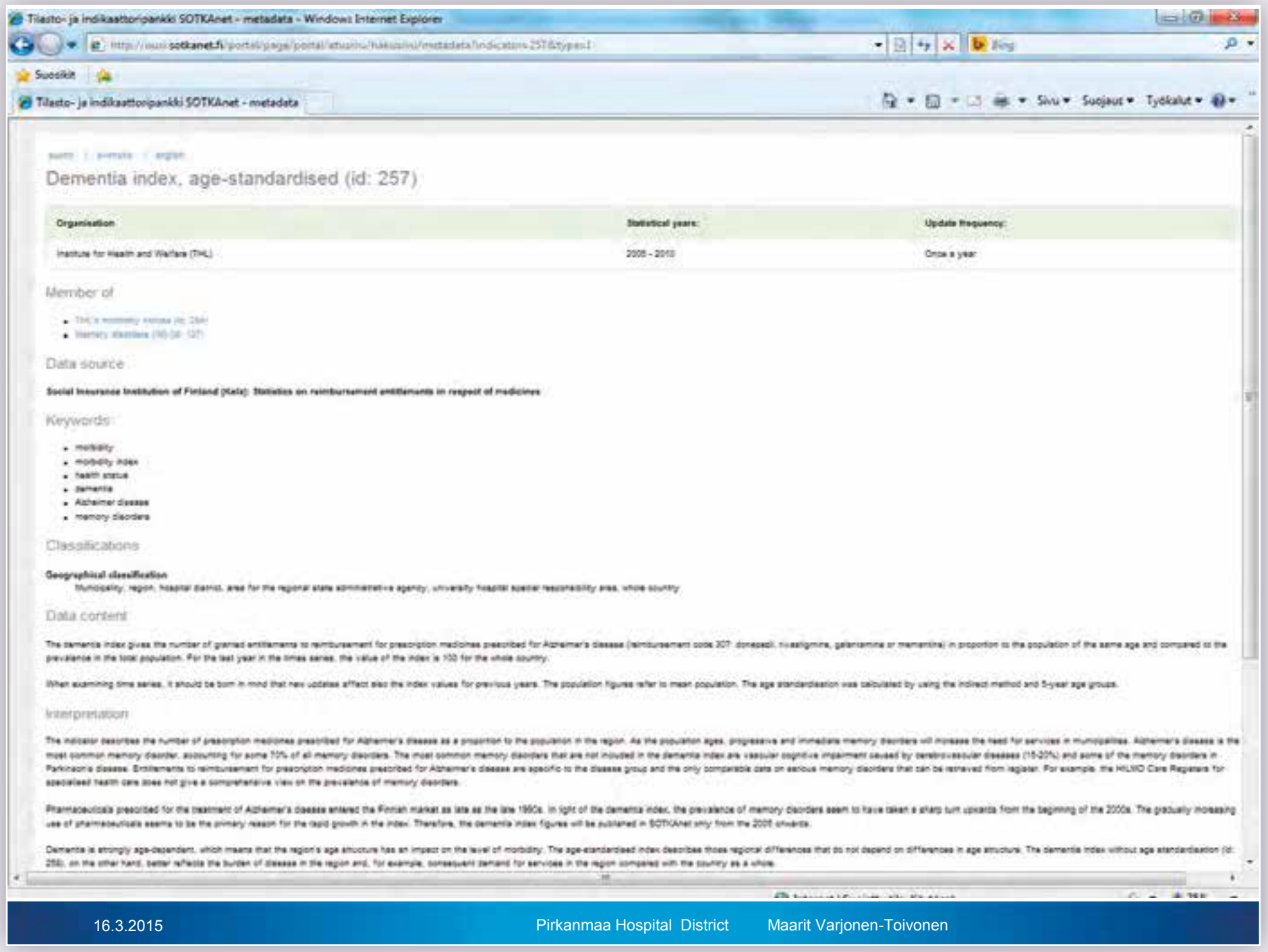
Elämän tähden

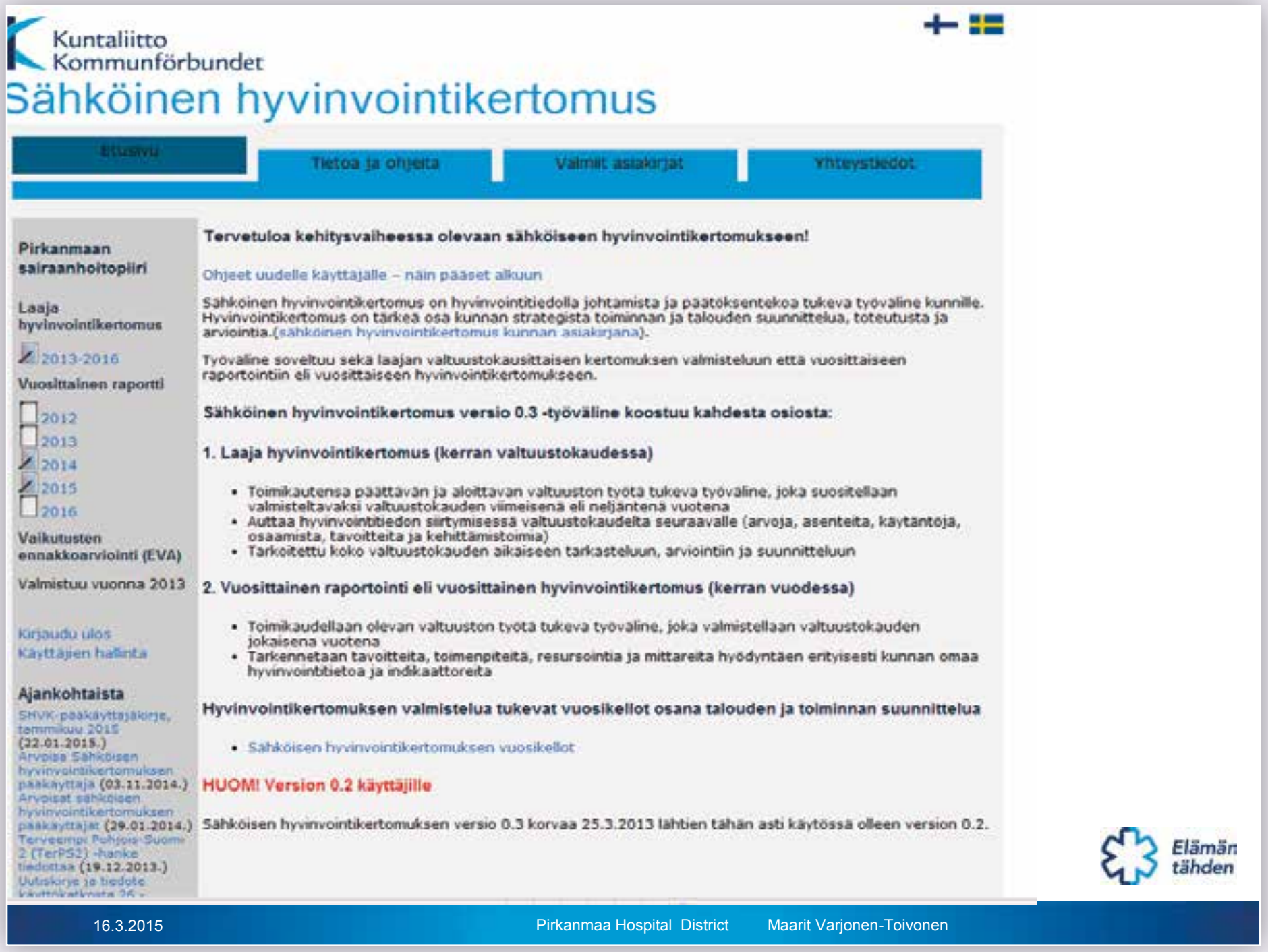
Paketti 6: Ikäihmiset

V1 = Koko maa
V2 = Tampere
V3 = Turku
V4 = Helsinki
V5 = Kangasala
V6 = Pälkäne
V7 = Akaa
V8 = Nokia
V9 = Kihniö
V10 = Mänttä-Vilppula

Connected to Sotkanet (http://sotkanet.fi)

Arvota	Teema	Perusindikaattori	Pirkanmaan sairaanhoitopiiri Arvo	Muutos	V1 Koko	V2 Tamp	V3 Turk	V4 Hels	V5 Kang	V6 Pälk	V7 Akaa	V8 Noki	V9 Kihn	V10 Mänt	Tulosta
↑	Henkinen hyvinvointi	Dementiaindeksi, ikävakioitu (2010) Info	94,7	↑	94,8	94,4	90,3	87,5	106,6	98,2	75,5	104,8	103,7	87,4	
↑	Terveys ja toimintakyky	Erityiskorvattaviin lääkkeisiin oikeutettuja 65 vuotta täyttäneitä, % vastaavanikäisestä väestöstä (2012) Info	63	↔	62,5	62,3	56	55,3	62,7	62,8	64,3	62,4	65,7	66,6	
↑	Asuminen ja ympäristö	Kotona asuvat 75 vuotta täyttäneet, % vastaavanikäisestä väestöstä (2012) Info	90,9	↔	89,6	91,3	88,5	88,1	91,1	90	90,3	91,1	89,8	89	
↑	Toimeentulo	Täytä kansanelaketta saaneet 65 vuotta täyttäneet, % vastaavanikäisestä väestöstä (2012) Info	2,5	↓↓↓	3,1	2,2	2,3	2	2	3	2,5	2	1,8	2,9	
↑	Kuntalaisten palvelut	Säännöllisen kotihoidon piirissä 30.11. olleet 75 vuotta täyttäneet asiakkaat, % vastaavanikäisestä väestöstä (2012) Info	12,2	↔	11,8	12,2	13,3	11,4	12,3	10,1	12,6	14,8	14,4	13,5	


Tilasto- ja indikaattoripankki SOTKAnet - metadata - Windows Internet Explorer
Suosikit
Tilasto- ja indikaattoripankki SOTKAnet - metadata
Sivu
Suojaus
Työkalut
Dementia index, age-standardised (id: 257)
Organisation
Statistical years:
Update frequency:
Institute for Health and Welfare (THL)
2005 - 2013
Once a year
Member of
Data source
Social Insurance Institution of Finland (Kela): Statistics on reimbursement entitlements in respect of medicines
Keywords
morbidity
morbidity index
health status
dementia
Alzheimer disease
memory disorders
Classifications
Geographical classification
Data content
Interpretation
16.3.2015
Pirkanmaa Hospital District
Maarit Varjonen-Toivonen


Kuntaliitto
Kommunförbundet
Sähköinen hyvinvointikertomus
Etusivu
Tietoa ja ohjeita
Valmiit asiakirjat
Yhteystiedot
Pirkanmaan sairaanhoitopiiri
Laaja hyvinvointikertomus
2013-2016
Vuosittainen raportti
2012
2013
2014
2015
2016
Vaikutusten ennakkoarviointi (EVA)
Valmistuu vuonna 2013
Kirjaudu ulos
Käyttäjien hallinta
Ajankohtaista
SHVK-pääkäyttäjäkirje, tammikuu 2015 (22.01.2015.)
Arvoisa Sähköisen hyvinvointikertomuksen pääkäyttäjä (03.11.2014.)
Arvoisat sähköisen hyvinvointikertomuksen pääkäyttäjät (29.01.2014.)
Terveempi Pohjois-Suomi 2 (TerPS2) -hanke tiedottaa (19.12.2013.)
Uutiskirje ja tiedote
Tervetuloa kehitysvaiheessa olevaan sähköiseen hyvinvointikertomukseen!
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Tarkennetaan tavoitteita, toimenpiteitä, resursointia ja mittareita hyödyntäen erityisesti kunnan omaa hyvinvointitietoa ja indikaattoreita
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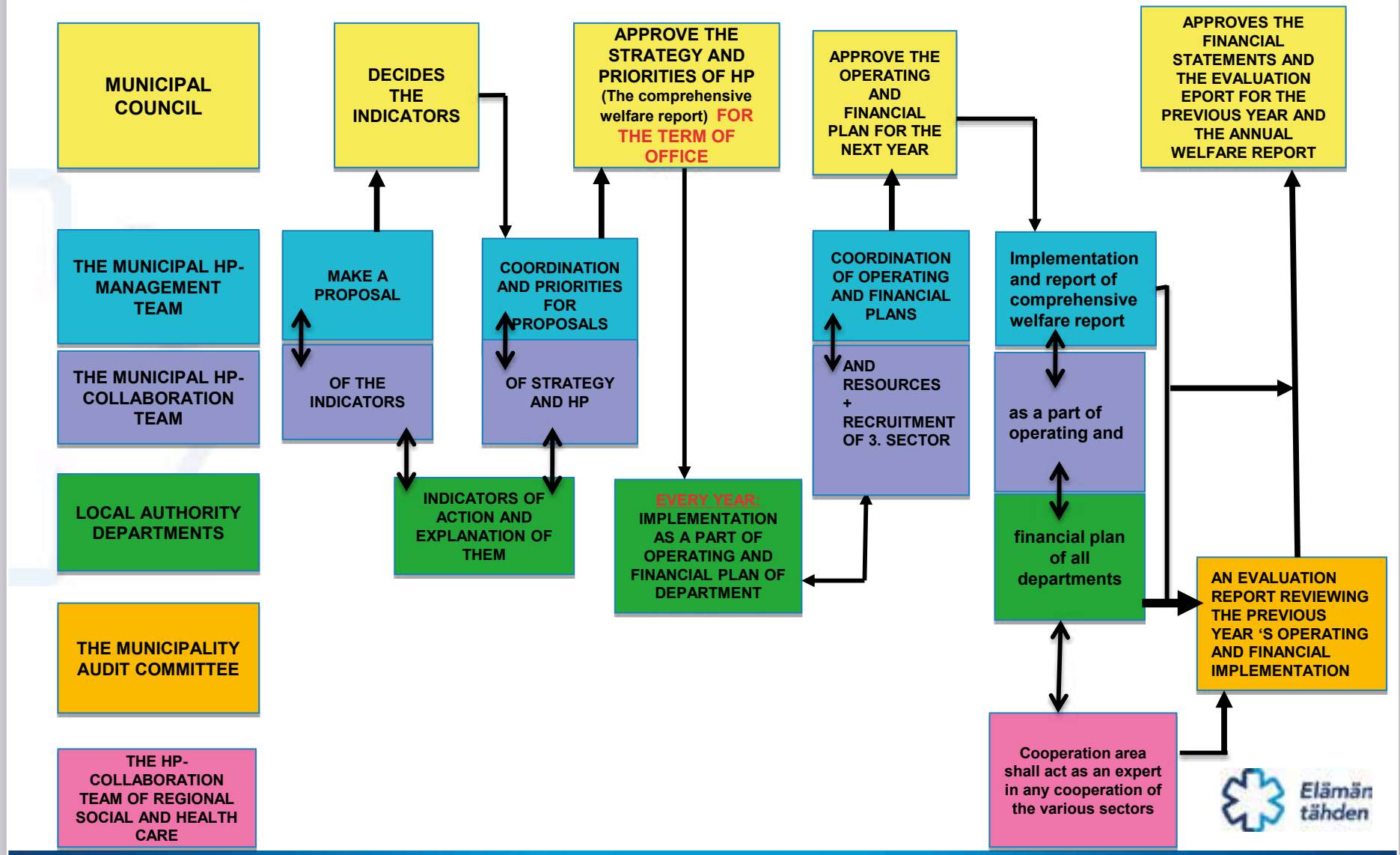
Sähköisen hyvinvointikertomuksen vuosikellot
HUOM! Version 0.2 käyttäjille
Sähköisen hyvinvointikertomuksen versio 0.3 korvaa 25.3.2013 lähtien tähän asti käytössä olleen version 0.2.
Elämän tähden
16.3.2015
Pirkanmaa Hospital District
Maarit Varjonen-Toivonen

Welfare report linked linked to Operations Planning & Budgeting on the Communal Level

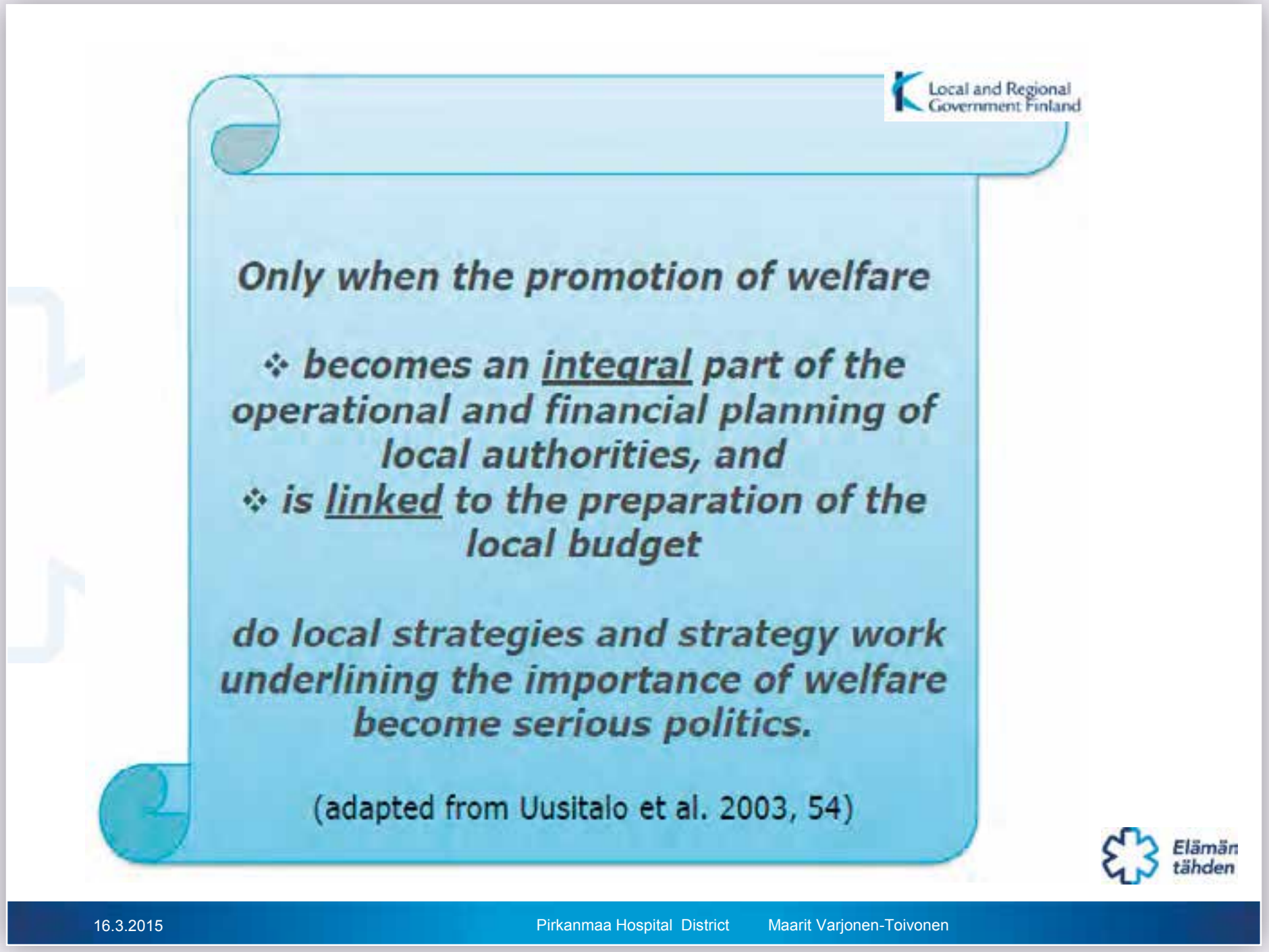


Advantages of electronic welfare report

Local and Regional Government Finland

- Helps to deliver the principles of good welfare leadership
- The challenges of welfare promotion are met together with the financial challenges
- The welfare perspective is included in local strategic management and in the implementation of the municipal strategy
- All administrative branches take more responsibility for the welfare of residents.

Elämän tähden

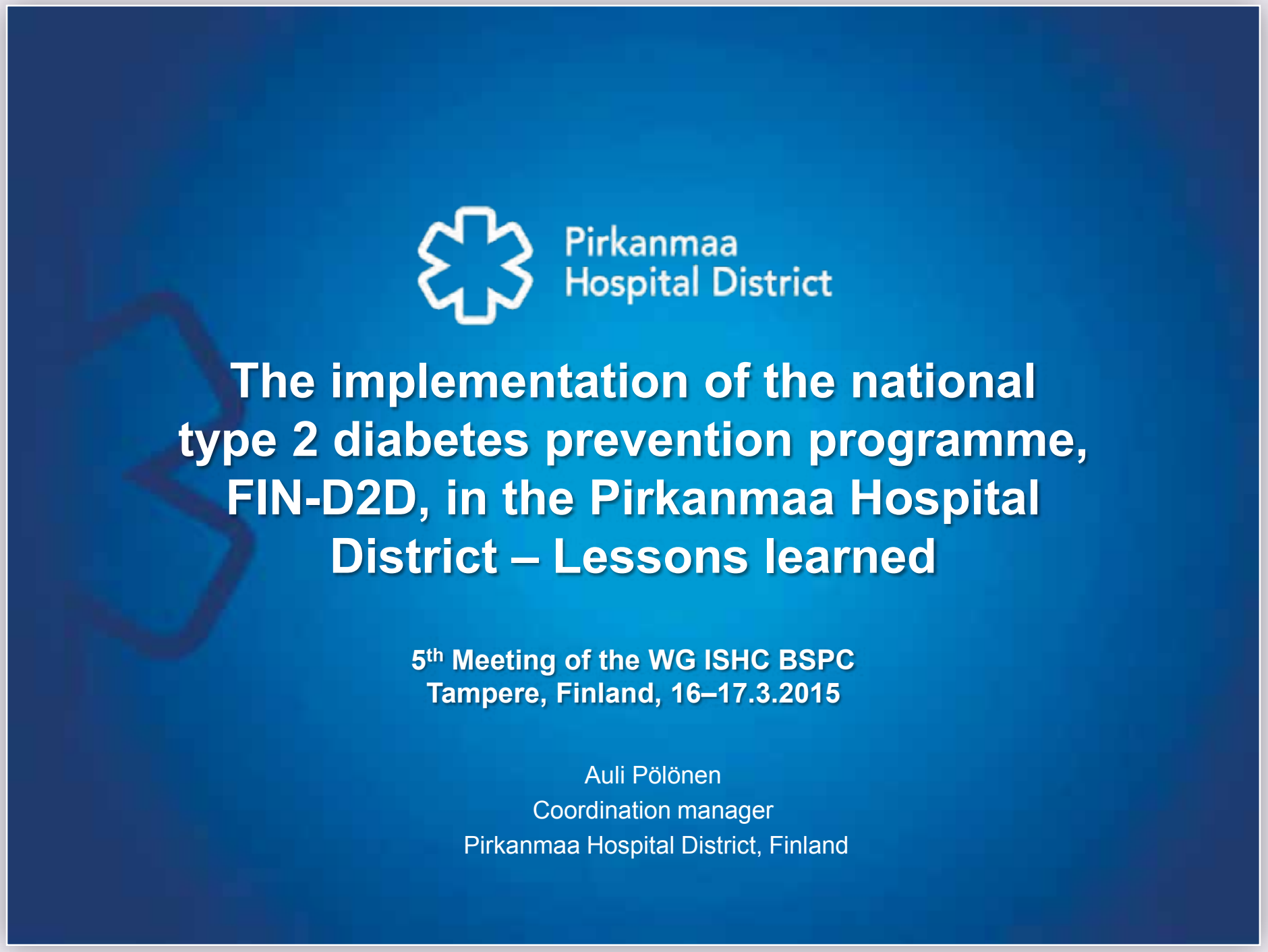

Local and Regional Government Finland
Only when the promotion of welfare
❖ becomes an integral part of the operational and financial planning of local authorities, and
❖ is linked to the preparation of the local budget
do local strategies and strategy work underlining the importance of welfare become serious politics.
(adapted from Uusitalo et al. 2003, 54)
Elämän tähden
16.3.2015
Pirkanmaa Hospital District
Maarit Varjonen-Toivonen

Thank You

Ms Maarit Varjonen-Toivonen
Chief Physician (Health Promotion)

maarit.varjonen-toivonen@pshp.fi

Elämän tähden


Pirkanmaa
Hospital District
The implementation of the national type 2 diabetes prevention programme, FIN-D2D, in the Pirkanmaa Hospital District – Lessons learned
5th Meeting of the WG ISHC BSPC
Tampere, Finland, 16–17.3.2015
Auli Pölönen
Coordination manager
Pirkanmaa Hospital District, Finland

Background

FIN-D2D Project

FIN-D2D model (high risk strategy)

FIN-D2D in practise

Experiences and models developed in Pirkanmaa

Results

Discussion

Pirkanmaa Hospital District

Background

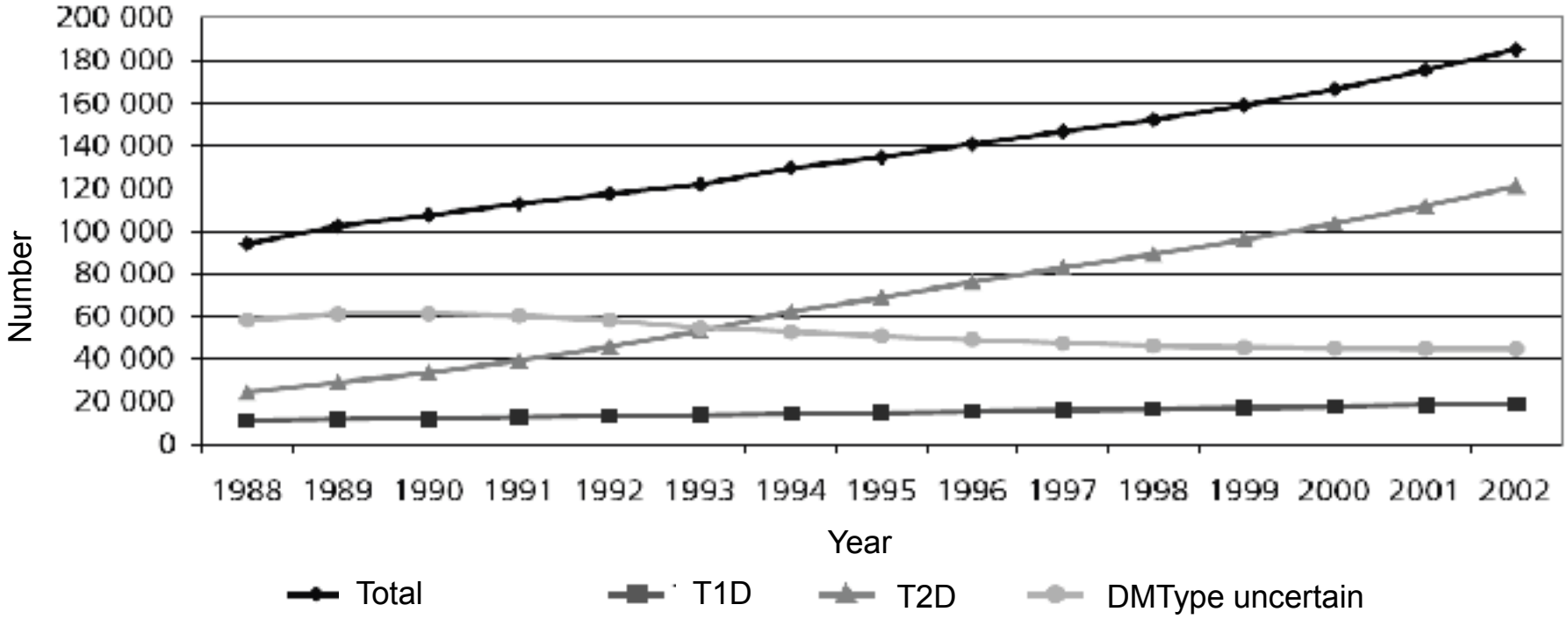
Type 2 diabetes (T2D) and its co-morbidities are rapidly increasing health problems in Finland and worldwide

Randomized trials have shown that lifestyle modification can postpone T2D among individuals at high risk for T2D

Pirkanmaa Hospital District

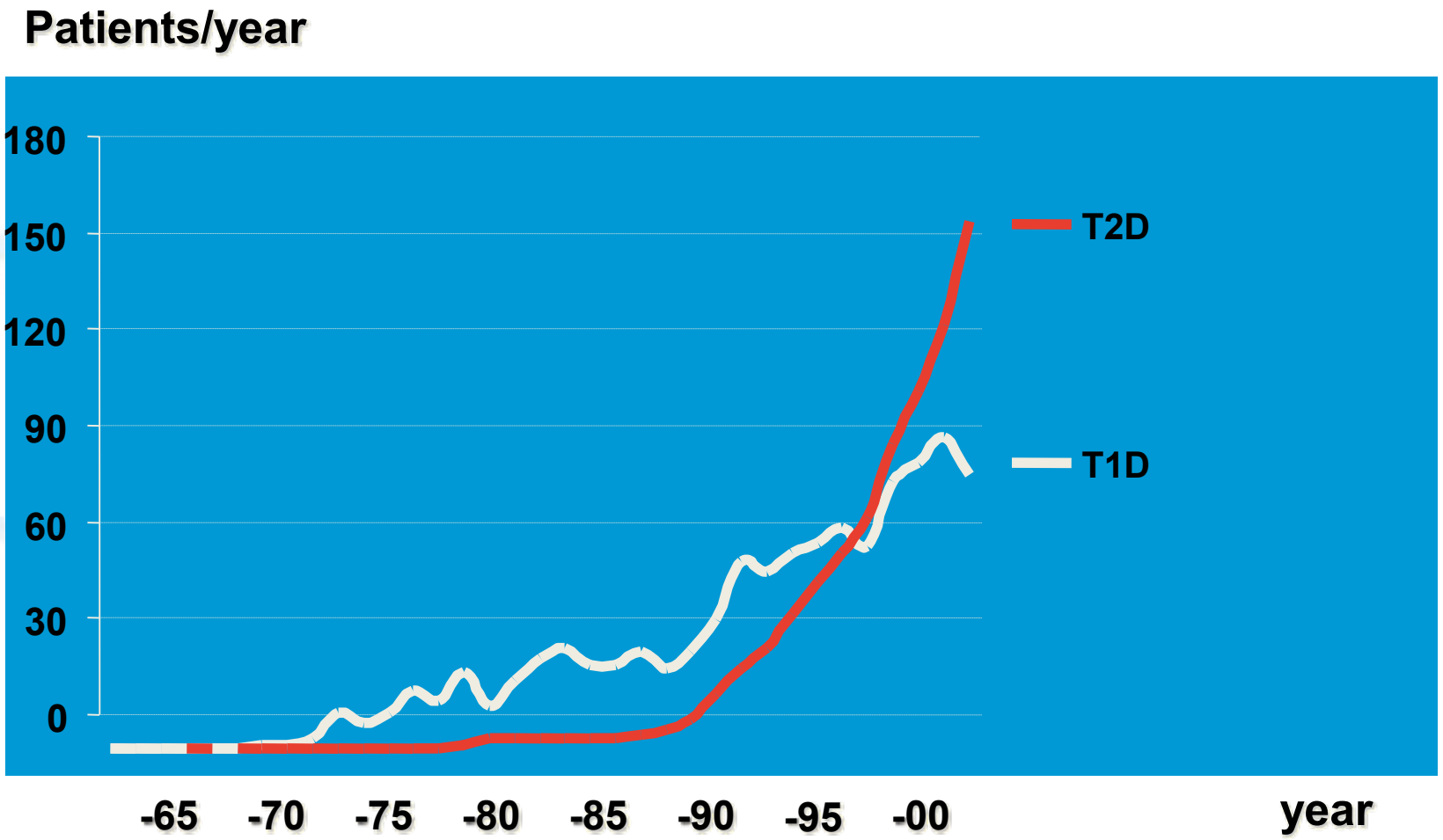
Diabetes prevalence in Finland

Niemi, Winell: Diabetes Suomessa, Stakes 2005



Pirkanmaa Hospital District

Diabetes patients in dialysis in Finland 1965 - 2000

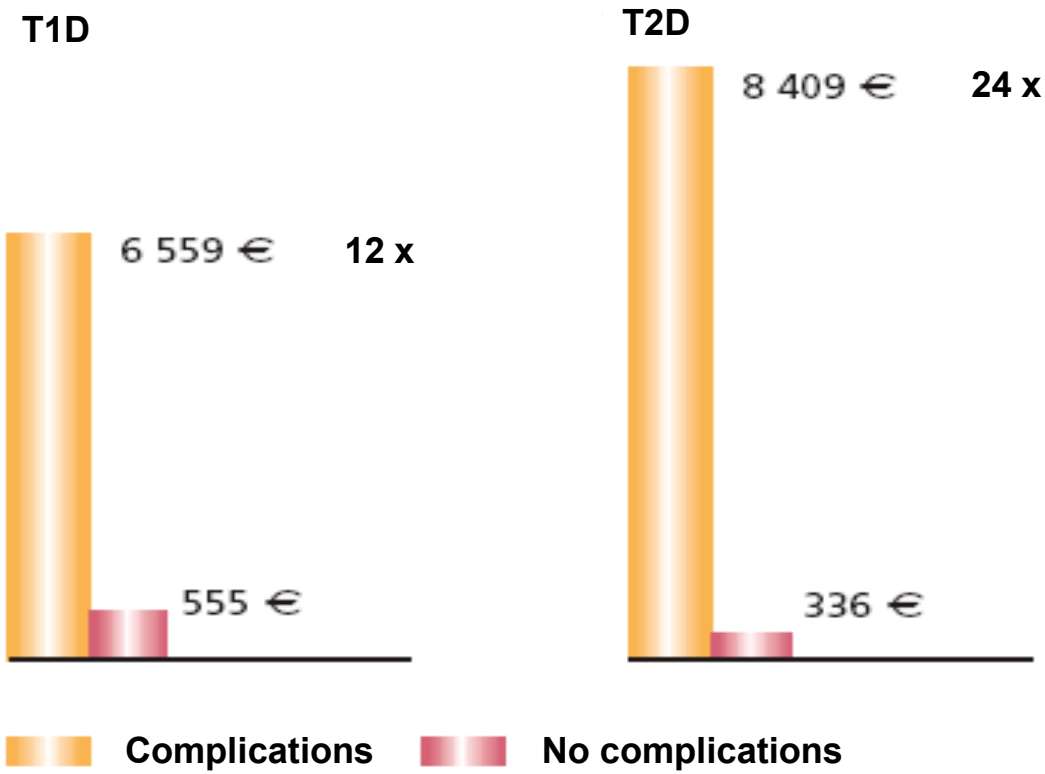


Finnish Registry for Kidney Diseases – Report 2000

Pirkanmaa Hospital District

Costs of diabetes care

(on average, euros/person/year, Finland)



Kangas 2002

Pirkanmaa Hospital District

Studies:
Risk factors of T2D and metabolic syndrome

- Obesity, central obesity and weight gain
  Physical inactivity and sedentary lifestyle
- Diet: high fat and saturated fat intake
- Diet: low nutrient fiber intake
- Insulin resistance
- Family history of diabetes
- Ethnicity
- Increasing age

⇒ Lifestyle modification and prevention?

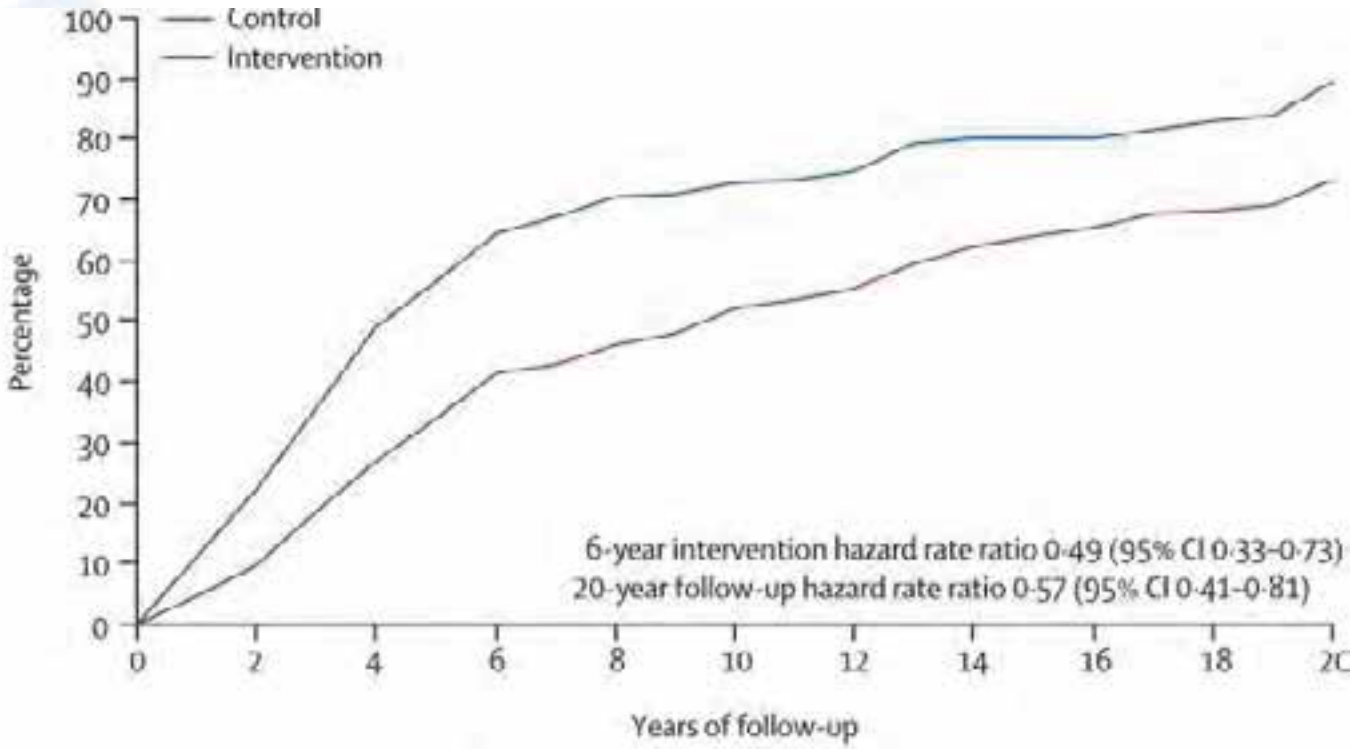
⇒ Trials

Pirkanmaa Hospital District

Effects of diet and exercise in preventing NIDDM in people with impaired glucose tolerance. The Da Qing IGT and Diabetes Study, China

Pan et al. 1997. Diabetes Care 20:537-544

The cumulative incidence of diabetes



Risk reduction at 6 years

Diet 31 %

Exercise 46 %

Diet + exercise 42 %

Control n=133

Diet n=130

Exercise n=141

Diet + exc. n=126

Pirkanmaa Hospital District

The Finnish Diabetes Prevention Study (DPS)

Tuomilehto et al. 2001. N Engl J Med 344:1343-1350

522 overweight, middle-aged men and women with IGT
Randomly allocated to:
intensive lifestyle intervention or control group

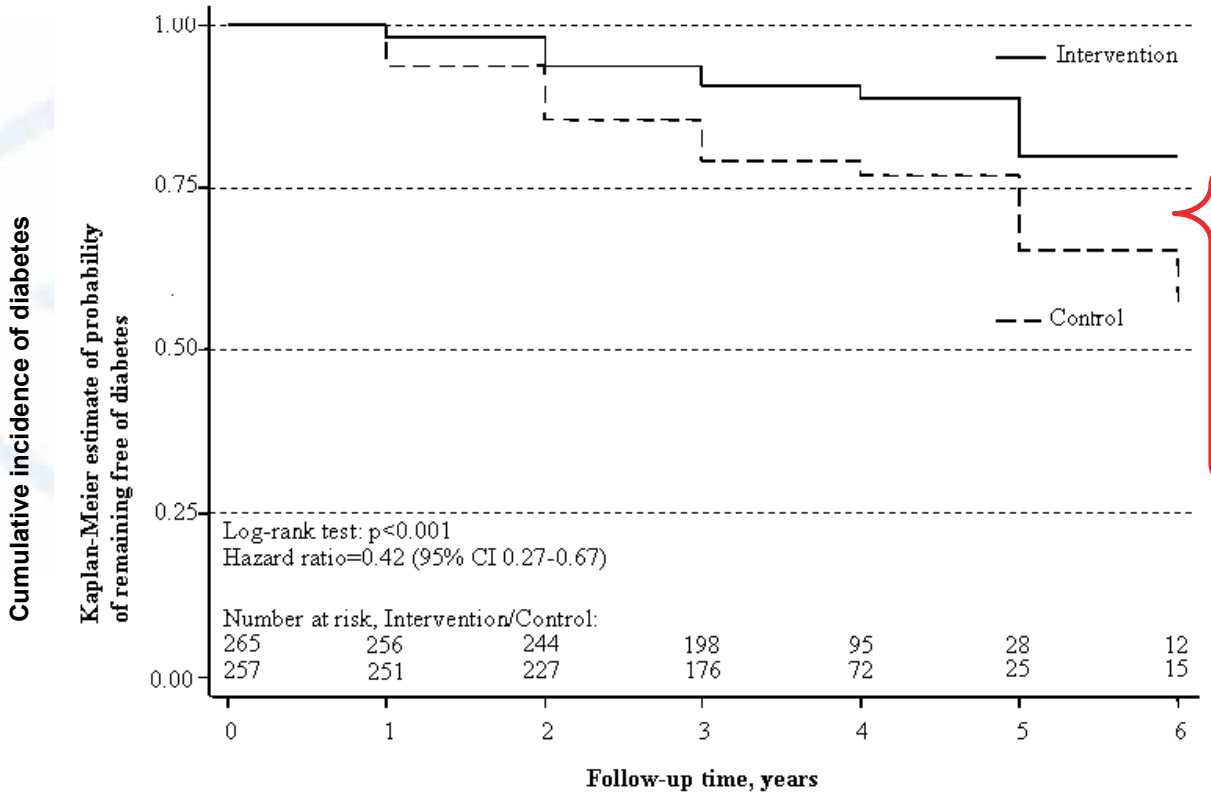
Intervention goals:

- Weight reduction > 5%
- Moderate fat < 30 E%
- Low saturated fat < 10 E%
- High fibre >15g /1000 kcal
- Physical activity > 30 min / day

7 individual dietary counselling sessions (by dietitians) during the first year, every 3 months thereafter

Pirkanmaa Hospital District

DPS: Diabetes incidence was 58% lower among the intervention group compared with the control group after mean follow-up of 3.2 years

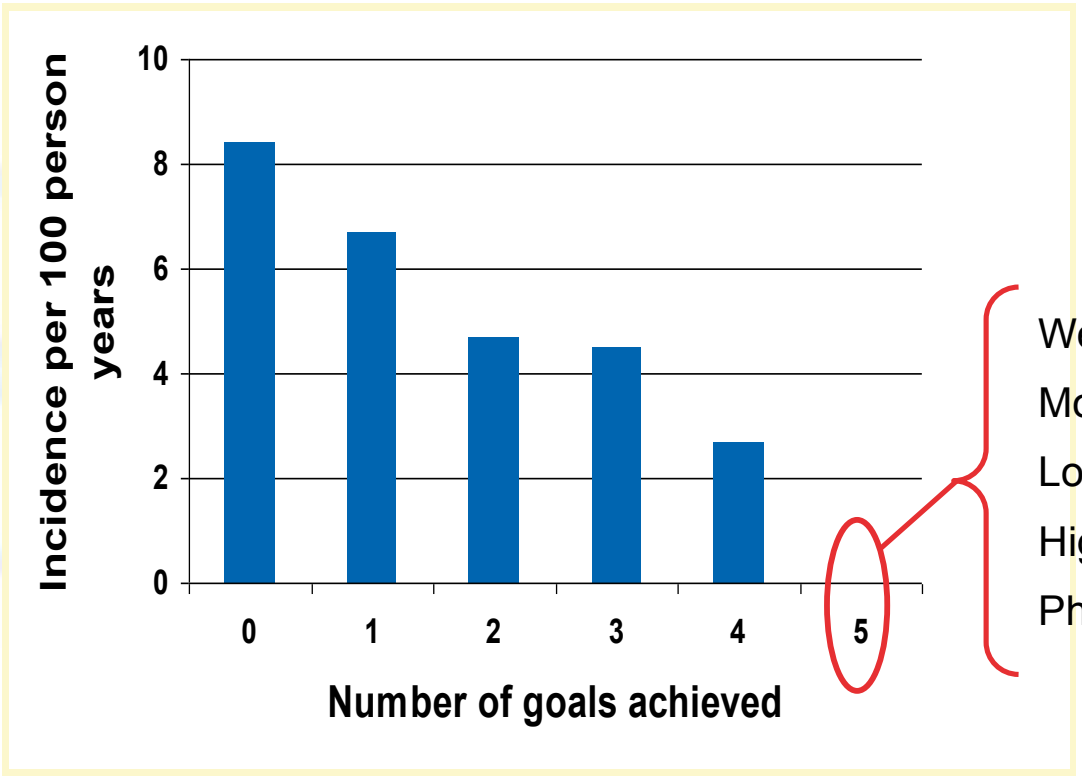


- Weight reduction ≥ 5%
- Moderate fat < 30 E%
- Low saturated fat < 10 E%
- High fibre ≥15g/1000kcal
- Physical activity ≥ 30 min/day

N Engl J Med 2001; 344:1343-1350

Pirkanmaa Hospital District

DPS: The more goals achieved, the lower the risk!



Weight reduction ≥ 5%

Moderate fat < 30 E%

Low saturated fat < 10 E%

High fibre ≥15g/1000kcal

Physical activity ≥ 30 min /day

Goals at year 3; incidence during 7 years follow-up

Pirkanmaa Hospital District

Diabetes Prevention Program (DPP)

N Engl J 2002, 346:393-403

N = 3234 , IGT and elevated fP-gluc

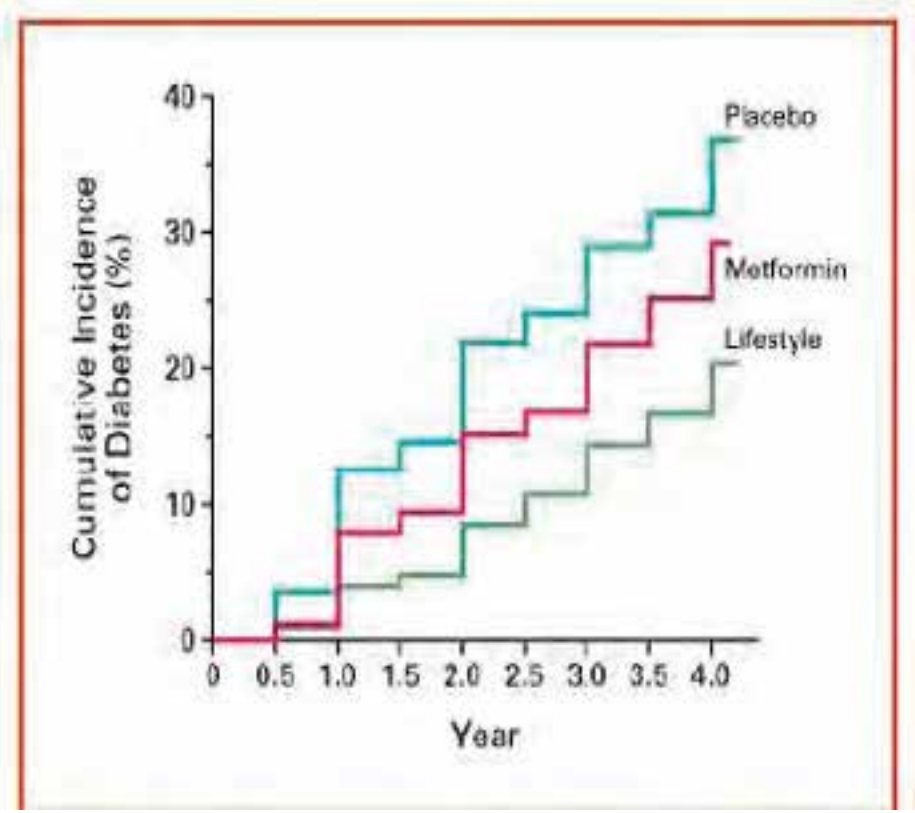
Control/Placebo group

Intervention groups:

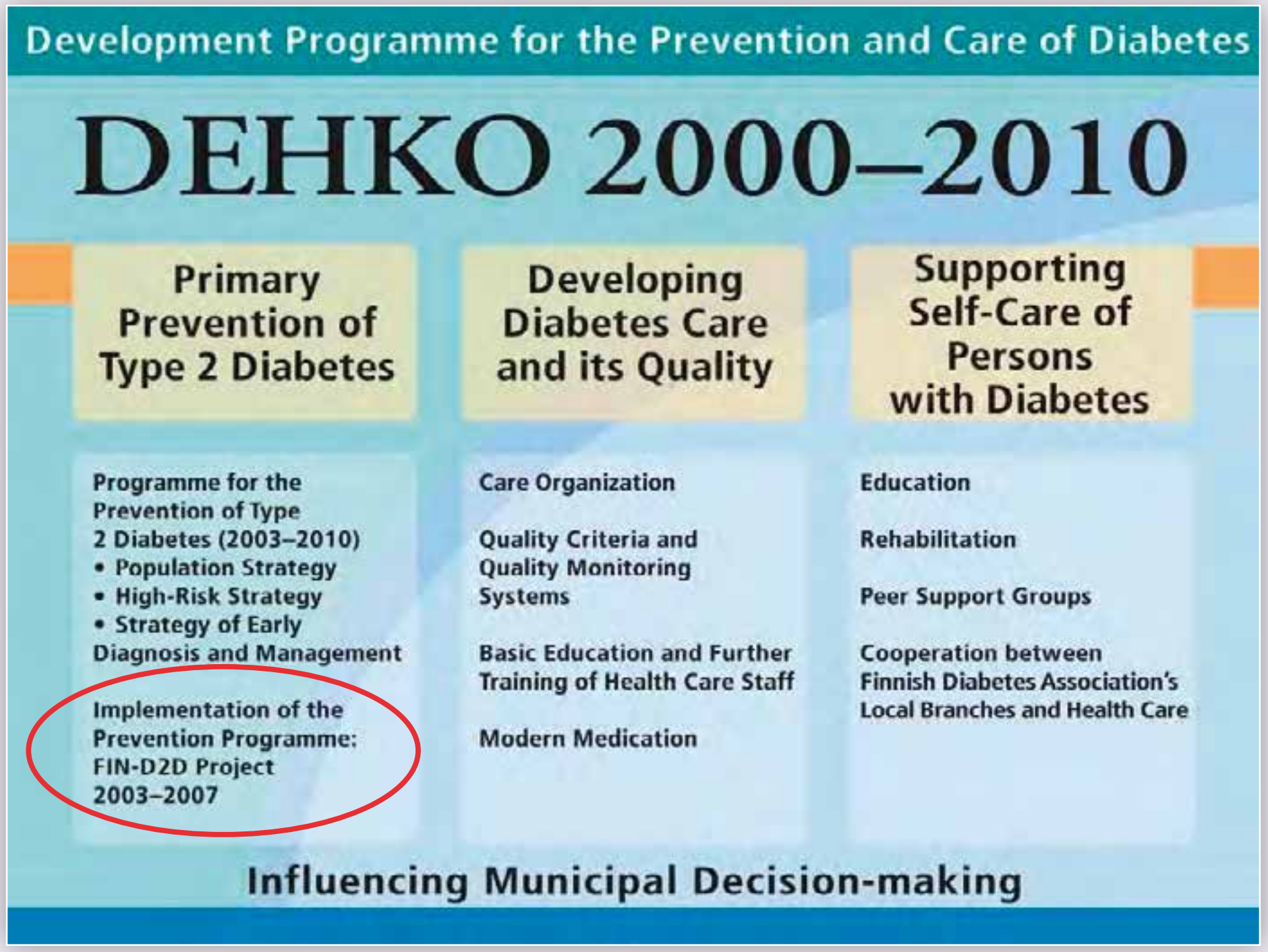
- **Metformin**
- **Life style**
  - **Weight reduction (≥7%)**
  - **Lower fat ja energy intake**
  - **Enhanching physical activity (≥150min/vko)**

Metformin intervention group risk for diabetes decreased 31%

Lifestyle intervention group: Risk for diabetes decreased 58%



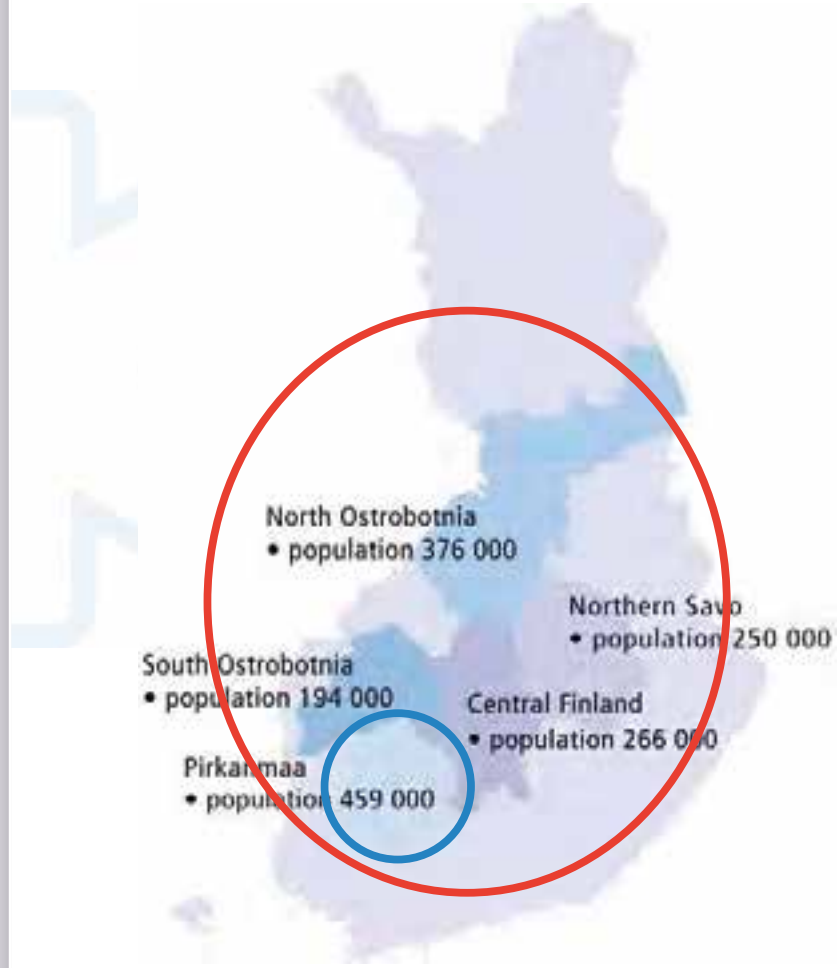
Pirkanmaa Hospital District


Development Programme for the Prevention and Care of Diabetes
DEHKO 2000–2010
Primary Prevention of Type 2 Diabetes
Developing Diabetes Care and its Quality
Supporting Self-Care of Persons with Diabetes
Programme for the Prevention of Type 2 Diabetes (2003–2010)
• Population Strategy
• High-Risk Strategy
• Strategy of Early Diagnosis and Management
Implementation of the Prevention Programme: FIN-D2D Project 2003–2007
Care Organization
Quality Criteria and Quality Monitoring Systems
Basic Education and Further Training of Health Care Staff
Modern Medication
Education
Rehabilitation
Peer Support Groups
Cooperation between Finnish Diabetes Association's Local Branches and Health Care
Influencing Municipal Decision-making

DPS (2001), DPP etc. evidence of the prevention of T2D

⇒ **Implementation Project of T2D Prevention Programme**

FIN-D2D Project 2003 - 2007 and the Follow-up Project 2008 - 2010



FIN-D2D: Partners

Four => Five hospital districts

Finnish Diabetes Association

National Institute for Health and Welfare

Target population 1.5 million people

400 health care centres

200 occupational health centres

> 2000 health care professionals

Pirkanmaa Hospital District

FIN-D2D Funding 2003 - 2007

Hospital districts	100 000 euros/year/district
Funding from the State	100 000 euros/year/district
Finnish Diabetes Association (The Slot Machine Association of Finland)	450 000 euros/year
National Public Health Institute	100 000 euros/year

Total: 8.4 million euros during the years 2003-2007

Target population 1.5 million $\Rightarrow$ 1.1 euro/person/year

The project had to apply for the funding every year (the State, the Slot Machine Association and municipalities separately)

Pirkanmaa Hospital District

FIN-D2D Project Goals

To reduce the incidence and prevalence of T2D and cardiovascular risk factors

To identify individuals with T2D

To generate new models for the prevention of T2D

To evaluate the effectiveness, feasibility and the cost-effectiveness of the project

To increase awareness
of T2D and its risk factors among the population

Pirkanmaa Hospital District

Three strategies:

Population Strategy:

Prevention of obesity and T2D at population level

High-Risk Strategy:

Screening of people with elevated risk (adults) and management of risk factors by lifestyle counselling

Early Diagnosis and Management Strategy:

Appropriate treatment and prevention of complications among newly diagnosed people with T2D

Pirkanmaa Hospital District

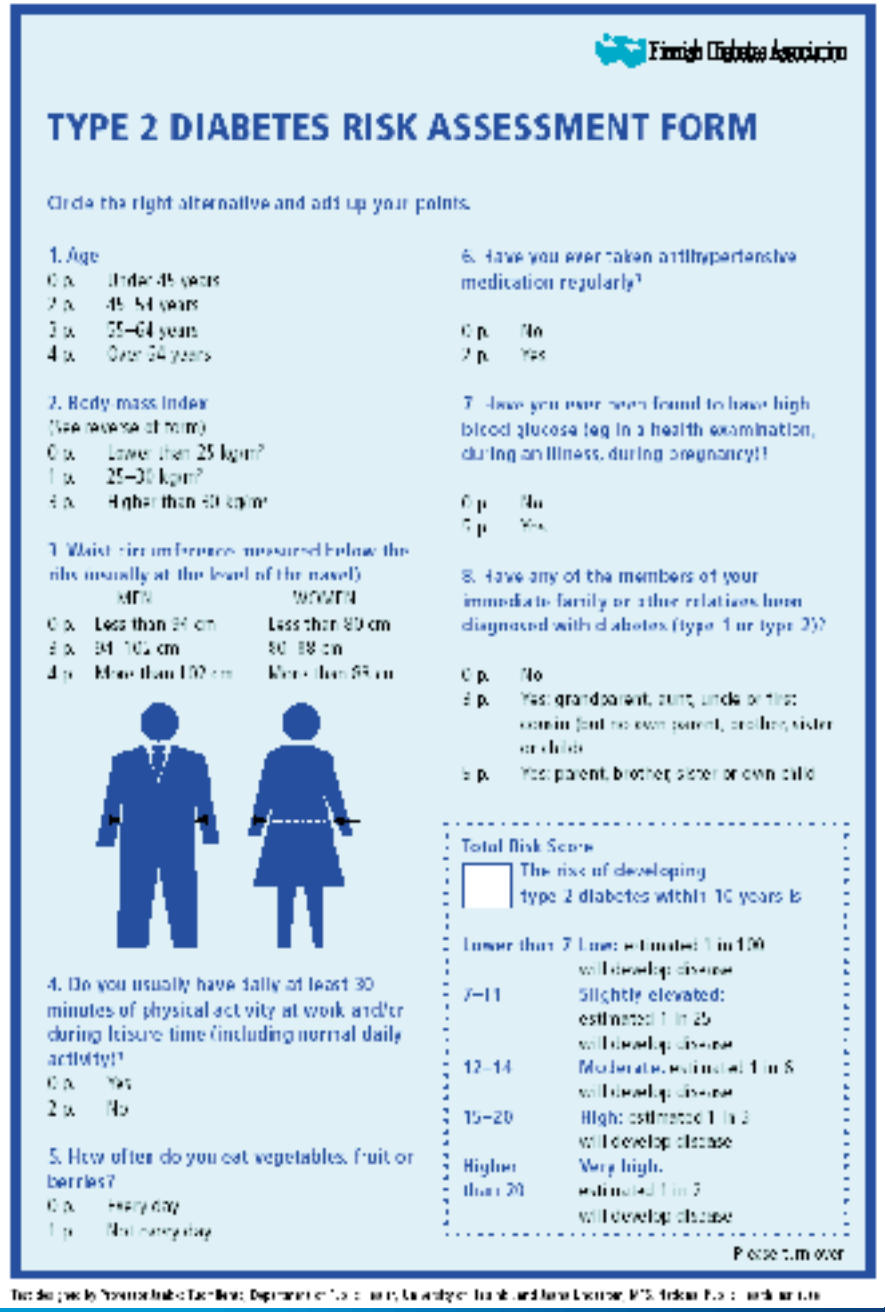
FINDRISC:

Age, BMI, Waist,
Physical activity, Nutrition,
Hypertension, Family history

Form available:

- On-line www.diabetes.fi
- In pharmacies
- At selected public events
- In newspapers
- Given by a health care provider at a normal visit
- As a part of routine health care check-ups
- At self-service check-up points

Diabetes Care 2003;26:725-31.



Finnish Diabetes Association

TYPE 2 DIABETES RISK ASSESSMENT FORM

Circle the right alternative and add up your points.

1. Age
0 p. Under 45 years
2 p. 45–54 years
3 p. 55–64 years
4 p. Over 64 years

2. Body mass index
(see reverse of form)
0 p. Lower than 25 kg/m²
1 p. 25–30 kg/m²
3 p. Higher than 30 kg/m²

3. Waist circumference, measured below the ribs, usually at the level of the navel)

	MEN	WOMEN
0 p.	Less than 94 cm	Less than 80 cm
3 p.	94–102 cm	80–88 cm
4 p.	More than 102 cm	More than 88 cm

4. Do you usually have daily at least 30 minutes of physical activity at work and/or during leisure time (including normal daily activity)?
0 p. Yes
2 p. No

5. How often do you eat vegetables, fruit or berries?
0 p. every day
1 p. Not every day

6. Have you ever taken antihypertensive medication regularly?
0 p. No
2 p. Yes

7. Have you ever been found to have high blood glucose (eg in a health examination, during an illness, during pregnancy)?
0 p. No
5 p. Yes

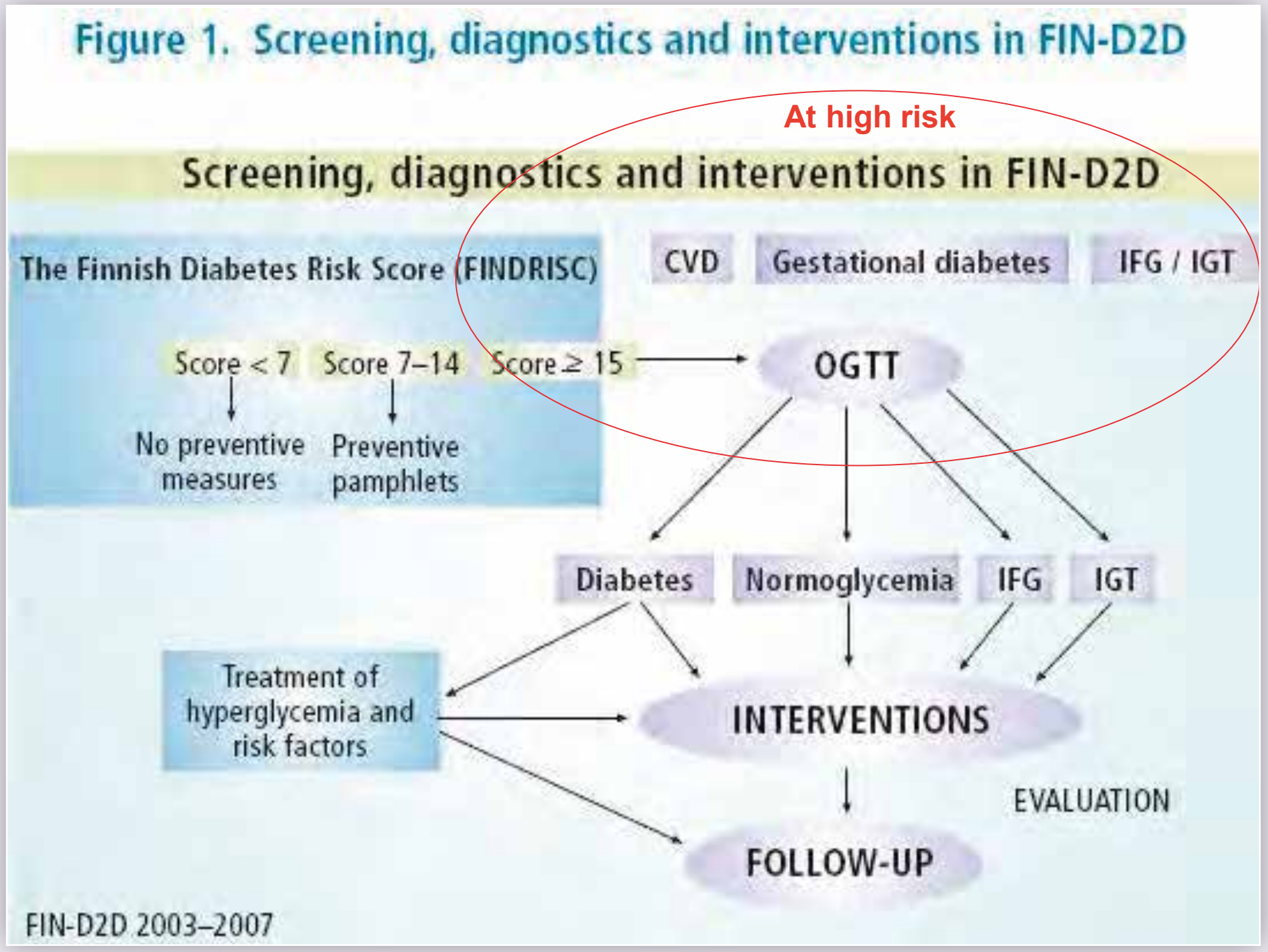
8. Have any of the members of your immediate family or other relatives been diagnosed with diabetes (type 1 or type 2)?
0 p. No
3 p. Yes: grandparent, aunt, uncle or first cousin (but not own parent, brother, sister or child)
5 p. Yes: parent, brother, sister or own child

Total Risk Score
The risk of developing type 2 diabetes within 10 years is

Lower than 7	Low: estimated 1 in 100 will develop disease
7–11	Slightly elevated: estimated 1 in 25 will develop disease
12–14	Moderate: estimated 1 in 6 will develop disease
15–20	High: estimated 1 in 3 will develop disease
Higher than 20	Very high: estimated 1 in 2 will develop disease

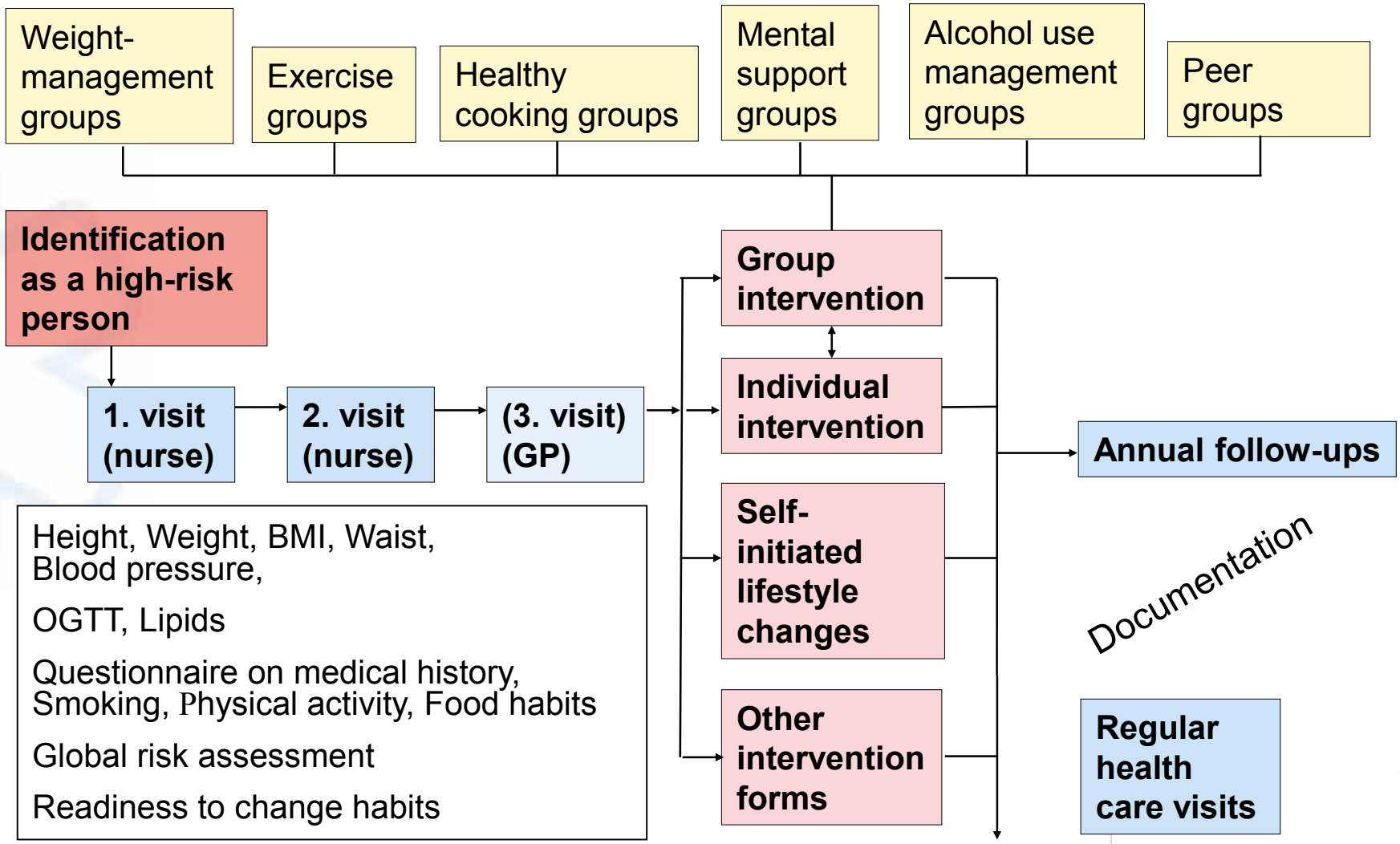
Please turn over

Figure 1. Screening, diagnostics and interventions in FIN-D2D



FIN-D2D Interventions

Primary health care or other service providers:



FIN-D2D Project: Intervention goals in life-style modification

Risk factor:	Overweight (BMI > 25 kg/m^2)
Goal:	≥ 5 % reduction
Risk factor:	Low physical activity
Goal:	> 30 min/day
Risk factor:	High saturated fat intake
Goal:	< 10 E%
Risk factor:	High fat intake
Goal:	< 30 E%
Risk factor:	Low fiber intake
Goal:	> 15 g/1000 kcal

Pirkanmaa Hospital District

FIN-D2D Project intervention

Based on:

- Research evidence
- Current Care Guidelines: Obesity, Hypertension, Dyslipidemias
- Finnish Nutrition and Physical Activity Recommendations
- FIN-D2D goals

Life-style modification as a long-term process, step by step:

Stages of the changes - model

New approach and methods for counselling - empowerment

Customer-oriented and target-oriented approach

Multiprofessionality ⇒ shared responsibities, expertice

Protocols for screening and intervention

Validated material for counselling

Documentation

Evaluation on individual and organisational levels

Collaboration networks:

public and private primary health care, specialised care

municipal actors, local organisations, associations etc.

Pirkanmaa Hospital District

FIN-D2D, Basic questionnaire

HEALTH STATUS

7. Have you ever been diagnosed with diabetes?

1. no
2. yes
3. yes, gestational diabetes

8. Has your biological father ever been diagnosed with diabetes?

1. no
2. yes

9. Has your biological mother ever been diagnosed with diabetes?

1. no
2. yes

10. How many siblings do you have?

|__|__|

11. Has at least one of your siblings been diagnosed with diabetes?

1. no
2. yes

12. Have you ever had any of the following diseases or abnormalities?

	Yes
Elevated blood pressure, hypertension	☐
Cardiac insufficiency	☐
Angina pectoris, chest pain during exercise	☐
Coronary artery disease	☐
Myocardial infarction	☐
Coronary (heart) bypass surgery or angioplasty	☐
Cerebral palsy stroke, stroke or TIA	☐
Intermittent claudication	☐
High or elevated blood cholesterol level or other lipoidosis	☐
Depression, other psychiatric illness	☐
Physically handicapped	☐
Other chronic disease, specify?_____	☐

FIN-D2D - basic questionnaire for high risk individuals

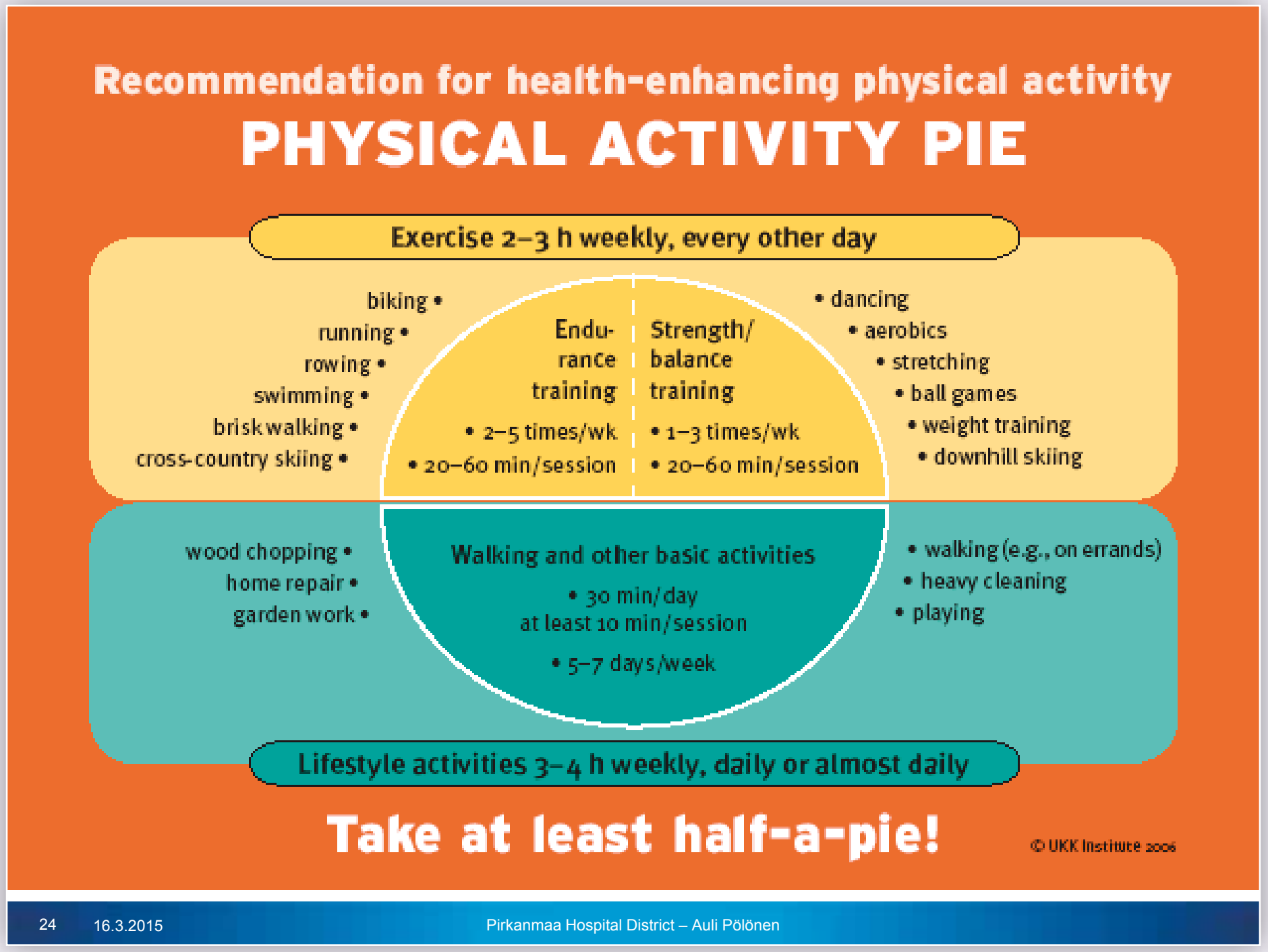
- **Health status**
- **Smoking**
- **Physical activity**
- **Diet**
- **Weight management**
- **Sleep**

As a tool for intervention and counselling

⇒ follow ups

How Are You?

Pirkanmaa Hospital District


Recommendation for health-enhancing physical activity
PHYSICAL ACTIVITY PIE
Exercise 2–3 h weekly, every other day
biking • running • rowing • swimming • brisk walking • cross-country skiing •
Endu-rance training
• 2–5 times/wk
• 20–60 min/session
Strength/ balance training
• 1–3 times/wk
• 20–60 min/session
• dancing • aerobics • stretching • ball games • weight training • downhill skiing
wood chopping • home repair • garden work •
Walking and other basic activities
• 30 min/day at least 10 min/session
• 5–7 days/week
• walking (e.g., on errands) • heavy cleaning • playing
Lifestyle activities 3–4 h weekly, daily or almost daily
Take at least half-a-pie!
© UKK Institute 2006

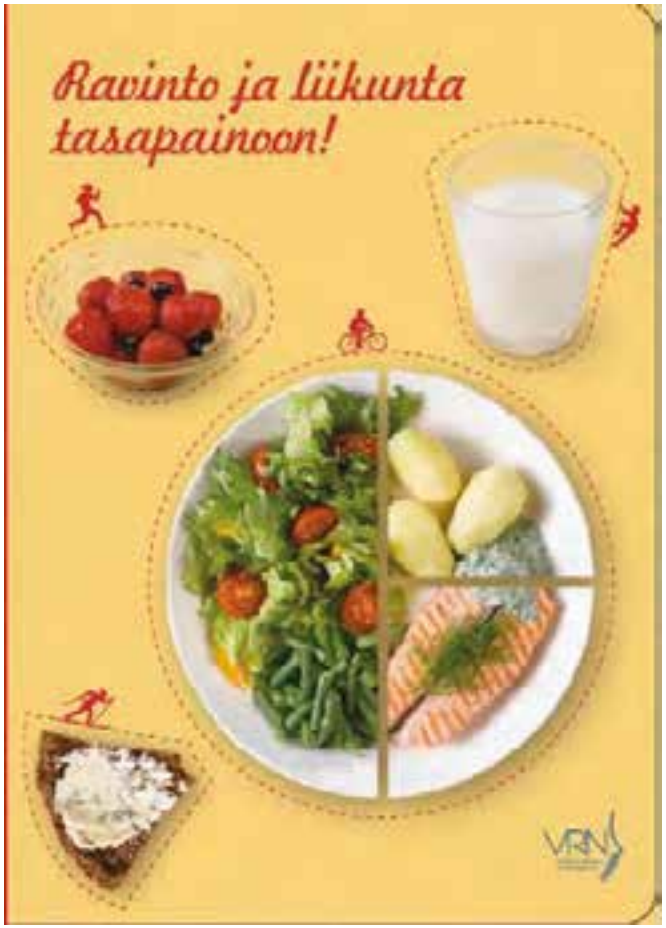
Everyday physical activity is beneficial as well

Examples of daily one-hour motion opportunities:

walking	
from home to bus	5 min
from bus to work	7 min
to and from lunch restaurant	6 min
from work to bus	7 min
from bus to store	8 min
from store to home	6 min
using stairs during the day	8 min
clearing snow away	13 min
total	60 min

Pirkanmaa Hospital District

Finnish Nutrition Recommendations

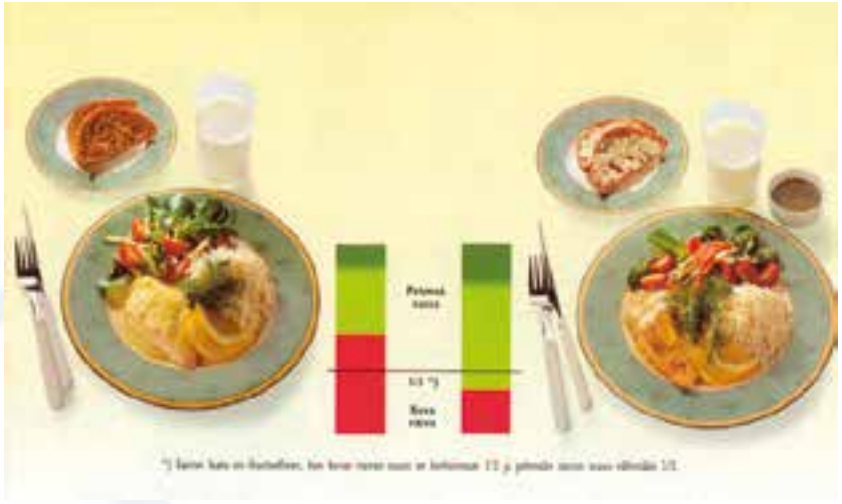


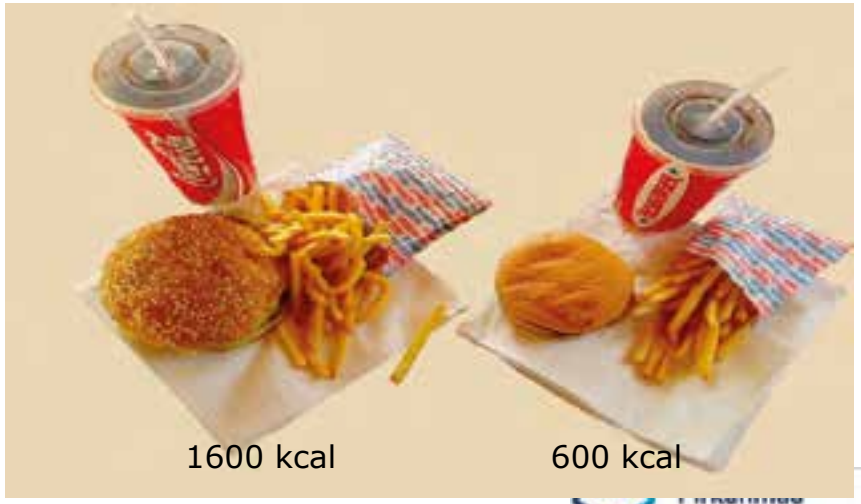
Pirkanmaa
Hospital District

Eat well – You are well

Pirkanmaa Hospital District

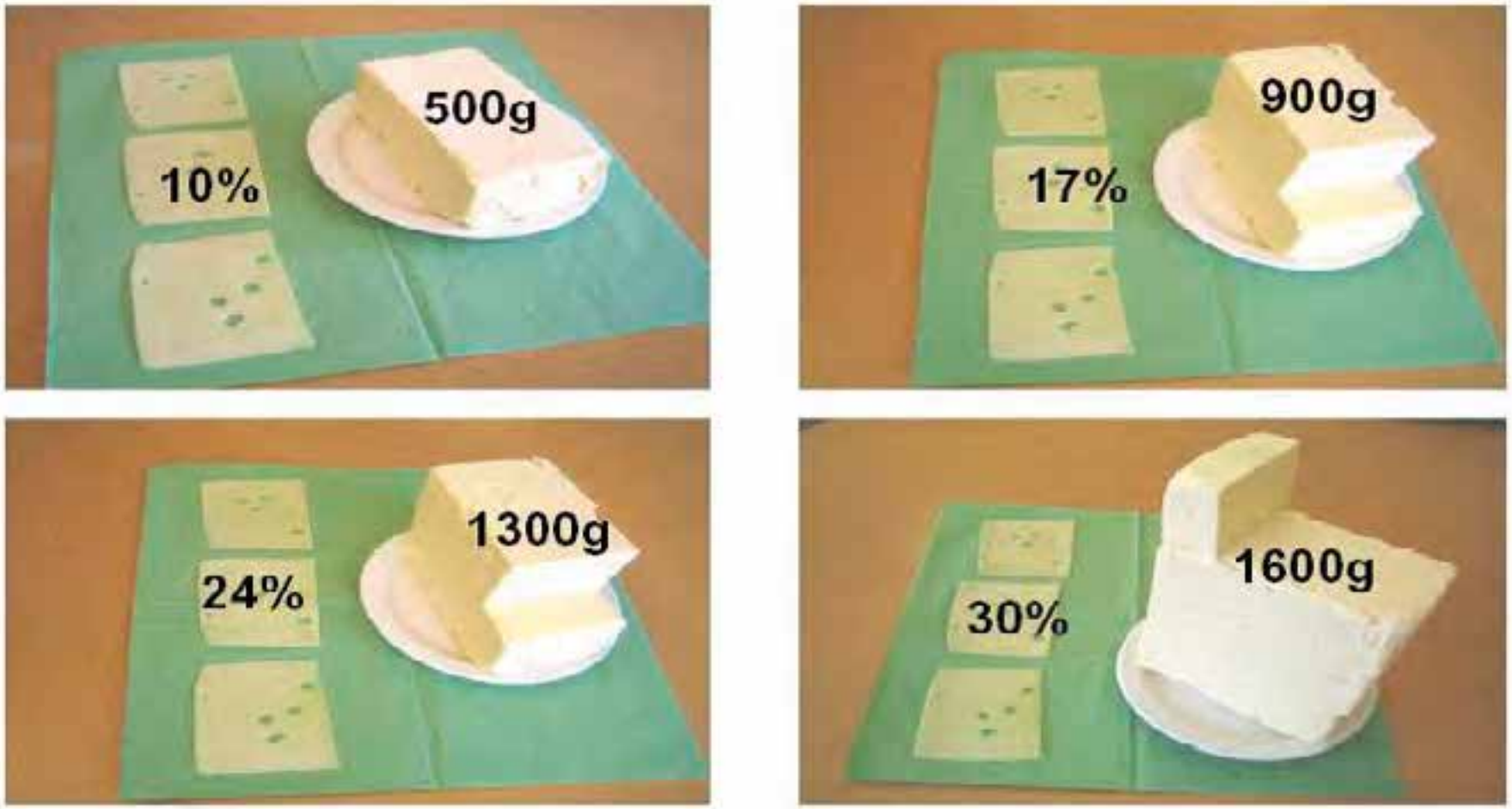
Making the Food Choices Visible





Hospital District

The Amount of Fat During Half a Year



KSSHP, D2D-hanke 2006

Media Campaings

FIN-D2D

Tuijota omaan napaasi

Look at Your Belly Button

A Small Decision a Day

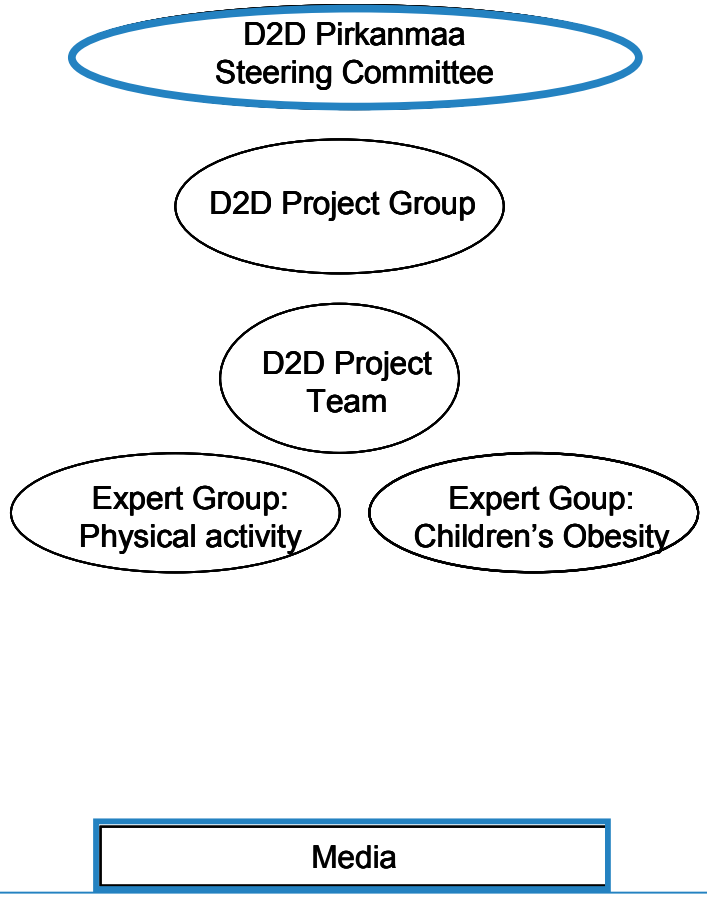
FIN-D2D in Pirkanmaa Hospital District

Pirkanmaa Hospital District

REGIONAL LEVEL

- Health Care Centres
- Occupational Health Care Units
- Tampere University Hospital and Regional Hospitals
- University of Tampere School of Public Health
- Pirkanmaa University of Applied Sciensies
- UKK Institute
- The Finnish Diabetes Association, Tampere District
- The Finnish Heart Association, Pirkamaa District
- The Finnish Sports Federation, Häme
- The Associations of Health Care, Occupational Health Care Professionals and Pharmacies
- The National Research and Development Centre for Wellfare and Health

FIN-D2D PROJECT PIRKANMAA NETWORK AND COLLABORATION



LOCAL LEVEL

- Municipall Governements
- Health Care Centres
- Actors in the Other Municipal Organs
  - sports and pfysical activity services
  - social services
  - catering services
  - schools and cultural services
- Occupational Health Care Services
- Pharmacies
- Catering Services in private sector
- Local Branches of the Diabetes and the Heart Associations
- Health Care and Other Associations
- Sports and Physical Activity Clubs
- Adult Education Centres

⇒ **Large variety of actors and professionals in screening and life style modification**

Pirkanmaa Hospital District

Visits to every health care center and occupational health care unit to chart resourcourses and needs for the prevention of T2D, working methods, tools, materials, and needs for education and training

⇒local D2D multidisciplinary teams, local D2D projects

Pirkanmaa Hospital District

Networks

Collaboration

Multidisciplinary work

Workshops

Eduction and training

Developing care chains, portocols

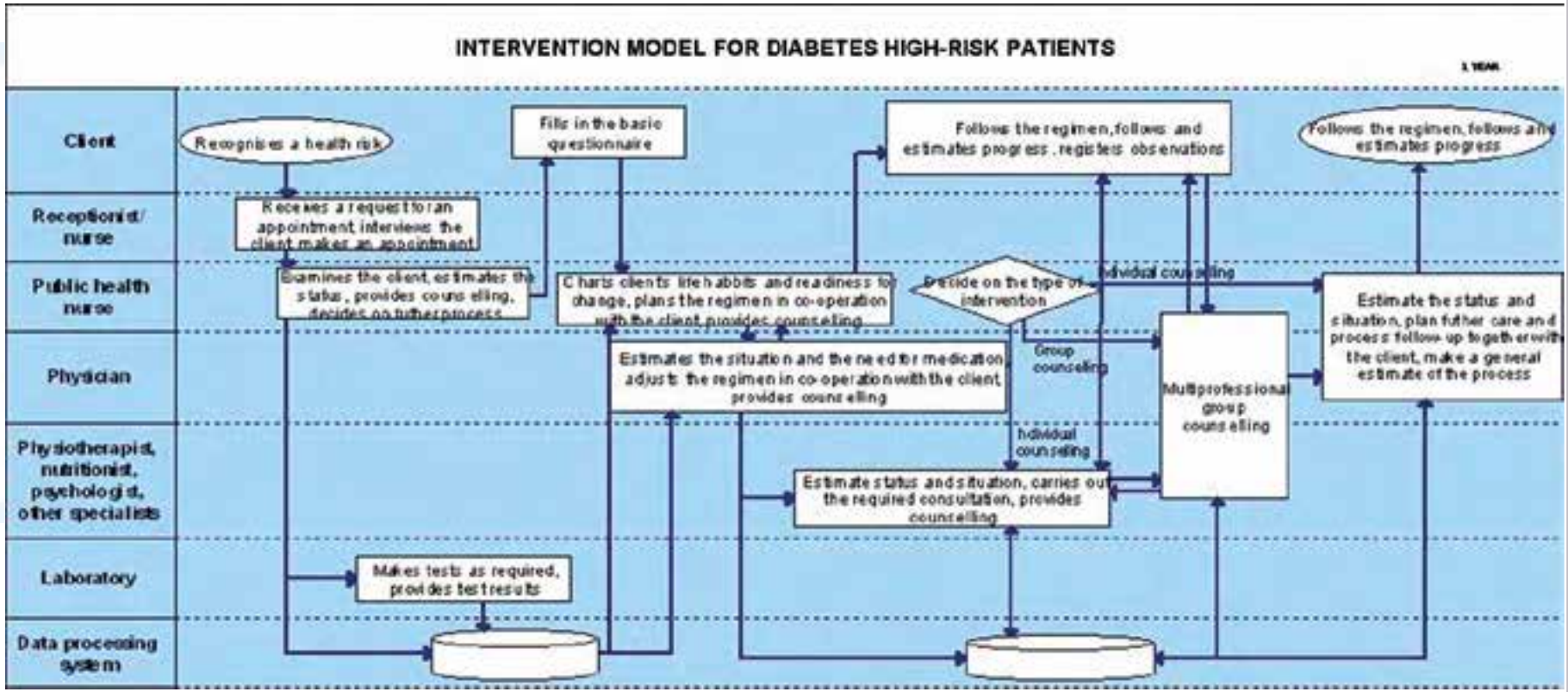
Projects plans and prosesses

34 16.3.2015 Pirkanmaa Hospital District – Auli Pölönen

Multidisciplinary work, roles, and responsibilities in health care protocols

The regional (Valkeakoski) protocol for the prevention and care of T2D in Pirkanmaa, 2008

The protocol for the Pirkanmaa hospital district 2011



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Documentation developed: food habits, physical activity
Data collection for FIN-D2D evaluation

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Annual reports of local projects
Workshops
Sharing experiencies
Planning further

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New models for the occupational health care

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Catering services

Good opportunities for health promotion and communication

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Pharmacies in collaboration

Pirkanmaa Hospital District

Sastamala board meeting:
”Something for men?
Competitions, diet information, physical activities, celebrities…”
Male personnel of the municipality in charge of planning the seminar.

Seminars for men in Sastamala once a year - real success

> 300 participants/event

Pirkanmaa Hospital District

Campaigns for decision-makers and personel

Sastamala: ”One cent out of your waist for the health” campaing

Virrat: Checking the waist circumference of the staff annually

Ylöjärvi: ”Light summer campaign” for the staff

Tays: Campaigns for the staff, well-being weeks, health promotion events

Pirkanmaa Hospital District

Participating fairs together with collaborators

Hand in hand with the third sector

Activating physically inactive men -

An adventurous approach (SuomiMies seikkailee)

FINNISH HEART ASSOCIATION PIRKANMAA

FINNISH SPORTS FEDERATION, HÄME

D2D PIRKANMAA

KKI-AWARD 2006

KKI product since 2007

Concern of the childrens' obesity problem

Multidisciplinary work since 2004

⇒ Special project to improve childrens' nutrition education at day care 2011 - 2013

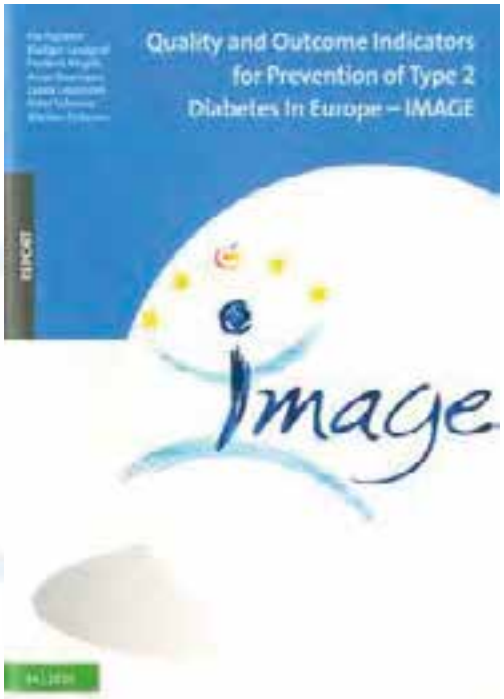
⇒ District care chain and service network 2013

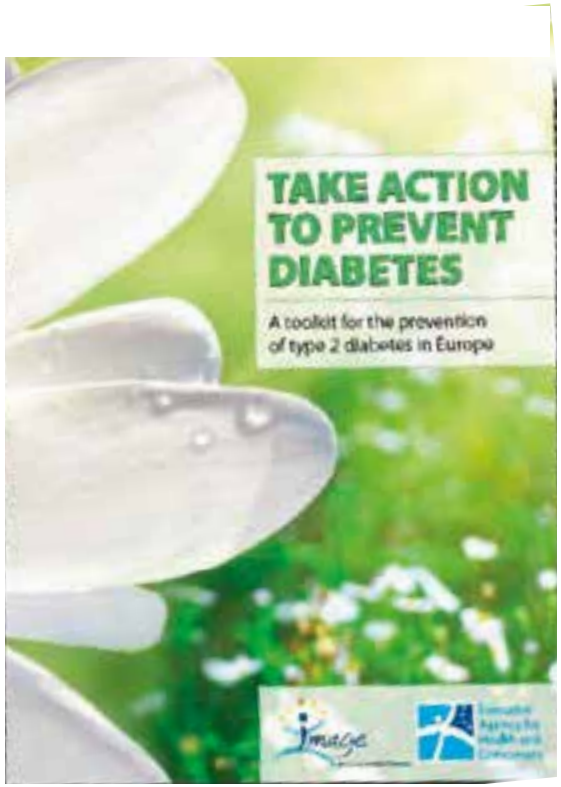
Pirkanmaa Hospital District

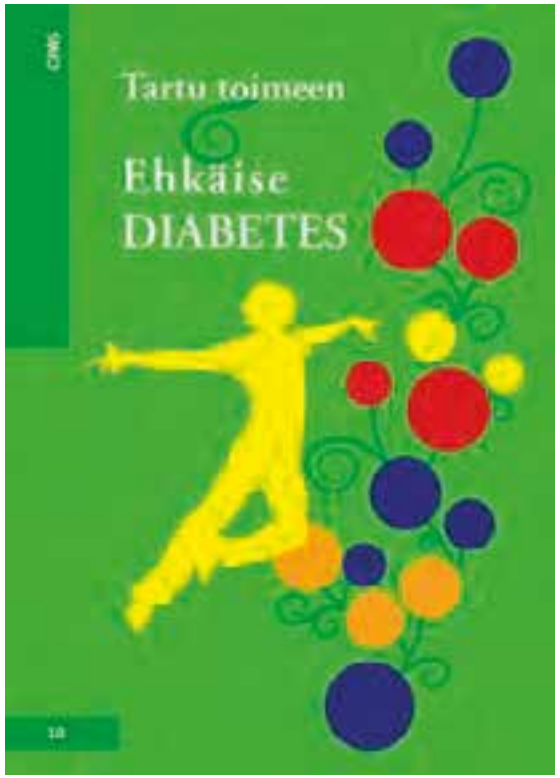
International Reporting Days 2006 and 2007 **WCPD** 2008

Pirkanmaa Hospital District

FIN-D2D ⇒ De Plan Project and Image Project (EU) and toolkits







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FIN-D2D
Results and Lessons Learned

Pirkanmaa Hospital District

FIN-D2D Survey 2004 (in three hospital districts): High prevalence of abnormal glucose tolerance in the middle-aged Finnish population (age group 45-74 yrs.)

	Men (n = 1396)		**Women** (n = 1500)	
Diagnosed type 2 diabetes	7.1%		3.9%	
Screen-detected type 2 diabetes	9.3%	**16.4%**	7.3%	**11.2%**
Impaired glucose tolerance	15.5%		17.0%	
Impaired fasting glucose	10.0%		5.2%	
Total*:	**42.0%**		**33.4%**	

* Age-adjusted

Saaristo T et al. BMC Public Health 2008.8:423

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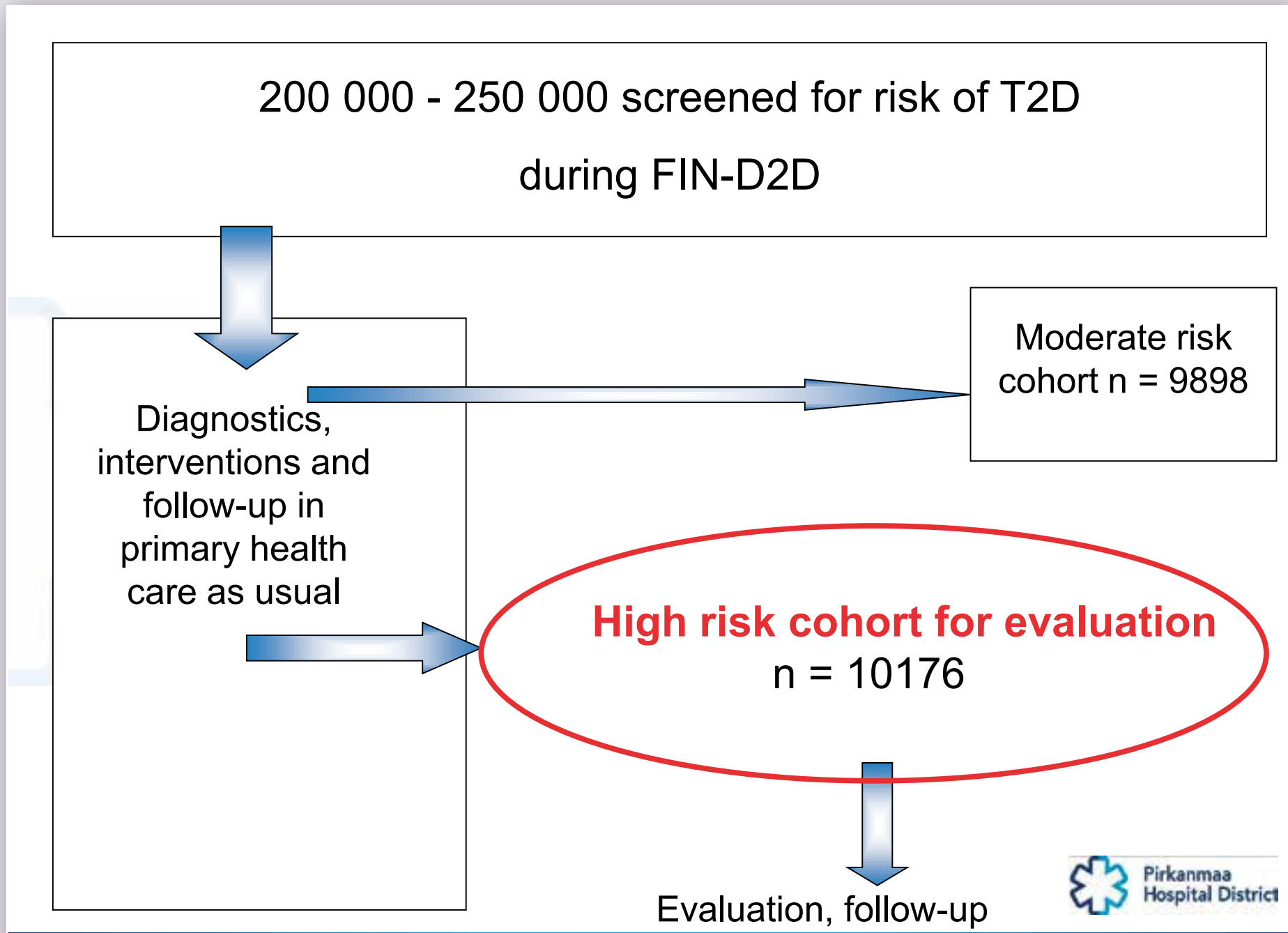
200 000 - 250 000 screened for risk of T2D
during FIN-D2D
Diagnostics, interventions and follow-up in primary health care as usual
Moderate risk cohort n = 9898
High risk cohort for evaluation
n = 10176
Evaluation, follow-up
Pirkanmaa Hospital District
51
16.3.2015
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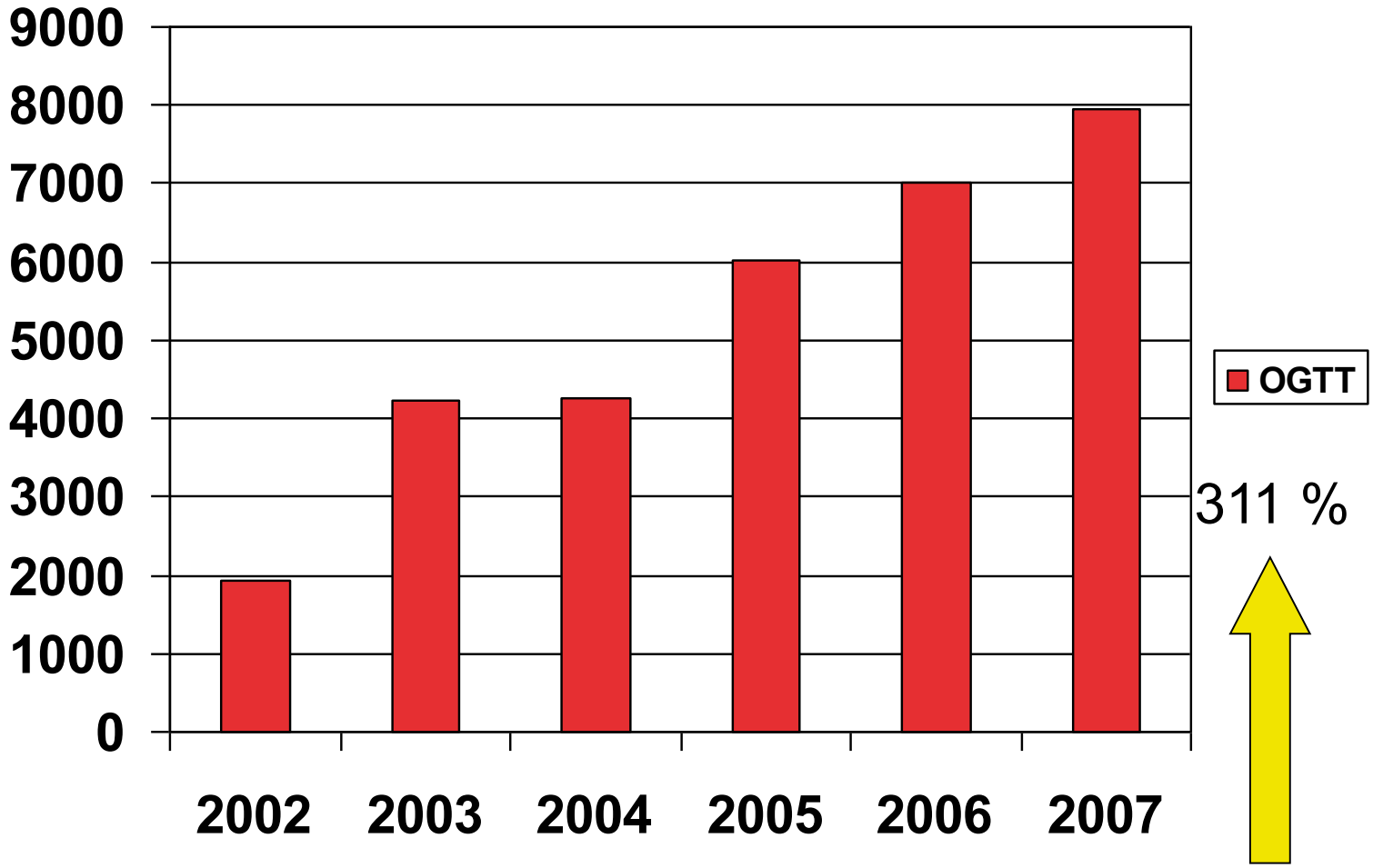
Performed Oral Glucose Tolerance Tests in the Pirkanmaa Hospital District 2002-2007



FIN-D2D high risk cohort participants

Number of participants 10 149 (33.4 % men)

	Mean
Age	53.6 (10.9) years
BMI, kg/m^2	31.3 (4.7)
BMI > 30 kg/m^2	59.6 %
Waist circumference	102.9 (13.1) cm
FINDRISC score	17.2 (3.2)

Saaristo T et al. Primary Care Diabetes 2010

Pirkanmaa Hospital District

Intervention visits in the high risk cohort of FIN-D2D

	%	
Number of visits	Men (n = 3421)	Women (n = 6845)
At least one	45	47
≥ 4	24	28
Visit to physician	33	27

Saaristo T et al. Primary Care Diabetes 2010

Pirkanmaa Hospital District

OGTT classification at the baseline and during the one year follow-up in the FIN-D2D high risk men and women

	Men (n = 926)		Women (n = 1972)	
OGTT	**Baseline**	**Follow-up**	**Baseline**	**Follow-up**
Normal	**39 %**	**45 %**	**54 %**	**60 %**
IFG	**30 %**	**23 %**	**18 %**	**16 %**
IGT	**31 %**	**22 %**	**28 %**	**19 %**
DM		**10 %**		**5 %**

Saaristo T et al. Primary Care Diabetes 2010

Pirkanmaa Hospital District

Change in risk factors in the FIN-D2D high-risk individuals during the 1st year of intervention, all hospital districts

	Men (n = 1492)		Women (n = 3196)	
	Baseline, mean	Absolute change	Baseline, mean	Absolute change
Weight kg	**96.5**	**-1.02**	**84.1**	**-0.88**
Waist cm	**107.8**	**-1.06**	**99.8**	**-0.98**
BP syst mmHg	**142.2**	**-0.75**	**138.9**	**-1.67**
BP diast mmHg	**88.1**	**-1.30**	**85.5**	**-1.33**
Cholesterol mmol/l	**5.1**	**-0.26**	**5.2**	**-0.12**

Saaristo T et al. Primary Care Diabetes 2010

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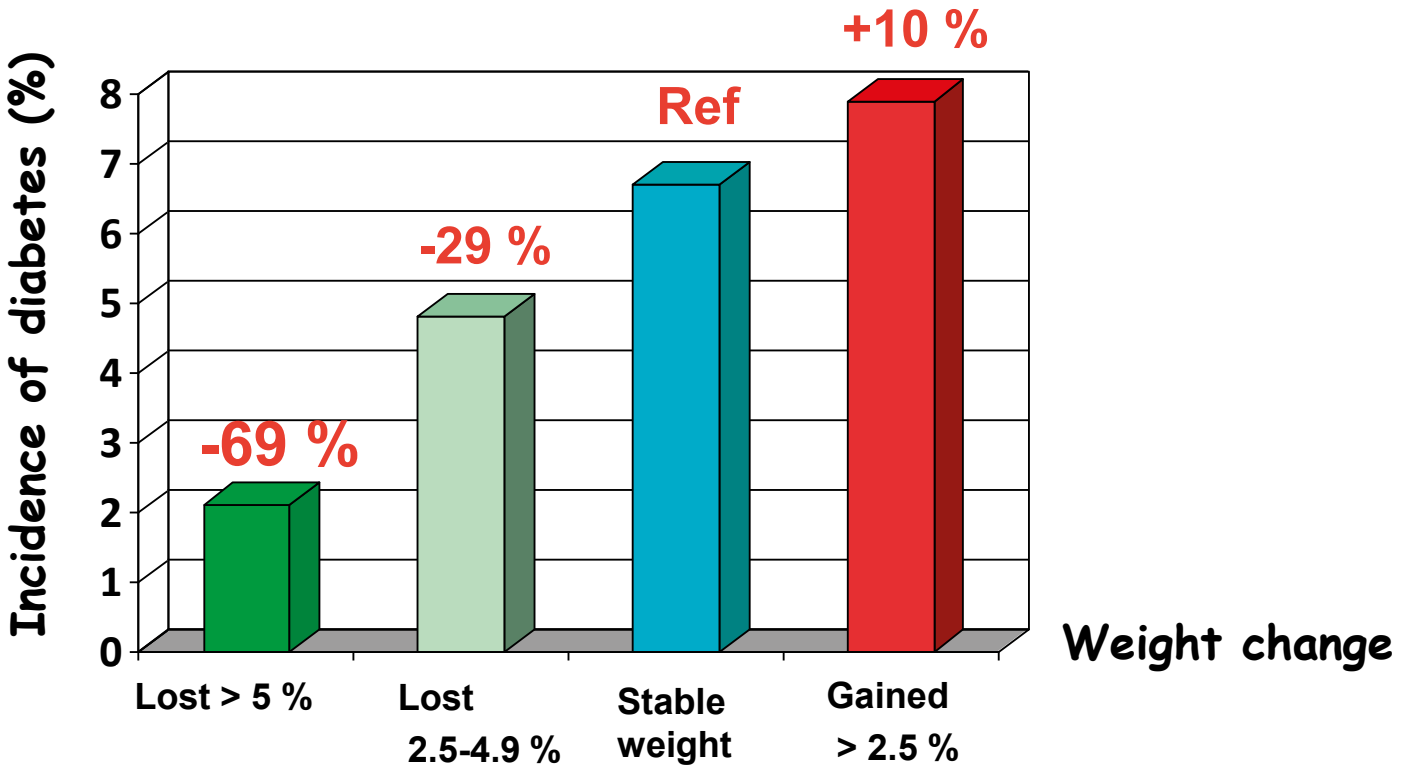
Diabetes risk in one year follow-up according to weight change in FIN-D2D

Adjusted to the age of 50



Diabetes Care 2010; 33: 2146-2151

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Results – practices and models (1)

FINDRISC has proved out to be a practical tool for screening and mini-intervention and a useful tool for the third sector.

D2D questionnaire has proved out to be a practical tool when identifying, registering and evaluating customers' habits. Shorter versions developed by Northern Savo and Pirkanmaa.

New material for the preventive work developed by the FIN-D2D was necessary.

The Model for the Stages of Change provides a practical model for understanding the character of changes in habits.

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Results (2)

FIN-D2D has shown the magnitude of the diabetic epidemic in Finland.

In 2004 the health care centres had no established practices for high-risk intervention.

During the project a multiprofessional local steering group co-ordinated the work in most health centres.

The D2D model has been adopted in most health care centres and some occupational health units for screening and interventions.

The FIN-D2D model has been included into the local and regional T2D prevention care protocols.

The FIN-D2D model has been adopted also for the prevention of other noncommunicable diseases.

Other prevention projects in Finland, De Plan, and Image Project in Europe have adopted the FIN-D2D model as well.

Pirkanmaa Hospital District

Results (3)

The need for nutrition and physical activity education became obvious. During the project health care professionals knowledge and skills of life style counselling improved.

Public nurses got a central role in the prevention of T2D. Multiprofessional guidance and support was needed.

Over 300 new models were documented.

Occupational health care got a new role in the prevention of T2D.

District and local networks of heath care, third, and private sector were established.

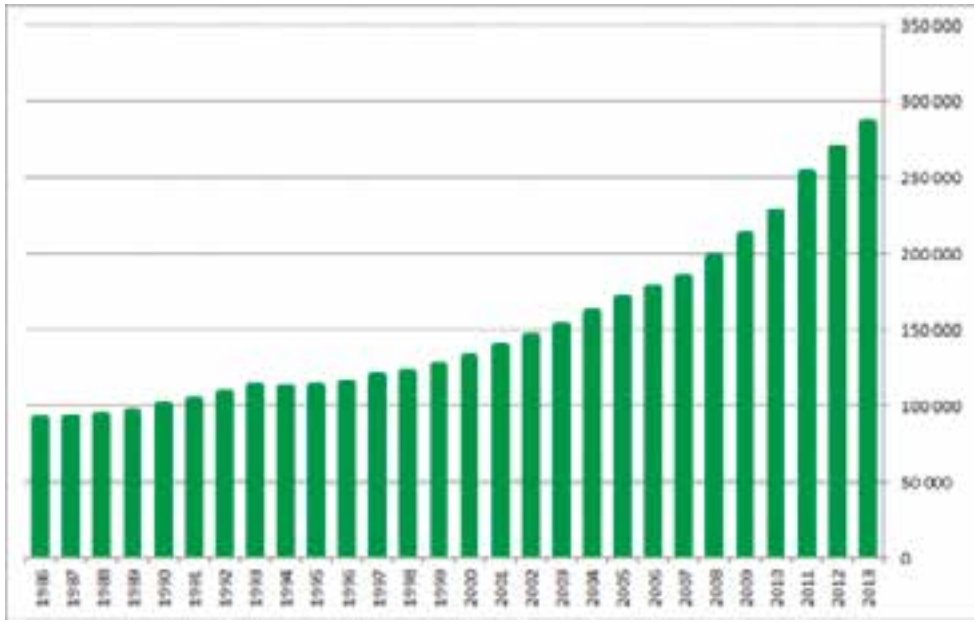
At the population level the awareness of T2D and its risk factors has increased.

Pirkanmaa Hospital District

Results – National Level

The Amount of diabetes patients based on reimbursement for diabetes medication (103) in Finland 1986 – 2013

The Social Incurance Institution of Finland

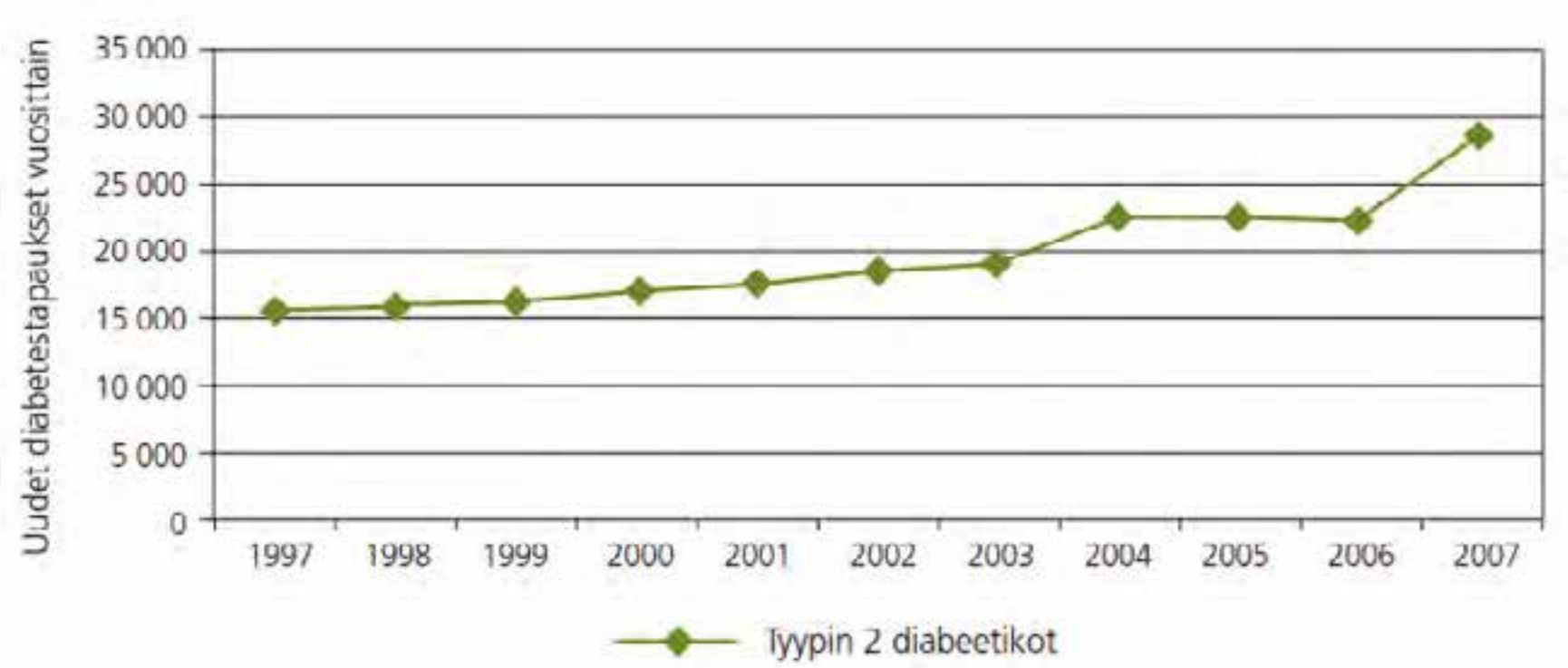


Kela: Diabeetikoiden määrä (erityiskorvausoikeus 103) 1986–2013

Suomen Diabetesliitto 2015

Pirkanmaa Hospital District

New T2D Patiens in Finland 1997 - 2007



Diabetesbarometri 2010

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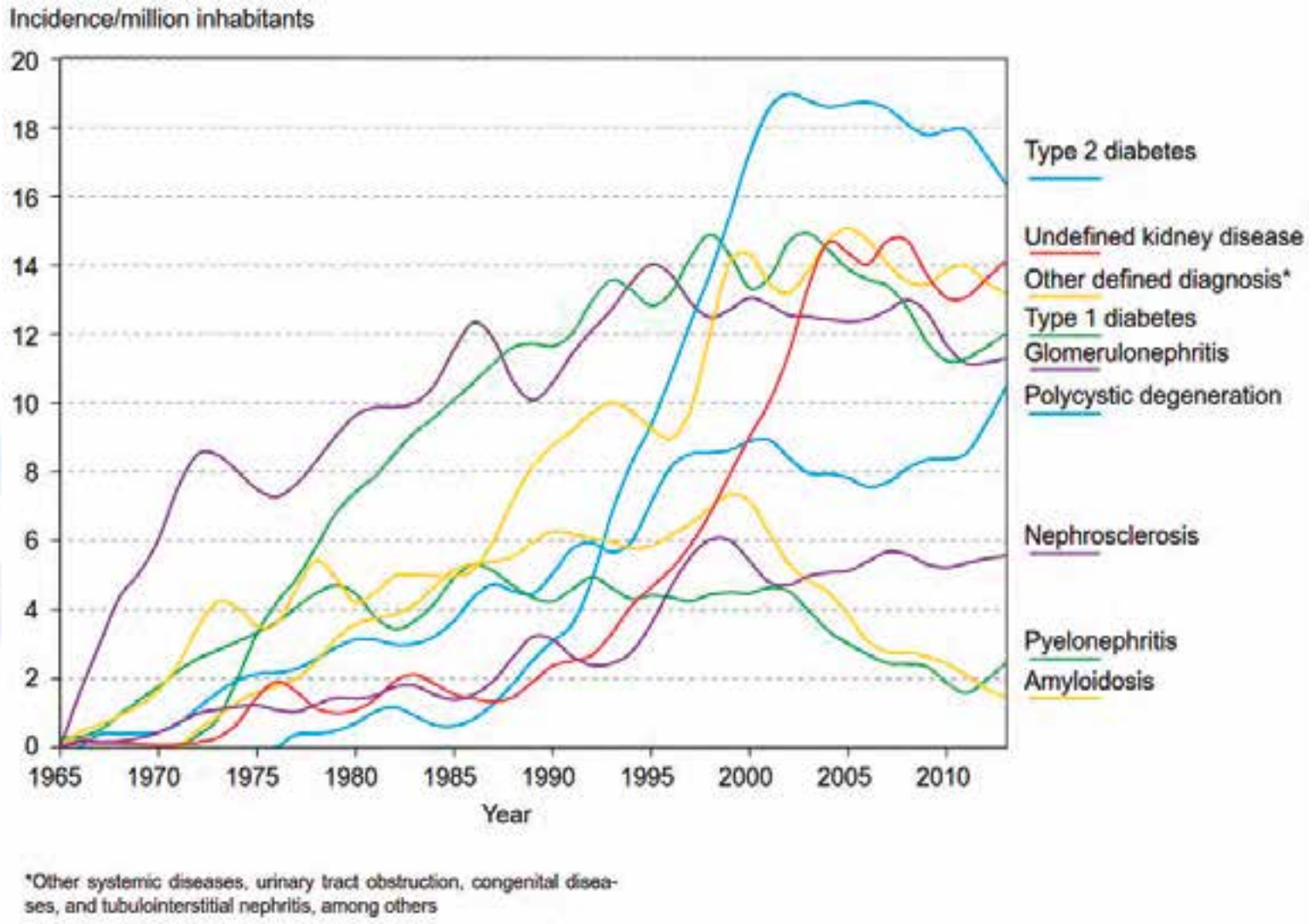
FIN-D2D Survey 2004 and 2007

Half of all T2D in the age group 45-74 are unidentified

Obesity trend in Finland seems to leveling off

Pirkanmaa Hospital District



Finnish Registry for Kidney Diseases – Report 2013

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Public awareness regarding T2D and its prevention has been raised

- Health communication and media visibility all over the country: TV, radio, journals, newspapers
- ”Look at yourself” campaign
- ”A small decision every day” campaign
- FIN-D2D exhibitions
- A wide selection of training material for people at risk
- Material for health care providers
- Various local innovations for raising awareness

Diabetes mentioned in the media in Finland during 1980-2006

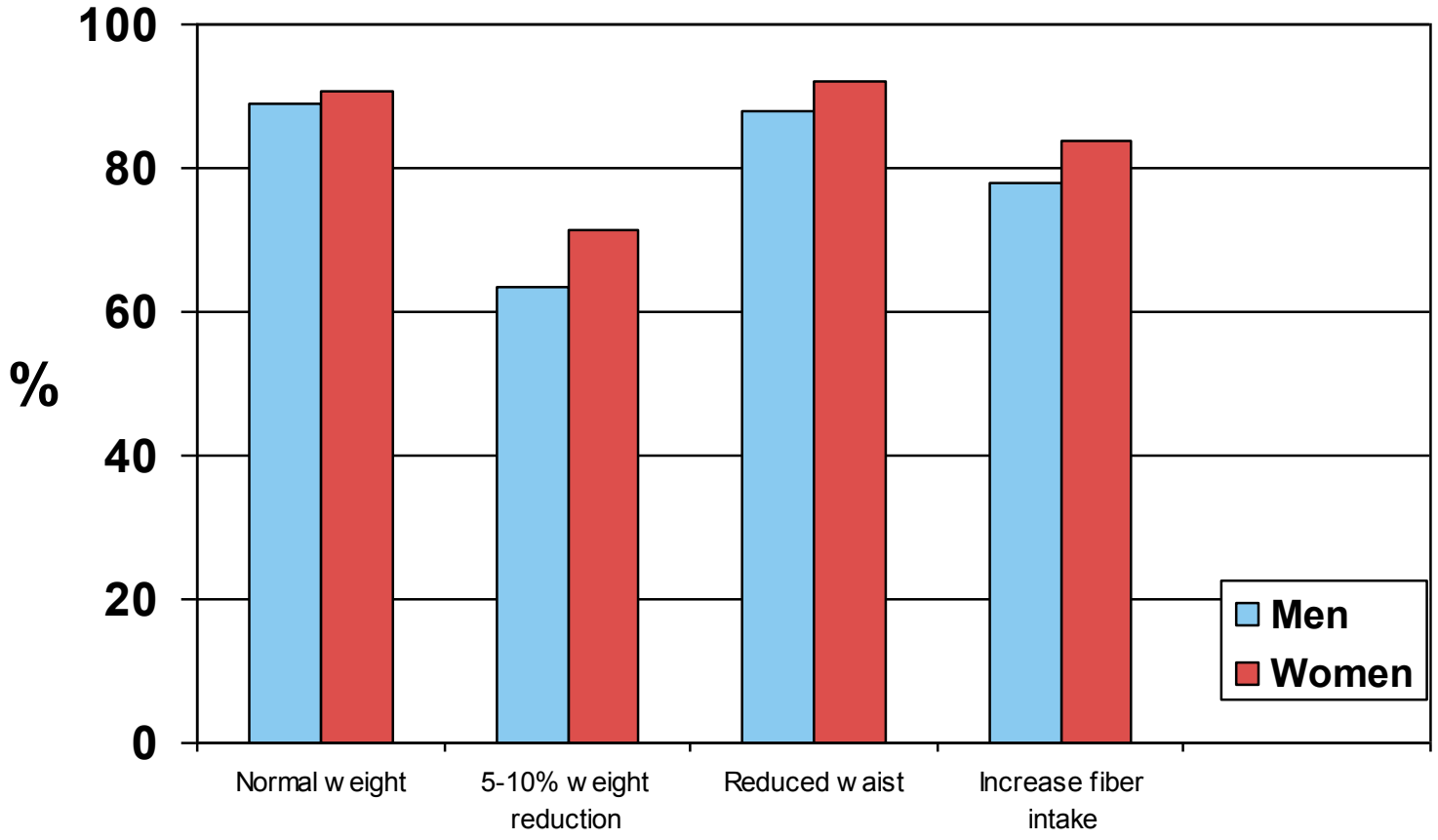
1980-1993	1300-1500
1994-1999	1800-2300
2000-2006	3700-6000

Finnish Diabetes Association 2008

Pirkanmaa Hospital District

Awareness of the prevention of diabetes in the 2007 population survey

Question: Which action results in the prevention of type 2 diabetes?



Pirkanmaa Hospital District

FIN-D2D: Factors to overcome

- Limited resources for prevention in primary health care.
- Strong focus on treatment, not prevention and health promotion, in primary health care.
- Lack of knowledge and skills of the health care personnel concerning life style modification.
- Lack of long term approach to life style modification.
- Lack of documentation and systematic follow-up of life style factors
- Lack of tradition and practices of group counselling.
- Lack of cross-sectional way of working in municipalities.
- Strict job descriptions limited cross-sectional work.
- FIN-D2D models and practices were seen as project work, not permanent practice in many health care centers.
- Physicians less committed to prevention work than other personnel.
- Men less active than women in participating in T2D prevention activities.
- Sedentary life style and unhealthy food habits as a counterforce to prevention.

Conclusions

Large-scale screening and effective life style intervention for preventing T2D are possible in primary health care setting.

There are plenty of interfering factors to overcome.

Change of paradigm is necessary both in health care organisations and in other sectors of public services.

Well-defined protocols for prevention and treatment, and systematically organised professional services are needed.

Local network and collaboration, and continuous multidisciplinary life style education and training are prerequisites for success.

Attention must be paid to the population strategy. The work must involve the entire community.

Politicians and other decision-makers are in a key role to realize the impact potential of health promotion and prevention of non-communicable diseases.

Pirkanmaa Hospital District

Acknowledgements

- **Pirkanmaa hospital district, health care centers, occupational health care**

  Heikki Oksa, Rauno Ihalainen, Ritva Himanka, Olli A Mäkinen, Anneli Salminen, Pirjo Aromaa, Scott Yoder

- **South Ostrobothnia hospital district, health care centers, occupational health care**

  Eeva Korpi-Hyövälti, Jaakko Pihlajamäki, Arja Hyytiä, Hilpi Linjama, Riitta-Liisa Rekiaro, Elina Leikkainen, Hannu Puolijoki

- **Northern ostrobothnia hospital district, health care centers, occupational health care**

  Sirkka Keinänen-Kiukaanniemi, Hannu Leskinen, Karita Pesonen, Jari Jokelainen, Leea Järvi, Antero Kesäniemi, Liisa Hiltunen

- **Central Finland hospital district, health care centers, occupational health care**

  Juha Saltevo, Mauno Vanhala, Timo Kunttu, Kaija Korpela, Jukka Puolakka, Illkka Kunnamo, Marita Poskiparta, Nina Peränen, Tapani Kiminkinen, Urho Kujala

- **Northern Savo hospital district, health care centers, occupational health care**

  Leo Niskanen, Matti Uusitupa, Matti Pulkkinen, Mervi Lehmusaho, Leena Moilanen, Annikki Sutinen, Markku Laakso

- **National Public Health Institute**

  Markku Peltonen, Jaakko Tuomilehto, Jaana Lindström, Pekka Puska, Johan Eriksson, Vladislav Moltchanov

- **Finnish Diabetes Association**

  Leena Etu-Seppälä, Jorma Huttunen, Satu Kiuru, Pirjo Ilanne-Parikka, Eliina Aro, Enna Bierganns, Jarmo Riihelä, Maria Aarne, Sari Koski, Tarja Sampo, Outi Himanen, Kirsi Heinonen, Liisa Heinonen, Mervi Lyytinen, Juha Mattila

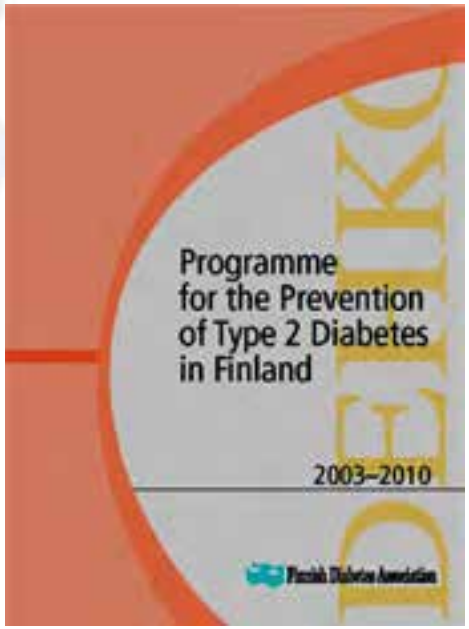
- **Other actors**

  Jouko Saramies, Aino Myllyluoma, Harri Sintonen Tapani Melkas, Jarno Viikki. Reijo Kärkkäinen, Noel Barengo, Pasi Aronen, Virginia Mattila, Robert Hollingsworth

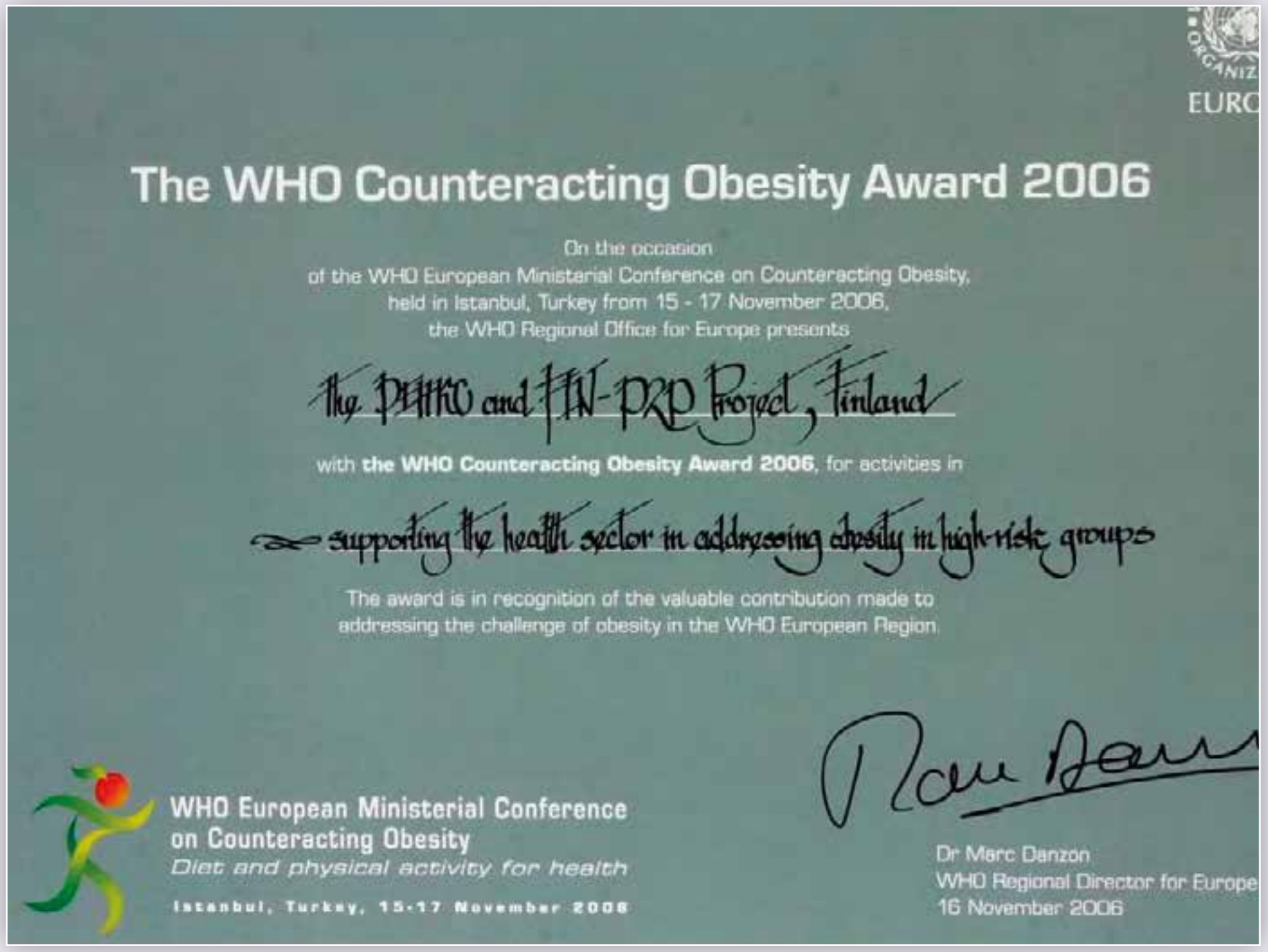
More information

www.diabetes.fi/en/finnish_diabetes_association/dehko

www.thl.fi (in English, på svenska, D2D)



Pirkanmaa Hospital District



The WHO Counteracting Obesity Award 2006

On the occasion
of the WHO European Ministerial Conference on Counteracting Obesity,
held in Istanbul, Turkey from 15 - 17 November 2006,
the WHO Regional Office for Europe presents

the PEPPO and FIN-PRP Project, Finland

with **the WHO Counteracting Obesity Award 2006**, for activities in

supporting the health sector in addressing obesity in high-risk groups

The award is in recognition of the valuable contribution made to
addressing the challenge of obesity in the WHO European Region

WHO European Ministerial Conference
on Counteracting Obesity
Diet and physical activity for health
Istanbul, Turkey, 15-17 November 2006

Dr Marc Danzon
WHO Regional Director for Europe
16 November 2006

The BSPC Working Group on Innovation in Social and Health Care
VRC, Tampere, 17 March 2015

Vaccine Research Center (VRC) and Vaccine Trial Network University of Tampere, Finland

Dr. Vesna Blazevic
Vaccine Research Center
University of Tampere

Academic Expertise in Vaccine Research

Vaccine Research Center
UNIVERSITY OF TAMPERE
Finland

Vaccine Research Center and Vaccine Trial Network

Director
Timo Vesikari, MD, Prof.
Lead Investigator
Office staff: 10

Clinical Trial Unit
Head: Aino Forstén, MD
Staff: 60

Vaccine Development Unit
Head: Vesna Blazevic, Ph.D.
Staff: 13

www.rokotetutkimus.fi

Main office
Biokatu 10
33520 Tampere, Finland

Vaccine Research Center - Concept

Established in 2004

All operations within the framework of University of Tampere

- Public institution but not connected with vaccine recommendations into NIP or purchases

1. Clinical trials (sponsored by the industry)
    - Medically and scientifically justified
    - Ethically approved
    - In children and adults
        - 11 study clinics (Helsinki-Oulu)
2. Basic (academic) research
    - Main target development of non-live norovirus-rotavirus vaccine
        - Research laboratory (Tampere)

Clinical trial phases of a new candidate vaccine

Phase I (safety)
- healthy adult volunteers

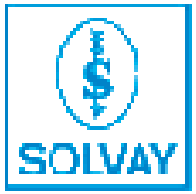
Phase II (safety and immunogenicity)
- adults and children

Phase III (safety and efficacy)
- efficacy trials in adults and children

Phase IV (real-life effectiveness and safety)
- postlicensure studies in target group

Vaccine Research Center does studies in all phases

Collaboration with Industry (vaccine manufacturers)



Vaccines in clinical trials at the VRC

- Rotavirus vaccines
- MMR-V vaccines
- Zoster vaccines
- Hepatitis B vaccines
- HPV vaccines
- Pneumococcal conjugate vaccines
- Meningococcal conjugate vaccines
- Meningococcal B vaccines
- Seasonal influenza vaccines
- Pandemic H1N1 influenza vaccine
- Prepandemic H5N1 vaccines
- Pediatric combination vaccines
- C.difficile vaccine

-condacted >80 vaccine trials

Number of study protocols per year

Rokotetutkimuskeskus
TAMPEREEN YLIOPISTO

Summary of the vaccine trials at the VRC

Clinical trials have been a successful operation within the University framework

Success scientifically and financially

- 70–100 persons employed for 15 years

Vaccine Research Center has made significant contributions to the licensure of several important vaccines:

- Live oral rotavirus vaccine
- Live intranasal influenza vaccine
- Meningococcal vaccines

Vaccine Research Center
UNIVERSITY OF TAMPERE
Finland

Live oral rotavirus vaccines

Two live oral rotavirus vaccines
licensed in 2006

Rotarix™ (GSK); “RV1”

Live attenuated human rotavirus
(first clinical trials done in Finland)

RotaTeq™ (SP MSD); “RV5”

Bovine-human reassortant rotavirus
Enrolment in Finland 23.429

Live RV vaccines have shown that RV gastroenteritis can be prevented by vaccination

Vaccine Research Center and Vaccine Trial Network

Recent challenges

Vaccine trials being conducted more internationally, with the share of Finland becoming smaller

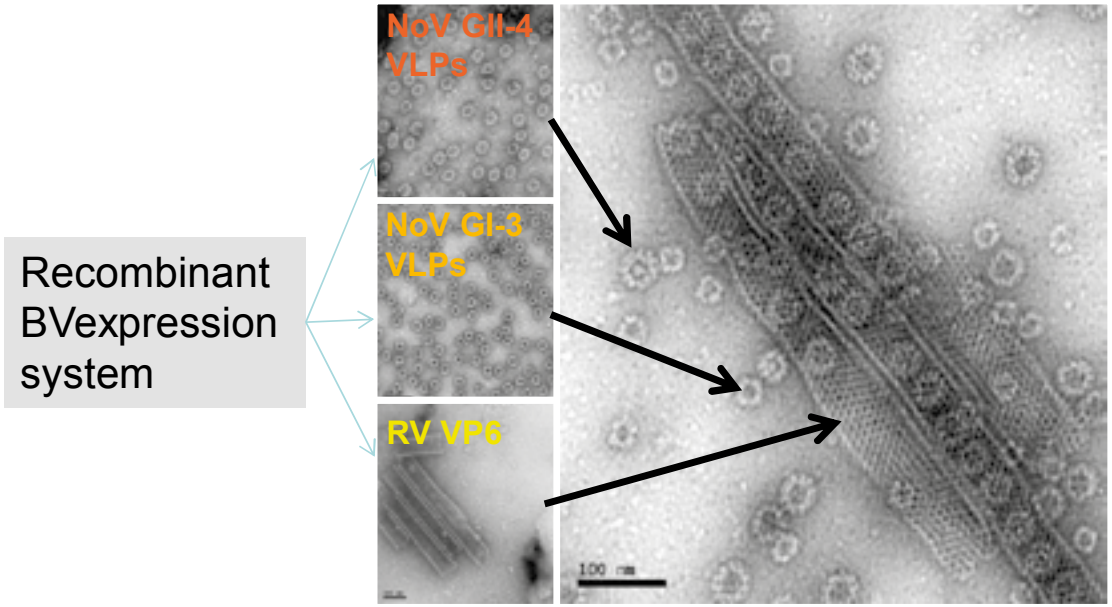
- NARCOLEPSY cases in Finland after pandemic influenza vaccine H1N1 (Pandemrix®) reducing recruitment into all vaccine trials

MORE INFORMATION AND CONFIDENCE BUILDING:
Web page, brochures, Facebook

Vaccine development: Combined vaccine against norovirus (NoV) and rotavirus (RV)

Original concept, since 2009:
- VP6 based heterologous protective immunity
- hypothesis that VP6 acts as an adjuvant to NoV VLP's

Non-live recombinant subunit vaccine -> NoV virus like-particles (VLPs) + RV VP6



Rationale for a combined vaccine against NoV and RV gastroenteritis (GE)

- Two most important causative agents of acute childhood GE globally
  - Annual deaths in children <5y: 450.000 for RV and 200.000 for NoV
- Same target age group from <6 months to 5 years for both viruses
- An effective NoV + RV combination vaccine would eliminate most of severe acute GE in children in developed countries
- No vaccine available for NoV (constrain: virus does not grow in cell culture)
- Live oral RV vaccines exist-> non-live vaccines are being considered (poor vaccine efficacy in developing countries)

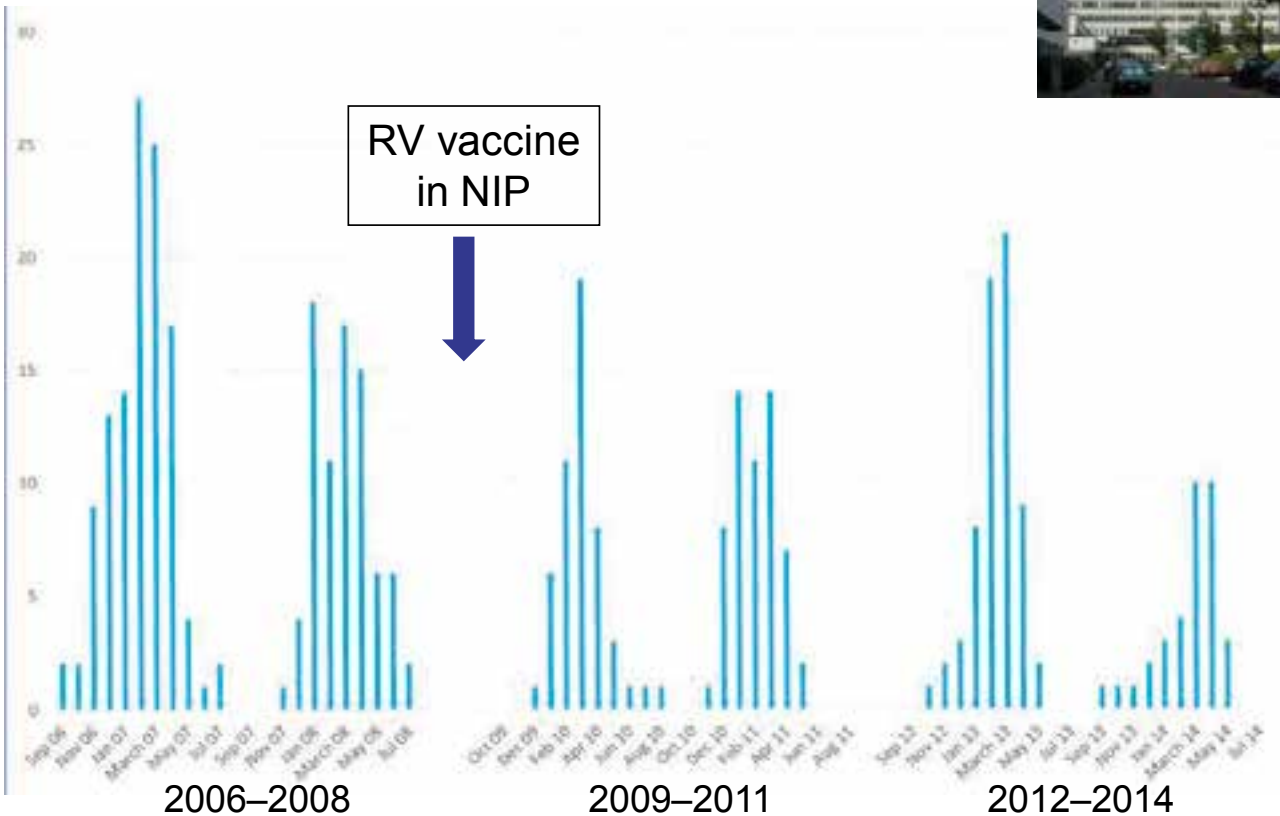
Norovirus gastroenteritis

1. Endemic (“sporadic”) NoV GE in children
2. The leading cause of food- and water-borne outbreak related NoV GE in all age groups

- military
- cruise ships
- schools
- the elderly in nursing homes

The same are potential targets of NoV vaccination

Norovirus gastroenteritis in Tampere University Hospital



2006–2008
24%

2009–2011
34%

2012–2014
27%

→ Norovirus has became the leading cause of AGE in children seen in hospital

Hemming et al. 2014

Applications of a combined NoV-RV vaccine in children

- For infants
  - Vaccinations before the age of 6 months and at 12 months
  - ➢ Primary and booster immunization for both RV GE and NoV GE

- For toddlers (vaccinated with the live oral RV vaccine according to NIP)
  - Vaccinations at the age 12-18 months
  - ➢ Primary vaccination against NoV GE and booster vaccination against RV GE

Patent family of the invention

"Norovirus capsid and rotavirus VP6 protein for use as combined vaccine"

Country	Appl. no.	National filing date	Status
Australia	2011315405	23.4.2013*	Pending
Brazil	BR1120130091649	15.4.2013*	Pending
Canada	2,814,175	9.4.2013*	Pending
China	201180049612.4	15.4.2013*	Pending
EPO	11832191.8	18.4.2013*	Pending
Finland	20106067	15.10.2010	Granted
India	723/MUMNP/2013	12.4.2013*	Pending
Japan	2013-533249	12.4.2013*	Pending
South Korea	10-2013-7012218	10.5.2013*	Pending
Mexico	MX/A/2013/004159	12.4.2013*	Pending
Russia	2013121815	13.5.2013*	Pending
Singapore	201302797-4	12.4.2013*	Granted
Taiwan	100137092	13.10.2011	Granted
USA	13/269,326	7.10.2011	Granted
* based on international filing date of 12.10.2011			

Licensing and Development Agreement with UMN Pharma and University of Tampere Vaccine Research Center in 2012

UMN Pharma Inc.
Addressing Unmet Medical Needs

- Clinical grade (GMP) production of the vaccine components together with Protein Sciences Corporation
- Preclinical and clinical testing of the vaccine
- Bigger partner needed in the near future

Kiitos!
Thank you

Academic Expertise in Vaccine Research

Vaccine Research Center
UNIVERSITY OF TAMPERE
Finland

Åland 11-12 June 2015

Thursday 11 June

1220-1330	Expert presentations by **Professor Dag Nyman** on the Clinic of Borellios Research, and by **MD Mathias Grunér** on the laboratory BIMEX
1330-1500	Expert presentations by Ålandic Minister of Health, **Carina Aaltonen**, Chief Medical Officer **Fredrik Almqvist**, Doctor of Infections **Marika Nordberg**, and **MD Katarina Dahlman**
1700-1900	WG meeting and preparation of WG Final Report

Friday 12 June

0900-1230	WG meeting and preparation of WG Final Report

The BSPC Working Group on Innovation in Social and Health Care (BSPC WG ISHC) held its **sixth meeting** on the Åland Islands on 11-12 June 2015. The meeting itself was preceded by a study tour of Health Care Clinic Medimar and Åland Central Hospital. The Working Group was briefed by **MD Mathias Grunér**, CEO Bimelix, on the Bimelix Laboratory and the Medimar Borrelia Clinic. Bimelix Biomedical Laboratory is based in Åland and provides laboratory services in microbiology for health care in Finland and other Nordic countries. It possesses unique expertise in tick-related diseases and specializes in Lyme disease. **Prof. Dag Nyman** from Medimar followed up with a presentation on lyme borreliosis. It is the most common vector-borne infectious disease in northern Europe. At the Åland Central Hospital **MD Katarina Dahlman** spoke about challenges with a hospital on a small island. The hospital is responsible for all public healthcare on the Åland Islands. Doctor of Infections, **Marika Nordberg**, followed with a presentation on tick-borne encephalitis (TBE) on the Åland Islands. Associate Professor of Surgery, **Mr Haile Mahteme**, shared his thoughts with the WG members on why he believes health professionals on Åland care more about their patients' well-being than elsewhere. Finally, the Åland Minister for Health, **Ms Carina Aaltonen**, spoke about Public Health on the island.

Lyme Borreliosis

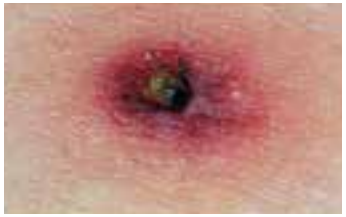
Dag Nyman

Medimar, Åland

Lyme Borreliosis is------

- A multisystemic vector-borne, inflammatory infectious disease

- Caused by the **immune-defence** to spirochetes of the Borrelia burgdorferi s.l. complex
- The most common vector-borne infectious disease in North-Europe

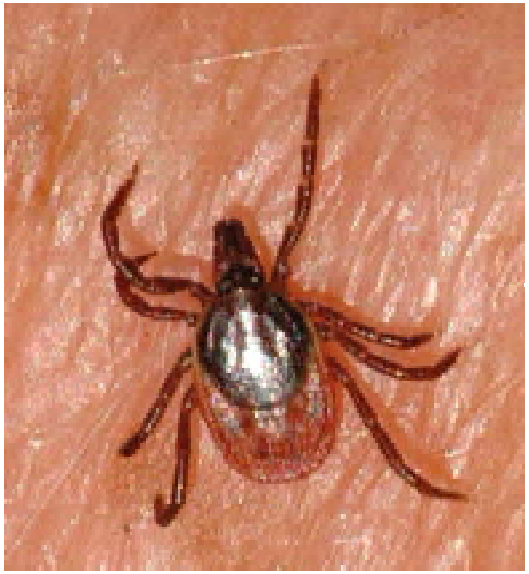


Borrelia burgdorferi s.l. and others

- B. b. sensu stricto
- B. afzelii
- B. garinii
- B. bavariensis
- B. spielmanii, valaisana
- B. miyamotoi

- Other – TBE, Anaplasma, Rickettsia SFG, Tularemia, Candidatus Neoehrlichia mikurensis

Ticks are the vectors



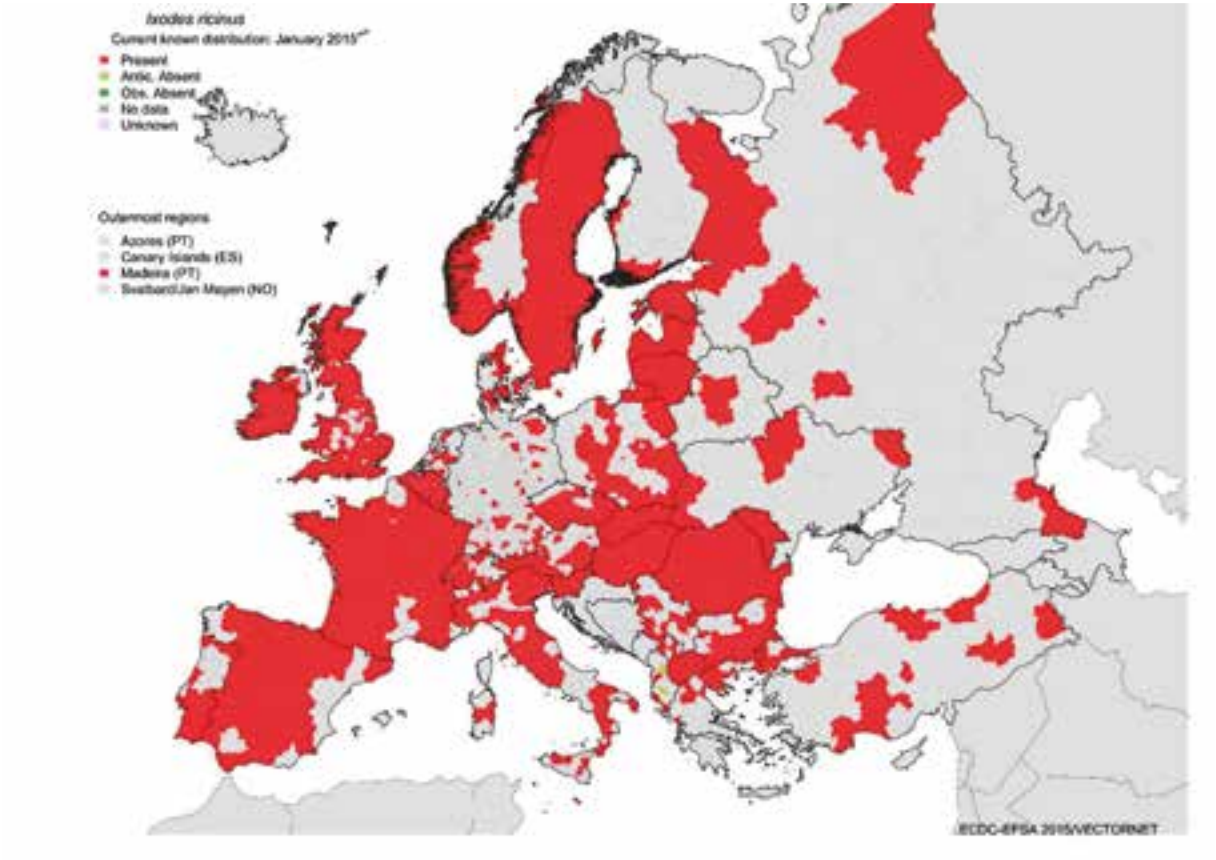
I. ricinus

I. persulcatus

Why a borreliosis clinic?

- Epidemiology
- Diagnostics and differential diagnostics
- Treatment
- Chronic infection
- Persisting symptoms

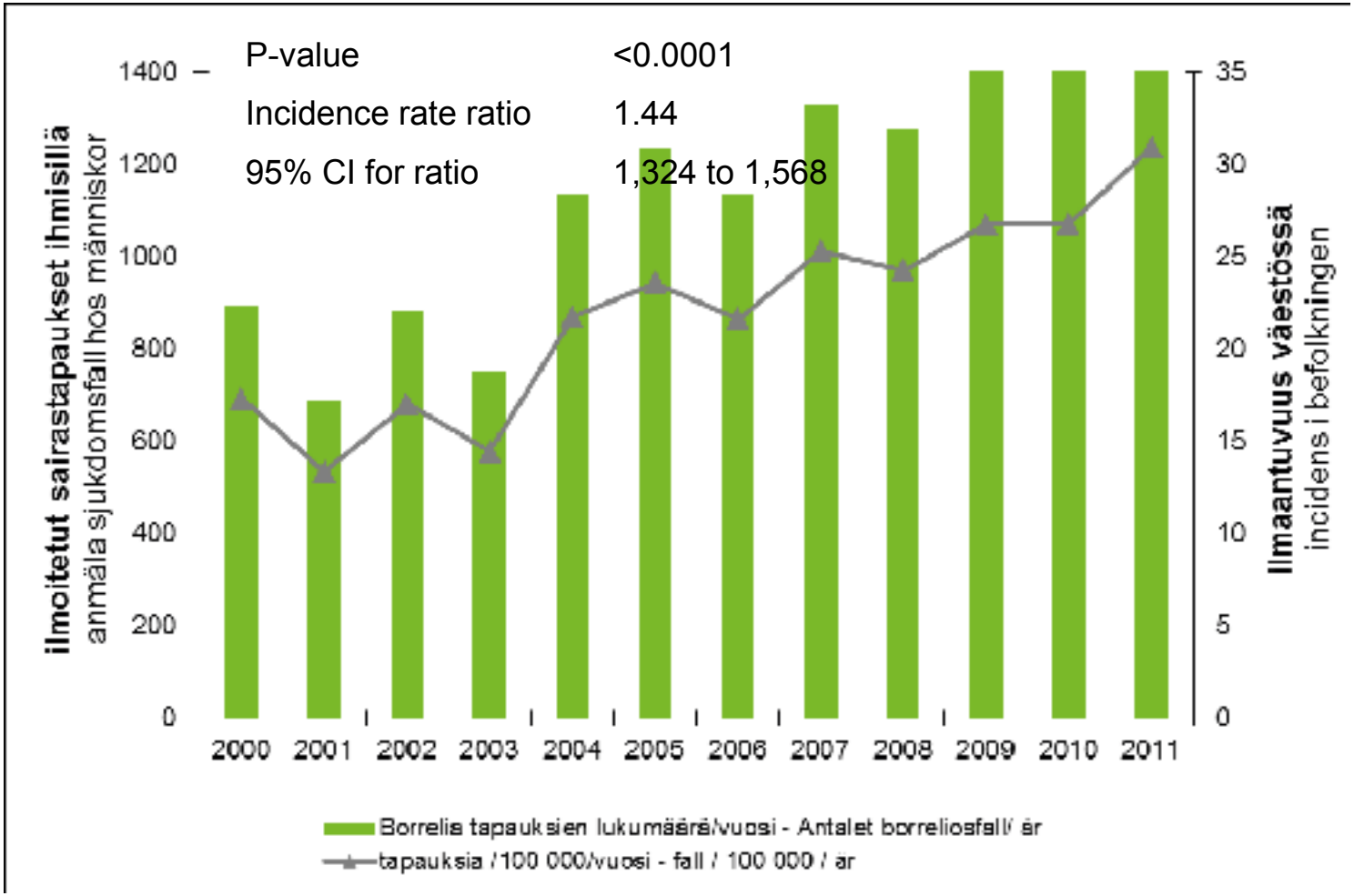
Ticks in Europe



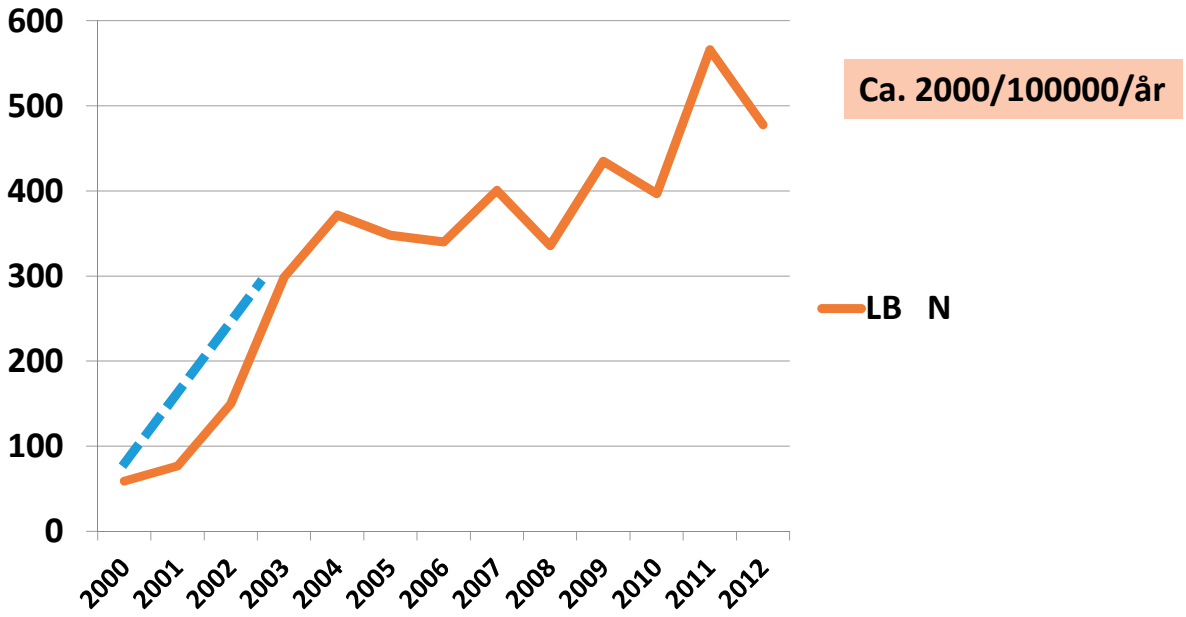
ECDC 2015

Reported borreliosis 2000-2011
(IHW Finland)

Serology based incidence!



Clinical borreliosis 2000 -2012 Åland



Borrelia prevalence and species in ticks, Åland Islands

Tick stage	No. (%) of ticks	No. (%) of positive	No. (%) of ticks containing *Borrelia* species determined by nucleotide sequencing								
			B. a	*B. g*	*B. v*	*B. b*	*B. m*	*B. s*	*B. l*	Mixed	UT
	777	178 (23)	86 (48)	42 (24)	14 (8)	4 (2)	2 (1)	5 (3)	--	1(1)	24 (13)
Adult male	5 (1)	--									
Adult female	118 (15)	35 (30)	10 (28)	11 (30)	5 (14)	3 (8)	1 (3)	1 (3)			4 (11)
Nymph	587 (74)	143 (24)	76 (53)	31 (21)	9 (6)	1 (1)	1 (1)	4 (3)		1 (1)	20 (14)
Larva	67 (8)	--									

Wilhelmsson 2013

Borrelia in ticks from Estonia

- Ixodes ricinus 8.2% (2293)
- Ixodes persulcatus 9.7% (2833)
- Total 4.7 - 24.2 % regional variation

- The most prevalent genospecies was *B. afzelii* which was detected in 53.5% of *Borrelia*-positive ticks, followed by *B. garinii* and *B. valaisiana* with 26.2% and 5.5%, respectively.

Geller *et al. Parasites & Vectors* 2013 **6**:202

Borreliosis in Europe

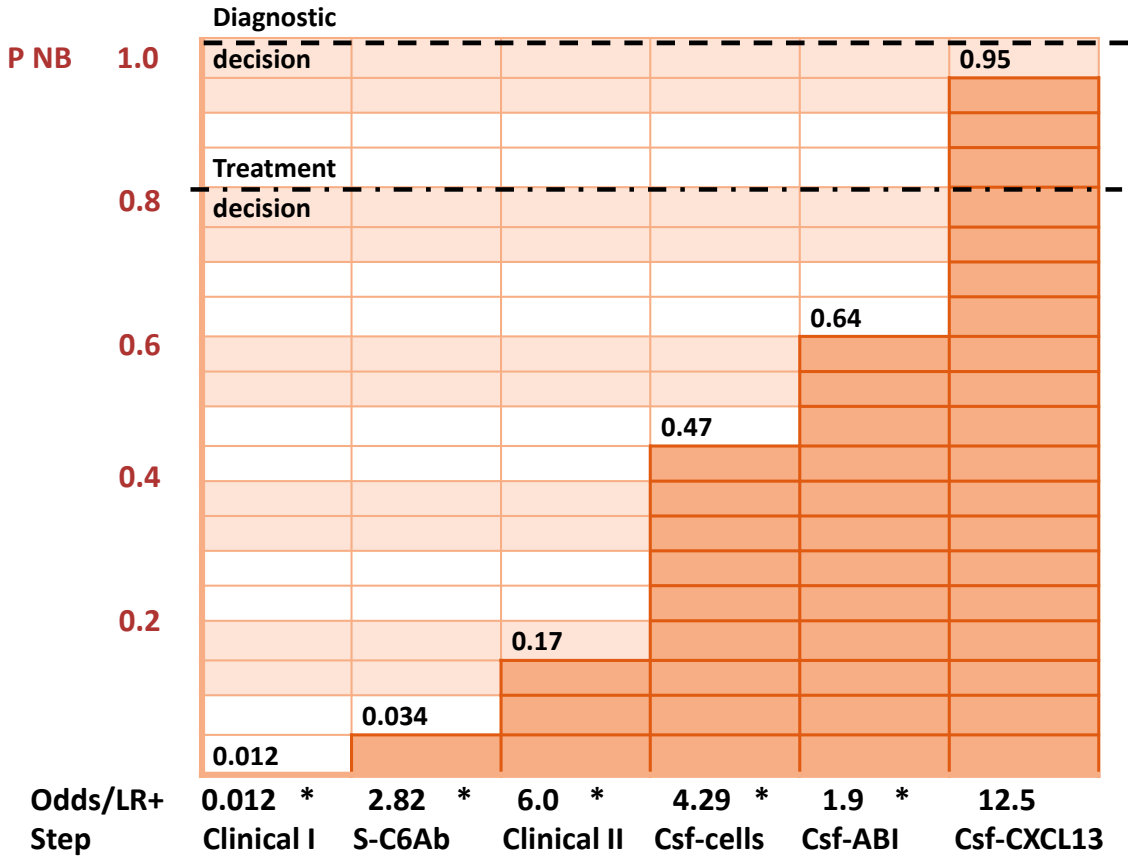
Year	2001		2002		2003		2004		2005	
Country	Incidence	[cases]	Incidence	[cases]	Incidence	[cases]	Incidence	[cases]	Incidence	[cases]
Slovenia	163	[3232]	169	[3359]	177	[3524]	193	[3849]	206	[4123]
Austria	-	-	-	-	-	-	-	-	135	-
Netherlands	74	[12000]	-	-	-	-	-	-	103	[17000]
Lithuania	33	[1153]	26	[894]	106	[3688]	50	[1740]	**34**	[1161]
Finland	13	[691]	17	[884]	14	[753]	22	[1135]	**24**	[1236]
Latvia	16	[379]	14	[328]	31	[714]	31	[710]	**21**	[493]
Estonia	25	[342]	23	[319]	42	[562]	36	[480]	**21**	[281]

Diagnosis

- Clinical picture
  - early, late
  - localized, disseminated
  - organ involved

- Laboratory verification
  - which test when
  - diagnostic performance

BUILDING A DIAGNOSIS NB



Nyman 2014

Do not be afraid of the nature!

MEDIMAR
borrelliaklinik

biMELix
BIOMEDICAL LABORATORY
specialized in borreliosis

Bimelix Laboratory and

Medimar Borrelia clinic

11.6.15 Medimar

Mathias Grunér, CEO Bimelix

Bimelix – unique competence in tick-related diseases, specialized in Borreliosis

- Accredited EN ISO 15189, FINAS
- The Bimelix test algorithm – a result of decades of research
  - Combines the best commercially available test systems
  - Developed after years of continuous **in-house research**
  - All possible outcomes for the patient are handled with minimum amount of re-visits

FINAS
Finnish Accreditation Service
T266 (EN ISO 15189)

MEDIMAR
borrelliaklinik

biMELix
BIOMEDICAL LABORATORY
specialized in borreliosis

Medimar Borrelia clinic

- Connects **clinic** and **laboratory**
  - **Medimar**, Borrelia Team
  - **Bimelix**, specialized in Borrelia diagnostics
- The fastest track to appropriate care

Borrelia clinic – comprehensive care package

- Borrelia clinic offers a **Borrelia Team:**
  - **Specialized physicians, nurses, physiotherapists and CBT therapist**

- Comprehensive care **package:**
  - **Blood tests, treatment, rehabilitation, follow-up and further investigations**

Professor Dag Nyman, Kliniskt ansvarig

Prof. Dag Nyman: " we offer safe methods to efficiently rule out borreliosis and can also perform further investigations and treatment plans for possible other causes of observed symptoms. An active borreliosis can in most cases be diagnosed and treated accordingly"

MEDIMAR borrelieklinik | biMELix BIOMEDICAL LABORATORY specialized in borreliosis

Mathias Grunér

Bimelix/Medimar Borreliaklinik

mathias.gruner@bimelix.ax

www.borreliakliniken.ax
www.bimelix.ax


www.
borreliakliniken
.ax

Borreliakliniken.ax

II.
WG homework

II. WG homework 1

The WG conducted three sets of homework on the general nature of public strategies and measures of ISHC, the ethical aspects of ISHC, as well as the demographic perspectives and the mobility of elderly. The homework was conducted to get an overall view of the issues at hand, prepare upcoming WG meetings and questions for experts, as well as to provide input and inspiration to the political recommendations of the WG.

Questions to the BSPC Member States on the general nature of public strategies and measures of ISHC

1. What, from your perspective, are the main challenges facing social and health care today and in the future?

2. Have you launched any public strategies and programmes for ISHC? Are any new initiatives planned? What are your experiences and results so far concerning public programmes and measures to support ISHC?

3. Have you launched any public awareness campaigns concerning ISHC? Are any new initiatives planned?

4. Have you launched any public economic support mechanisms for ISHC, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?

5. In general, what do you see as the main obstacles for promoting and implementing ISHC? What kind of political support and measures are conceivable to overcome the obstacles?

II
WG homework 1
Answer from Denmark

BSPC Working Group on Innovation in Social and Health Care

Homework 1

Contribution from Denmark

1. What, from your perspective, are the main challenges facing social and health care today and in the future?

- To ensure sustainable healthcare in times of economic constraint and demographic pressure
- To strengthen disease prevention and health promotion
- To strengthen prevention and treatment of psychiatric conditions
- To ensure high quality and evidence based treatment and care
- To include patients in decision-making and to promote patient empowerment
- To make patient pathways coherent and transitions smooth
- To ensure equality in healthcare

2. Have you launched any public strategies and programmes for ISHC? Are any new initiatives planned? What are your experiences and results so far concerning public programmes and measures to support ISHC?

e-health strategy 2013-2017
In June 2013, the Danish Government, Local Government Denmark [Kommunernes Landsforening] and Danish Regions launched a new strategy for digitalization of the Danish healthcare sector. The strategy sets the direction for the digitalization efforts in the health care sector till 2017.

The title of the strategy is "making e-health work". This is to emphasize that the main focus of the strategy is to ensure that we fully exploit the potential and benefits of existing digital solutions in the health care system.

National action plan for dissemination of telemedicine
In august 2012, the Danish Government, Local Government Denmark and Danish Regions launched a national action plan for dissemination of telemedicine. The main aim of the plan is to speed up large scale spreading of telemedicine solutions that we know work.

With the plan we have launched the biggest telemedicine initiatives in Denmark to date including:

- Nationwide telemedical assessment of ulcers: By using telemedicine, the nurse in the local home care together with the doctors at the hospital will be able to treat patients' ulcers

more efficiently and with greater patient satisfaction. We expect to reduce healing time by 30 percent.

- Nearly 1,500 patients in Northern Jutland with severe or very severe C.O.P.D. [Chronic obstructive pulmonary disease] will have their disease monitored by the use of telemedicine.

Partnership for healthcare- and hospital innovation
The Market Development Fund (Markedsmodningsfonden) and the five Danish regions have established a partnership for healthcare and hospital innovation. The purpose of the partnership is to develop new and effective products and solutions for the new Danish hospitals under construction. The partnership has funded 14 new products where private companies and public hospitals collaborate to develop products in the areas of logistics, telemedicine and hygiene.

Testing and adapting new products for healthcare and welfare
The Market Development Fund has granted funding for 40 projects where private businesses and public sector institutions together test new innovative solutions for either healthcare or welfare. The projects are aiming to commercialize the tested products. The Market Development Fund has also granted funding for 12 public sector institutions that are working in innovative ways to purchase new products that will enhance the public service in healthcare and welfare. These projects include pre-commercial procurement efforts and other innovative procedures for procurement.

Total cost of ownership models for the health and welfare sector
During the next two years the Danish Ministry of Business and Growth will chair a working group with participants from relevant ministries, municipalities and regions which will develop total cost of ownership models for selected health and welfare areas. The aim of the initiative is 1) to make it easier for public sector institutions to calculate total costs associated with the purchase and procurement of innovative health and welfare sector solutions, and 2) to stimulate additional private sector development of innovative cost reducing products and services with export market potential.

Market development test projects
During 2014 the Danish Ministry of Business and Growth will chair a working group with participants from relevant ministries and regions which will select market development projects related to the development of new hospitals. The aim of the initiative is to make it possible for private businesses to benefit from knowledge and competencies in the public health system, in order to develop specific products and services that can be marketed internationally as well as acting as service operators within areas such as logistics, assistive technology solutions etc.

Government strategy for intelligent public procurement
The strategy aims to promote efficient public procurement that supports innovative solutions, green public procurement and the use of total cost of ownership. The Strategy introduces seven guiding principles for intelligent public procurement, e.g. increased use of functional requirements in public tenders. To promote a differentiated approach to public procurement the strategy comprises 29 different initiatives including a cross sectorial test programme for innovative and pre-commercial procurement.

3. Have you launched any public awareness campaigns concerning ISHC? Are any new initiatives planned?

Denmark has initiatives such as "the health promotion packages". The purpose of the health promotion packages is to give the municipalities in Denmark an evidence-informed tool to assist municipal decision-makers and health planners in setting priorities, planning and organizing local health promotion and disease prevention initiatives.

Health promotion packages are prepared for significant risk factor areas within which the municipalities are already active and that are expected to require considerable focus in the coming years because of new evidence and developing societal norms.

Health promotion packages focusing on tobacco, alcohol, physical activity, mental health, sexual health, sun protection, indoor climate in schools, hygiene, healthy food and meals have been published, and packages on obesity and preventing drug abuse are underway.

4. Have you launched any public economic support mechanisms for ISHC, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?

- As a part of the new e-health strategy 2013-2017 and the National action plan for the dissemination of telemedicine, DKK 155 million has been allocated to investments in telemedicine.

- Denmark has for a number of years funded a public, strategic health research programme. The funding is allocated by The Danish Council for Strategic Research. The council announces an open call on a yearly basis, and the funding is allocated as relatively large grants. The research covers a broad range of health topics and is often carried out in public-private collaboration. The research aims at contributing to solving important societal challenges within health, and contributes to innovation within public health service and organization. For further information about the council: http://fivu.dk/en/research-and-innovation/councils-and-commissions/the-danish-council-for-strategic-research?set_language=en&cl=en

- The Council for Technology and Innovation has not funding dedicated to specific thematic areas. The council has – among other things - financed innovation activities within health and welfare technology by drawing up performance contracts with the nine institutions in the Advanced Technology Group (GTS institutions) in Denmark, especially Bioneer (medicine and biotechnology), Danish Technology Institute (medicine, biotechnology and welfare technology) and DELTA (welfare technology and medical equipment). The council has also approved three Innovation Networks within the field of health and welfare that spans from July 2014 to July 2018; two of which are new Innovation Networks within welfare technology and medico technology respectively. The thirds is a continuation of the established network Bio-people: an Innovations Network for Bio-health. For further information about the council: http://fivu.dk/en/research-and-innovation/councils-and-commissions/the-danish-council-for-technology-and-innovation?set_language=en&cl=en

- In 2011 The Danish Council for Strategic Research has - in collaboration with The Danish Council for Technology and Innovation - funded a strategic platform for research and innovation regarding welfare technology. The platform is a public private collaboration with

53 partners involved with a total budget of 190 m. DDK. The platform is aiming at developing new welfare technology solutions for the benefit of patients, the health care sector and private enterprises in the social and healthcare sector.

- In 2014 Denmark will initiate a societal partnership on innovation regarding clinical research. The funding for the partnership will be allocated by a new foundation called The Danish National Innovation Foundation. The foundation is expected to be established by April this year. The partnership will be a public-private collaboration aiming at making Denmark the preferred country for conducting early stage clinical trials on new medicines within a number of disease areas and within a period of five years. The partnership is to establish three to five pilot centers for experimental treatment and clinical proof of concept studies of a quality that can attract 10-20 studies of new medicines in the centers. The center solutions developed are expected to be able to strengthen professional competencies at hospitals through excellent research environments, boosting quality of treatment and health service efficiency. At the same time the solutions will further strengthen the strong Danish business cluster in the field. For further information about the partnership: http://fivu.dk/en/publications/2013/inno-catalogue

- There are a number of other public councils and foundations within the field of research and innovation supporting research and innovation activities regarding social and healthcare topics. These bodies do not have dedicated funds for the topics. Danish universities and institutions of higher education also conduct research and innovation activities within the social and healthcare areas within their non-dedicated public funds.

5. In general, what do you see as the main obstacles for promoting and implementing ISHC? What kind of political support and measures are conceivable to overcome the obstacles?

One of the major challenges associated with promoting ISHC is the lack of knowledge and consequently public, political and organizational resistance to many of the actions that otherwise could be the solution to future health challenges. It is a challenge and an obstacle both in terms of policy planning and adoption of technology solutions, as well as in the actual implementation at the user level.

There is no doubt that the introduction of technology solutions and healthcare IT, such as telemedicine, can have significant socio-economic benefits, as well as human potential to better care for patients and citizens. The big challenge is to spread knowledge about it and implement it in a way that citizens and patients' organizations, etc. see as positive. Considerable knowledge sharing – including user studies documenting the positive effects – is necessary. It is necessary that we also at the political level try to spread knowledge about best practices and communicate that it will lead to significantly improved quality of life for the individual and at the same time be a socio-economic benefit, especially in an export perspective.

Close cooperation between relevant actors is necessary. Regions, municipalities, patient- and user- organizations and politicians must work together to raise awareness and draw attention to ISHC.

II
WG homework 1
Answer from Estonia




sotsiaal ministeerium

Baltic Assembly
Silga.Lejasmeiere@baltasam.org

Your ref: 16 December 2013 No 1/1113-214

Our ref: 6 February 2014 No 6.1-10/5829

Questions to the member states

Dear Mrs Lejasmeiere

I am writing in reply to your letter of 16 December in which you requested the Ministry of Social Affairs' input regarding innovation in social and health care.

1. What, from your perspective, are the main challenges facing social and health care today and in the future?

In Estonia, the main challenge of social care today is and in the future will be meeting the needs of aging population. Other obstacles to overcome in reaching those in need of social care in Estonia are migration (both outward and within the country), small size of local authorities and uneven quality of social services provided.

The main challenges of health care in Estonia are ageing society together with rising multimorbidity, growing health and social costs, and rising expectations in society as well as limited resources and free movement of patients and personnel.

2. Have you launched any public strategies and programmes for ISHC? Are any new initiatives planned? What are your experiences and results so far concerning public programmes and measures to support ISHC?

In social care Estonia has not launched any public strategies or programmes for innovation in the field. However, there is a possibility to finance ISHC projects through ESF measures.

All national health activities are planned in the National Health Plan 2009–2020, its action plan 2013–2016, and its annual activity programs.

Nationwide e-health system has been launched and is operative, permanent improvements and future developments are carried out. Currently we are conducting a survey to develop telemedicine possibilities.

Estonia has established the Estonian Genome Centre, where we have data for approximately 50 000 gene donors. The centre is also a strong advocate for developing personalised medicine in Estonia.

Within the framework of Estonian Research and Development and Innovation Strategy 2007–2013, the Health Care Programme is carried out to advance health research. Also, a long-term Health Care Research and Development Strategy for Estonia is currently being developed.

Ministry of Social Affairs of Estonia
Gonsiori 29
15027 Tallinn
ESTONIA
Phone +372 626 9301
Fax +372 699 2209
www.sm.ee
info@sm.ee

Estonian Parliament has just adopted the new Estonian Research and Development and Innovation Strategy 2014–2020, where health technologies and services (incl. biotechnology and e-health) are selected as areas for smart specialisation.

3. Have you launched any public awareness campaigns concerning ISHC? Are any new initiatives planned?

Regarding public awareness campaigns none have been launched specifically in health and social care area, but within the existing Estonian Research and Development and Innovation Strategy 2007-2013 there have been several public awareness campaigns, media projects and other activities to promote research and innovation, which also cover health and social care area.

The new Estonian Research and Development and Innovation Strategy 2014–2020 also includes such activities.

4. Have you launched any public economic support mechanisms for ISHC, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?

We do not have separate economic support mechanisms for innovation in social care. But innovative projects can be financed through grants distributed by Foundation Innove Enterprise Estonia for example.

Regarding health care, many large-scale projects are and were financed through the use of EU Structural Funds administered by the Estonian Ministry of Education and Research and the Ministry of Economic Affairs and Communication, as well as with seed money via Estonian Development Fund. Similar support mechanisms will carry on to the period 2014–2020.

5. In general, what do you see as the main obstacles for promoting and implementing ISHC? What kind of political support and measures are conceivable to overcome the obstacles?

The main obstacles for promoting and implementing ISHC:

- Limited human and financial resources, innovation is mainly financed through EU Structural Funds.
- Lack of clear vision on possible innovation (other than further ICT implementation) in social field, absence of separate national action plan, insuring the financial sustainability of launched projects.

Political support and measures conceivable to overcome the obstacles:

- Stabile and sustainable financing, especially after the EU Structural Funds funding period comes to an end.

Please accept my apologies for the delayed answer.

Yours sincerely,

Taavi Rõivas
Minister

Kristiina Hunt 6269 262
kristiina.hunt@sm.ee

II
WG homework 1
Answer from Finland

BSPC WG ISHC Homework 1 – Answers from Finland 19.2.2014

1. Main challenges:
    a. Age Structure of Population, aging society, need of services increases in social and health care
    b. Economic situation in national and public economy
    c. Structural changes on social and health care service delivery and funding

2. Programs
    a. KASTE-2-program is national R&D&I-program by the Ministry of Social Affairs and Health for stakeholders in development of welfare, health, and services
    b. TEM, and other Ministries made Agreement for growth with major cities
    c. Finnish Innovation Center/Tekes has several programs to promote and support development of innovations eg.
        i. Innovations in Social and Health Care-program
        ii. Innovative Cities: Future Health - program
        iii. Innovative procurement-program
    d. ICT-2015 - national program to promote innovative development ict in Finland
    e. SITRA, Finnish Independence Fund: Health program support innovative project in social and health care
    f. planning of new programs:
        i. strategy for future health, 3 ministries together
        ii. strategy for bio- and gene technology
        iii. Strategy for national ICT-development in social and health care: From data to knowledge in
    g. Innovillage - new national open interactive innovation environment for welfare, health and social and health service

3. Awareness campaigns:
    a. Prizes for Innovative solutions
        i. Inno-prize annually by Innovillage
        ii. Prize for eHeatlh solutions, SITRA
    b. startups, SLUSH-match making, Tekes
    c. open seminars and happenings

4. New Support Mechanisms
    a. tax decrease for companies for R&D&I-expenses
    b. Tekes has new tools and funds for capital investments to companies 1.1.2014-
    c. see point 2. different programs to support ISCH

5. Obstacles vary a lot depending of programs etc. However there are several evaluations available of Finnish Innovation Ecosystem and programs.

II
WG homework 1
Answer from Germany

Language Service
- Translation -

German Bundestag

Franz Thönnes, MdB
Former Parliamentary State Secretary
Deputy Chairman of the Foreign Affairs Committee
Chair of the German-Nordic Parliamentary Friendship Group
Member of the BSPC Standing Committee

Franz Thönnes MdB • Platz der Republik 1. 11011 Berlin

Ms Andrea Nahles, MdB
Federal Minister of Labour and
Social Affairs
Wilhelmstr. 49
10117 Berlin

30 January 2014

BSPC Working Group on Innovation in Social and Health Care (BSPC WG ISHG)

Dear Minister,

At the 22nd Baltic Sea Parliamentary Conference (BSPC) in August 2013 in Pärnu, the conference participants decided to form the Working Group mentioned above. In my function as a member of the German Bundestag's delegation, I am part of the working group.

This working group deals with the issue of qualitative and equitably distributed social and medical services for the citizens of the Baltic Sea Region. The Working Group's objective is to elaborate political positions and recommendations pertaining to innovation in social and health care. These would be addressed to the national and regional governments concerned. They would be an expression of the political views and positions of parliamentarians from the Baltic Sea Region.

In a first step, we aim to obtain a comprehensive picture of the challenges which exist and measures taken so far by the national and regional governments, and to collect a set of concrete examples of projects. To this end, the Working Group has compiled the following list of questions for all the countries in the Baltic Sea Region:

1. What, from the perspective of your ministry, are the main challenges facing social care today and in the future?
2. Have you launched any national public strategies and programmes for innovation in the area of social care? Are any new initiatives planned? What are your experiences and results so far concerning public programmes and measures to support innovation in social care at federal level?
3. Have you launched any public awareness campaigns concerning ISHC?

4. Has the Federal Government launched any public economic support mechanisms in the area of social care, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?
5. In general, what do you see as the main obstacles for promoting and implementing innovation in the area of social care? What kind of political support and measures are conceivable to overcome the obstacles?

Despite the short notice, I would be grateful if you could answer these questions on behalf of your ministry by 24 February 2014.

Thank you very much in advance for your assistance

Yours sincerely,

Sgd. Franz Thönnes
Member of the Bundestag

Federal Ministry
of Labour and Social Affairs

Mr Franz Thönnes
Member of the German Bundestag
11011 Berlin

Andrea Nahles
Federal Minister
Member of the German Bundestag
OFFICE ADDRESS Wilhelmstraße 49, 10117 Berlin
POSTAL ADDRESS 10117 Berlin

TEL +49 (0)30 18 527-2323
FAX +49 (0)30 18 527-2328
E-MAIL ministerbuero@bmas.bund.de

6 March 2014

Dear Mr Thönnes, (m.p.) *Dear Franz*,

Thank you for your letter of 30 January 2014. I am pleased to take this opportunity to answer the questions from the 22nd Baltic Sea Parliamentary Conference (BSPC) Working Group on Innovation in Social and Health Care. My answers are set out in the annex to this letter.

I should point out that from the perspective of the Federal Ministry of Labour and Social Affairs, not all the questions can be answered in full. Assuming that the terms “social care” and “health care” are defined as needs-based rather than contributory social welfare schemes, the following situation applies to Germany:

In Germany, various benefits are provided to safeguard the sociocultural subsistence level under social law. They encompass a living allowance and health care provision in the absence of other forms of cover, as well as provision for persons in need of long-term care, and assistance to deal with the effects of disability and other social difficulties and circumstances. These benefits are provided under social assistance law and are governed by Book Twelve of the German Social Code (SGB XII). The precondition for claiming these benefits is that recipients must lack the requisite means and capacities to support themselves and are therefore dependent on assistance.

The second major minimum income scheme is the basic provision for job-seekers under Book Two of the German Social Code (SGB II). The passive benefits comprise a living allowance, health insurance and long-term care insurance.
In light of this situation, programmes and initiatives are of secondary importance in Germany, where benefits are provided in accordance with the welfare principle pursuant to Books Two and Twelve of the Social Code. For certain groups who cannot be reached to an adequate extent or at all by state benefits or whose circumstances require that they be given special promotion or support, programmes and initiatives may provide additional assistance. “Additional”, in this

context, means that these services are provided as a supplement to, not as a substitute for, their legal entitlements.

Social care, as a means of safeguarding a level of subsistence that is in line with human dignity, is enshrined in Germany's constitution, the Basic Law. This states that Germany is a social state under the rule of law. As regards living allowances under Books Two and Twelve of the Social Code, the German Federal Constitutional Court, in its judgment of 9 February 2010 on the level of the standard benefits provided under SGB II, recognised the fundamental right to a subsistence minimum that is in line with human dignity. This fundamental right may not be limited solely to living allowance benefits and must be transposed into legal entitlements in (federal) legislation. Persons in need of assistance may only be referred to benefit schemes operated by third parties when legal entitlements under these schemes take precedence.

Among other things, this means that further developments in the field of social care largely take place through amendments to existing legislation or the adoption of new laws. A specific example is the forthcoming reform, during this electoral term, of the current provisions on integration assistance in Chapter Six of SGB XII. There is a need to take account of the new social understanding of disability assistance and develop integration assistance into a right of participation that is appropriate for today's society.

Yours sincerely,

Annex

Preliminary remarks: Social care and health care

The minimum income schemes covered by Book Two of the Social Code (SGB II) and Book Twelve of the Social Code (SGB XII) comprise social care and health care. Persons entitled to claim benefits under SGB II are generally provided with mandatory insurance cover under statutory health and long-term care insurance schemes, unless they have private health and care insurance cover.

Persons entitled to claim benefits under SGB XII are generally covered by statutory or private health and long-term care insurance. In individual cases where this does not apply due to special circumstances, the social assistance system covers the costs of health care under the "Assistance for Health" provisions contained in Chapter Five of SGB XII, with the scope of benefits corresponding to those provided under statutory health insurance. There is therefore no specific need for action on health care within the sphere of social care.

Question 1:

What, from the perspective of your ministry, are the main challenges facing social care today and in the future?

Answer:

The main challenges are as follows:

- Delimitation of the care schemes, as regards the scope of benefits and recipient groups, in relation to the other branches of the social welfare system.
- Maintaining the efficiency of the care schemes in order to safeguard continued reliable provision of the sociocultural subsistence level as regards the level of benefits and access for all persons in need of assistance. This will require ongoing adaptation to changing social and economic conditions.
- The legal bases are established in federal law, but delivery largely takes place at the municipal level, at least as far as social assistance is concerned. The financing of the benefits is generally coupled to delivery, resulting in financial burdens for the municipalities. For that reason, the Federal Government has increasingly taken on financial commitments in the form of reimbursement of expenditure in some areas of social assistance (basic retirement pension, and pensions for persons with reduced earning capacity) and has pledged to ease the financial burden on the municipalities as part of the forthcoming reform of integration assistance.

Question 2:

Have you launched any national public strategies and programmes for innovation in the area of social care? Are any new initiatives planned? What are your experiences and results

so far concerning public programmes and measures to support innovation in social care at federal level?

Answer:

No such national strategies and programmes exist in Germany beyond those set out by the Federal Government in national action plans, reports and the Coalition Agreement for the 18th electoral term. Germany therefore has no experience that it can share in this area.

Question 3:

Have you launched any public awareness campaigns concerning ISHC?

Answer:

Please refer to the answer to Question 2.

Question 4:

Has the Federal Government launched any public economic support mechanisms in the area of social care, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?

Answer:

To the extent that this question relates to support for infrastructure, no information is available to the Federal Government. The responsibility for infrastructural measures lies with the municipalities or the federal states (*Länder*), as appropriate.

Question 5:

In general, what do you see as the main obstacles for promoting and implementing innovation in the area of social care? What kind of political support and measures are conceivable to overcome the obstacles?

Answer:

As in all policy areas, the question of the ensuing additional costs and how they are to be funded arises in relation to implementing innovation in the area of social care. Please also refer to the answer to Question 1.

Language Service
- Translation -

German Bundestag

Franz Thönnes, MdB
Former Parliamentary State Secretary
Deputy Chairman of the Foreign Affairs Committee
Chair of the German-Nordic Parliamentary Friendship Group
Member of the BSPC Standing Committee

Franz Thönnes MdB • Platz der Republik 1. 11011 Berlin

Mr Hermann Gröhe, MdB
Federal Minister of Health
Friedrichstr. 108
10117 Berlin

30 January 2014

BSPC Working Group on Innovation in Social and Health Care (BSPC WG ISHG)

Dear Minister,

At the 22nd Baltic Sea Parliamentary Conference (BSPC) in August 2013 in Pärnu, the conference participants decided to form the Working Group mentioned above. In my function as a member of the German Bundestag's delegation, I am part of the working group.

This working group deals with the issue of qualitative and equitably distributed social and medical services for the citizens of the Baltic Sea Region. The Working Group's objective is to elaborate political positions and recommendations pertaining to innovation in social and health care. These would be addressed to the national and regional governments concerned. They would be an expression of the political views and positions of parliamentarians from the Baltic Sea Region.

In a first step, we aim to obtain a comprehensive picture of the challenges which exist and measures taken so far by the national and regional governments, and to collect a set of concrete examples of projects. To this end, the Working Group has compiled the following list of questions for all the countries in the Baltic Sea Region:

1. What, from the perspective of your ministry, are the main challenges facing health care today and in the future?
2. Have you launched any national public strategies and programmes for innovation in the area of health care? Are any new initiatives planned? What are your experiences and results so far concerning public programmes and measures to support innovation in health care at federal level?
3. Have you launched any public awareness campaigns concerning ISHC?

4. Has the Federal Government launched any public economic support mechanisms in the area of health care, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?
5. In general, what do you see as the main obstacles for promoting and implementing innovation in the area of health care? What kind of political support and measures are conceivable to overcome the obstacles?

Despite the short notice, I would be grateful if you could answer these questions on behalf of your ministry by 24 February 2014.

Thank you very much in advance for your assistance

Yours sincerely,

Sgd. Franz Thönnes
Member of the Bundestag

Federal Ministry
of Health

POSTAL ADDRESS Federal Ministry of Health, 53107 Bonn

Mr Franz Thönnes
Member of the German Bundestag
11011 Berlin

Hermann Gröhe
Federal Minister
Member of the German Bundestag
OFFICE ADDRESS Rochusstraße 1, 53123 Bonn
POSTAL ADDRESS 53107 Bonn

TEL +49 (0)228 99 441-1003
FAX +49 (0)228 99 441-1193
E-MAIL poststelle@bmg.bund.de

5 March 2014

Dear colleague,

Many thanks for your letter of 30 January and your interest in the subject of social and health care in the Baltic Sea region. I regret that I was unable to reply earlier.

In general, one major challenge in the field of health is inequality of access to health services and variations in the quality of care in the Baltic Sea countries. This is partly due to the systems concerned, but in part it is also a consequence of the size and location of certain countries, parts of whose territory are located in the Arctic.

The biggest health risks can be found in the following areas: HIV/AIDS in conjunction with co-infections such as tuberculosis and hepatitis, resistance to antibiotics, and lifestyle diseases (obesity, heart diseases). Alcohol abuse also poses a challenge in some Baltic Sea states.

No economic support mechanisms or campaigns exist at federal level. One key instrument for the region, however, is the European Union Strategy for the Baltic Sea Region (EUSBSR). This strategy aims to intensify cooperation within the Baltic Sea region. As the EU's first "macro-regional strategy", the EU Strategy for the Baltic Sea Region is a pilot project for a new form of cooperation between the EU and its neighbouring countries. The regional focus and indicators of these macro-strategies flesh out the Europe 2020 targets. "Health" is one of the priority areas in the Strategy for the Baltic Sea Region.

This priority area of the EU strategy is coordinated by the Northern Dimension Partnership in Public Health and Social Wellbeing (NDPHS), in which Germany is actively involved. Along with the EU and WHO EURO, this partnership is the biggest stakeholder in the field of health in the Baltic Sea region. The partnership brings together all of the countries bordering the Baltic Sea, with the exception of Denmark.

I understand that the NDPHS and the Baltic Sea Parliamentary Conference are already cooperating with each other. I believe that it would be worthwhile for your new Working Group on Innovation in Social and Health Care to work towards intensifying this cooperation.

As you are undoubtedly aware, last autumn Germany took over as Chair of the NDPHS for a two-year period. This work is being coordinated within my Ministry by the Global Health Policy Division (Z 23). Please do not hesitate to contact this Division at any time if you should have any further questions.

In addition, the enclosed documents provide a good overview of health projects in the Baltic Sea region between 2007 and 2013.

I hope that this information will be of assistance to you.

Sincerely,

Yours (m.p.)
Sgd. Hermann Gröhe

II
WG homework 1
Answer from Hamburg

Baltic Sea Parliamentary Conference BSPC
The BSPC Working Group on Innovation in Social and Health Care

9 December 2013/The WG Secretariat

Homework 1

1. Purpose

This first homework of the BSPC Working Group on Innovation in Social and Health Care (WG ISHC) addresses a number of questions of a general nature concerning the existence of public strategies and measures to support ISHC. It will also provide an indication of the level of political support for ISHC.

At this stage, and as a basis for the subsequent orientation of the activities of the WG, it is important to obtain an overall picture of the situation and status of ISHC in the BSPC member states.

Members of the WG are kindly requested to produce a concise response (a couple of pages) to the questions below. The response should be submitted to the WG Secretariat no later than 26 February 2014. The answers will be compiled and distributed to the WG before the next WG meeting in Tromsø on 27-28 March 2014.

The answers will also be used to amend and develop the WG Scope of Work and to provide input and inspiration to the political recommendations of the WG.

2. Background

The preliminary interpretation of ISHC by the Working Group is that ISHC deals with the issue of securing the provision of qualitative and equitably distributed social and medical services to the citizens in a situation of changing demographics, altering patterns of somatic and mental ailments, and constrained financial resources.

The overarching objective of the WG is to elaborate political positions and recommendations pertaining to innovation in social and health care. The recommendations constitute an expression of the political views and positions of parliamentarians from the entire Baltic Sea Region. It is essential that the recommendations focus on the political added value that parliamentarians can bring to the process of stimulating ISHC.

In a first step, the WG should aim at obtaining a comprehensive picture of the challenges and drivers of ISHC, as well as a representative overview of measures that have been applied to promote ISHC. The overview should also include examples of gaps and needs for new or other forms of support for ISHC. In its follow-on work, the WG should i.a. collect and compile a set of representative practical examples of ISHC.

3. Questions to the BSPC Member States on Strategies and Measures to Support Innovation in Social and Health Care (ISHC)

1. What, from your perspective, are the main challenges facing social and health care today and in the future?

- Helping long-term benefits claimants to get back into employment
- Reducing the risk of poverty, especially preventing poverty in old age
- Bringing social policies into line with demographic change
- Encouraging and making use of cultural diversity
- Increasing labour market participation
- Generationally just, adequate pension provision
- Quality-controlled, effective health and social care provision
- Reform of legislation on participation and inclusion (implementation of the UN Convention on the Rights of Persons with Disabilities, reform of integration assistance, reform of Book IX of Social Security Code: SGB IX).

The biggest challenge is demographic change. It is obvious that changes in the size and composition of the population have direct effects on morbidity (e.g. dementia, cancer, cardiovascular disease, metabolic diseases), on care requirements and on the state of health of the population in general. It must also be borne in mind that demographic change has an impact on the number of people employed in the health professions, and that requirements here are projected to increase. The structure, content and organisation of healthcare provision will have to be adapted to meet the challenges. As far as healthcare structures are concerned, the relationship between urban and peripheral regions presents a particular challenge. Regarding content, it should be pointed out that the sensible goal, not just in view of demographic change, of avoiding the incidence of chronic illness in particular cannot be achieved through curative-based healthcare alone. It will be necessary to put prevention and health promotion on a firmer footing and to support them better.

After demographic change, the second huge trend is the acceleration of technological progress, particular in the fields of communications and biosciences. ICT in the healthcare sector (e-health) is gaining greater acceptance. Biotechnology (genomics, proteomics, personalised medicine) can be expected to play a greater role in healthcare provision as costs become competitive. Concrete challenges here are overcoming the difficulties of introducing and integrating new technology into existing care systems, on the one hand, and ethical aspects, funding and ensuring fair public access to care on the other.

2. Have you launched any public strategies and programmes for ISHC? Are any new initiatives planned? What are your experiences and results so far concerning public programmes and measures to support ISHC?

It will be less a question of developing new initiatives than organising better cooperation between systems. For instance

- better linkage between labour market programmes and local government services in the psychosocial counselling area, or
- collaboration between the youth welfare service, Jobcenter (for long-term unemployed) and Arbeitsagentur (employment agency for short-term unemployed) on an agency for young jobseekers (Jugendberufsagentur: JBA) to ensure no young person is left behind, or
- Hamburg state action plan for implementing the UN Convention on the Rights of Persons with Disabilities; Confederation of Ministers for Labour and Social Affairs (ASMK) process to reform legislation on integration assistance and participation; federal reform of the care sector.

3. Have you launched any public awareness campaigns concerning ISHC? Are any new initiatives planned?

- Hamburg's JBA (see 2 above) is a model for the Federal Government which plans to introduce it Germany-wide.
- The Hamburg action plan on the UN Convention on the Rights of Persons with Disabilities represents the start of a programme to implement it in all spheres of life.

4. Have you launched any public economic support mechanisms for ISHC, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?

see 2 above

5. In general, what do you see as the main obstacles for promoting and implementing ISHC? What kind of political support and measures are conceivable to overcome the obstacles?

see 2 above

II
WG homework 1

Answer from Latvia

In response to your letter on 16 December 2013 No. 1/1113-214, please find attached the answers by the Ministry of Health of the Republic of Latvia to the questions of the Baltic Assembly and the Baltic Sea Parliamentary Conference Working Group on Innovation in Social and Health Care

1. What, from your perspective, are the main challenges facing social and health care today and in the future?

In our perspective, the main challenges are:

- to reduce premature mortality and morbidity of most common chronic non-communicable diseases - cardiovascular diseases, cancer, mental illness, perinatal and neonatal period conditions;
- to achieve increase of health care funding;
- establishment of the new health care financing system, linking state funded health care delivery by paying taxes, while defining vulnerable groups who will receive state funded health care, regardless of the fact of paying taxes;
- e-health implementation and development;
- health care workforce development.

2. Have you launched any public strategies and programmes for Innovation in Social and Health Care (ISHC)? Are any new initiatives planned? What are your experiences and results so far concerning public programmes and measures to support ISHC?

We have launched a number of policy planning documents concerning innovation in health care:

- There was developed and adopted medium term policy planning document **The Public Health Strategy 2011 – 2017** in Latvia. The aim of this document is to prolong the healthy life years of the Latvian population and to prevent untimely deaths, while maintaining, improving and restoring health.

- In order to improve maternal and child health in Latvia (including reduced perinatal mortality and maternal mortality) the Ministry of Health of the Republic of Latvia has elaborated and the Cabinet of Ministers has approved the Maternal and Child Health Improvement Plan 2012 – 2014, which includes **infertility treatment into a state-funded services** that include assessment of the prevalence of infertility in Latvia by collecting data.

- The Ministry of Health has developed and the Cabinet of Ministers has approved Action Plan to Prevent Heart and Cardiovascular Diseases for 2013-2015. The aim of the Action Plan is to decrease the morbidity and mortality of heart and cardiovascular diseases and to decrease their risk factors negative impact on the public health.

According to Action Plan the general practitioner nurse`s will carry out the cardiovascular risk screening once a year.

- The Cabinet of Ministers has approved the **Action plan for Reduction of Alcohol Consumption and Restriction of Alcohol Addiction for 2012-2014**. The aim of the Action Plan is to reduce alcohol related harm for public health, which is ensured by planned, harmonized and coordinated actions.

- New amendments in **Handling of Alcoholic Beverages Law** have come into force in year 2013. For example, the amendments define that alcoholic beverages cannot be sold on the Internet; persons (aged 18 to 25) are obligated to show a personal identification document when purchasing alcoholic beverages. At the end of 2013, the Ministry of Health has developed next draft on the advertising restrictions.

- Since 23 February 2013, **new psychoactive substances** are put under control by generic approach, which means that clusters of psychotropic drugs which evolve from the same basic chemical formula are banned in advance. The term "new psychoactive substance" is introduced in the law since 14 November 2013.

- In spite of a significant reduction of tobacco environmental smoking in workplaces, there is still high environmental smoking prevalence at homes. To reinforce civic awareness on tobacco harm and to limit smoking in the presence of children, there was amended **Law on Protection of Children Rights** in the beginning of 2013. The Law states that smoking in the presence of a child is physical violence. After that, initiative to protect pregnant women from tobacco smoke was passed in Parliament under tobacco control law.

- In 2012, the Ministry of Health initiated new approach for organization of health promotion in municipalities. Local governments were encouraged **to delegate a contact person from the municipality** to the Ministry for cooperation in health promotion questions and for dissemination of actual information related to health promotion activities.

- At the end of 2012, the Ministry of Health together with Centre for Disease Prevention and Control (CDPC), WHO Country office in Latvia, Latvian Union of local governments and Riga Stradins University started development of new initiative "**National Healthy Municipality Network**" to coordinate activities of WHO "Healthy Cities" movement, to provide methodological support, to assist municipalities in developing health promoting programmes, to organize regular meetings and training for contact persons etc.

- In order to involve more the municipalities in health promotion activities, the Ministry of Health has elaborated **„Guidelines for Health Promotion in Municipalities"** (approved with the Order of the Ministry of Health No.243 of 29 December 2011). The Guidelines provide municipalities with science-based information to implement health promotion (physical activities; nutrition; prevention of addiction-inducing

substances; family health, including safety promotion; injury prevention etc.) and to improve the development of healthy behaviours and lifestyle of the local population.

- On 22 August 2006, Regulations of the Cabinet of Ministers were adopted with the aim **to restrict the availability of soft drinks, sweets and salty snacks in education institutions (schools and kindergartens).** According to the Regulations, soft drinks with added food additives (colours, sweeteners, preservatives), caffeine and amino acids (i.e. energy drinks), sugar confectionery containing colours, sweeteners (candies, caramels), chewing gum containing colours, snacks containing 1.25g or more salt per 100g or 0.5g or more sodium per 100g are not distributed in education institutions.

- In March 2012 Regulations of the Cabinet of Ministers **regarding dietary standards in schools, kindergartens, long-term social care institutions and hospitals were adopted**. Regulations provide that the everyday menu of pupils and patients in these institutions should include food products rich in complex carbohydrates; vegetables and fruit, including fresh ones; food products rich in proteins. Following food products should be excluded – French fries and similar products, margarine and confectionery containing partially hydrogenated vegetable fats, instant soups and potato mashes, oils from genetically modified ingredients etc.

- **National Health Insurance Concept** foresees establishment of the new health care financing system, linking state funded health care delivery by paying taxes, while defining vulnerable groups who will receive state funded health care, regardless of the fact of paying taxes.

- **E-health Latvia** is a policy planning document for more efficient use of information and communication technology tools. The main objectives of e-health development are to: improve health, promote individual control of their health; reduce wasted time spend on patients contacts with medical institutions; increase the effectiveness of the health care, providing health care specialists with a quick access to necessary patient health data; reduce the amount of information that health care specialists need to enter into the documents; increase the amount and usability of a structured information; increase effectiveness of medical institutions; increase health care data reliability and security.

- In the **Policy Document's "Improvement of Inhabitants' Mental Health for 2009-2014" Implementation Plan for 2013-2014** is planned to research the deployment options and solutions of the „Mobile psychiatric team" (professionals, services provided, recipients of services). Also if the necessary funding will be granted, it is planned to introduce Emotional Support telephone services to the residents of Latvia 116123.

- In 2006, the **National population genome database** was created. The use of resources included in the database for human genome research, revealing the genetic health risks, as well as creating of new medical preparations are essential for

forecasting of the progress of diseases, for prevention and initiating of appropriate treatment thereby improving the welfare of the people.

- The Ministry of Health has prepared a short-term policy planning document **"Primary Health Care Development Plan for 2014-2016"** with the aim to strengthen primary health care as the most available, effective and comprehensive health care level, by increasing the role of primary health care in prevention, diagnostics and treatment, as well as to improve the quality of primary health care.

Future initiatives:

- The Ministry of Health **has developed a draft of legislation to reduce industrially produced trans fatty acids in food products**. The proposal includes the development of a legal act to restrict the amount of trans fatty acids in food products.

- To develop **legal regulation for defining energy drinks and to regulate the marketing and advertising of energy drinks**. This year one Member of the Parliament initiated that the use of energy drinks in Latvia should be restricted to children and he developed a draft of law for energy drinks in cooperation with Ministry of Health, Centre for Disease Prevention and Control and nutrition specialists. This draft of law for energy drinks also includes restriction of trading, advertising and marketing of energy drink to persons who are younger than 18.

- There is a plan **to develop legal framework for electronic cigarettes** in Latvia.

3. Have you launched any public awareness campaigns concerning ICHC? Are any new initiatives planned?

We have not launched any public awareness campaigns concerning ICHC.

4. Have you launched any public economic support mechanisms for ISHC, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?

We have launched **Action plan for Reduction of Alcohol Consumption and Restriction of Alcohol Addiction for 2012-2014** that provides for the Ministry of Finance to develop an evaluation report to implement the optimum excise rate of alcoholic beverages, taking into account the objectives of national fiscal and health protection.

5. In general, what do you see as the main obstacles for promoting and implementing ISHC? What kind of political support and measures are conceivable to overcome the obstacles?

5

One of the barriers for promoting and implementing innovation in health care is insufficient funding. In the most cases for the innovative activities in health care there is need for additional funding. In order to introduce innovative activities or services not only political support is needed, but also medical institutions and health worker support, adaption of infrastructure is needed.

II
WG homework 1
Answer from Lithuania

Originalas nebus siunčiamas

LIETUVOS RESPUBLIKOS SVEIKATOS APSAUGOS MINISTERIJA

MINISTRY OF HEALTH OF THE REPUBLIC OF LITHUANIA

Budgetary institution, Vilniaus str. 33, LT-01506 Vilnius, Lithuania, phone: +370 5 266 1400,
fax: +370 5 266 1402, e-mail: ministerija@sam.lt, http://www.sam.lt.
Data are accumulated and stored in the Register of Legal Entities, code 188603472, VAT payer code LT100001082215

Raimonds Vejonis, President of the Baltic Assembly, Chairman of the BSPC Working Group on Innovation in Social and Health Care
Laine Randjarv, Vice President of the Baltic Assembly
Giedre Purvaneckiene
Vice President of the Baltic Assembly, Member of the BSPC Working Group on Innovation in Social and Health Care
Silga Lejasmeiere, silga.lejasmeiere@baltasam.org

22 January 2014 No. (9.1.3-10)10- 799
16 December 2013 No. 1/113-214

Dear Colleagues,

Let me congratulate the Baltic Assembly and the Baltic Sea Parliamentary Conference Working Group on Innovation in Social and Health Care with the closer cooperation between Latvia, Estonia and Lithuania in the field of social and health care.

We have to recognize that collaboration between the countries and regions is crucial due to the important role that health plays in various sectors including economy and foreign policy of our countries. Regional efforts in these fields should be continued and strengthened using the potential of international cooperation of international organizations, particularly World Health Organization and the European Union and regional cooperation frameworks seeking for modern and sustainable health systems. This is particularly important dealing with today's health challenges such as reduction of health inequalities, ageing of population, financial pressure on health systems, migration of health professionals, increasing burden of communicable and non-communicable chronic diseases or uncertainties related to them, global health threats etc.

In our view, health systems should be understood as widely as possible including social, economic, political, cultural and other dimensions and this is becoming new area of European policy as well. It means that only an appropriate level of population health could contribute to better productivity and the increasing of overall competitiveness of European countries. This also means further discussions about strengthening of health policy making and international cooperation at regional, European and global levels are needed.

LIETUVOS RESPUBLIKOS SOCIALINĖS APSAUGOS IR DARBO MINISTERIJA

MINISTRY OF SOCIAL SECURITY AND LABOUR OF THE REPUBLIC OF LITHUANIA

A.Vivulskio str. 11, LT-03610 Vilnius Tel. +370 5 266 8176 Fax +370 5 266 4209 E-mail: post@socmin.lt

Baltic Assembly

2014 -01- 21 No. (29.6-61) SD - 435
Ref. 16-12-2013 No. 1/1113-214

Ministry of Social Security and Labour of the Republic of Lithuania has considered your questions about Innovation in Social and Heath Care and submits the following answers under its competence:

Question 1–2. The society is getting older and the need for services and funding of State budget is increasing. It is necessary to hold elderly independent persons at home as much as possible and create infrastructure of services, developing alternative forms of institutional social care.

In 2012 Integrated Help Development Program was approved (hereinafter - Integrated Program) (Order of the Minister of Social Security and Labour of 20 July 2012, No A1-353). The main goal of this program is to ensure the accessibility and expansion of social care services (including nurse care services), integrated home support for the elderly, disabled adults, children and for family members by consulting and involving informal carers (volunteers, neighbours and other) into the process.

During the period of 2013-2015 21 projects will be implemented in the different municipalities. According to these projects it is expected to discover the best models of integrated help and to adapt them in other municipalities that don't implement Integrated Program.

Question 3. In 2014-2015 study/research of the efficiency and adaptability of Integrated Program, foreseeing trends of long-term care social support system development, is planned. The study/research will evaluate the efficiency and adaptability of integrated help (day social care and nursing) provided by 21 pilot projects. It will highlight the advantages and disadvantages of used models in the projects and integrated help model for all municipalities of the country will be prepared on the basis of the findings. The development of services for families, who are caring for elderly and disabled persons at home, provide opportunities for them to combine family and work commitments.

LIETUVOS RESPUBLIKOS SOCIALINĖS APSAUGOS IR DARBO MINISTERIJA

MINISTRY OF SOCIAL SECURITY AND LABOUR OF THE REPUBLIC OF LITHUANIA

A.Vivulskio str. 11, LT-03610 Vilnius Tel. +370 5 266 8176 Fax +370 5 266 4209 E-mail: post@socmin.lt

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In order to integrate the social care services at home (including nurse care) into system of social services in Lithuanian, the study/research will provide the analysis of the needs for social services of elderly persons and will forecast the need of social services until 2040 and strategic suggestions for the provision of development of social services for the elderly. A study/research is supported by recourses of European Social Fund.

Question 4. From 2007 according to the Law on Social Services the municipalities finance by target subsidies for disabled and their families the social care (assistance) in respect of persons with a severe disability. Municipalities subsidize short term care, long term care, day care for persons with severe disabilities.

Question 5. In social care institutions are living a lot of disabled adults, who could live in communities. Unfortunately the negative opinion toward mentally disabled and people with mental disorders is dominating in the society.

In 2013 the Transition Plan from Institutional Care to Community Based Services for Disabled, Children without Appropriate Parental Care and Disabled Adults 2014-2020 (hereinafter – Transition Plan) was approved (Order of the Minister of Social Security and Labour dated December, 2013, No A1-696). According to Transition Plan consistent and coordinated transition system from institutional care to community based services for disabled, children without appropriate parental care and disabled adults with mental disability and people with mental disorders, including infants and help for families in a communities, fosters families will be created.

During 2014-2020 it is planed to focus on society education: to organise trainings for society, trainings of positive tutorial methods and etc. Also, self – depended or partly self – depended people will receive intensive social services in a community, possibility to participate in a community daily life and according their capacities and needs they will receive proposal for employment, occupation, integrated education, etc.

Transition Plan will be implemented during period of 2014-2020 by resources of European Structural funds.

Vice Minister Gintaras Klimavičius

Kristina Vyšniauskaitė-Radinskienė, tel. +370 706 64231, e-mail:
kristina.vysniauskaite@socmin.lt
Agnė Uogintienė, tel. +370 706 68263, el. p. agne.uogintiene@socmin.lt

II
WG homework 1
Answer from Mecklenburg-Vorpommern

Landtag Mecklenburg-Vorpommern

Wolfgang Waldmüller, MP
Member of the BSPC Working Group
Innovation in Social and Healthcare

Raimonds Vejonis
Chairman of the BSPC Working Group
„Innovation in Social and Healthcare"
Working Group Secretariat
Ved Stranden 18
DK-1601 Copenhagen

Contact:

Landtag Mecklenburg-Vorpommern
Committee on European and Legal Affairs
International Secretariat
D-19053 Schwerin
Lennéstraße 1 (Schloss)
Phone: +49 385 525-1530
Telefax: +49 385 525-1535
E-Mail: pa3mail@landtag-mv.de
Internet: www.landtag-mv.de

Schwerin, February 20, 2014

Working Group „homework" – questionnaire on the state of innovation in social and healthcare in Mecklenburg-Vorpommern

Dear Mister Chairman,

With reference to the Secretariat's email from December 9, 2013 regarding the 1st Working Group's decision to carry out a "homework" on the state of innovation in social and healthcare in our respective countries and regions, I hereby convey to you the completed questionnaire of the state of Mecklenburg-Vorpommern.

My colleague Julian Barlen and I have forwarded the Working Group's survey to the ministries dealing with innovation in social and healthcare in our state: the Ministry of Social Affairs and the Ministry of Economic Affairs.

In the appendix you will find a translation of the ministries' responses, whereas the feedback of the Ministry of Economic Affairs can especially be regarded as an answer to questions 2 and 4 of the survey.

I'm looking forward to a constructive Working Group meeting in Tromso.

Best regards,

Wolfgang Waldmüller

Appendix

Appendix 1

Response by the Ministry of Social Affairs to the BSPC questionnaire on innovation in social and healthcare

1. *What, from your perspective, are the main challenges facing social and healthcare today and in the future.*

Regarding healthcare:

The main challenges for healthcare in Mecklenburg-Vorpommern are the demographic shift in connection with sparsely populated areas and partially disadvantageous socio-economic structures.

The demographic shift leads to an advance and shift of the burden of disease, especially among the group of elderly citizens. At the same time it also becomes more difficult to ensure a comprehensive, high-quality provision for shrinking population groups, for instance children and youth.

When factors such as an ageing society, low incomes, and sparsely populated rural areas interact with the consequences of long distances to healthcare infrastructure as well as reduced public transport services, mobility and accessibility can become the central factors for the utilization of healthcare services.

At the same time the demographic shift also impacts those who supply healthcare services. Among others, the average age of, for instance, doctors, rises and it becomes increasingly difficult to recruit new generations for the tasks of healthcare provision.

The financing of public health is furthermore seen as being problematic. Rising costs are increasingly a result of a rising need for treatment of the ageing population, but also of medical progress.

Taken together, the ageing and shrinking population shows a growing and changing need for healthcare provision and prevention. Despite the shrinking population there is an above-average need for treatment and care all the while major challenges in sparsely populated rural areas and disadvantageous socio-demographic conditions remain. This demand is linked with a rising shortage of skilled workers and funding problems.

These challenges already exist and will become more problematic in the years to come.

Regarding social care:

Also in the social domain the demographic shift poses major challenges. At the federal level Volume II of the Social Code (SGB II) applies – which also regulates municipal services (for instance costs for accommodation and heating as well as education and participation) – as well as Volume XII of the Social Code (SGB XII). In Mecklenburg-Vorpommern especially the state law for the blind and the execution of the Pact for Education and Participation via the law governing the implementation of SGB II apply.

Furthermore, the new coalition partners at the federal level have, among others, agreed that the integration assistance shall be developed into a modern participation law. The implementation of the participation of people with disabilities shall be reorganized in their favor. Against the background of the UN convention to protect the rights of persons with disabilities it is no longer acceptable to refer people with disabilities to the social security system. It is the goal to relieve the municipalities of all states from € 5 billion per annum in integration assistance costs. A Benefits Act shall enter into force. Already before its adoption the municipalities shall be relieved of € 1 billion per annum. Furthermore, the introduction of a participation supplement at the federal level for people with disabilities shall be evaluated.

The same demographic aspects, which apply in the case of healthcare, are relevant in the nursing sector. This is true both for the expected strong increase in the number of elderly people with nursing needs and dementia patients as well as for the need for well-educated nursing staff. At the same time it is imperative to structure and adapt the nursing structures in such a way they comply with the principle “outpatient rather than in-patient” both in urban and rural areas in line with what is asked for. This and the adaptation of the municipalities to the diverse needs in the work with and the care for elderly people, along with a strengthening of people’s individual responsibility, are a prerequisite for keeping costs in the nursing sector in check

The vast part of the population in Mecklenburg-Vorpommern above the age of currently 65 years receives benefits from the public pension scheme. The current acceptable general pension level cannot be maintained without effective and sustainable measures. Due to times of unemployment, incomplete full-time working hours and low wages the number of retirees suffering from poverty will increase in the future.

Unemployment, on the one hand, and long distances to the work place, on the other, have proven to constitute factors which stand in the way of a strong civil society. The government of Mecklenburg-Vorpommern intends to improve the framework conditions for interested citizens of various backgrounds and with their individual abilities to assume responsibility for a democratic society. Voluntary civil engagement contributes to political and social integration.

2. *Have you launched any strategies and programs for Innovation in Social and Healthcare (ISHC)? Are any new initiatives planned? What are your experiences and results so far concerning public programs and measures to support ISHC?*

Regarding healthcare:

The provision of healthcare lies first and foremost with the healthcare actors. The association of statutory health insurance registered doctors – an institution incorporated under public law – is responsible for the provision of outpatient care. The financing of outpatient care is organized via performance fees from the health insurance companies. The provision of hospital care is a task of general public interest for the state, the administrative districts and the urban municipalities. It is realized by hospitals whose necessary investment costs are financed from the state budget. The state carries 60 % and the administrative district and the urban municipalities 40 % of the costs for the financial support of the hospitals. The

operating costs of the hospitals are financed through performance fees from the health insurance companies.

The legal frameworks for healthcare are predominantly set at the federal level.

Against this background, comprehensive strategies and programs to support innovation in healthcare are not a primary task of a federal state. Therefore, the initiatives of the state mainly concentrate on bringing healthcare actors together, thus contributing to solutions for the provision of healthcare.

The Minister of Social Affairs is steering a concerted action group with the respective healthcare actors to deliberate questions on innovation in healthcare, especially the close coordination of in-patient and outpatient care and regional healthcare provision concepts. The participants of the group usually meet twice a year.

The following strategies have been developed with the involvement of the Ministry for Social Affairs regarding individual aspects of healthcare provision and prevention:

- state geriatrics plan,
- plan for the further development of an integrated aid system for mentally ill people in Mecklenburg-Vorpommern,
- a code of practice for the cooperation between child and youth welfare and child and youth psychiatry in Mecklenburg-Vorpommern,
- a state action plan for the promotion of health and prevention
- child health goals
- action program on workplace health promotion .

Generally, the experience gained from the implementation of such strategies shows that this can only succeed with the inclusion and support of the relevant actors in the healthcare sector and that regional circumstances play an important role.

In the future, approaches to initiating regional healthcare provision concepts shall be pursued.

Regarding social care:

At the state level, strategic milestones for a care strategy in the context of a “Roundtable Care MV” are being developed. The following aspects are relevant:

- the development of a healthcare provision infrastructure that is tailored to suit actual needs
- the development of a personnel acquisition and skilled labor initiative for the health- und eldercare under the leadership of the healthcare sector
- the further development of quality management
- reform of the definition of the term “long-term care” at the state and federal level
- improvement of the support for dependents, strengthening of individual responsibility and further development of care center infrastructure
- improvement of prevention and rehabilitation
- extension of the municipal focus – strengthening of municipal responsibility and structures
- definition and design of needs of rural areas
- inclusion of research and technology

- securing and expansion of financial basis.

Furthermore, the "Report on the Situation of Nursing Professions in Mecklenburg-Vorpommern" is intended to contribute to the development of nursing professions in the state. This report is currently being drafted by the Center for Social Research Halle on behalf of the Ministry of Social Affairs. The report focuses on the nursing staff and companies with their working and framework conditions. The results shall contribute to high-quality nursing in Mecklenburg-Vorpommern and shall yield recommendations from which concrete measures can be deduced, for instance in order to attract skilled workers and to improve the image of nursing professions.

The state program "Ageing in Mecklenburg-Vorpommern" intends to set an impetus for politicians in the state to work with the older generation on the demographic shift in order to design the societal parameters in such a way that the societal integration of the older generation is promoted and that its specific participation prospects are improved.

Equally as part of the reporting on social issues, a study on the situation of people with disabilities in Mecklenburg-Vorpommern was conducted between 2010 and 2012 on behalf of the Ministry of Social Affairs. The study aimed at gaining a specific and valid scientific basis to evaluate the current situation of people with disabilities in the state. The results were considered in the process of drafting a plan of action by the state government on the implementation of the UN convention to protect the rights of persons with disabilities, which became legally binding in Germany in March 2009. With its action plan the state government provides an important and future-oriented contribution on the path towards an inclusive society.

3. *Have you launched any public awareness campaigns concerning ISHC? Are any new initiatives planned?*

Regarding healthcare:

Campaigns aimed at increasing public awareness are mainly conducted within the field of prevention. This is predominantly achieved by the support of nationwide campaigns, e.g. equity in health, sexual health and alcohol prevention.

Regarding social care:

The democratic participation especially of the elderly population in the lawmaking process of the state is emphasized through certain rights of participation in that process.

Networking between institutions and projects concerned with volunteer work and civil engagement is conducted and subsidized by the state government. Civil engagement is recognized by broad support and awards.

Volunteerism and individual responsibility is also strengthened by restructuring parts of the social code, redesigning care support facilities as well as by supporting municipalities in their planning and organization of policies for elderly people and long-term care.

4. *Have you launched any public economic support mechanism for ISHC such as dedicated funding, seed money or tax incentives? Are any initiatives planned?*

Regarding healthcare:

Current support is granted by public means of the Federal State with regard to

- (co-)funding of substance abuse centers of the counties
- (co-)funding of contact- and information centers for self-help groups
- consultation aimed at prevention of sexually-transmitted diseases (STDs) by charter institutions
- support of projects of institutions dedicated to health promotion and prevention

The funding is not explicitly focused on the creation of innovative approaches yet aims implicitly at it.

One example for the funding of innovative approaches in health care is the project "Psychiatry on the case", which focuses on advancing the care of mentally ill elderly people.

Another small portion of funding of innovative approaches goes to projects dealing with the challenges of demographic change in regards to health care. The funding used to subsidize studies for pharmaceutical supply/ polypharmacy conducted with elderly/ chronically ill patients as well as evaluating job satisfaction of general practitioners. Funding of an innovative project relating to transition- and discharge management (transition from inpatient to outpatient care) is planned for 2014.

In the context of an action program to strengthen health promotion at the work place in Mecklenburg-Vorpommern innovative and high-quality projects with sustainable approaches are promoted.

Regarding social care:

Current support granted by public funding of the Federal State with regard to

- funding of guardianship associations
- funding of social and professional integration as well the participation of migrants
- funding of universal counselling
- funding of crisis intervention (crisis line)
- funding of aid for people under onerous circumstances (other outpatient measures)
- funding of debt counselling offices/ consumer insolvence advisory offices
- funding of outpatient measures dedicated to persons with disabilities
- funding of networks and senior representations
- funding of volunteer projects
- training and advanced training for volunteers

As an example the target plan of the Social Code II (SGB II) can be referenced. In accordance with § 48b SGBII target plans are agreed upon between the Federal Ministry of Labor and Social Affairs and the responsible state authority (in the case of Mecklenburg-Vorpommern: Ministry of Labor and Social Affairs) as well as between the responsible state authority and the municipal agencies endorsed by the SGB II.

This aims to reduce individual assistance requirements, to grant a professional integration, to avoid long-term benefit payments and to improve social participation.

Besides the use of flagship project financing from the federal level as well as the swift implementation of the reform of the concept of care dependency, the federal state will continue its financial support especially in the following areas:

- funding of care facility centers as an instrument of consulting and development in the community
- funding of care planning and outpatient pilot projects in districts and administratively independent towns
- funding of expansion of outpatient and semi-residential care
- funding of semi-residential care
- funding of expansion of offers of day and night care as well as short-term care
- funding of low threshold care

5. *In general, what do you see as the main obstacles for promoting and implementing ISHC? What kind of political support and measures are conceivable to overcome the obstacles?*

Regarding healthcare:

The separation between the health sectors obstructs the support and implementation of innovation in healthcare, particularly the separation between inpatient care (hospitals) and outpatient care (usually approved doctors) meant to be guaranteed by various actors and to be subsidized in line with various regulations. The term is also related to the separation between medical treatment, rehabilitation and care.

Especially the nexus between outpatient and inpatient care bears the risk of inefficient care. Pharmaceutical supply serves as an example of communicational problems between inpatient and outpatient care as well as between general practitioners and medical specialists. This may lead to unintended double medication.

Furthermore, as a consequence of the demographic shift the requirements for health care are changing. With the rising average age of patients the gravity and complexity of the status of health problems and requirements of patients increases as well. Therefore, a steady, continuous provision of healthcare needs to be ensured across healthcare sectors.

Especially with regard to a sparsely populated state as is Mecklenburg-Vorpommern, one has to consider that where certain health sectors may no longer be viable – for instance with regard to the availability of general practitioners in the countryside – the boundaries of such sectors may have to be transcended. Healthcare in rural areas is therefore one central future project.

Against this background, concepts of cross-sector care have lately been pursued. Volume V of the Social Code (SGB V) refers to the possibilities of integrated care (§ 140 a pp. SGB V) which is granted thanks to intertwinement between outpatient and inpatient care and rehabilitation as well as between medical and non-medical

service providers. This kind of care is suited for complex disease symptoms, which are diagnosed by various service providers. Since the conclusion of contracts of integrated care takes place outside the system of collective contracts and the service guarantee of the association of statutory health insurance registered doctors, conflicts may arise more easily.
The new Federal Coalition Agreement approves of the harmonization of legal frameworks and the abolishment of implementation obstacles with a view to the integration of integrated and selective types of care. To his end the states have agreed to the initiation of a working group, in which Mecklenburg-Vorpommern is also represented.

One major challenge concerns the extensive provision of high quality care in a sparsely populated state. This encompasses the access to healthcare infrastructure, mobility and a minimum amount of patients that are necessary to provide adequate care. Options for action include the establishment of centers for specialized healthcare services, for instance with a view to cancer treatment, improved mobility, general medical treatment. Telemedicine can be seen as an additional important pillar of extensive care.

In the coalition agreement Mecklenburg-Vorpommern focuses on regional supply concepts and emphasizes the necessity of networking and interconnectedness with special regard to outpatient and inpatient offers. These issues are a frequent topic of the concerted action group, which the Minister of Social Affairs leads (see above).

Further obstacles for innovation in healthcare are the division of labor, particularly in the case of the medical and the nursing professions, and the working conditions especially in the nursing professions, which aggravates the shortage of skilled labor. New forms of division of labor might help improve the situation.

Regarding social care:

The deficient definition of connections between the sectors and their diverging forms as well as the funding issue all constitute obstacles to an adequate implementation of care. The reform at the federal level must go hand in hand with reforms at the state level.

Finally, we refer to the report of the inter-ministerial working group on the demographic shift which also deals with aspects of healthcare and social affairs. The report is currently in the departmental consultation and is going to be decided on by the Cabinet by the end of the year.

Response by the Ministry of Economic Affairs to the BSPC questionnaire on innovation in social and healthcare

The paper drafted by the Secretariat of the Working Group constituted on December 9, 2013 comprises five questions directed at BSPC member states about strategies and measures on how to foster Innovation in Social and Health Care – ISHC.

Additionally, item 2. – "Background" – describes in what way the Working Group defines and interprets innovation in social and health care. According to the Working Group's paper ISHC deals with the issue of securing the provision of qualitative and equitably distributed social and medical services to the citizens in a situation of changing demographics, altering patterns of somatic and mental ailments, and constrained financial resources.

Taking this definition as well as the introductory question of the survey into account, the survey primarily deals with classic aspects of social and health policy, which lie within the competencies of the Ministry of Social Affairs.
In that sense we also refer to the answer of the Ministry of Social affairs to the questionnaire of the Working Group.

The field of social and medical services naturally also incorporates economic opportunities and contributes as one part of the health economy to the overall national economy. By now the issues of health, health economy and healthcare can no longer be regarded solely as cost factors but rather as a future growth sector. In particular, growth rates in employment, productivity and added value have been achieved, which rely on the sustainable basis of the demographic development, the medical-technical advance as well as the rising conscience for health issues on the part of the population.

This claim is backed up by numbers from April 2013 published by the Federal Ministry of Economics and Technology on the state of health economy in a macro-economic context. According to these figures, the gross added value in 2020 amounted to € 260 bn., or 11.1 % of the entire economy.

This sector is an important contributor to employment. More than one in seven employees in Germany (4.5 million people) is occupied in the health economy. In Mecklenburg-Vorpommern about 97,600 people are employed in this sector. Of these, 70 % work in in-inpatient, semi-residential and outpatient care. A smaller fraction works in medical engineering, health trade professions and administration. Between 2000 and 2010 employment grew by 24.3 % in Mecklenburg-Vorpommern. In contrast to that, total employment has decreased by 9.3%.

The state government has identified the health economy as a strategic future market and has undertaken several important steps in this regard.

On the on hand, the Landtag has declared the health economy as an essential development theme in an act of parliament from 2004 and has defined a framework for action "Masterplan Health Economy 2010", which was updated in 2011 on behalf of the Ministry of Economics until 2020.

On the other hand, the „Board of Trustees Health Economy" and its five affiliated strategy groups paved the way for a nationally unique „Health Parliament." This

parliament allows for an integration of all decision-makers from science, economics and politics into the overall context.

One result of this process is the fact that over € 2 bn. have been invested in the various sectors of the health economy since 1990. Mecklenburg-Vorpommern features 39 modern hospitals, including two university hospitals as well as 60 prevention and rehabilitation facilities and 60 state-certified health resorts (top of a nationwide ranking).

Another part concerns the services sector, in particular health services. This field receives particular attention. Within the framework of the "Board of Trustees Health Economy" a separate strategy group area is responsible for this thematic field and deals with the updated Masterplan Health Economy. Its main themes are rehabilitation, prevention and high-performance medicine. As these are located at the crossroads between the contributions-based healthcare system and the privately financed „health market" they also have to be regarded from an economic viewpoint.

The modern high-performance medicine, above all, is of particular importance for the continued economic growth in the health economy in Mecklenburg-Vorpommern. Especially the link between science, medicine and the economy constitutes an inevitable precondition for innovation and value creation in Mecklenburg-Vorpommern.

At this point the state government, and especially the Ministry of Economic Affairs, considers the funding of research, development and innovation as a high priority since international competitive products and services ensure future-orientated employment. By means of orientation towards this kind of employment we intend to sustainably increase value creation and the level of income in the state. The technology policy especially aims to more effectively use the potential of science, benefitting the development of the regional economy.

Promotion of research, development and innovation

During the Funding Period 2007-2013 a total of € 155 m. from the European Social Fund (ESF) and the European Regional Development Fund (ERDF) could be used and applied to promote research, development and innovation in Mecklenburg-Vorpommern. Until December 2013 € 151.3 m. could already be committed; 37.3 % of that to biotechnology and medical engineering. 808 projects are being funded with the money. During the new Funding Period 2014-2020 an estimated € 137 m. will be available via the ERDF for the promotion of research, development and innovation.

In principal two different funding schemes are available:

a) Support through the allocation of venture capital currently via the Technology Fund Mecklenburg-Vorpommern (TFM-V)

The TFM-V invests venture capital in innovative, growth-oriented technology companies in Mecklenburg-Vorpommern. Small businesses in their seed-, start up- and first expansion phase receive financial support. The TFM-V invests, as far as possible, in cooperation with private investors. The fund management of the TFM-V has bought Genius Venture Capital GmbH. The TFM-V investments comply with the investment principles according to the relevant EU official publication. The allocation

occurs via open capital interest (usually minority shareholding) or a combination of open and silent participation in incorporated enterprises.

Emerging innovative technology companies that fulfil the following criteria receive funding:

- companies with less than 50 employees and less than € 10 m. volume of sales or less than € 10 m. total,
- companies younger than 6 years,
- companies with a registered office or main commercial unit in Mecklenburg-Vorpommern.

Capital ownership averages € 150,000 up to € 1.5 m. over a 12 months period.

Co-Investments of private investors are sought and are required in case of expansion capital and later-stage financing.

b) Support through promotion of research, development and innovation

Directive for the promotion of research, development and innovation (extended until end of 2014)

Measures of the directive:

1. Scheme for research and development projects
   (a) single enterprise projects; b) joint research projects)
2. Technical feasibility studies
3. Commercial property law activities through SMEs
4. Support of upcoming innovative companies
5. Process- and business innovations in the services sector
6. Innovation consulting services and innovation support services
7. Loan of highly qualified personnel from research institutions or large enterprises to SMEs
8. Technology-oriented networks

In addition to 1a) Single Enterprise Projects
Small, medium and large enterprises are eligible for funding. The following aspects are eligible for funding: labor costs including fixed costs (up to 25%), project-specific instruments and equipment, research and technical knowledge expenses, miscellaneous expenses and material. The reimbursement rates vary according to project and company size (industrial research/small enterprises up to 70%, medium enterprises up to 60%, large enterprises up to 50%, experimental development/small enterprises up to 45%, medium enterprises up to 35%, large enterprises up 25%).

In addition to 1b) Joint Research- and Development Projects

Small, medium and large enterprises in cooperation with research institutes are eligible for funding. The following aspects are eligible for funding: labor costs including fixed costs (up to 25%), project-specific instruments and equipment, research and technical knowledge expenses, miscellaneous expenses and material. The reimbursement rates vary according to project and company size (industrial research/small enterprises up to 80%, medium enterprises up to 75%, large enterprises up to 60%, experimental development/small enterprises up to 60%,

medium enterprises up to 50%, large enterprises up 40%). Joint research institutes can be supported with up to 100%.

Successful examples of funded projects:

- Miltenyi Biotech GmbH,
- Cortronik GmbH,
- IT Dr. Gambert GmbH,
- Human Med AG,
- DOT GmbH.

II
WG homework 1

Answer from Norway

February 2014

Homework 1 – NORWAY

1. Purpose

This first homework of the BSPC Working Group on Innovation in Social and Health Care (WG ISHC) addresses a number of questions of a general nature concerning the existence of public strategies and measures to support ISHC. It will also provide an indication of the level of political support for ISHC.

At this stage, and as a basis for the subsequent orientation of the activities of the WG, it is important to obtain an overall picture of the situation and status of ISHC in the BSPC member states.

Members of the WG are kindly requested to produce a concise response (a couple of pages) to the questions below. The response should be submitted to the WG Secretariat no later than 26 February 2014. The answers will be compiled and distributed to the WG before the next WG meeting in Tromsø on 27-28 March 2014.

The answers will also be used to amend and develop the WG Scope of Work and to provide input and inspiration to the political recommendations of the WG.

2. Background

The preliminary interpretation of ISHC by the Working Group is that ISHC deals with the issue of securing the provision of qualitative and equitably distributed social and medical services to the citizens in a situation of changing demographics, altering patterns of somatic and mental ailments, and constrained financial resources.

The overarching objective of the WG is to elaborate political positions and recommendations pertaining to innovation in social and health care. The recommendations constitute an expression of the political views and positions of parliamentarians from the entire Baltic Sea Region. It is essential that the recommendations focus on the political added value that parliamentarians can bring to the process of stimulating ISHC.

In a first step, the WG should aim at obtaining a comprehensive picture of the challenges and drivers of ISHC, as well as a representative overview of measures that have been applied to promote ISHC. The overview should also include examples of gaps and needs for new or other forms of support for ISHC. In its follow-on work, the WG should i.a. collect and compile a set of representative practical examples of ISHC.

3. Questions to the BSPC Member States on Strategies and Measures to Support Innovation in Social and Health Care (ISHC)

1. What, from your perspective, are the main challenges facing social and health care today and in the future?

    - **Demographic changes:** Due to population growth and population ageing the need for health care and social services will increase. There is thus a risk of shortage of manpower. A large number of people will live longer without any severe health problems but many will also live longer with chronic diseases and a complex clinical picture.

- **Increased demands:** The citizens have large expectations towards the health system. They claim services to be quickly delivered, advanced methods of treatment and a focused, efficient and individual treatment.
- **Growth in lifestyle illnesses;** most of them also being widespread diseases.
- **Health inequality;** both nationally and globally.

2. Have you launched any public strategies and programmes for ISHC? Are any new initiatives planned? What are your experiences and results so far concerning public programmes and measures to support ISHC?

Norway has several public strategies and programmes for ISHC. Two white papers and one official report have been made, and these constitute the basis for several programmes directed towards researchers, business life, users, patients, municipalities and the state. The programmes intend to facilitate development of new technological products and services, and to improve processes and ways of organizing. The aim is to enhance quality and efficiency within the health sector, to improve satisfaction among patients, next of kin and employees, and finally, to establish more competitive businesses on the health market, both nationally and globally.

Examples of programmes:

- **Innovation for a better health- and care service (2007-2017)**

This programme concentrates on research and demand-led innovation and commercialization. It includes elements as IT, medical technical equipment, public procurement, and it deals with challenges such as chronic diseases, ageing population, better interaction and cooperation between service levels. It facilitates meeting arenas for the supplier industry, the health sector and the policy administration.
Actors; regional health enterprises, Innovation Norway, the Norwegian Research Council, the Norwegian Association of Local and Regional Authorities, Directorate of Health and InnoMed.

- **InnoMed**

InnoMed is a national competence network for need driven innovation in the health sector. Our goal is to contribute to increased efficiency and quality in the health care sector through the development of new solutions. These are based upon national needs and have international market opportunities. The solutions are developed in close collaboration between users in the health sector, Norwegian companies, reputable specialists and funding agencies. Read more on http://www.innomed.no/en/

- **National program for developing and implementing welfare technology**

32 municipalities (out of 428) participate in this programme and will be testing different types of welfare technology, f. ex. a variety of safety packages, GPS, electronical locking systems and other solutions enhancing safety for users and their relatives. The goal is to make it possible for elderly people to live at home as long as possible.

- **Health care 21**

A national process aiming to develop a strategy for research and innovation in the health- and care sector. This work is intersectorial and all relevant actors are welcome to contribute and participate.

- **Strategy for increased innovation effect of public procurements**

3.What are the results and effects?
It is too early to evaluate the effects of the strategies and programmes mentioned above. However, the first one ("Innovation for a better health- and care service 2007-2017") was evaluated in 2011 and the results indicated it had played a considerable role in establishing a common, national focus on innovation in the health sector. Further, it has created a common focus and frame for the ministries and the actors in the health sector. Nevertheless, the effects on the actual innovation activity in concrete projects remain uncertain.

4. Have you launched any public awareness campaigns concerning ISHC? Are any new initiatives planned?
The public effort is focused on establishing networks and including different actors through open processes. Public awareness campaigns have not been a priority. However, a yearly innovation conference is organized in order to inspire various actors to get involved with innovation in health and care. The conference presents real and concrete innovation stories from Norway and other countries. Next conference will be in November 2014.

5. Have you launched any public economic support mechanisms for ISHC, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?
Innovation Norway enhances companies' competitive advantage and creates new development in the corporate sector and in the Norwegian rural districts. It has six priority areas, one of them being health, including development of new medicines, medical technology and health related IT. Innovation Norway thus offers three types of grants; installation, research- and development, and innovation loans.

Further, some of the public programmes described in point 2 do also offer grants for trying out new ideas and experiments. Some examples:

- The Directorate of Health has a subsidy scheme for municipalities wanting to try out different kinds of technological safety systems for elderly people living at home (28 million NOK in 2014).
- The Norwegian Research Council distributes grants to different innovation projects in the health-and care sector. One example is a grant programme supporting new businesses and commercial actors using results from publicly financed research institutions in their activities.

5. In general, what do you see as the main obstacles for promoting and implementing ISHC? What kind of political support and measures are conceivable to overcome the obstacles?

- Few investor environments, financial as well as industrial. Lack of capital and financial support in the initial phase and in the long run.
- Limited cooperation between business- and research actors.
- A gap between the research institutions and the health service, in particular the municipal one.

Evaluations of different public efforts confirm these obstacles. Hospitals, municipalities and other practical orientated public institutions are not sufficiently involved in development projects. Further, while public project owners claim that limited resources (time and economy) is the most important barrier to innovation, private project owners blame the lack of financial sources outside their business.

II
WG homework 1

Answer from the Russian Federation

Public policies and programs on social security and health care in the Russian Federation

In the Russian Federation, the state program "Social support to citizens" is under implementation till 2020 (the program was approved by the Russian government in December 2012).
State program aimed at improving social support certain categories of citizens, family support, the development of an effective system of social services.
The program focuses on four sub-programs:
- development of social support certain categories of citizens
- modernization and development of social services
- improving social support for families and children
- Improving the efficiency of state support for socially oriented non-profit organizations

The objectives of the program are: the creation of conditions for the growth of welfare of citizens of the recipient of social support, increasing the availability of social services
The program solves the following problems:
- fulfillment of the obligations of the state for social support of citizens
- meet the needs of senior citizens, the disabled, families and children in social care
- creation of favorable conditions for the family functioning of the institution of the family, the birth of children
- increasing the role of non-state sector of commercial organizations to provide services.

Russian Government approved the Strategy for long-term development of the pension system, its implementation will ensure a decent level of pensions to citizens on the basis of the principle of social justice.

Modernization of social services is constrained by budgetary constraints due to increased instability, suited for the Russian economy.

In Russia there is a road map "Improving the efficiency and quality of services in the sphere of social services in 2013 - 2018", it provides that the share of non-governmental organizations dealing with social services among the total number of institutions of all forms of ownership will be 10%.

The proposed comprehensive changes to legislation will create the necessary conditions for the development of public-private partnerships and to attract investment in social services.
The introduction of public-private partnership in social services will help overcome limitations of federal, regional and municipal governments to finance investment projects, as well as transfer part of the risks to the private sector, to use management skills, expertise and experience of the private sector to improve the quality of social services provided to the population increase efficiency infrastructure management.

II
WG homework 1
Answer from Schleswig-Holstein

Bernd Heinemann, MdL

26. Februar 2014

Vermerk zur Vorbereitung:

BSPC Working Group on Innovation in Social and Health Care

1. What, from your perspective, are the main challenges facing social and health care today and in the future?

For Schleswig-Holstein the main challenges of social and health care at present (and probably growing in the future) are:

- The demographic and social change. The growing average age causes a decreasing number of payers to social insurances while the number of recipients of benefits grows. The willingness to unpaid social work declines. The demographic change also leads to an increasing number of handicapped and disabled persons, care recipients and age-related diseases. Especially in rural areas, the growing age of the inhabitants leads to new challenges, such as mobility, adaption of public services and a growing need of social and health care, which are contrary to the following two points.
- A lack of qualified personnel, especially for nursing care. It is mainly caused by unattractive conditions such as a low reputation of the career, relatively low payment and dissatisfying working circumstances.
- General medical care. Especially in rural areas, there's a lack of general practitioners. Within the next five years, one quarter of the GPs in rural areas will retire. Young academics shy away from establishing themselves in rural areas because of high workload, high investment costs and living in rural areas in general, which commits them to their surgery for years. Many young doctors prefer not to be self-employed.
- Funding. Due to the debt limit and the pressure on social insurances it gets harder to finance social and health care projects – in times, when modernization and change are exceptionally needed.
- High insurance rates and a drop in the birthrate apply pressure on midwifery, especially in the peripheral areas

2. Have you launched any public strategies and programs for ISHC? Are any new initiatives planned? What are your experiences and results so far concerning public programs and measures to support ISHC?

3. Have you launched any public awareness campaigns concerning ISHC? Are any new initiatives planned?

There are different strategies and programs in Schleswig-Holstein, initiated by different actors in the social and health care sector. Because of the autonomy of the German public health sector and the federal structure only specific programs and initiatives from Schleswig-Holstein or (co)financed by Schleswig-Holstein are mentioned.

- **"Gesundheitsinitiative Schleswig-Holstein"** (since 2000) – Network-building between providers of health services, medical associations, health insurances and science. Intention is to provide information and transparency about health proposals and to secure a regional and socially just medical care.
- **"Medibüro"** – medical care for people without health insurance, especially immigrants; since 2014, Schleswig-Holstein provides financial support to such initiatives
- **"Kompetenzzentrum Demenz"** – coordination and support of helpdesks and facilities dealing with dementia
- **"Pflegestützpunkte"** – support and guidance for people with care dependency
- Funding of innovative low-threshold care and self-help projects, especially for people effected by dementia
- **"Sozialräumliche Eingliederungshilfe"** – model project of financing and planning of public social benefits for disabled people in Nordfriesland
- **"Partyprojekt Odyssee"** – prevention of addiction of young people, especially against alcohol and drug addiction by guidance in discotheques and during festivals

Initiatives financed by other public institutions:

- **"Land.Arzt.Leben"** – Image campaign of the KVSH (association of the CHI physicians) with support for students and general practitioners in training to promote settlement in rural areas

Planned or in development:

- A Chamber of Nursing
- Modernization of nurse schooling and a nursery degree course
- Regional health conferences – network-building in regional contexts
- An agenda for disabled people
- An dementia agenda
- Modernization of the psychiatry structure, particularly ambulantory care and psychosomatic care
- A concept for midwifery
- An initiative for diabetes prevention

4. Have you launched any public economic support mechanisms for ISHC, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?

Because of the federal structure of Germany, the possibilities of tax incentives funding for the federal states are relatively limited. Funding of social projects and initiatives is mostly realized by structural funding or project funding. The project funding could often be described as kind of seed money.
The health care projects and programs are often co-financed or initiated by the public social insurances and/or the medical associations. The influence of the states is often limited to network-building or cooperation. Dedicated funding is reduced to a special group of projects like debt counseling, which is partly financed by gamble fee.

5. In general, what do you see as the main obstacles for promoting and implementing ISHC? What kind of political support and measures are conceivable to overcome the obstacles?

Main obstacles for a federal state in Germany are:

- t
  he self-administration of the German health system, which includes many actors with different political and economical aims
- t
  he mostly communal-based and partly private social care structure

Both structures have well justified historical and political origins, but are very hard to change for a single federal state. Innovation is mostly implemented by the structures themselves, but public furtherance is limited by financial aspects and competence of levels.

From the view of a German federal state there are mainly two ways to implement innovative projects concerning social and health care: First, to implement model projects in cooperation with different welfare and communal actors. Second is to affect to changes at federal or communal level.

II
WG homework 1
Answer from Åland

Questions to the BSPC Member States on Strategies and Measures to Support Innovation in Social and Health Care (ISHC)

Answers from Annette Holmberg-Jansson, member of the Åland Parliament and BSPC ISHC working group

1. What, from your perspective, are the main challenges facing social and health care today and in the future?

- Ageing populations
- The problem of choosing what health care measures/technologies to implement in publicly funded healthcare services as increasing medical possibilities with innovation an development seems to inevitably increase healthcare costs (although it can lead to decreased costs elsewhere - decrease sick leave/pensions payments etc.)
- Downsides of a more globalized healthcare/population: emergence of new types of as well as an increase in known mulitresistant bacteria, cultural and linguistic challenges, follow-up of procedures/medication initialized elsewhere etc.
- The need within elderly care for and availability of multi-professional staff to work the prevention, activating and rehabilitation.

2. Have you launched any public strategies and programs for ISHC? Are any new initiatives planned? What are your experiences and results so far concerning public programs and measures to support ISHC?

- A public vaccination program against TBE (tick-borne encephalitis) was introduced in Åland in 2006 (Austria is the only other territory in Europe that provides this). Complete evaluation results are pending. The initiative has from a pure medical standpoint had a positive effect; annual cases of TBE in the Åland islands has decreased since launching the program.
- Prevention and enhanced structures for discontinuation of tobacco usage in the Åland islands. Åland has the lowest prevalence of tobacco smoking among adults in the EU (12 %). Including other usage of tobacco (snus) the figure is substantially higher but still lower than the EU average. The same figures for youths are not as good comparatively for Åland. In order to further lower and maintain a top position in regards to tobacco usage among adults and to lower the figures among youths the government of Åland will

2014 launch a public health program, Tobakskampen, which gives the general public access to a new smoking cessation program in a primary health care setting, as well as information campaigns and special training for school nurses for tobacco prevention.

- There are plans for reorganization of social care in order to make sure that all get the same benefits regardless in which municipality the individual has its home.

3. Have you launched any public awareness campaigns concerning ISHC? Are any new initiatives planned?

- Increased awareness of and easier access to diagnostics of sexually transmitted infections (STIs). Åland has for the past three years had the highest incidence of genital chlamydia in Finland. Syphilis reemerged 2012. There are a number of HIV cases. Talks on STIs has been given to all high school pupils (grade 1) in Åland 2013 and will be held annually (and augmented with talks for health care providers), the educational health care services and the publicly funded health care provider (ÅHS) have facilitated access to testing for STIs, the government of Åland will in the beginning of 2014 launch a website, www.klamydia.ax, where the public will be able to order test kits for chlamydia and gonorrhea for home use free of charge and also will be able to read up on STIs.

- Researching occurrences of previously unknown tick-borne diseases in the Åland islands. Primarily (first half of 2014) the government of Åland funds planned testing of lab specimen from 100 islanders for the occurrence of antibodies against borrelia miyamotoi, a borrelia species originally found in Japan and in recent years found to exist in Russia among other more nearby places to Åland. Infection with b miyamotoi cannot be diagnosed with currently used testing for borrelia (Lyme disease) in the Nordic countries. Symptoms can be similiar.

4. Have you launched any public economic support mechanisms for ISHC, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?

- There have been resources allocated in the budget approved by the parliament last december. The government is about to investigate how to change the existing tax regulations (tax reductions for health care) in order to pinpoint individuals that need them most.

5. In general, what do you see as the main obstacles for promoting and implementing ISHC? What kind of political support and measures are conceivable to overcome the obstacles?

- It is though for our small community to upheld social and health care taking into account the continuous development in these fields and the economic realities that exists. That can only be done in close cooperation with others and if possible by sharing physicians and investments.

II
WG homework 1

Answer from Sweden

Homework 1

What, from your perspective, are the main challenges facing social and health care today and in the future?

An *aging population* in combination with *urbanization and technological development* in the health and medical area bring challenges in relation to:

- Stable financing of the welfare sector.
- Meeting rising demands of health and social care.
- Meeting demands of more technologically advanced (and more expensive) treatment methods.
- Ensuring equal access to health and social care of high quality in all of Sweden
- Ensuring the long-term provision of health and social care professionals in all of Sweden

In the health care area there is right now intensified national political focus on cancer care, care of people with chronic diseases, reproductive health and psychiatric health and care.

Have you launched any public strategies and programs for ISHC? Are any new initiatives planned? What are your experiences and results so far concerning public programs and measures to support ISHC? Have you launched any public awareness campaigns concerning ISHC? Are any new initiatives planned? Have you launched any public economic support mechanisms for ISHC, such as dedicated funding, seed money or tax incentives? Are any new initiatives planned?

Examples of strategies, programs and projects in ISHC are listed below. The list is not exhaustive. Some programs and projects have been evaluated, but it is not possible to summarize those evaluations in this document, so the question of experiences and results will not be answered.

- ***The National Innovation Strategy***

In 2012 the government decided on the National Innovation Strategy. The strategy is available through this link. The strategy concerns several policy areas including innovation for a more effective public sector (thus including health and social care).

- ***VINNOVA, The Swedish Innovation Agency***

VINNOVA is a Swedish government agency working under the Ministry of Enterprise, Energy and Communications. Health and Healthcare is one of VINNOVA's strategic areas. The key areas identified by VINNOVA are: services within health and social care, the link between health, climate and environment and the healthcare sector as a production system. The VINNOVA program *Innovations for Future Health* aims to utilise high-quality Swedish research in order to prevent and treat lifestyle diseases and drug-resistant infections.

- ***Agreement between VINNOVA and SALAR (Swedish Association of Local Authorities and Regions)***

SALAR and VINNOVA has agreed to work together to support local authorities and regions to develop leadership and organizational prerequisites for innovation. The cooperation is also meant to stimulate the development of smart welfare services supported by new technology.

- ***Technology for elderly***

During six years, the Swedish Government supported the development of products and services that can assist elderly people and their relatives in everyday life. The Technology for Elderly Programme was coordinated by the Swedish Institute of Assistive Technology. 100 projects received support from Technology for Elderly 2007–2010. For the period 2010–2012, the Government has reserved an

addition of 66 SEK million (approximately 6,97 EUR million). Companies, organizations and local government authorities applied for project funding in this area through two applications which are open twice during the period. The objective was to test and develop new technology for elderly in their homes.

- ***Innovation Centers and Test beds within the Health Service***

The idea of Innovation Centers and Test beds within the Health Service is that these will support the development of ideas into needs-driven innovations from the health service within county councils and municipalities. The total potential for further developing innovations within the field is, according to VINNOVA, considered to be great. However, systems/milieus which can advance concrete ideas from those working in the health service need to be developed. Calls for proposals under this programme have been held 2009 and 2013.

- ***Innovation procurement***

Procurement for development and implementation of new solutions, i.e. innovations. Innovation procurement includes both procurement made in such a way that it does not rule out new solutions, so called innovation-friendly procurement, and procurement of innovations, i.e. procurement of the development of new solutions not yet available on the market. VINNOVA launched it's Innovation Procurement programme in 2011, aiming to increase and extend the development of innovation procurement, chiefly in the public sector.

- ***National e-health strategy***

The National e-health strategy was adopted by the government I 2010. was adopted in 2010.[1] The aim of the strategy is accessible and secure information in health and social care.

- ***Swedish Agency for Economic and Regional Growth have worked with "Development checks" for companies in health and social care.***

The companies have applied for funding for developing new knowledge, methods, processes or goods. The program ran from 2011 to 2013 and distributed 15,3 MSEK to 163 companies in health and social care.

- ***The Committee for Digitization***

The Committee for Digitization was established by the Swedish Government in 2012 to analyse and monitor progress in terms of meeting the ICT-policy goal; that Sweden should become the best in world at exploiting the opportunities of digitization. The Committee is also tasked with highlighting the benefits associated with digitization, sharing best practice and communicating the actions and goals of the Swedish Digital Agenda. The Committee is responsible for managing the signatories of the Digital Agenda which are companies, not-for-profit entities and others who have agreed to work in line with the objectives of the Digital Agenda. Finally, the Committee should present policy proposals needed to achieve the ICT-policy goal.

[1] National eHealth – the strategy for accessible and secure information in health and social care

II. WG homework 2

Questions to the BSPC Member States on ethical aspects of ISHC

1. What, in your opinion, are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies?

2. What policies and methods have you applied, or planned, in order to guide the prioritizing between different patient groups (different kinds of diseases and ailments), in a situation where treatment potentials are growing but practical resources are scarce? Who has the responsibility for setting and making priorities?

3. To what extent will a patient´s lifestyle, behavior and self-responsibility influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments?

4. What steps (legislation, regulations, technical, etc) are taken or planned in order to safeguard patient security and integrity in the increasingly digitized patient information systems? How is the patient´s access to her/his own information secured and regulated?

5. To what extent and how are ethical issues acknowledged and incorporated in education, training and competence enhancement of health and social welfare personnel?

II
WG homework 2
Answer from Denmark

BSPC Working Group on Innovation in Social and Health Care

Homework 2

Contribution from Denmark

1. ***What, in your opinion, are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies?***

   Progress in medical treatment does not only create ethical dilemmas, but can also help overcome some of these e.g. by way of improving services, improving the easy and equal access to healthcare, reducing patient-risk, improving knowledge based decision-making and patient involvement etc.

   Among ethical issues and dilemmas which can be expected in the future due to medical progress, an example could be the issue of early diagnostics e.g. the possibility of predicting a person's future diseases either based on new ways of (very early) biomedical screening or by way of genetic prediction or probability.

2. ***What policies and methods have you applied, or planned, in order to guide the prioritizing between different patient groups (different kinds of diseases and ailments), in a situation where treatment potentials are growing but practical resources are scarce? Who has the responsibility for setting and making priorities?***

   Overall principles
   The Danish Healthcare Act (Sundhedsloven) states specifically that the purposes of the law is to ensure respect for each individual and to establish the requirements to the healthcare system in order to ensure, firstly, the easy and equal access to the system.

   One of the overall principles governing the Danish healthcare system is the equal access to services. And the healthcare system is, with few exceptions, financed collectively trough taxes.

   The level of service in the Danish healthcare sector is – in general – not regulated directly by law. However, there are a few exceptions - for in-stance regarding treatment for assisted reproduction. In this case the service level at the regional hospitals has been regulated by law.

   This allows the regions and municipalities to organise the health service for their citizens according to local priorities and available facilities. Thus, the individual regions or municipalities can adjust services and prioritise within the financial possibilities and within the national legal limits.

   So there is no overall a priori prioritization between diseases and ailments. The access to healthcare is first and foremost guided by the individual need of the specific patient.

However, both the national, regional and municipal governments (all three levels are responsible for the healthcare sector) can make strategic political and/or financial prioritizing in order to improve quality and services in specific areas. This has been seen e.g. in cancer care and, more recently, within psychiatric care.

Specific tools and structures to guide prioritization in treatment
A number of different tools and structures are used in order to support the underlying prioritization and clinical choices regarding the individual patient

Clinical Guidelines and evidence based approaches
The overall principle guiding prioritization is the evidence based approach.

There is widespread use of clinical guidelines outlining evidence-based approaches and best practice. These guidelines are made on a national, regional and, to a limited degree, municipal level as well as within each medical society, the nursing society etc.

In 2012 a major national program to establish national evidence based clinical guidelines was started. This program is run by the Danish Health and Medicines Authority.

Also in recent years, there has been an increased development and use of clinical guidelines for visitation.

If evidence based treatment is not available in Denmark.
In cases, where the needed highly specialized treatment is only available abroad, it is possible for the patient to be referred to treatment abroad.

In cases where all evidence based possibilities for treatment are exhausted, the patient can be referred to a national second opinion panel.

The Coordination Council for the Application of Hospital Medicine (KRIS)
The Danish Regions' board established KRIS in 2012 with the purpose of coordinating the application of new hospital medicine, including indication extensions, across the regions.

The council shall in particular coordinate the application of cancer medicine.

The Council for the Application of Expensive Hospital Medicine (RADS)
In 2009, the board of Danish Regions established RADS with the aim of agreeing on the application of expensive hospital medicine across the regions.

The purpose of RADS is to ensure that all patients have equal access to treatments. This is accomplished through common clinical treatment guidelines.
RADS has been authorized to develop recommendations for the products that account for 80% of total expenditure for hospital medicine.

While KRIS mainly deals with new cancer medicine, RADS' work concerns potentially all areas, where medicine can be ranked in order to guide the healthcare professionals and for the purpose of making tenders.

3. ***To what extent will a patient´s lifestyle, behaviour and self-responsibility influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments?***

   It is too narrow a question just to focus on for example lifestyle as the deciding factor in who gets access to new and more expensive treatments. The Danish Health Sector is publicly funded and with free and equal access. Of course there can probably be instances when a doctor on medical grounds cannot recommend a certain procedure for example when a patient has an excessive drinking habit. But the key is patient involvement and empowerment.

   Patient empowerment is for many reasons a high political priority in Denmark and part of the future development of the healthcare sector. The Danish government has announced its decision to launch a strategy of patient empowerment that will emphasise the many positive effects of involving patients and their relatives and establish goals for the changes that the different actors in the sector must strive to achieve.

   A key element in patient empowerment is for patients to be actively involved in the choice of treatment and that patients are well informed and educated in order to enable them to manage their own health. Therefore one aim is to spread the effects of shared decision-making. Shared decision-making supports the patient's active disease management and informed choices.

   By involving patients in the decisions about their own health and treatment, the health outcomes, compliance and the quality of the health care can be improved. Empowerment can bring greater control of symptoms, better compliance and lifestyle changes, less anxiety over health issues, enhanced quality of life and more independence and autonomy. Empowered patients are able to make informed choices about treatment and options for managing their own condition. And studies show, that patients choose the more conservative treatment, when they are faced with the choice and are well informed about the consequences.

   Patient empowerment is already widespread in the Danish healthcare system, with more than 300 projects around the country. The aim of the strategy is to place patients at the centre of the healthcare system, and make sure that patients are part of the decisions concerning their own health, treatment and rehabilitation.

4. ***What steps (legislation, regulations, technical, etc) are taken or planned in order to safeguard patient security and integrity in the increasingly digitized patient information systems? How is the patient´s access to her/his own information secured and regulated?***

   The Danish legislative system contains one track regarding data protection (based on the European data protection directive) which regulates the technical and organisational handling of sensitive data, and another track regarding access to patient data (in our health legislation). The legislation includes requirements to log access to patient data and to follow up on possible unauthorized accesses. Unauthorized access is subject to a fine and/or imprisonment, and may - in very severe cases - have consequences for upholding an authorisation to practice as a health professional.

   Patients have access to their own information based on a general principle of access to own information under the freedom of information legislation. Furthermore a direct electronic access is established to a range of patient data systems, which are made available via the Danish eHealth portal www.sundhed.dk. Access is regulated with a technical solution called nemID, which is a digital signature, making sure access is only granted to the citizens' own information. For some systems the patient also has direct electronic access to log data showing who has accessed his/her data.

5. ***To what extent and how are ethical issues acknowledged and incorporated in education, training and competence enhancement of health and social welfare personnel?***

   Ethical issues are part of the professional activities for health personnel and are a multifactorial process. Competences are achieved through education both theoretical and clinical. The main aim of the education for all health personnel is respect of the integrity and autonomy of patients in everyday practice.

   In the postgraduate education for physicians competences are listed for the seven physician roles, medical experts, communicator, collaborator, manager, health advocate, scholar and professional in the curriculum for specialization. All competences must be achieved through the formalized medical training either by courses including patient cases or in the clinical setting. Ethical issues are part of competences in all roles but may especially be a part of competences listed for the professional role. Some of the elements that are included in the competence-based education are:

   - Identification of and solution to healthcare problems including medical priority-setting
   - Exercise diligence and conscientiousness
   - Management of professionalism in compliance with the Hippocratic Oath and legislation
   - Use of the professional expertise while acknowledging the ethical dilemmas and the complexity, unpredictability and uncertainty that arise in everyday practice.
   - Knowledge of conflict resolution and be able to act accordingly

II
WG homework 2

Answer from Estonia




sotsiaal ministeerium

Laine Randjärv
President of the Baltic Assembly
anete.kalnaja@baltasam.org

Your ref: 30. May 2014 No 2/0514-103

Our ref: 15 July 2014 No 1.4-2/2742

Reply to request

Dear Ms Randjärv

In your letter of May 30, 2014 you asked concrete questions concerning the ethical aspects of innovation in social and health care. Please find below the answers to your questions.

1. What, in your opinion, are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies?

We agree that innovations come with ethical aspects, which have to be evaluated separately in every case. It is very hard to categorize them as separate themes.

2. What policies and methods have you applied, or planned, in order to guide the prioritizing between patient groups (different kinds of diseases and ailments) in situation where treatment potentials are growing but practical resources are scarce? Who has the responsibility for setting and making priorities.

According to Health Insurance Act § 30 the list of health services of the Health Insurance Fund will be established by a regulation of the Government of the Republic on the proposal of the Minister of Social Affairs to which the written opinion of the supervisory board of the Health Insurance Fund concerning the proposal is appended. The making of a proposal for amendment to the list of health services may be initiated by the associations and professional associations of interested health care providers by entering into negotiations with the Health Insurance Fund. Detailed mechanism as to how one or the other service or pharmaceutical is added to the abovementioned list is regulated by Health Insurance Act § 31.

3. To what extent will a patient's lifestyle, behavior and self-responsibility influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments?

In Estonian Healthcare system patient's discretion is respected. In case of a patient with active legal capacity, then after process of informing the doctor, patient decides whether to agree or not to agree with the treatment. In case of a patient with restricted active legal capacity, their legal guardian is informed about the situation, and then together with patient he/she decides whether to agree or not to agree with the treatment. In cases of emergency, action is taken by assumed

Ministry of Social Affairs of Estonia
Gonsiori 29
15027 Tallinn
ESTONIA
Phone +372 626 9301
Fax +372 699 2209
www.sm.ee
info@sm.ee

512

agreement, meaning that we assume that everybody agrees with medical help in emergency situations. It is prohibited to discriminate patients for non-medical reasons.

4. What steps (legislation, regulations, technical, etc) are taken or planned in order to safeguard patient security and integrity in increasingly digitized patient information systems? How is the patient's access to her/his own information secured and regulated?

Estonian eHealth Foundation maintains and administrates the Estonian central Health Information System. In its activities the organisation follows the Statute of the Health Information System as well as all legal acts applicable in case of sensitive personal data in Estonia.

Medical documents stored and maintained in the Estonian Central Health Information System can be seen and used by patients via the National Patient Portal only if the person identifies herself/himself by using an ID-card or Mobile ID. All medical documents sent to the central Health Information System by health care providers are signed or stamped digitally. Whenever medical data or documents are requested from the Central Health Information System it will leave an unchangeable secure trail in the system. All patients can see from the National Patient Portal who and when has seen and used their data.

Medical documents in the Central Health Information System are encrypted. It removes the confidentiality risk which can arise from the technical administrators of the data in the Central Health Information System. The central health information data and its usage is regularly monitored with counter measures (organizational and technical). If any misuse is identified, deeper investigation will be conducted.

5. To what extent and how are ethical issues acknowledged and incorporated in education, training and competence enhancement of health and social welfare personnel?

Ethical issues are acknowledged and incorporated in education, for example at University of Tartu, in medical education program, ethics are taught for 15 study-weeks. Also the study curriculum of nurses and welfare personnel includes ethics.

Yours sincerely,

Urmas Kruuse
Minister of Health and Labour

Ingrid Ots-Vaik + 372 626 9168
ingrid.ots-vaik@sm.ee

II
WG homework 2

Answer from Finland

Baltic Sea Parliamentary Conference BSPC
The BSPC Working Group on Innovation in Social and Health Care

26 May 2014/The WG Secretariat

Homework 2 – Ethical Aspects of ISHC

1. Purpose

This is the second homework of the BSPC Working Group on Innovation in Social and Health Care (WG ISHC). It addresses a number of questions concerning the ethical aspects of innovation in social and health care.

Members of the WG are kindly requested to produce a concise response (a few pages) to the questions below. The response should be submitted to the WG Secretariat preferably before the next WG meeting in Birstonas 19-20 June. If this is not possible, please inform the WG Secretariat asap.

The answers will also be used to amend and develop the WG Scope of Work and to provide input and inspiration to the political recommendations of the WG.

2. Background

In general, innovation in social and health care (ISHC) is conducive to an enhanced capacity to provide qualified health and social services. Novel and improved medical and social solutions makes it potentially possible to diagnose, prevent, treat and cure a wider range of illnesses and ailments. New forms of treatment and therapies, such as distance treatment, self-care and client monitoring, are enabled. More efficient and comprehensive systems for registering, coordinating and monitoring patient information facilitates treatment and follow-up of patients. Digital systems facilitate prescription of pharmaceuticals.

However, ISHC also entails a number of ethical questions and dilemmas, based e.g. on the fact that resources will in all likelihood always be insufficient to cure all needs fairly and equitably. These dilemmas concern for instance resource allocation between emerging health technologies, prioritizing between different patient groups, balancing between specialized (narrow) care and general (broader) care, weighing patient integrity with information access, et cetera.

Against this background, the BSPC Working Group on ISHC would like to hear your comments on the questions below. We would like to stress that our wish is to obtain brief and concise answers, not extensive dissertations. The purpose is to acquire a cursory and hopefully comparable overview of how the ethical dilemmas posed by ISHC are approached in the countries of the Baltic Sea Region.

3. Questions

1. What, in your opinion, are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies?

In health care, the overarching ethical issue revolves around the prioritisation and cost-effectiveness of care. A key question is where to draw the line: for how long is it reasonable to offer care that has high costs but only modest effects on the patient? Furthermore, it should be discussed to what extent decisions regarding prioritisation of

care should be made by health care professionals and experts, and to what extent by political decision-makers.

In the domain of social services, at least in Finland the question is not so much of prioritisation, but of how to make these services reach those who are most in need. Often those who benefit the most from different services and measures are those who have lesser need for them in the first place.

2. What policies and methods have you applied, or planned, in order to guide the prioritizing between different patient groups (different kinds of diseases and ailments), in a situation where treatment potentials are growing but practical resources are scarce? Who has the responsibility for setting and making priorities?

Finland introduced a National Health Care Guarantee in 2005. The guarantee defines maximum waiting times for hospital and primary care services. In addition, uniform grounds for access to non-emergency care were introduced. The guarantee ensures that patients' need for treatment is assessed within three days of their contact with a health centre, and any treatment that is considered necessary must be provided within three months of the assessment.

Some important changes have been brought about by the EU directive on the application of patients' rights in cross-border healthcare. According to the Article 7 of the directive, a member state must reimburse the costs of a patient's cross-border health care on the same grounds that they would be reimbursed if the care was given in the member state itself. In consequence, Finland must for the first time determine the health care service range in order to create an understanding of which treatments are eligible for compensation. Determining the service range required the parliament to add a new section to the Health Care Act in December 2013. The new section also states that health care that has low effectiveness, as well as costs that are unreasonable in relation to the perceived health benefits to the patient, may be excluded from the service range.

Work on determining the service range has recently begun in the service range council under the direction of the Ministry for Social Affairs and Health. Current scientific and evidence-based knowledge on health care and the effectiveness of treatments will be used as a basis for this work. The service range will also be constantly updated according to new knowledge in the field of medicine and advances in technology.

The final responsibility for assessing individual patients' treatment needs will remain with the health care professionals, however. Their work is supported by the Current Care Guidelines. They are independent, evidence-based clinical practice guidelines that are produced with public funding and developed by the Finnish Medical Society Duodecim, in association with various medical specialist societies. The guidelines cover important issues related to Finnish health, medical treatment as well as prevention of diseases. The guidelines are intended as a basis for treatment decisions, and can be used by physicians, healthcare professionals and citizens.

In addition, the National Advisory Board on Social Welfare and Health Care Ethics ETENE, operating under the Ministry of Social Affairs and Health, provides assistance on ethical issues. The Advisory Board submits initiatives, publishes recommendations and statements, provides expert assistance, prompts public debate, and disseminates information on national and international ethical issues in the field of social welfare and health care.

Faced with an increasing scarcity of resources, there is a growing need for better methods to evaluate and assess the effectiveness and cost-effectiveness of different methods of treatment, as well as their effects on quality-adjusted life years of patients.

However, the main purpose of this work should not be cost-effectiveness in itself, but increasing patients' ability to sustain oneself and live independently, with the support of social and health care professionals when necessary.

3. To what extent will a patient's lifestyle, behavior and self-responsibility influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments?

All diseases should always be treated, in spite of the extent to which they have been caused by the patient's lifestyle or behavior. However, it is increasingly important to provide information on the consequences and health effects that different lifestyles may have on an individual. In addition, certain medical procedures, such as certain surgeries, may necessitate changes in a patient's lifestyle, e.g. weight loss, if only for medical reasons.

4. What steps (legislation, regulations, technical, etc) are taken or planned in order to safeguard patient security and integrity in the increasingly digitized patient information systems? How is the patient´s access to her/his own information secured and regulated?

Finland is in the process of introducing the new electronic Patient Data Repository, or KanTa. It offers citizens the possibility to examine their own medical records online. A national patient data management service is also maintained as a part of the archive. Through this service, a healthcare professional will get an overview of the patient's state of health, in the same way that citizens do on their own My KanTa pages.

Patient information held in the Patient Data Repository is available to the service provider that entered the information. Disclosure of the information to other healthcare service providers requires consent from the patient. The patient's consent covers all medical records already held in the system, as well as any records entered into it later. Consents and refusals can be managed through a healthcare service provider that has joined the service, and in the future through the My KanTa pages.

Healthcare professionals can access patient data systems with their healthcare professional cards. All data transfers between the healthcare system and Patient Data Repository are encrypted. Every access to patient records is entered in a log which permits ex-post control.

The development of the information systems in social and health care is based on the Act on the Electronic Processing of Client Data in Social and Health Care, and the Act on Electronic Prescriptions, which were both passed in the Finnish parliament in 2007. These acts include sections and guidelines on patient security as well as on the supervision of information security.

5. To what extent and how are ethical issues acknowledged and incorporated in education, training and competence enhancement of health and social welfare personnel?

The role of ethical issues is becoming increasingly important both in the education and practical training of social and health care professionals. Also questions arising from the treatment of patients from different cultures have been taken into account to a much greater extent in recent years.

The National Advisory Board on Social Welfare and Health Care Ethics ETENE (see question 2) also provides ethical guidelines. In addition, each different professional group have their own sets of ethical guidelines which are maintained by their respective

professional organisations. Furthermore, many work communities in the field of social and health care also have their own guidelines and principles concerning ethical issues. All of these guidelines are being constantly updated to keep up to date with the rapid changes in work environment.

II
WG homework 2
Answer from Germany

Franz Thönnes, MdB
Former Parliamentary State Secretary
Deputy Chairman of the Foreign Affairs Committee
Chair of the German-Nordic Parliamentary Friendship Group
Member of the BSPC Standing Committee

Franz Thönnes MdB • Platz der Republik 1 • 11011 Berlin

Mr Hermann Gröhe, MdB
Federal Minister of Health
Friedrichstr. 108
10117 Berlin

12 June 2014

BSPC Working Group on Innovation in Social and Health Care

Dear Minister,

At the 22nd Baltic Sea Parliamentary Conference (BSPC) in August 2013 in Pärnu, the participants decided to form the Working Group mentioned above. In my capacity as a member of the German Bundestag's delegation to the BSPC, I am part of the working group.

This working group deals with the issue of qualitative and equitably distributed social and medical services for the citizens of the Baltic Sea Region. The Working Group's objective is to elaborate political positions and recommendations pertaining to innovation in social and health care. These will be addressed to the national and regional governments concerned. They will be an expression of the political views and positions of parliamentarians from the Baltic Sea Region.

At the start of this year, I wrote to you with an initial list of questions relating to this working group. Now, as a second step, the working group is drawing up a comparative overview of how the Baltic Sea states are approaching the ethical challenges posed by innovations in social and health care:

1. What are the most important ethical questions and challenges in the context of progress in medical treatment methods and therapies?
2. What political steps or methods should guide the prioritisation of different groups of patients (with different clinical pictures and conditions) at a time when the potential to treat conditions is growing but resources are limited in practice? And who takes responsibility for these priorities?
3. To what extent will the patient's lifestyle, behaviour and personal responsibility influence the choice of treatment/therapy, at a time of new and ever more expensive treatment methods?
4. What steps (legal, regulatory, technical, etc.) are being taken or planned to ensure the patient's safety and integrity as patient records are increasingly digitised? And how is the patient's access to his or her own data safeguarded and regulated?
5. To what extent are ethical issues taught and incorporated in the education, training and continuing education of health workers?

Bundestag
Platz der Republik 1
11011 Berlin
Tel.: +49 (0)30 / 227-7 11 28
+49 (0)30 / 227-7 13 28
Fax: +49 (0)30 / 227-7 68 28

Email addresses
franz.thoennes@bundestag.de

buergerbuero@thoennes.de

Constituency office
Oldesloer Straße 20
23795 Bad Segeberg
Tel.: +49 (0)4551 / 96 83 83
Fax: +49 (0)4551 / 96 73 38
http://www.thoennes.de

Despite the short notice, I would be very grateful if you could answer these questions on behalf of your ministry by 30 June 2014.

Thank you very much in advance for your assistance.

Yours sincerely,

Federal Ministry
of Health

POSTAL ADDRESS Federal Ministry of Health, 53107 Bonn

Mr Franz Thönnes
Member of the German Bundestag
Deputy Chairman of the Committee on Foreign Affairs
Former Parliamentary State Secretary
11011 Berlin

Hermann Gröhe
Federal Minister
Member of the German Bundestag
OFFICE ADDRESS Rochusstraße 1, 53123 Bonn
POSTAL ADDRESS 53107 Bonn

TEL +49 (0)228 99 441-1003
FAX +49 (0)228 99 441-1193
EMAIL poststelle@bmg.bund.de

8 July 2014

Dear Mr Thönnes,

Many thanks for your letter of 12 June 2014, in which you raise important questions relating to the ethical challenges posed by innovations in social and health care, in connection with your work as a member of the Baltic Sea Parliamentary Conference.

Although the situation in terms of social and health policy is very varied in the Baltic Sea countries, and the focus is currently on challenges such as communicable diseases (HIV/AIDS, TB, hepatitis) and antibiotic resistance, it is useful to look beyond the present day, to reflect on the future of our social and health systems and to discuss criteria and strategies to ensure their further development is ethically responsible. Of course, national regulations and experiences cannot be duplicated exactly in other countries, but they can provide important suggestions and possibly guidance for the discussions taking place there. With this in mind, I am pleased to provide the enclosed answers to your questions.

I hope that this statement will be of some assistance to you in your work as a member of the Baltic Sea Parliamentary Conference, and I would like to take this opportunity to offer you my best wishes.

Sincerely,

Yours (m.p.)

Sgd. Hermann Gröhe

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4 July 2014

Statement from the Federal Ministry of Health in response to questions submitted by Franz Thönnes, Member of the Bundestag and former Parliamentary State Secretary, in connection with the Working Group on Innovation in Social and Health Care of the Baltic Sea Parliamentary Conference

Question 1 (What are the most important ethical questions and challenges in the context of progress in medical treatment methods and therapies?):

In view of demographic change and the scientific and technical progress being made in medical provision and long-term care, we need a broad debate about the kind of society in which we want to live in future, how that society should deal with people who are ill, elderly, in need of care or dying, and how we can strike and shape the balance between personal responsibility, subsidiarity and solidarity. As we seek to answer these questions, we have, alongside our individual values, a common, binding framework in the principles enshrined in the Basic Law (the German constitution), above all that of human dignity. The constitutions of other European countries enshrine similar values.

We should seek as broad a consensus as possible in the fundamental debate about the future of our solidarity-based health system. Once society has reaffirmed how it sees itself – a process which must be repeated periodically – decisions can then be taken at political and legislative level, based on this, about the appropriate legal framework and the administrative implementation.

In our view, one of the fundamental principles of our welfare state is that no one should be left to face the risk of illness and the associated costs and burdens alone. Everything that is medically and reasonably necessary should continue to be covered by statutory health insurance in future.

Question 2 (What political steps or methods should guide the prioritisation of different groups of patients (with different clinical pictures and conditions) at a time when the potential to treat conditions is growing but resources are limited in practice? And who takes responsibility for these priorities?):

Any "prioritisation of different groups of patients (with different clinical pictures and conditions)" would be ethically problematic and is unnecessary in practice. However, the elimination of oversupply and undersupply of services in the health system and inappropriate treatment remains a permanent challenge. The common aim should be to ensure equal access to health services and goods, provided that they are medically and reasonably necessary. At the same time, society as a whole needs to recognise that high-quality health care for all, in a system based on solidarity, has a cost – particularly in an ageing society in which – happily – research and development is constantly producing new, more targeted means of helping and treating people. The fundamental

debate referred to in the response to question 1) should help to bring about this recognition.

It would be neither ethically justifiable nor economically advisable, however, to spend the funds pooled by the community of insured persons on unnecessary services, as that would mean this money was no longer available for health-care objectives whose importance is accepted. For this reason, an evidence-based approach and efficiency and quality assurance are key instruments for a health system based on the principles of subsidiarity, solidarity and good health care for *all* who need it.

The Fifth Book of the Social Code already stipulates that services which are unnecessary or uneconomic may not be paid for by statutory health insurance. At the same time, all insured persons are entitled to services whose quality and effectiveness is in line with the generally accepted state of medical knowledge and which reflect medical progress.

A proven system is in place in Germany to determine what is appropriate, medically necessary and economic. The decision is taken by a body which forms part of the health system's joint self-government structure: the Federal Joint Committee. On the basis of clear statutory regulations, it issues guidelines specifying what entitlement people insured under the statutory health insurance scheme have to certain treatments or investigations. The Federal Joint Committee is composed of representatives of panel doctors and dentists, psychotherapists, hospitals and health insurance funds; representatives of patients' organisations are also entitled to participate in its discussions and put topics on its agenda. The Federal Joint Committee establishes the generally accepted state of medical knowledge on the basis of evidence-based medicine; its decision-making process is transparent. It is supported by the Institute for Quality and Efficiency in Health Care (IQWiG), which carries out assessments of this kind (known internationally as "health technology assessments") on its behalf. In addition, the Federal Joint Committee takes decisions on quality assurance measures for the out-patient and in-patient sectors of the health system. However, Parliament has not empowered the Federal Joint Committee to exclude medically necessary services to which no alternative is available (rationing), or to establish priorities among these services (prioritisation).

Another important instrument in safeguarding a high level of quality and equal access to health services for the future, despite limited financial resources, is strengthening the competitive focus of the health system. Patient-centred competition on prices and quality raises the quality of care and allows efficiency reserves to be unlocked ("rationalisation instead of rationing"). A solidarity-based framework ensures that the competition focuses on the needs of the insured and patients.

Question 3 (To what extent will the patient's lifestyle, behaviour and personal responsibility influence the choice of treatment/therapy, at a time of new and ever more expensive treatment methods?):

Our health-care system must be supplemented by disease prevention and health promotion. Our aim should be to use health education to foster the individual's will and ability to lead a health-conscious lifestyle. When people fall ill, however, they should receive the medically necessary treatment, and the costs should be covered by statutory health insurance. This also holds true in particular for the new and expensive treatment methods you mention, provided that they meet the requirements set out in the response to question 2) and have undergone, where necessary, the Federal Joint Committee's benefit assessment and decision-making process. In this context, it must be ensured that the choice of therapy is always guided only by the best interests of the patient, and that his or her stated wishes are respected. The economic interests of the service provider must not play any role.

The choice of therapy should only take place after a full and comprehensible discussion of the treatment options with the patient, and with the patient's free, informed and specific consent. As part of such discussions, information is often provided about how patients can support their recovery and avoid relapses by making changes to their lifestyle.

At the same time, we must strengthen the incentives for health-conscious behaviour. This is already the case for dental care, for example, where a higher share of patients' costs are reimbursed if there are records that they have attended annual preventive care appointments. It is also already the case that preventive services are funded by the health insurance funds. The prevention law which is to be passed in the current electoral term will strengthen this focus on disease prevention and prophylaxis.

Question 4 (What steps (legal, regulatory, technical, etc.) are being taken or planned to ensure the patient's safety and integrity as patient records are increasingly digitised? And how is the patient's access to his or her own data safeguarded and regulated?):

With the electronic health card and telematics infrastructure, the conditions are being created in Germany for greater patient autonomy, economy and efficiency in the health system, with the aim of ensuring sustainable, integrated services. The use of medical telematics applications is voluntary for patients.

Legal and technical steps have been taken to protect sensitive patient data from unauthorised access. Firstly, the electronic health card individually encrypts the data using state-of-the-art technological processes. Secondly, in addition to the electronic health card and the insured person's PIN, a second key – the doctor's health professional card – is required to access medical data. The ways in which the data may be used are

clearly defined in law. Misuse is subject to criminal prosecution.

Legal requirements with which bodies that collect, process or use personal data must comply are contained in general data-protection legislation (Section 9 of the Federal Data Protection Act) and, as regards the protection of social-security data, in Section 78a of the Tenth Book of the Social Code. To assist non-hospital doctors, the German Medical Association and the National Association of Statutory Health Insurance Physicians have issued recommendations on medical confidentiality, data protection and data processing in doctors' surgeries (published in the *Deutsches Ärzteblatt*, 23 May 2014), while guidance on hospital information systems (published in March 2014) is available for hospitals from the working group on health and social affairs established by the Conference of Data Protection Commissioners of the Federation and the *Länder*.

The right of patients to view their complete medical records is enshrined in Section 630g of the Civil Code.

Question 5 (To what extent are ethical issues taught and incorporated in the education, training and continuing education of health workers?):

The federal laws and statutory instruments governing the health professions, which regulate the training required to become a doctor, dentist, psychotherapist, nurse, midwife, physiotherapist, paramedic and a number of other kinds of medical professional, are implemented by the competent authorities of the *Länder* (federal states). The requirements enshrined in federal law form the framework for the training, which the *Länder* or the universities flesh out in detail in the specific curricula. This includes determining to what extent ethical issues are to be examined during the training. The training regulations for medicine, nursing and physiotherapy, for example, expressly require ethical issues to be covered during training.

Continuing education is a matter for the *Länder*. The same is true of health professions which are regulated by the *Länder* without federal involvement, such as the training required to become a health-care or care assistant.

In general, it should be noted that ethical issues are of greatest relevance for health professionals in relation to specific individual cases. Given this, their training and continuing education should, above all, equip them to reflect on the ethical issues involved in specific cases and to act responsibly in their dealings with the people affected. By contrast, the preceding questions focus primarily on ethical and responsible policy-making in the further development of health-care provision.

II
WG homework 2

Answer from Latvia

LATVIJAS REPUBLIKAS LABKLĀJĪBAS MINISTRIJA

Skolas iela 28, Rīga, LV-1331 • Tālr. 67021600 • Fakss 67276445 • E-pasts: lm@lm.gov.lv

Uz 30.05.2014. Nr. 2/0514-103

Baltic Assembly and the Baltic Sea Parliamentary Conference
Working Group on Innovation in Social and Health Care

anete.kalnaja@baltasam.org

The Ministry of Welfare of Republic of Latvia has received the questions of the Baltic Parliamentary Conference on Strategies and Measures to Support Innovation in Social and Health Care.

We would like to inform you that Ministry of Welfare is the leading institution of the state administration in the areas of labour, social security, children's and family rights as well as equal rights for people with disability and gender equality.

At present the services of social care are available to all those individuals who have difficulties in self-care because of their age or functional disabilities and are in need of such services. The Ministry of Welfare hasn't established any constraints due to client's lifestyle, behavior or self-responsibility.

Also the Ministry of Welfare doesn't store any medical data apart from the data stored by the Ministry of Health.

I.Martinsone 67021668,
Inga.Martinsone@lm.gov.lv,

Ethical Aspects of ISHC

1. What, in your opinion, are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies?

The main ethical issues and dilemmas are in the following areas:

- Genetic research and implementation of personalized medicine;
- Transplantation of organs and tissues;
- New medicines and new technologies of treatment;
- Artificial insemination;
- Patients' data safety and protection.

2. What policies and methods have you applied, or planned, in order to guide the prioritizing between different patient groups (different kinds of diseases and ailments), in a situation where treatment potentials are growing but practical resources are scarce? Who has the responsibility for setting and making priorities?

The Regulation of the Cabinet of Ministers of the Republic of Latvia No.1529 "Procedures for Organization and Financing of Health Care" (adopted on 17 December, 2013) determines the priority patient groups:

- emergency care,
- children and maternity care, and
- health care services in case when a patient has prognosis of disability.

The Regulation of the Cabinet of Ministers of the Republic of Latvia No.899 "Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment" determines the conditions for reimbursement of medicines. All medicines are classified into one of three reimbursement categories (100%, 75% or 50%) depending on the illnesses for which they have been approved.

Taking into account the mortality and morbidity data, for planning period 2014 – 2020 the priorities will be planned in the field of oncology, cardiology, perinatal and neonatal period care, and in mental care.

3. To what extent will a patient´s lifestyle, behavior and self-responsibility influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments?

Each person has the right to receive medical treatment corresponding to his state of health. Any discrimination is prohibited.

Biological, psycho-emotional, social, economic, environmental, as well as lifestyle factors influence the health of each individual and, therefore, public health.
A healthy lifestyle has an essential role in preserving and improving health. The most significant public health problems in Latvia are cardiac and circulatory diseases, oncology diseases and external causes of death. The main behavior factors, which facilitate the development of circulatory diseases and oncology diseases, are unhealthy nutrition, insufficient physical activity and smoking. On the other hand, harmful alcohol use and risky behavior are the main reason of external causes of death. The features of a healthy lifestyle are sufficient physical activity, a rational or physiological diet, and an absence of harmful habits (smoking and alcohol consumption).

A patient has possibility to choose the most expensive treatment, but it is not always covered by the state budget.

4. What steps (legislation, regulations, technical, etc) are taken or planned in order to safeguard patient security and integrity in the increasingly digitized patient information systems? How is the patient´s access to her/his own information secured and regulated?

Patients' data security is determined in several laws: Medical Treatment Law, Law on the Rights of Patients, and Personal Data Protection Law.

According to The Regulation of the Cabinet of Ministers of the Republic of Latvia No.243 "By-law of the Ministry of Justice" (adopted on 29 April, 2003) the functions of the Ministry of Justice shall be to formulate policy in the field of the protection of personal data.

Additional on 11 March 2014 was approved The Regulation of the Cabinet of Ministers of the Republic of Latvia No.134 "The provisions on the single electronic health information systems". This regulation determines the single electronic health information system manager, health information system

data stored and the processing procedures, as well as procedures for issuing data. Health information system manager is the National Health Service. One of the issues on the NHS agenda is ensuring security of patient data.

5. To what extent and how are ethical issues acknowledged and incorporated in education, training and competence enhancement of health and social welfare personnel?

Medical treatment institutions and professional organizations of medical practitioners shall establish medical ethics committees. Such committees shall examine ethical matters related to activities of medical practitioners and new medical technologies.

The Central Medical Ethics Committee shall operate in accordance with Cabinet regulations and it shall examine ethical issues of biomedical progress relating to social problems.

As regards health care personnel, it should be noted that everyone has an equal right to receive appropriate health care services, qualitative and qualified medical treatment regardless of gender, age, race, language, religion, sexual orientation, political or other opinion, national or social origin, ethnic origin, education, social and financial status, occupation, nature and severity of his or her disease, and other circumstances.

According to the Medical Treatment Law the competence of medical practitioners in medical treatment, as well as the amount of theoretical and practical knowledge shall be determined by the Cabinet, taking into account the point of view expressed in conformity with their competence by the Latvian Medical Association, Union of Professional Organizations of Medical Practitioners of Latvia or Latvian Nurses Association.

Students who have acquired the first or second level of a professional higher medical education programme and the amount of knowledge and skills that comply with specified qualification and competence requirements may take part in medical treatment. The qualification requirements and amount of competence is determined by the Cabinet Regulation No 286 of the Cabinet of Ministers from 24 of March, 2009 “Regulation on medical practitioner and student, who study in first or second level higher professional medical education programs, competence in health care and theoretical and practical level”.

The clinical and practical sections of medical education (including that which may be acquired in residency) in the medical professions and specialties shall be implemented by medical treatment institutions and medical practitioners, which have obtained the right to educate medical

practitioners in accordance with the procedures specified in regulatory enactments.

In addition, recommendations for the health care practitioner for specific therapeutic activities are included in clinical guidelines – taking into account medical principles based upon evidence, an established systematic description of the medical treatment process for a particular patient group in which the following are specified - the necessary activities, the order of performance thereof and the essential criteria for the choice of tactics for the medical treatment of a patient to achieve the best medical treatment result.

II
WG homework 2

Answer from Lithuania

Originalas nebus siunčiamas

LIETUVOS RESPUBLIKOS SVEIKATOS APSAUGOS MINISTERIJA

MINISTRY OF HEALTH OF THE REPUBLIC OF LITHUANIA

Budgetary institution, Vilniaus str. 33, LT-01506 Vilnius, Lithuania, phone: +370 5 266 1400,
fax: +370 5 266 1402, e-mail: ministerija@sam.lt, http://www.sam.lt.
Data are accumulated and stored in the Register of Legal Entities, code 188603472

Baltic Assembly

03-07-2014 No.(11.20-23)10-6127
Re: 30-05-2014 No. 2/0514-103

Dear Colleagues,

Hereby we present the answers to your questions:

1. What, in your opinion, are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies?

One of the main sources of ethical dilemmas in modern medicine, especially in the countries of transition is related to the shift from traditional paternalism to patient autonomy-based ethics. Medical paternalism has nowadays become hardly compatible with a good clinical practice where prevalent causes of morbidity shifted from acute and infectious diseases towards the chronic diseases. In these circumstances, patient's preferences, values and world-views start to play a crucial role in the medical decision making and therefore lead to autonomy-based therapeutic relationship. Another ethically sensitive issue is related to the fact that the cost of modern medicine (e. g., expensive cancer drug treatments, organ transplantation) has risen enormously during the last few decades, the rationing of scarce health care resources is becoming a necessary condition of the sustainable health care system, capable of providing equitable access to health care services to the citizens, which is especially important in the societies with limited health care resources. Medically assisted reproduction, medical end-of-life decision-making, organ transplantation, integration of medical research into clinical practice, establishing of biobanks of human biological materials can be identified as another set of the most pressing ethical issues in Lithuanian context at the moment.

2. What policies and methods have you applied, or planned, in order to guide the prioritizing between different patient groups (different kinds of diseases and ailments), in a situation where treatment potentials are growing but practical resources are scarce? Who has the responsibility for setting and making priorities?

In the environment of increasing number of innovative health technologies and remaining limited financial resources the priorities are set based on data proving higher efficacy of the offered services (impact on patients' safety, outcomes of diagnostics and treatment as well as duration of treatment process). These data should be substantiated by the recommendations of at least one organisation, a member of EUNETHTA network, carrying out the assessments of medicine technologies, and if such recommendations are not available – by the publications based on meta-analysis of randomised controlled clinical studies published in scientific sources rated with ISI (International Score Index) available in the internet search systems "Medline" (http://medline.cos.com) and "Cohrane" (http://www.cohrane.org). If data on such meta-analysis are

not available, recommendations presented in the treatment guidelines developed by the associations uniting European physicians specialists should be considered.

The priorities for financing certain health care services for the different groups of patients and diseases have also be chosen considering statistical morbidity and mortality data and health inequalities in the country. These include:

- the target measures that will be implemented in the target territories;
- the measures which implementation will be focused on and will contribute health preservation and strengthening in the populations of target territories;
- the measures of national level, required to improve health care system, aiming to ensure systemic changes in a health care system of the country, leading to an uniform and accessible for all health care in this area.

As an example the orders of the Minister of Health could be noticed on the approval of prioritised services for stroke treatment applying thrombolysis and invasive thrombectomy or treatment of myocardial infarction involving stent implantation in the coronary arteries. The costs of these services will be paid from the Compulsory Health Insurance Fund budget as a priority. This will result in increased accessibility of timely diagnostics and treatment of myocardial infarction and acute cerebral stroke, in reduced mortality rates of the patients with vascular diseases as well as in reduced number of cases of new type one myocardial infarctions and cerebral strokes in the target territories.

In this context the Committee on the Assessment of Health Care Technologies established in 2014 by the Minister of Health should be mentioned; the task of this Committee is to ensure coordination and development of health care technologies assessment implementation and application. The priorities in technology assessment will be given for their effects on morbidity and mortality rates of certain diseases, scientific validity, costs of technologies, differences in treatment practice among different service provides, etc. It has been expected that integrated model of health care technologies assessment will be develop.

3. To what extent will a patient's lifestyle and behaviour and self-responsibility influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments?

Increasing attention has been paid in the modern medicine to involve the patients in the processes of personal health care, it is very important for this approach to ensure a possibility for a patient to choose – a specialist, service, treatment or diagnostics method. It is also obvious that patient's involvement is not possible without clear, accessible and understandable information on the structure of services provided in the health care establishments, the best possible treatment alternatives for specific diseases, rights and duties of the patients. The current dynamics of patients' complaints demonstrated that patients admitted to the health care establishments get insufficient information or are not confident in their knowledge and competence, thus do not exercise or rarely exercise their rights to choose a physician specialist, treatment or diagnostics methods, thus the biggest issue is low motivation of the patient to take part in the treatment related processes being responsible for personal health, following the principles of healthy living, healthy nutrition and physical activity rather than a choice predetermined by patient's behaviour or life style. It is necessary to encourage patients' participation in making decisions important for their health and treatment quality implementing complex measures.

However, supporting self-management is not a panacea, and is likely to work best when implemented as part of wider initiatives to improve care from one side through educating general practitioners, applying best evidence, and using technology, decision aids and community partnerships effectively and from another side involving patients themselves to use self management. Different clinical conditions require varying approaches to support self-management. So it depends on individual patients needs. Hospitals train their patients in self-management motivating them to care for themselves better, what includes eating well, exercising, taking

medicines, keeping in good mental health, watching for changes, coping if symptoms worsen and knowing when to seek professional help. It require a continuum of interventions, with passive information provision about healthy behaviours and other 'technical' topics at one end of the scale and initiatives that more actively seek to support behaviour change and increase self-efficacy. Some hospitals use patients associations, which together with doctors help patients using experience from each other. Other methods are one to one counselling, group education sessions, telephone coaching, monitoring symptoms with distance technology.

The idea of responsibility for personal health becomes increasingly more important in the modern medicine, however different practices striving to discipline the patients ignoring healthy living principles or physicians' recommendations have been qualified ambiguously. Therefore patient's life style, nature of disease, social position basically does not have any influence on the choice of treatment methods in Lithuania. Such choice is predetermined by the spread of disease, general condition of a patient and treatment standards. One of few instances of discipline measures in the context of Lithuania could be the provision incorporated in the draft order of the Minister of Health on the approval of rules for the provision of services of kidney transplantation and reimbursement rules that a person missing an appointment in a transplantology centre without justifiable reason can be removed to a list of temporarily inactive recipients.

4. What steps (legislation, regulations, technical, etc) are taken or planned in order to safeguard patient security and integrity in the increasingly digitized patient information systems? How is the patient's access to his/her own information secured and regulated?

Processing of patient's personal and specific data by electronic means has been regulated by the Law of the Republic of Lithuania on Legal Protection of Personal Data. The information on the services rendered for the patient and issued prescriptions for the reimbursable medicines is transferred using the safe tools and processed in the information system of Compulsory Health Insurance Fund "Sveidra". The patients do not have a direct access to "Sveidra", however there are some public electronic services accessible through the electronic governmental gateway (for example, a person can check his (her) compulsory health insurance status or to find out a price of received health care services). The identity of patients is established applying the identity establishment functions of the electronic governmental gateway (using electronic banking authorisation systems, electronic personal ID cards, etc.).

All National Information Systems (SIS) must be registered in National Registry (www.registrai.lt). All SIS must have Data Safety documentation, which shall meet the requirements set by the Law on Health Care System, Law on Rights of Patients and Health Damage Compensation, also Electronic Information Technical Safety requirements. State Data Protection Inspectorate (www.ada.lt) must evaluate SIS Data Safety documentation before registering SIS in National Registry.

Patients have the right to see what his/her personal data is stored at SIS and who has accessed his/her personal data. Hospital staff can only see the data of patients who are registered in that particular hospital. Patients and hospital staff can access SIS using National Identification system called VIISP (identification types – using Bank login, Certified Smartcard, USB, Mobile signature, Passport ID-card, EU ID-card, Cross-border authentication card).

5. To what extent and how are ethical issues acknowledged and incorporated in education, training and competence enhancement of health and social welfare personnel?

Medical ethics (bioethics) has been introduced into the curriculum of medical studies for all medical specialties in all medical schools in the early nineties. Lectures or seminars on specific topics of medical ethics are also included into the courses or events of postgraduate medical education. It is also important to note that Hospital Ethics Committees have been established in major health care institutions in the country since 1995, which have the responsibility to introduce, consult and assist the personnel on issues of medical ethics.

A comprehensive research ethics infrastructure has been developed in Lithuania for the last two decades. National Bioethics Committee is organizing educational seminars for young

researchers and together with two regional research ethics committees is carrying out ethical review of biomedical research in the country. The activities of the Research Ethics Committees in reviewing biomedical research projects and consulting researchers could also be regarded as a means of implementation of research ethics principles and guidelines into practice.

Sincerely,

Minister

Vytenis Povilas Andriukaitis

Eugenijus Gefenas, phone + 370 5 8 5) 212 45 65, e-mail: lbek@sam.lt
Kęstutis Miškinis, phone: +370 5 266 14 20, e-mail: kestutis.miskinis@sam.lt

LIETUVOS RESPUBLIKOS SOCIALINĖS APSAUGOS IR DARBO MINISTERIJA

MINISTRY OF SOCIAL SECURITY AND LABOUR
REPUBLIC OF LITHUANIA

Secretariat of the Baltic Assembly
Anete.Kalnaja@baltasam.org

2014 -06- 30
Ref. 30 05
2014

No. (28.5-62) SD - 4695
No. 2/0514 - 103

REGARDING QUESTIONS ON ETHICAL ASPECTS OF INNOVATION IN SOCIAL AND HEALTH CARE

Dear Colleagues,

On behalf of the minister of Social Security and Labour of the Republic of Lithuania Mrs Algimanta Pabedinskienė I would like to thank you for your letter of inquiry about ethical aspects of innovation in social and health care.

Enclosed you will find information that falls under the competence of the Ministry of Social Security and Labour. We hope this information will be useful for members of the Baltic Sea Parliamentary Conference Working Group on Innovation in Social and Health Care.

The provision of social services in the Republic of Lithuania is governed by the Law on Social Services. According to the principles of management, allocation and provision of social services established in the Law, the social services must be provided ethically and respecting the rights of service recipients. One of the main principles established in this legal act is the securing the participation of both the individual receiving the services (or his/her representative) and the organisations defending the rights and interests of relevant social groups in the social services' allocation and provision process. Social services are provided by social workers and other persons engaged in social work (individual care staff, employment specialists etc.). Social workers take guidance from the professional code of conduct in their work. Therefore, the issue of violation of ethical standards in the social services' area in Lithuania arises only in isolated cases, due to the lack of professional competences or responsibility on the part of individual social workers, e. g. when the client is not included in the social care plan; the client becomes a passive service recipient without assuming any responsibility. This reduces the overall service efficiency, the client is not enabled to make changes; his/her motivation and ability to function independently are not promoted.

Provision of social services is started when the need for such services is set. Social services are provided without prioritisation of client groups. According to the Law on Social Services, municipalities are responsible for the ensuring the social services' provision to residents in their respective territories. They carry out evaluations of residents' needs, plan and organise social services, and forecast and determine the scope and types of the social

A.Vivulskio str. 11
LT-03610 Vilnius
Lithuania

Tel.: +370 5 266 8176, +370 5 266 8169
Fax.: +370 5 266 4209
E-mail: post@socmin.lt

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services required. Financial liability for the provision of social services to individuals with severe disabilities lies with the State: social care for such persons is financed from the special-purpose allocations made from the national budget to municipal budgets.

As already mentioned, provision of social services is started only upon assessment of the individual's needs for the services. Social services are provided irrespective of the individual's social status or assessed social risk. The social services' provision is focused on the enhancement of the recipient's responsibility and motivation to change, so that the individual would realise the importance of self-help and become a full-fledged member of society.

Personal data protection in Lithuania is governed by the Republic of Lithuania Law on Legal Protection of Personal Data. The purpose of the law is to protect the individual's right to the immunity of his/her private life by processing personal data and information. Social services are provided following the principle of confidentiality. This is one of the key principles to be adhered to by specialists providing social services. The duty to maintain confidentiality is established in all legal acts governing the quality assurance in social services; all social service institutions' staff engaged in the service provision must sign confidentiality undertakings.

Curricula of educational establishments training social workers include subjects on ethical principles and issues arising from non-compliance; students are made conversant with the Code of Conduct of Social Workers. The Procedure for the Professional Skills Improvement for Social Workers and Assistant Social Workers approved by Order of the Minister of Social Security and Labour establishes that all social workers and assistant social workers must take part in skills improvement course for at least 16 hours per year. Management of institutions providing social services have the right to propose subjects related to professional ethics for inclusion in the skills improvement programmes.

Yours faithfully,

Vice-minister Gintaras Klimavičius

LIETUVOS RESPUBLIKOS SOCIALINES APSAUGOS IR DARBO MINISTERIJA

MINISTRY OF SOCIAL SECURITY AND LABOUR
REPUBLIC OF LITHUANIA

seeretariat of the Baltic Assembly
Anete.Kalnaja@baltasam.org

2014·06·3 0
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A. Vivulskio str. 11
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Yours faithfully,

Vice-mi.nister Gintaras Klimavicius

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II
WG homework 2
Answer from Mecklenburg-Vorpommern

Landtag Mecklenburg-Vorpommern

Wolfgang Waldmüller, MP
Member of the BSPC Working Group
Innovation in Social and Healthcare

Olaug Bollestad
Chairman of the BSPC Working Group
„Innovation in Social and Healthcare"
Working Group Secretariat
The Norwegian Parliament
0026 Oslo, Norway

Contact:

Landtag Mecklenburg-Vorpommern
Committee on European and Legal Affairs
International Secretariat
D-19053 Schwerin
Lennéstraße 1 (Schloss)
Phone: +49 385 525-1530
Telefax: +49 385 525-1535
E-Mail: pa3mail@landtag-mv.de
Internet: www.landtag-mv.de

Schwerin, 10 October 2014

Working Group „homework" – questionnaire on the state of innovation in social and healthcare in Mecklenburg-Vorpommern

Dear Ms. Chairman,

With reference to the Secretariat's email from May 27, 2014 regarding the 2nd Working Group's decision to carry out a "homework" on the state of innovation in social and healthcare in our respective countries and regions, I hereby convey to you the completed questionnaire of the state of Mecklenburg-Vorpommern.

My colleague Julian Barlen and I have forwarded the Working Group's survey to the Ministry of Social Affairs in our state.

In the appendix you will find a translation of the ministry's responses.

I'm looking forward to a constructive Working Group meeting in Copenhagen.

Best regards,

Wolfgang Waldmüller

Appendix

Appendix

Response by the Ministry of Social Affairs to the BSPC questionnaire on innovation in social and healthcare

1. *What, in your opinion, are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies?*

Medical progress is not possible without new medication and therapies being tested on humans. In the field of tension between the desire for medical progress on the one hand and the protection of the integrity of the human body on the other hand, ethical questions are continuously posed, especially if medical research involving human subjects is carried out in developing and emerging countries. The same is true with regard to animal testing, especially when the medical use of the substances to be tested is rather doubtful.

2. *What policies and methods have you applied, or planned, in order to guide the prioritizing between different patient groups (different kinds of diseases and ailments), in a situation where treatment potentials are growing but practical resources are scarce? Who has the responsibility for setting and making priorities?*

One form of prioritizing in the healthcare field already takes place with regard to the definition of the Statutory Health Insurance's services through the institutions of self-government of the social insurance funds.
Here it becomes apparent how difficult the dealing with services cuts in the healthcare sector is and how difficult it is to communicate these cuts to the patients – especially with regard to severely ill people.
Also considering the judgments of the German Federal Constitutional Court, according to which a prioritizing of health services might not be in line with the German Basic (constitutional) Law, a civil society should abstain from discussing individual benchmarks, along which a prioritizing of patient groups should take place. A civil society will not be strengthened through separation or division but through active solidarity, as is mostly the case in the case of the social security system in the Federal Republic.

3. *To what extent will a patient´s lifestyle, behavior and self-responsibility influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments?*

Regarding healthcare:

Every person is called upon to self-responsible mind their health and to contribute to their health with the adaption of their lifestyle and food patterns in case of illness. Nevertheless, new and cost-intensive treatment methods have to be made available as equally as possible to all people, irrespective of their personal lifestyles and their financial backgrounds.

4. *What steps (legislation, regulations, technical, etc) are taken or planned in order to safeguard patient security and integrity in the increasingly digitized patient information systems? How is the patient´s access to her/his own information secured and regulated?*

The protection of private data is an important, constitutionally protected good. Therefore, the necessary regulations in this regards will have to be determined at the federal level as well as in the data protection laws of the federal and state level. Everyone participating in the provision of healthcare has to ensure that in practices as well as in hospitals and in every other healthcare or care treatment the integrity of patients' data is guaranteed.

5. *To what extent and how are ethical issues acknowledged and incorporated in education, training and competence enhancement of health and social welfare personnel?*

Ethical issues are part of the education, training, and continuous professional development of medical staff.

II
WG homework 2

Answer from Norway

Homework 2 – Ethical Aspects of ISHC

Norway

1. **What, in your opinion, are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies?**

- Ethics must prevail over technology;
- ethical awareness of the causes of an innovation and its effects;
- ensuring patient security, information and integrity;
- medical possibilities can create demand for expensive medicines and treatments, entailing a risk for inequalities between patient groups;
- medical innovation can create dilemmas about ethically controversial treatments, like stem cell treatment and prenatal diagnostics;
- overdiagnostics;
- care personnel is replaced with machines;
- medical surveillance methods might conflict with integrity.

2. **What policies and methods have you applied, or planned, in order to guide the prioritizing between different patient groups (different kinds of diseases and ailments), in a situation where treatment potentials are growing but practical resources are scarce? Who has the responsibility for setting and making priorities?**

- Parliament and Government have the responsibility for overarching priorities;
- at local level and in constrained resource situations, the municipal health services, under the Municipal Board, conducts prioritizations. Some municipalities have ethical committees;
- no formal prioritization guidelines at municipal level;
- concrete prioritization is carried out by the medical services at operational level, guided by the Prioritization Ordinance;
- public inquiry 1987 on prioritization;
- in 2013, launch of a new prioritization committee, to report in 2014;
- National Board for Quality and Prioritization in Health Services.

3. **To what extent will a patient´s lifestyle, behavior and self-responsibility influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments?**

- prevention and information have central roles in curbing the growth of lifestyle-related diseases;
- lifestyle, behaviour and "self-inflicted" diseases should not be taken into account when determining the care need for a patient;
- on purely medical grounds, however, changes in behavior/lifestyle might be requested/prescribed in order to achieve full effect of a cure;
- assessments can be made on pure medical grounds whether a behaviour might counteract the effects of a therapy/cure.

4. **What steps (legislation, regulations, technical, etc) are taken or planned in order to safeguard patient security and integrity in the increasingly digitized patient information systems? How is the patient´s access to her/his own information secured and regulated?**

- Health care personnel is by law forbidden to share any patient info with any other than those directly involved in the patient´s care;
- the patient has the right to access his/her own journal;

- several electronic information systems, but no comprehensive national journal;
- Legislation on patient journals and on health information registers is currently under treatment;
- reconcile the objective of swift access to accurate patient data with the goal to secure patient security and integrity;
- new and clearer routines for authorization, authentication, electronic signature, data logging etc are under development, to be presented to the Parliament in 2014.

5. To what extent and how are ethical issues acknowledged and incorporated in education, training and competence enhancement of health and social welfare personnel?

- Ethical issues are an integral part of all strands of health education;
- the different groups of medical practitioners have their own ethical committees;
- Center for Medical Ethics in Oslo carries our research, e.g. on ethics and psychiatric care;
- in 2007, start of a national effort to bolster ethical competence in municipal health services.

II
WG homework 2
Answer from Åland

BSPC Working Group on Innovation in Social and Health Care

Homework II

Answers from Annette Holmberg-Jansson, member of the Åland Parliament and BSPC ISHC working group

1. **What, in your opinion, are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies?**

   The continuous development and innovation in medical treatment both create and ease ethical dilemmas. It will probably continuously be more difficult to grant equal access to all citizens when treatments become more costly. There are also ethical aspects regarding what diseases society should try to ease and what kind of patients (e.g. even very old and weak) that should have help from the society. Innovation also creates possibilities of predicting a person's future diseases.

2. ***What policies and methods have you applied, or planned, in order to guide the prioritizing between different patient groups (different kinds of diseases and ailments), in a situation where treatment potentials are growing but practical resources are scarce? Who has the responsibility for setting and making priorities?***

   The first paragraph in the Åland healthcare Act (Landskapslag om hälso- och sjukvård) states that the law intends to ensure that the entire population of Åland is entitled to such health care as everyone's health condition requires, within the limits available to health care available at the respective time.

   The healthcare system is, with few exceptions, financed collectively trough taxes and quite small fees. One of the overall principles governing the healthcare system is the equal access to services. The Åland Parliament decides annually the budget for the Åland healthcare authority (Ålands hälso- och sjukvård). The authority are runned by a board that decides where to allocate the resources. The final responsibility for assessing individual patients' treatment needs will remain with the health care professionals, however.

3. ***To what extent will a patient´s lifestyle, behaviour and self-responsibility influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments?***

   Health care should, except in statutory exceptions, be given in cooperation with the patient. Patients are more enlightened today because the information is easily available on the internet. Legislation on cross-border health care also gives opportunities to receive healthcare from other

countries. New and more expensive treatments create a challenge for health care, given its costs, that calls for demands on prioritising. Work on prioritising has begun.

4. ***What steps (legislation, regulations, technical, etc) are taken or planned in order to safeguard patient security and integrity in the increasingly digitized patient information systems? How is the patient´s access to her/his own information secured and regulated?***

   According to the Åland of the Act on the patient's status and rights as the Finnish law of the patient's status and rights (FFS 785/1992) with specified derogations apply on the Åland Islands. Only personnel involved in the care of a patient read or manage patient records only to the extent that their duties and responsibilities require. The systems have a log that can control who has been inside the patient records.

   Unfortunately a patient is not able to access their medical record in digitally. In order to be able to offer the possibility the Åland healthcare authority must change medical record system.

5. ***To what extent and how are ethical issues acknowledged and incorporated in education, training and competence enhancement of health and social welfare personnel?***

   In training ethics is a special subject where you get acquainted with various ethical theories. These theories are deepened through various discussions on ethical issues. Discussions of the various ethical issues are ongoing on different units within the Åland healthcare authority. This fall all supervising nurses and chief nurses will to participate in an ethics training to increase the supervising nurses' opportunities to lead this type of discussions. There is also an ongoing work on various units in the development of values. In this work includes much ethical discussions.

II
WG homework 2

Answer from Sweden

What, in your opinion, are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies?

Swedish National Council on Medical Ethics (SMER)
There has been a National Council on Medical Ethics in Sweden since 1985, when it was established by the Government. The Council is entrusted with task of providing guidance to the Government and the Riksdag. In light of rapid developments in the field, the Council is to assess the consequences of medical research, diagnostics and treatment for human dignity and the privacy of the individual.[1]

According to its directives, the Swedish National Council on Medical Ethics has the following tasks:

- to serve in an advisory capacity to the Government and the Riksdag, for example as a referral body
- to "keep a look-out" for developments in the area of research and
- to be a "bridge-builder" between researchers and decision-makers

The work and areas of interest of the Swedish National Council on Medical Ethics extend over most disciplines in the medical field.[2][3]

What policies and methods have you applied, or planned, in order to guide the prioritizing between different patient groups (different kinds of diseases and ailments), in a situation where treatment potentials are growing but practical resources are scarce? Who has the responsibility for setting and making priorities? To what extent will a patient´s lifestyle, behavior and self-responsibility influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments?

Priorities in health and medical care

In 1997, the Riksdag decided on priorities for health and medical care. According to the Riksdag decision, all priorities are to be made consciously, be part of a transparent process and be based on three ethical principles. The care providers have to account for the reasons for their priorities and base their decisions on the best possible knowledge. The National Board of Health and Welfare's *National guidelines* are intended to support them in their work.4

The ethical platform as decided on by the Riksdag is to govern all the priorities made in health and medical care. These priorities shall be based on three fundamental principles:

- **Human dignity -** All human beings are of equal value and have the same rights regardless of personal characteristics and functions in society.

[1] SMER's website, http://www.smer.se/om-smer/, visited on 24 February 2015

[2] For further information about the Swedish National Council on Medical Ethics, see http://www.smer.se/

[3] Link to National guidelines

[4] The website of the National Board of Health and Welfare, www.socialstyrelsen.se/effektivitet/resursfordelningochprioriteringar/prioriteringarihalso-ochsjukvarden, visited on 23 February 2015.

- **Needs and solidarity** – Resources should be distributed primarily to the areas in which the needs are greatest.
- **Cost-effectiveness** – A reasonable relationship between costs and effects should be sought when choosing between areas of activity or measures measured in terms of health and quality of life.

The three principles are ranked in such a way that the principle of human dignity goes before that of needs and solidarity, which in turn goes before the principle of cost-effectiveness. This means for example that serious illnesses take precedence over more minor ones, even in cases where the care of the more serious illnesses costs substantially more.[5]

It is not compatible with ethical principles to generally allow need to be given lower priority because of a patient's age, birth weight, lifestyle or economic circumstances. However, it is compatible with the ethical principles in individual cases to take into consideration circumstances that limit the usefulness of particular medical treatment for the patient.[6]

There is a national model to determine how priorities should be set by health and medical care in a certain area,that is how priorities should be set vertically. According to the National Board of Health and Welfare, the purpose of the model is to improve communication between both professions and care providers, and county councils and municipalities concerning the priorities that must be made. The question of priorities is applicable on several levels, for example between organisations and authorities and between different regions.[7][8]

What steps (legislation, regulations, technical, etc) are taken or planned in order to safeguard patient security and integrity in the increasingly digitized patient information systems? How is the patient´s access to her/his own information secured and regulated?

The Patient Data Act (2008:355)
The processing of personal data in health and medical care is regulated in the Patient Data Act (2008:355), which came into force in 2008. The Act regulates for example:

- coordination of patient records, which means that several care providers can allow and obtain direct access to each other's medical documentation provided they meet the requirements of the Patient Data Act.
- internal secrecy, a regulation stating that only the person who needs the information in his/her work in health and medical care may be given access to patient data. This is clarified by the fact that the Act places demands on assigning authorisation and access controls.
- the extent to which patients can block data, both in the care providers' system of medical records and for other care providers in the case of coordinated patient records.

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] For further information, see for example the website of the National Board of Health and Welfare, http://www.socialstyrelsen.se/effektivitet/resursfordelningochprioriteringar/prioriteringarihalso-ochsjukvarden and the Priority Centre or National Centre for Priority Setting in Health Care, http://www.imh.liu.se/halso-och-sjukvardsanalys/prioriteringscentrum?l=sv

- how a patient can obtain direct access to his/her data. A care provider may give a patient direct access, for example via the Internet, to documentation and logs. [9]

In accordance with the Patient Data Act, a care provider has the possibility, but no obligation, to give a patient access to his/her own patient data by electronic means. A requirement, however, is that the care provider first makes an assessment of which data it is suitable to release. The care provider must also take appropriate security measures. [10]

Furthermore, the Patient Data Act says that a care provider at the request of a patient shall provide information about the access to a patient's data that has occurred. The care provider is obliged to provide the information on paper and may, but has no obligation to, give the patient direct access to the information. This presupposes that the security requirements have been met in the same way as applies to patients' direct access to their own medical records. However, the patient has only the right in this way to find out which care centre (but not which user) has had access to the data and at what time. The information should be formulated in such a way that the patient can judge whether access was justified or not.[11][12]

[9] The Data Protection Authority's website, http://www.datainspektionen.se/lagar-och-regler/patientdatalagen/#1, visited on 23 February 2015

[10] The Data Protection Authority, *The Patient Data Act and personal privacy*, November 2008 www.datainspektionen.se/Documents/faktablad-patientdatalagen.pdf

[11] The Data Protection Authority, *The Patient Data Act and personal privacy*, November 2008 www.datainspektionen.se/Documents/faktablad-patientdatalagen.pdf

[12] For further information, see the Data Protection Authority's website, http://www.datainspektionen.se/lagar-och-regler/patientdatalagen/#1

II. WG homework 3

Questions to the BSPC Member States on the demographic perspectives and the mobility of elderly

1. What is the situation: What are the demographic perspectives for your country?

2. What is done: If your country faces an elderly boom, how does it prepare for this?

3. How is the mobility of elderly people, both at home and outside of their homes, organized in order to allow for a self-determined life? (f.ex. what services and tools are offered within elderly people's homes)

II
WG homework 3
Answer from Denmark

31.10.14.

BSPC Working Group on Innovation in Social and Health Care

Homework 3, Contribution from Denmark

What is the situation: What are the demographic perspectives for your country?

An ageing population combined with an increasing demand for health and care services will cause an increasing pressure on public expenditure and thereby challenge the possibility of upholding a sustainable economy.

Approximately 5.6 million people live in Denmark and about 18 % of the population is 65 years old or older. In 2040 Denmark is expected to have a population of 6 million people, and about 25% of the population is expected to be 65+. The number of Danes over 80 years of age is, however, expected to rise from about 235,000 in 2014 to about 609.000 in 2050. This is worth noticing since the majority of users of homecare services are above the age of 80: About 50 % of the 85 to 89-year-olds and about 85% of the citizens above the age of 90, who still live at home, receive home care services.

What is done: If your country faces an elderly boom, how does it prepare for this?

By 2040 the number of Danes above the age of 67 is expected to have grown with 60 %, and the demographic development has forced Denmark to rethink its social protection system.

While some of tomorrow's seniors will be in need of extensive care, others will be in good health and lead active lives. Consequently, Denmark has aimed at developing solutions that fit both the need of those seniors who can get by with little help and those who are in need of extensive care.

The Danish healthcare system is undergoing structural reforms which in combination with other reforms are designed to help and preserve the Danish welfare system including the healthcare system. The structural reforms in the healthcare sector focus on providing more high quality healthcare for the total resources. Recent reforms and policy initiatives:

Policy initiative:

In august 2014 a new strategy for the Danish health care system was presented. With the strategy comes 700 billion euros in 2015-2018 to invest in chronic diseases, cancer, better quality and a more coherent health care system.

General reforms:

- Structure reform of local government (2007)
- New budget law – cap and sancations (2012)

Healthcare specific reforms:

- A better and more centralized planning of specialized functions
- New hospital structure (ca. 5,5 billion euros)
- Incentive committee - improving financial incentives

In addition, there is a major focus on preventive measures to improve the healthcare status of the population, on building a healthcare system which is more coherent (hospitals, GP's and municipal health care) and on involving patients in their own treatment by new technology ect. These measures aim at avoiding extended hospitalizations and readmissions in general, improving quality of care and controlling public health expenditure in the future. The aim is to deliver healthcare services at the lowest possible cost level while maintaining the same or better outcome and quality.

How is the mobility of elderly people, both at home and outside of their homes, organized in order to allow for a self-determined life? (f.ex. what services and tools are offered within elderly people's homes)

In Denmark, there is a general focus on providing citizens in need of assistance with personal care, training and practical support in order to enable them to take care of themselves in everyday life, for as long as possible.

Traditionally, Denmark has offered two types of eldercare: Homecare and Nursing homes.

Homecare is targeted at elderly Danes, who live at home but are unable to manage everyday life without help. Citizens are both entitled to practical assistance (e.g. cleaning and laundering) and personal assistance (e.g. bathing or shaving). Both types of assistance are free of charge and are available 24 hours a day.

Citizens, who stay at nursing homes, are usually in need of more care than receivers of home care. By law the citizen's apartment at the nursing home is his or her home. It is furnished with the citizen's own furniture, and he or she has the same rights as tenants, who rent an apartment anywhere else in Denmark. The care, which the citizen receives, is provided free of charge.

In order to accommodate the needs of those seniors, who are in relatively good health activating care is emphasized as a supplement to homecare and nursing homes. Activating care means that the old person learns how to minimize or how to cope with his or her disabilities, e.g. by using welfare technology. Activating care takes both the citizen's physical and mental well-being into account, e.g. by offering to help a lonely senior getting into contact with other seniors.

II
WG homework 3
Answer from Finland

BSPC ISHC Homework, November 2014

1. What is the situation: **What are the demographic perspectives for your country?**

As elsewhere, also in Finland the population is aging and the age structure of the society is starting to change rapidly. By the year 2030, the working age population (15–64 years old) is expected to decrease by 117 000, even if immigration is accounted for. The share of working age population would decline from 65 % in 2012 to 58 % in 2030. The shift is almost entirely due to an increase in the population over 65 years of age.

2. What is done: **If your country faces an elderly boom, how does it prepare for this?**

- Decision on pension reform: Finnish labour market organisations recently reached an agreement on a pension reform that will gradually increase the minimum retirement age from 63 to 65 by the year 2025. After this, the minimum retirement age will be tied to the increase in life expectancy. For example, the projected minimum retirement age for someone born in 1990 would be 67 years and 9 months. There will also be incentives to keep working even after reaching the minimum retirement age. The government is expected to propose the law amendments in the summer of 2015.
- Social welfare and health care reform: Social welfare and health care services are currently organised by municipalities. In the new model, the arrangement and the provision of services will be separated. The responsibility for organising the services will rest with five social welfare and health care regions. The reform will integrate social welfare and health care services as widely as possible, so that primary and specialised services form a seamless service package. The reform should guarantee more equal services across the country, while limiting the increase of expenses due to aging and higher need for care. The new regions should be running in 2017.
- Structural Policy Programme: The reduction of the number of people in working age is causing issues for Finland's financial sustainability. In 2013, the Finnish government started a Structural Policy Programme aimed at strengthening economic growth conditions and bridging the sustainability gap. The programme is built on a large number of concrete structural policy measures to improve the productivity of the public service system and to increase the employment rate. The implementation of the programme is currently underway. As a part of the programme, institutional care in care for the elderly will be reduced in favour of care provided at home.

3. How is the mobility of elderly people, both at home and outside of their homes, organized in order to allow for a self-determined life? (f.ex. what services and tools are offered within elderly people's homes)

- Informal care carried out by family members, relatives etc.: Improvements in support for informal care have been implemented over the years. A new Act on Support for Informal Care came into effect in 2006. Support for informal care is a service entity that consists of any necessary services for the care receiver, care allowance and leave for the carer, and supporting services to informal care. The number of persons receiving support has increased steadily. The number of persons collecting support has increased from 13000 in 1994 to approximately 36000 in 2010. From a municipal viewpoint, informal care is a very inexpensive form of arranging care, and thus it will be more strongly encouraged in the future. New legislation is currently being planned to improve the support system.
- New legislation in care services: The Act on Care Services for the Elderly entered into force in July 2013. It includes a number of measures to ensure that elderly people will receive care and treatment according to their individual needs and on an equal basis nationwide through high-quality social welfare and health care services. Elderly persons now have the right to a comprehensive evaluation of service needs, which will then be used to draw up an individual service plan. Precedence is given to services provided at home, and institutional long-term care will only be considered if medically justified. Elderly couples, whether married or not, will have to be offered the option of cohabitation in long-term care. Home service and home nursing care assist when an older person requires help at home due to diminished functional capacity or illness.

II
WG homework 3

Answer from Latvia

Baltic Sea Parliamentary Conference on Strategies and Measures to Support Innovation in Social and Health Care:

Answers to questions concerning demographic problems

1. ***What is the situation: What are the demographic perspectives for your country?***

At the beginning of 2014 the number of population in Latvia was 2 001 468, compared to 2013 the population has decreased by 1.10 % (Source: Central Statistical Bureau). Even though the population decrease is slower in recent years, there is a population decline of over a fifth since 1990. Such situation has occurred mainly due to negative natural increase of population, low birth rate and emigration.

In 2013 the crude birth rate in Latvia was 10.2 per 1 000 inhabitants having a tendency to increase as birth increase is observed for the last three years. However, at the same time Latvia had one of the highest crude death rates observed in the EU - 14.3 per 1 000 inhabitants. Consequently, Latvia was one of thirteen EU Member States, which had negative natural population change having one of the largest decreases -4.0 persons per 1 000 inhabitants (Source: Eurostat).

Beyond the natural rate of population decline, high rates of emigration is notable in Latvia, which increased after the accession of the EU and economic crises. After a peak in 2001, workforce emigration slowed down in 2002-2007 and regained momentum in mid-2008 and especially in 2009. In 2010 the emigration was at the highest point for the last 10 years. In past 13 years 259 thousand people (more than 10% of all inhabitants) have emigrated to other countries and have not returned (Source: Central Statistical Bureau).

However, working-age population is decreasing even faster than the overall population, which is primarily due to low birth rates in 1990s and high emigration rates of the population under the age of 35 years in recent years. As a result currently 40% of the population (793274 persons) are aged 50 or older, constituting nearly 30 percent of the working-age population.

According to the World Bank calculations based on data from the UN Population Division and Latvia's Central Statistical Bureau the population is projected to continue to decline, shrinking by just under 10 percent over 2012-2030. However, these projections might be over-optimistic taking into consideration past trends. The medium-fertility variant assumes that the total fertility rate increases to a range of 1.6 to 1.8 in Latvia over 2010-2030. In 2012 Total fertility rate in Latvia was 1.44. If total fertility rate remains at the current rate, then the population will decrease further.

2. ***What is done: If your country faces an elderly boom, how does it prepare for this?***

Issues linked to the ageing population recently feature relatively highly in the public and political debate in Latvia. There have been some promising initiatives organized

by different Ministries, social partners and NGOs but a need was identified to ensure a more comprehensive and structured approach in this field. Therefore in order to address active ageing challenges the Ministry of Welfare is implementing a project „Latvia: Developing a Comprehensive Active Ageing Strategy for Longer and Better Working Lives" with the support from the EU. The objective of the project is to develop an evidence-based and comprehensive active ageing strategy in Latvia that would facilitate longer and better working lives. Within this project the World Bank is carrying out a study and will give recommendations for improving active ageing policy and for developing an active ageing strategy. The Ministry of Welfare has also formed strategic partnership with the Austrian Federal Ministry for Labour and Social Affairs and Consumer Protection, Ministry of Labour and Social Policy of Poland and Ministry of Social Affairs of the Republic of Estonia in order to exchange good practice examples and experience. General active ageing issues as well as specific topics, such as employment, health, social security and care for family members will be covered. The implementation of the project is in the initial stage, mainly best practices have been identified and possibilities to adjust them for the Latvia's situation have been discussed.

Concerning labour market also the Ministry of Economics of Latvia, which is working with labour market forecasts, draws attention to the ageing population and changing labour force supply due to it. Analysis shows that aging of the labour force are a particular concern among managers in areas of manufacturing and specialized services as well as senior specialists in science and engineering, health care and education.

Another area of particular interest regarding active ageing is life-long learning, especially taking into consideration that in 2013 in Latvia only 2.6% of persons in age group 55-74 were involved in lifelong learning, while the indicator for persons in the age group 18-74 was 10.1% (Source: Eurostat).

The Ministry of Health of Latvia develops and implements public health policy with the aim to prolong the healthy life years of the Latvian population and to prevent untimely deaths, while maintaining, improving and restoring health. Currently as main priority areas for investment are set cardiovascular diseases, oncology, perinatal and neonatal period care and mental health care. Meanwhile there is an emphasis on the access to health services and especially for people at risk of social exclusion and poverty, including elderly. Healthy ageing is also promoted by emphasizing the role of local governments in building a healthy environment. The Ministry of Health of Latvia has developed Guidelines for Health Promotion in Municipalities, which provide municipalities with science-based information about health promotion (physical activities; nutrition; prevention of addiction-inducing substances; family health, including safety promotion; injury prevention etc.) and development of healthy behaviours and lifestyle of the local population.

Apart from the promotion of healthy ageing, there is a wide range of active ageing activities implemented in local governments. Mostly these activities are implemented with the aim to promote social activity of elderly, however there are also good practice examples of providing social support, ensuring the environmental accessibility and promoting life-long learning.

Additionally, there have been recent changes of transfers for retirees are aimed to ensure long-term sustainability of the pension system and to deal with demographic challenges (such as ageing, shrinking of working age population, low birth rate and emigration).

According to the Law on State Pensions, as of 2014:

– the retirement age has been increased gradually by three months every year until reaching 65 years by 2025. At the same time, the possibility to request an old-age pension two years prior to reaching the defined retirement age is preserved;
– the minimum length of social insurance period has been increased from 10 to 15 years, granting the rights to receive an old-age pension and from 15 to 20 years starting with 2025;
– expenditures for payment of an old-age and disability pension will be ensured from the state general government budget, thus unburdening the social insurance special budget;
– the social contribution cap has been restored – EUR 46.4 thousand per year.

3. ***How is the mobility of elderly people, both at home and outside of their homes, organized in order to allow for a self-determined life? (f.ex. what services and tools are offered within elderly people's homes)***

At the end of 2012, there were 82 municipal nursing homes for elderly people, with 5647 recipients. The average number of beds is 5798, which constitutes 15,28 beds per 1.000 persons aged 65+.

There are no specific cash benefits for older people, but there is a personal care cash benefit of discretionary use for disabled people. In 2012 there were 11,480 persons receiving this state benefit each month. Most beneficiaries, 58.3% of all, were people above the age of 65 years.

There is also a cash benefit for disabled people with walking difficulties. It aims to compensate for expenses on specially adapted cars or other means of transportation. The number of recipients was 17,500 in 2013, 45,6 % of them older than 65 years.

Nursing homes for elderly as a rule are organized and run by the local municipalities. There are also several private and NGO-run elderly homes; municipalities usually pay for the services of these institutions subject to means-testing of recipients and negotiated prices with the institution.

Formal home care is provided by local social services, NGOs, charities, some private entities (agencies) and individuals. Some municipalities offer other types of home support for older people like security buttons, delivery of warm meals, laundry services and assistance.

There are no benefits for elderly home care foreseen at the state level. However, a new benefit for disabled persons who need personal care was introduced in 2008, irrespective of the age and income of beneficiary. The benefit is granted on the basis of a formal disability status and the need for personal care according to medical assessment. The amount of this benefit is set at the level of EUR 142 per month. The introduction of this benefit was a response to a persistent shortage of accessible and

affordable specialised nursing home services and personal care services. Therefore, disabled persons are presumably using this benefit to pay for the provision of care services.

Depending on the municipality additional services are offered to support independent living among elderly and disabled persons. In 2012, there were 10 day care centres for older people with 4944 recipients. Day care centres for people with dementia are recently becoming more widespread in Latvia. Several municipalities have developed new ICT services like security buttons. Also mobile care teams are used to provide more differentiated services. However, coverage of these services is low and territorially uneven. No assessment on effectiveness of any prevention or rehabilitation measures is available.

Although it has always been recognized that alternative care should be more widely developed there has been very little progress in this direction especially during the crisis years. Home care services are underdeveloped and high demand for institutional care is persistent.

The Ministry of Welfare has recently published the Concept paper on the development of social services for 2014 - 2020 (the government has approved it on 04.12.2013) where the move from institutional to home care is one of the top priorities for people with limited abilities to perform their activities of daily living. Special attention is given to the two target groups: children and people with mental disorders. For elderly people, the document set a target of 100% coverage in municipalities with home care services until 2017, to increase the number of recipients (elderly and disabled) of home care services from the current 41 per 10,000 inhabitants to 55 in 2017 and to increase the number of recipients in day care centres from 58 to 65 per 10,000 inhabitants.

II
WG homework 3
Answer from Lithuania

LIETUVOS RESPUBLIKOS SOCIALINĖS APSAUGOS IR DARBO MINISTERIJA

MINISTRY OF SOCIAL SECURITY AND LABOUR OF THE REPUBLIC OF LITHUANIA

A.Vivulskio str. 11, LT-03610 Vilnius Tel. +370 5 266 8176 Fax +370 5 266 4209 E-mail: post@socmin.lt

Secretariat of the Baltic Assembley
Citadeles Street 2-616
Riga, LV-1010
Latvia

anete.kalnaja@baltasam.org

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CONCERNING QUESTIONS TO THE MEMBER STATES OF THE BALTIC SEA PARLIAMENTARY CONFERENCE ON STRATEGIES AND MEASURES TO SUPPORT INNOVATION IN SOCIAL AND HEALTH CARE

Concerning the letter in which you ask member states to answer questions of the Baltic Sea Parliamentary conference on strategies and measures to support innovation in social and health care, please, find our answers attached (4 pages).

Vice-minister Algirdas Šešelgis

Contact person: Ieva Rutkauskaitė, tel. +37052668165, e-mail: ieva.rutkauskaite@socmin.lt

euras.lt

1. What is the situation: what are the demographic perspectives for your country?

The average annual population in Lithuania in 2013 was 2.958200: women- 53.9%, men- 46.1% (Annex 1). 18.2% of the population were 65 years and older: every eighth man and every fourth woman were 65 years of age and older; for 100 children- 124 elderly people.

Population in Lithuania is still relatively young and most of the people are in productive age. Although a large part of population that was born during the baby boom are in age groups between 40-55 years and they will retire during the next 10-25 years. Fertility rate in 2013 was 1.61 and is expected to increase further till 1.79 in 2060. Because of the high emigration according to Eurostat demographic projections 2013 Lithuania's population is forecasted to decrease dramatically and age pyramid to flatten by 2060 (Annex 2). Even though, the majority of the population is still expected to be in the productive ages by then. The population is projected to decrease fastest until 2027 mostly in young age groups because of high projected emigration. Although population decrease in younger age groups continues until 2040 when positive migration flow is projected. This is why old age dependency ratio rises dramatically during this period and peaks at 55.7% in 2041.

Later as positive migration flows are projected share of young persons start to increase and dependency rate drops to 45.7% in 2060. At the same time life expectancy at 65 years rises by 6.5 years for men and 5.4 years for women from 2013 to 2060. Rise of dependency rate seems to be caused more by decreasing number of younger persons because of high projected emigration than by increasing longevity (Annex 3).

2. What is done: if your country faces an elderly boom, how does it prepare for this?

Growing elderly population and, as well as shrinking working-age population, will result increased government spending (GDP share) on pensions and long-term health care. According to age-related spending projection provided in Lithuania's Convergence Programme 2014 from 2010 to 2060, pension spending will grow by 1% of the GDP, long-term health care spending by 1.3% of the GDP.

The main measure to counteract the aging of population is to increase the retirement age. Since 2012 the retirement age is being increased by 4 months every year for women and by 2 months for men until 2026, when it reaches 65 for both genders. This measure has a positive and continuously increasing effect for a balance of social insurance fund's budget. According to projections the effect will reach 0.6 % GDP in 2026.

Pension spending will be mitigated by the pension reform launched in 2004, which created the sub-scheme of voluntary pension accumulation (Pillar II of the state social insurance pension scheme) which is financed with a part of mandatory state social insurance contributions that is shifted to private pension funds. The fraction of the social insurance contribution was increasing from 2.5% to 5.5% of gross wage in 2004-2007 and reduced to 2% from the 1st of July, 2009 due to budget constrains. To ensure that there are sufficient funds for all the commitments of the State Social Insurance Fund, in 2012, the pension accumulation tariff was reduced to 1.5%, and in order to compensate for this reduction, it was increased by 2.5% in 2013.

Following the principle of raising the efficiency of Pillar II private pension scheme and seeking to establish optimal rates of state social insurance pension contributions for social insurance and pension savings, on 14th November 2012 the amendments in pension accumulation system were made. Starting from 1 January 2014 the rate of pension accumulation contributions from Social insurance contributions is 2% of the person's wage. In addition, participant of the pension accumulation himself has to pay 1% of his wage and state budget contributes additional 1 % from average statistical gross monthly wage. Since 2016, both individual and the state budget pension contribution rates will increase to 2%. Growing spending for pensions will be tamed by further increased fraction of the social insurance contribution to Pillar II pension funds making 3.5% as of 2020.

According to Lithuanian Department of Statistics in 2013 37.76 thousand elderly received home services in residential institutions, day care centres. There are 102 elderly social care homes, with population of 4,6 thousand persons, about 150 day-care centres (community-based, social assistance, social care), in which services are delivered to 19.7 thousand elderly persons, services to homes received by 16.2 thousand elderly persons in Lithuania. During 23 years (since 1991) the number of stationary social care institutions for the elderly has increased 5.7 times, i.e. from 18 institutions in 1991 to 102 institutions in 2013, the number of beneficiaries of these institutions increased 2 times, i.e. 1991 lived 2167 persons, in 2013 the number increased to 4,665 persons. Quality of life has also changed: the average single institution had 120 persons in 1991, in 2013- 46 persons. This shows the dynamics of the orientation of the small, cosy residential home development and quality assurance services for the elderly.

All municipalities provide support services at home, but the scale is different: the average number of recipients per 10 thousand inhabitants in a Municipality might range from 5.5 to 84.9 benefit receivers.

In summary it can be said that, given that the fact that population is aging and there is growing need of the service, the service infrastructure for the elderly is developing each year. By the implementation of national programs and the use of EU structural funds, care institutions improve their infrastructure and quality of services for the elderly.

3. ***How is the mobility of elderly people, both at home and outside of their homes, organized in order to allow for a self-determined life? (f.ex. what services and tools are offered with elderly people's homes)?***

It is very important to keep the elderly independent in their own homes as long as possible and for that it is necessary to develop a wide range of stationary social care forms, services at home.

During 2014-2015 year period we have been carrying a study, which will help to evaluate effectiveness and applicability of the Integrated Development Programme and provide direction of long-term care social support system development. In 2012 Minister of Social security and Labour approved Integrated Development Assistance Program (hereinafter - the Program), which aims at the integral aid (social care and nursing) for persons with disabilities, the elderly and advisory assistance for family members caring for persons with disabilities, the elderly at home, and setting up the development of a breakthrough.

The program funds 21 pilot project activities in municipalities. It is planned that during the entire project implementation period (2013-2015) 70 mobile teams will be set up, 340 nurses trained, 663 employees recruited, aid granted to 840 persons with disabilities and the elderly. Mobile units are created in 21 municipalities to provide integrative services at home. Mobile teams are composed of social workers, assistants of social workers, nurses, assistants of nurses, if necessary, physiotherapists and others.

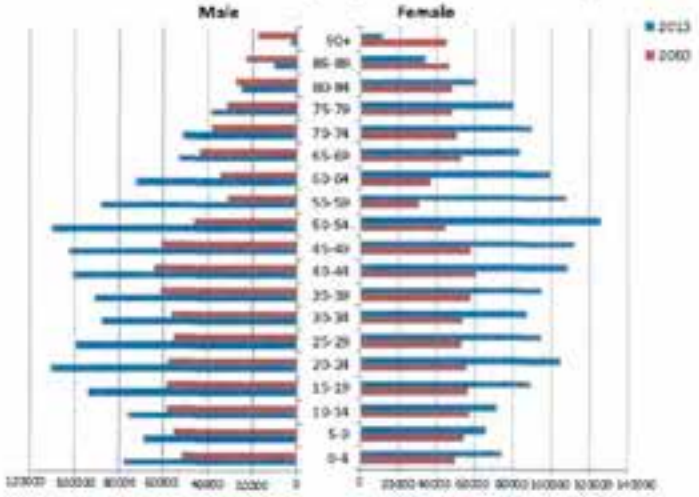
In order to support the integration of the integral aid to the Lithuanian system of social services, analysis on the need for social services for the elderly, forecasts of social service needs until 2040 will be carried out and strategic proposals for the provision of development of social services for the elderly will be provided.

Annexes

Annex 1. Lithuanian Population Forecast (millions)

Year	United Nation	„Eurostat"
2010	3,329	3,329
2035	2,999	2,977
2060	2,705	2,676

Annex 2. Number of Lithuanians by Age and Gender Groups in 2013 and 2060.



Annex 3. Demographic Perspectives.

Demography	2013	2020	2030	2040	2050	2060	Peak year
Population (thousands)	2958,2	2646,7	2183,3	1992,1	1906,4	1832,6	2013
Population growth rate	-1,1	-2,6	-2,5	-0,7	-0,4	0,4	2060
Old-age depoendency ratio (pop65/pop15-64)	27,4%	32,3%	48,0%	55,7%	51,6%	45,7%	2041
Ageing of the aged (pop80+/pop65+)	26,7%	30,2%	27,6%	33,8%	44,1%	44,2%	2054
Men - Life expectancy at birth	68,7	70,8	73,6	76,3	78,7	80,9	2060
Men - Life expectancy at 65	14,3	15,3	16,8	18,2	19,5	20,8	2060
Women - Life expectancy at birth	79,6	80,9	82,7	84,4	86	87,4	2060
Women - Life expectancy at 65	19,2	20	21,2	22,4	23,5	24,6	2060
Net migration (thousands)	-16,8	-37,4	-21,1	1,0	0,4	0,0	2035

II
WG homework 3
Answer from Mecklenburg-Vorpommern

Landtag Mecklenburg-Vorpommern

Julian Barlen, MP
Member of the BSPC Working Group
Innovation in Social and Healthcare

Olaug Bollestad
Chairman of the BSPC Working Group
„Innovation in Social and Healthcare“
Working Group Secretariat
The Norwegian Parliament
0026 Oslo, Norway

Contact:

Landtag Mecklenburg-Vorpommern
Committee on European and Legal Affairs
International Secretariat
D-19053 Schwerin
Lennéstraße 1 (Schloss)
Phone: +49 385 525-1530
Telefax: +49 385 525-1535
E-Mail: pa3mail@landtag-mv.de
Internet: www.landtag-mv.de

Schwerin, 13 November 2014

Working Group „homework“ – questionnaire on the state of innovation in social and healthcare in Mecklenburg-Vorpommern

Dear Ms. Chairman,

With reference to the Secretariat's email from 24 September 2014 regarding the 3rd Working Group's decision to carry out a "homework" on the state of innovation in social and healthcare in our respective countries and regions, I hereby convey to you the completed questionnaire of the state of Mecklenburg-Vorpommern.

My colleague Wolfgang Waldmüller and I have forwarded the Working Group's survey to the Ministry of Social Affairs in our state.

In the appendix you will find a translation of the ministry's responses.

I'm looking forward to a constructive Working Group meeting in Copenhagen.

Best regards,

Julian Barlen

Appendix

Appendix

Response by the Ministry of Social Affairs to the BSPC questionnaire on innovation in social and healthcare

1. *What are the demographic perspectives for your country?*

In the period of 2010-2030 Mecklenburg-Vorpommern will lose about 10% of its population. In some rural areas, the loss will amount to as many as 25%. At the same time the population is aging rapidly. During this period, the percentage of those aged above 65 will increase from 22% to 30%; in some rural areas even up to 40%. Mecklenburg-Vorpommern is facing major demographic challenges.

2. *Your country faces and elderly boom, how does it prepare for this?*

The strategy report of the State Chancellery from January 2011 about the demographic change formulates strategic action guidelines for dealing with the consequences of the demographic change in our state. Further details can be found at: www.demografie-mv.de/cms2/Demografie_prod/Demografie/de/start/Demografiestrategie/index.jsp.

Mecklenburg-Vorpommern features a clearly structured and robust central allocation system, which offers a good compromise between accessibility and the need for sufficient coverage. It is an important tool of spatial planning to establish equal living standards. Adapted to the specific regional structures of the state, its central locations make up the nodal points of the supply network, where institutions for the provision of public services are bundled. Central locations feature direct binding effects for public providers of existential requirements, but they are also attractive for private providers. Within the system, priorities regarding, among others, the locations of institutions for inpatient and outpatient medical care and drug and emergency provision as well as care services for the elderly and handicapped are determined.
Additionally, the designation of rural areas with special demographic challenges and the definition of measures for these areas – which can also include aspects of health provision – are currently discussed.
Committees moderated by the federal state (as for example the Concerted Action in Healthcare, the state committee for cross-sectoral provision issues, the “Round Table” for palliative and hospice care, the psychiatric advisory board and the state care committee) provide opportunities for discussion and the cross-sectoral development of new and innovative measures concerning care.
With the provision of care support points and social stations, central locations ensure basic services in the field of care for disabled and elderly people.
In the field of medical care provision, especially in rural regions, new forms of care are established or are being tested. Particularly relevant is for instance the application of telemedicine. The new profession as telemedicine-nurse – AGNES – was integrated successfully into basic health care.
Apart from these facts, the Health Centers Woldegk and Mirow are examples for new approaches to improve medical care, providing primary care and periodically specialist treatment.

3. *How is the mobility of elderly people, both at home and outside of their homes, organized in order to allow for a self-determined life? (f.ex. what services and tools are offered within elderly people's homes)*

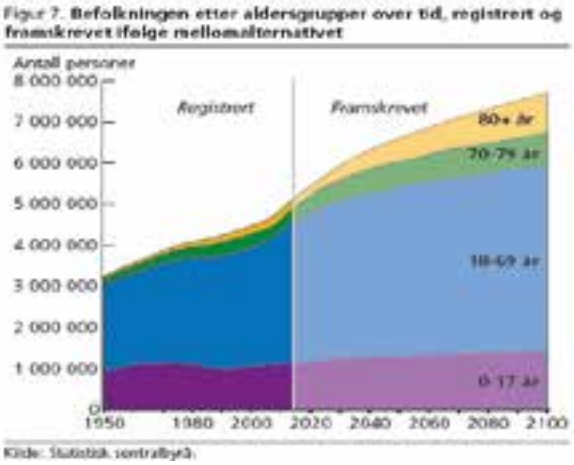
Aspects of mobility and considerations regarding mobile offerings of health care include the bodies and round tables referred to under item 2. Furthermore, the Landtag commission of inquiry „Ageing in Mecklenburg-Vorpommern" has commissioned a study on mobility of elderly people.
The planning of public transport is the responsibility of municipal level. Currently, a comprehensive research package for municipalities and regions that undergo demographic change (InnovaKomm) is initiated by the German Government that will lead to tangible improvements for the local population through innovations in the interaction between humans and technology. The School of Applied Sciences in Wismar is applying with a project.

II
WG homework 3

Answer from Norway

Homework 3 – NORWAY

1) **What are the demographic perspectives for your country?**



This figure shows that Norway will have a much older population in the coming years. Today around 11 % of the population is 70 years or older. In 2060 this group will constitute 19 % of the population (in 2100, 23 %). Further, the amount of people over 80 will increase significantly.

The critical growth of elderly in Norway is expected to happen from 2025. Until then it will be relatively poor. Nevertheless, the elderly boom will be much weaker in Norway than in many other countries due to a less negative birth rate (ab.1,8 in 2014) and immigration of younger cohorts.

2) **If your country faces an elderly boom, how does it prepare for this?**

The government's white paper (nr. 29 2012-2013) "Care of tomorrow" present guiding lines on how Norway should deal with the elderly boom. This will mainly be done through: developing preventative services, early intervention and rehabilitation. Further, one concentrates on mobilizing different actors outside public sector (e.g. volunteers and relatives), and on developing welfare technology so that the elderly could better manage their everyday life. Several programs are developed to deal with this. Finally, in Norway, it is also a stated objective to induce a higher proportion of the healthy elderly population to retire later than the statutory minimum retirement age. One of the aims of the recent pension reform is to contribute to this. Examples of ways of doing this are:

- to increase annual retirement pensions incrementally if the individual decides to remain in work longer
- to adjust retirement pensions to average life expectancy within the population at large.

3) **How is the mobility of elderly people, both at home and outside of their homes, organized in order to allow for a self-determined life?**

Norwegian municipalities use more resources on home-based services than on institutional care. Examples of such home-based services are nursing, ergonomics and physiotherapy. The elderly can get personal assistance in their homes, e.g. help to self-care, personal care/treatment, and personal practical help for household shopping, food making, laundry and house cleaning. The municipalities also assist the elderly in participating in leisure activities, e.g. providing a support person/befriender. Further, the municipalities receive

grants from the state for developing day activities for dement people still living at home. Elderly or functionally handicapped persons who are not able to use ordinary public transport are offered a taxi-based arrangement.

The government's white paper (nr. 25 2005-2006) pointed at five main challenges for care services today: daily life, meals, activities, and social and cultural relationships. This requires increased professional and technical competence, involvement of more occupational groups and focus on both activities and socio-psychological well-being.

The government sends signals of making «active elderly» as one of its main areas of commitment.

II
WG homework 3
Answer from Åland

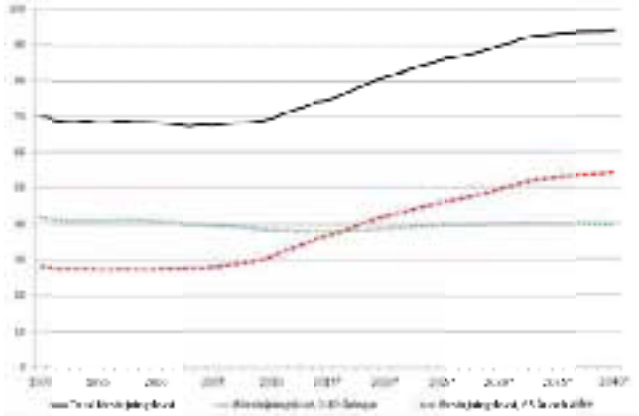
Answers from Annette Holmberg-Jansson, member of the Åland Parliament and BSPC ISHC working group

Homework 3 – ÅLAND

1) **What are the demographic perspectives for your country?**

The total dependency ratio is expected to rise from just under 70 to 82 within ten years and to 91 within 20 years. The change is more rapid in Åland than in the Nordic average. This means that each person in working age within two decades except itself will supply almost another person.

Dependency ratio % (20-64)



2) **If your country faces an elderly boom, how does it prepare for this?**

The Åland Government have had the intention to prepare a new Act regarding elderly care. The work has proved to be difficult to do before it is decided how the new Social Welfare Act will be formulated in Åland. Both legislations are under work at the Åland government. Åland is divided into 16 municipalities with responsibilities regarding social care. It is now discussed to centralize some of these responsibilities to a new municipal body. Next year the government will appoint a working group regarding the new Act for elderlycare.

3) **How is the mobility of elderly people, both at home and outside of their homes, organized in order to allow for a self-determined life?**

The general principle is that old people should have the opportunity to stay home as long as possible. In order to do this they receive services from the municipalities. The elderly can get nursing, personal assistance in their homes, personal care/treatment and personal practical help for household shopping, food making or delivery, laundry and certain house cleaning. The municipalities also provide transports to able elderly to participate in normal life. The

government provide the municipalities with virtual elderly care services. These services is in fact a kind of interactive wellbeing TV in order to rise the elderly peoples physical and social wellbeing, to increase safety and decrease loneliness through social interaction. The government continue its work to create a system for service vouchers that give the elderly people their own right to choose what kind of service the need and want.

II
WG homework 3
Answer from Sweden

What are the demographic perspectives for your country?

Like many other states, Sweden faces an aging population. In 2013, 19.4% of the Swedish population was aged over 65 years, compared to an OECD average of 16%, while 5.2% of the population was aged over 80, compared to an OECD average of 4.2%. Demographic projections signal that the share of the population over 65 and over 80 years will increase, but will be below the OECD average by 2050. Today, average life expectancy in Sweden is 84.4 years and is expected to rise by 2.6 years by 2050.[1]

The main challenge is maintaining stable finances for the welfare system in a situation where the working age population decreases in relation to the not working population – a rising dependency quota. Calculations from Statistics Sweden show that one working person in 2013 provided for 0,71 not working persons. By 2060 it is estimated that one working person will have to provide for 0,92 persons that doesn't work.[2] The demographic challenge will be different in different parts of Sweden since the effects of the aging population is reinforced by an ongoing urbanization. Especially rural areas will develop an increasingly problematic demographic structure with a rising dependency quota. The number of Swedish municipalities with a dependency quota above 1,0 has been estimated to increase from 1 percent in 2013 to 41 percent in 2050. Mostly small and rural municipalities are found in this group.[3]

What is done: If your country faces an elderly boom, how does it prepare for this?

There are many policy decisions that is directly or indirectly influenced by the aging population. This section will not include all of these. Focus will be on national government policy, but it may be noticed that both EU policy (for example the EU 2020 strategy) and local policy is of importance to the issue.

The main policy areas in relation to the demographic challenge is employment policy, pension policy and health care policy. Several policy measures aim to increase the number of years that people work. One example is extra tax relief for people that continue working after the age of 65. Also, there is ongoing policy discussion about raising age limits both in the pension system and the employment legislation. A government committee suggested several changes in age limits in 2013, among these was a raised retirement age and a right to work

[1] OECD (2013), "Long-term care in Sweden", in OECD Reviews of Health Care Quality: Sweden 2013, OECD Publishing http://dx.doi.org/10.1787/9789264204799-7-en

[2] Ds 2013:8 *Framtidens välfärd och den åldrande befolkningen*

[3] Ds 2013:8 *Framtidens välfärd och den åldrande befolkningen*

to 69 instead of 67. These suggestions are now processed in the "Pension Group" consisting of representatives from five parties in the Swedish Riksdag. Changes in age limits will be discussed in government talks with the social partners.[4] In the end of the 1990's the implementation of a new pension system started. The new system was adopted to achieve a sustainable pension system in relation to the demographic challenges ahead.

There are also policy discussions and measures aiming to achieve a more flexible employment market to allow people to "change paths" midlife, which also has bearing on education policy.

One of the challenges of an aging population is the demand for health care and social services. Besides the financing of these services, there is also a challenge in ensuring the provision of health and social care professionals. Decisions have been taken to educate more people in the health care area. Also, validation of competence for immigrants with healthcare education from other countries has been prioritized. There are also measures to get young people to choose a career in health care and social services to a higher extent than today.

Besides the above mentioned, all measures to increase effectivity and quality in health care and elderly care may be included in what is done to meet the "elderly boom". All of those activities cannot be listed here. Projects in ISHC is described in homework 1.

How is the mobility of elderly people, both at home and outside of their homes, organized in order to allow for a self-determined life? (f.ex. what services and tools are offered within elderly people's homes)

Long term Care for the elderly in Sweden includes both varying forms of assistance in a home environment and institutional (or special-housing) care (old people's homes, residential care, homes for the demented/dementia units, nursing homes and similar). It includes personal care – such as help with bathing, getting dressed and getting in and out of bed – as well as help with shopping, cooking, cleaning and laundry. It also provides elderly in need with assistive devices, transportation, housing adaptations, handicap aids and support for informal caregivers. Services are provided after a care assessment process. Some municipalities have however started to provide services such as home alarms to all persons over 65 that want one, without care assessment.

The service user pays fees and co-payments for the different services, but the costs are highly subsidized. Fees may vary between municipalities and regions. For people living in institutions, the cost of board and lodging is covered, with a co-payment based on the income of the recipient.

Assistive technology at home for elderly in Sweden[5]

[4] Labour market actors such as labour unions and employer´s organizations.
[5] Information from The Swedish institute of Assistive technology, webpages in English

The Swedish Institute of Assistive technology (SIAT) writes that assistive technology includes traditional products such as those which assist with bathing, dressing and eating, walkers, wheelchairs as well as ICT-based assistive technology. Assistive technology makes it possible for elderly to age in their home.

Examples of ICT- based assistive technology that can support older persons to age in their home (often called welfare technology in Sweden) include social alarms, video communication via TV and memory support devices to remind persons to take necessary medication or to organize their day and remind them when to carry out activities. SIAT writes that such products are available on the market but not yet commonly used in Sweden. Some municipalities however, have begun to use ICT-based services, and have seen that by doing so they can efficiently deliver service to their clients by reducing travel time and have more capacity to support those who are in most need of support from a career on site.

The Swedish Institute of Assistive technology (SIAT) was commissioned by the government to manage two large programs, "Technology for Elderly" and "Growing Older – Living Well", that aimed at promoting innovation and development of products and services that can enable older persons to age in place. More than 220 projects were funded in the programs and involved more than one hundred municipalities, groups of senior persons, professionals, decision makers and researchers.

The following are some examples of technology for elderly included in the "Technology for elderly"-project:

Housing

- Care IP – Alarm Unit with GSM-backup
- Accessibility – CAD-tools for building design
- Outdoor training for elderly– Preventive training with outdoor equipment

Information of and accessibility to products and technology

- Doro – Mobile phone designed for elderly
- ELSA 85 – 85-year old persons' perception of home technology in everyday life
- Nintendo WII Sport – Computer games as an activity for fun and joy of movement within the domain of elderly-care in Sweden

Technology for elderly and their relatives

- ACTION – ICT for the elderly, caregiver support and communication in sparsely populated areas in Sweden
- Caredo – Wireless home care safety system
- Call Centre for relatives – Videophone support to relatives from

Source: The Swedish Institute of Assistive Technology