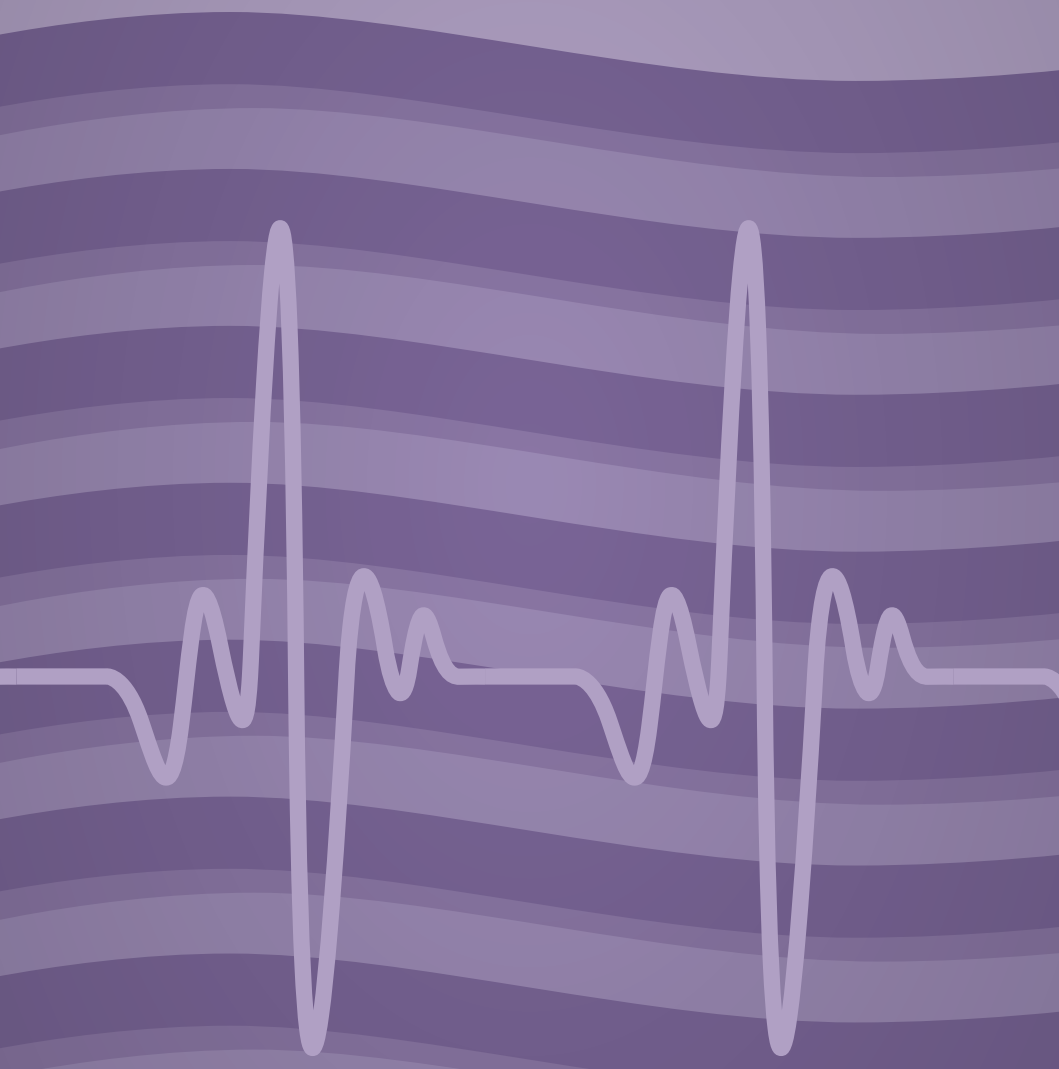
Baltic Sea Parliamentary Conference

The BSPC Working Group on Innovation in Social- and Healthcare

Final Report
August 2015



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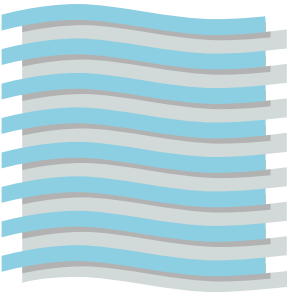

The BSPC Working Group
on Innovation in Social- and Healthcare

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The Baltic Sea Parliamentary Conference (BSPC) was established in 1991 as a forum for political dialogue between parliamentarians from the Baltic Sea Region. BSPC aims at raising awareness and opinion on issues of current political interest and relevance for the Baltic Sea Region. It promotes and drives various initiatives and efforts to support a sustainable environmental, social and economic development of the Baltic Sea Region. It strives at enhancing the visibility of the Baltic Sea Region and its issues in a wider European context.

BSPC gathers parliamentarians from 11 national parliaments, 11 regional parliaments and 5 parliamentary organisations around the Baltic Sea. The BSPC thus constitutes a unique parliamentary bridge between all the EU- and non-EU countries of the Baltic Sea Region.

BSPC external interfaces include parliamentary, governmental, sub-regional and other organizations in the Baltic Sea Region and the Northern Dimension area, among them CBSS, HELCOM, the Northern Dimension Partnership in Health and Social Well-Being (NDPHS), the Baltic Sea Labour Forum (BSLF), the Baltic Sea States Sub-regional Co-operation (BSSSC) and the Baltic Development Forum.

BSPC shall initiate and guide political activities in the region; support and strengthen democratic institutions in the participating states; improve dialogue between governments, parliaments and civil society; strengthen the common identity of the Baltic Sea Region by means of close co-operation between national and regional parliaments on the basis of equality; and initiate and guide political activities in the Baltic Sea Region, endowing them with additional democratic legitimacy and parliamentary authority.

The political recommendations of the annual Parliamentary Conferences are expressed in a Conference Resolution adopted by consensus by the Conference. The adopted Resolution shall be submitted to the governments of the Baltic Sea Region, the CBSS and the EU, and disseminated to other relevant national, regional and local stakeholders in the Baltic Sea Region and its neighbourhood.

Contents

Purpose of the Report

The purpose of this Report is to present a set of political recommendations from the BSPC Working Group on Innovation in Social- and Healthcare (WG ISHC) to the 24th BSPC in Rostock in Mecklenburg-Vorpommern 1 September 2015.

The report also gives a cursory account of some trends and challenges that the WG sees as drivers behind the need for innovation in social welfare and healthcare services. A definition of the concept of innovation in social- and healthcare is also presented, together with brief remarks on its potentials and barriers.

Foreword

Olaug Bollestad

Many countries today face the same type of challenges within social welfare and healthcare – an ageing population, health inequalities, an increase in lifestyle-related diseases and financial pressure on the service systems.

We know that the percentage of elderly is increasing at the same time as the number of young people entering the workforce is declining.

We also fear health inequalities between different socio-economic groups as well as between rural and urban areas. Further, a rising need for treatment of the ageing population, but also medical innovation and progress, increase the financial pressure on the service systems.

More or less all countries have to cope with these challenges caused both by external development trends, such as the financial crisis, but also by internal transformations. As a consequence, we need to learn to think differently. Innovation could be an important tool and strategy to counter these challenges. In this way they could be perceived as main drivers of innovation, while innovation can also

be considered a main strategy and tool to meet and manage these challenges.

The Working Group was established in August 2013 in order to raise the political attention on these issues. The aim has been to contribute to exchange of knowledge and best practices and to develop a set of recommendations that should be pursued in national parliaments and governments.

In this report you will find summaries from our six Working Group meetings, study trip and visits to different institutions and actors who have given us input during these two years of work. We have learned from each other, shared best practices and discussed a range of issues related to innovation, prevention and care. This report also includes a Volume II, which contains details of the WG meeting programmes, expert presentations, and WG homework. Volume II can be accessed via the BSPC website at *http://www.bspc.net/page/show/694*.

As members of the Working Group and parliamentarians from nine different countries, we will do our best to follow up the recommendations in our national parliaments. On behalf of the Working Group I therefore encourage you to engage in these essential issues for our future.

Olaug Bollestad, MP, Parliament of Norway

Chairperson of the BSPC Working Group on Innovation in Social- and Healthcare 2013-2015

Summary – Political recommendations for the 24th Baltic Sea Parliamentary Conference[1]

On the basis of its mandate, the Baltic Sea Parliamentary Conference Working Group on Innovation in Social- and Healthcare proposes the following political recommendations as a result of its work. The recommendations are also a result of deliberations and proposals of the meetings of the Standing Committee of the BSPC in Brussels (21 January 2015) and Stralsund (29 May 2015) and include the contribution of the BSPC to the 4th Northern Dimension Parliamentary Dialogue with regard to the Northern Dimension Partnership in Public Health and Social Well-being. The following political recommendations will be conveyed to the 24th BSPC in Mecklenburg-Vorpommern on 30 August – 1 September 2015:

The BSPC Working Group on Innovation in Social- and Healthcare calls on the Governments, and where appropriate the Parliaments, of the Baltic Sea Region:

Regarding Cross-border Cooperation in Healthcare

- to expand and deepen cross-border cooperation in healthcare in the Baltic Sea Region because of the common challenges all Baltic Sea Region countries face in the field of social- and healthcare, and therefore
- to support the Northern Dimension Partnership in Public Health and Social Well-being (NDPHS) as a highly valued and innovative regional network, significantly contributing to the improvement of peoples' health and social well-being in the Northern Dimension area, including its efforts to coordinate the new NDPHS 2020 Strategy and its Action Plan and
- to launch and develop concrete cross-border healthcare initiatives, such as ScanBalt or the WHO's Healthy Cities project;
- to improve the borderless cooperation and medical

1 For details see chapter 5.

specialisation in treatment of rare diseases, bearing in mind the cost-effective usage of medical equipment;
- to broaden the scope of the *Könberg report* to the entire Baltic Sea Region, in order to gain a comparable overview of the status of health and care in the Baltic Sea Region and
- to intensify exchanges of experience and the cooperation with the aim of fighting multi-resistant microbes and to implement research in this area;
- to spread innovative practices throughout the Baltic Sea Region to become a model region in healthcare and continue the development of the Baltic Sea Health Region;
- to strive to introduce same standards in the treatment of contagious infectious diseases on a high level all around the Baltic Sea Region;

Regarding Health Economy

- to use synergies with existing strategies, such as the ScanBalt Strategy 2015-2018;
- to improve the support for the development of innovations in healthcare to undertake measures in order to prevent a brain drain;
- to improve the conditions to support the development of innovations in healthcare, especially in the fields of e-health and telemedicine;
- to improve early intervention to strengthen a good public health through social investment like vaccine programmes, and work towards a stronger alcohol, tobacco and illicit use of drugs prevention, diabetes and other lifestyle illnesses;
- to support the usage of cost-reducing methods for better life quality, like cultural and physical health-related activities in treatment;
- to foster the development of health-related services within the tourism strategies of the Baltic Sea Region countries;

Regarding Sustainable and Accessible Social- and Healthcare

- to ensure affordable healthcare for everybody and emphasise the focus on the needs of the patient;
- to raise the awareness of the people living in the Baltic Sea Region to support approaches for more responsibilities of the patients;
- to take strong measures to ensure equitably available social welfare and healthcare services, e.g. between urban and rural areas and between socio-economic groups;
- to develop and strengthen strategies addressing the demographic change, an important issue affecting all partner regions;
- to carry out studies with the aim of developing prevention strategies in healthcare, such as the *North-Trøndelag Health Study* (HUNT);
- to create incentives to improve the conditions of the nursing and care professions;
- to install geriatric healthcare centres and modify social rehabilitation centres to ensure healthcare in rural areas as well as to improve age-appropriate medicine;
- to recognise that strong social partners in the social- and healthcare professions exist, and to protect their activities;
- to consider health in all policies;
- to commission a regular report on the status of health in the countries of the Baltic Sea Region.

1. Mandate and Scope

The WG members in Riga, Latvia at their inaugural meeting

Mandate

The Working Group was established by the 22nd BSPC on 27 August 2013. It is constituted as an ad-hoc Working Group under the auspices of the Standing Committee of the Baltic Sea Parliamentary Conference in accordance with the BSPC Rules of Procedure.

The overarching objective of the Working Group is to elaborate political positions and recommendations pertaining to innovation in social- and healthcare.

The Working Group and its members should aim at raising the political attention on innovation in social- and healthcare, for instance by pursuing those issues in their national parliaments and with their governments. Moreover, the Working Group should contribute to the exchange of knowledge and best practices within its area of responsibility.

Scope of Work

The overarching scope of the Working Group should include, but not be limited to, areas such as:

- Social innovation, with focus on social- and healthcare
- Innovation in healthcare systems and services
- Innovation in social care systems and services, with focus on elderly people.

The Working Group should place great weight on prevention in social- and healthcare. The issues and priorities of the Group are further described in the separate Scope of Work of the Working Group. The work should cover the following main issues:

- Innovation in Social- and Healthcare (ISHC) – general concepts
- Trends and challenges in social- and healthcare
- Progress in ISHC, including best practices
- Barriers for ISHC
- Action to promote ISHC

Output

The core output of the WG is its political recommendations on the subject of ISHC. The first part of the political recommendations was presented to the 23rd BSPC in 2014 (see part 5.1). The final and consolidated recommendations can also be found in the conclusive part of this report and are submitted to the 24th BSPC in 2015 (see part 5.2).

2. Challenges for Social- and Healthcare

Social welfare and healthcare systems and services face a number of challenges, which are caused both by external development trends and internal transformations. These challenges can also be perceived of as main drivers of innovation. Conversely, innovation can be seen as the main tool to meet and manage the challenges.

The WG sees the following main challenges of social- and healthcare today and tomorrow.

2.1 Attitudes

At the individual and social level, there are ingrained attitudes about what mental and physical health means, about the roots and causes of somatic and mental illnesses, and about the means by which social and medical services should be provided and mental and physical illnesses treated and cured. For generations, people have been accustomed to associate social services and mental and medical treatment with large public systems and programmes, hospital and institutionalised care, and prescription of pharmaceuticals. However, the demand for social, mental and medical services is growing and changing, and it is doubtful whether it can be satisfied within existing paradigms and structures. Efforts will be necessary to create and disseminate a heightened awareness of social- and healthcare and the ways it should be delivered and implemented, placing much emphasis on prevention.

2.2 The Ageing Population and the Demographic Structure

The population is ageing. Those aged 65 years or over will account for 29.5% of the EU-27's population by 2060 (17.5% in 2011). The share of those aged 80 years or above in the EU-27's population is projected to almost triple between 2011 and 2060. The number of young people entering the workforce is declining. This will affect the state of public health and is exacerbated by an ageing population and ensuing care requirements. The needs for

social- and healthcare services will increase, and it will also cause structural and spatial changes on social- and healthcare service delivery and funding.

2.3 Health Inequalities

From a social- and healthcare perspective, and within predicted socio-economic trends, an ageing population could mean on the one hand that a growing share of the population is becoming more affluent and educated, meaning they will be more active in demanding high quality social and medical services. They are also reaching advanced age in a more healthy fashion, meaning they will demand these services for a longer period of time. On the other hand, the

socio-economic development could also produce a growing segment of the older population that will become poorer, sicker and less capable of seeking and paying for qualified care, meaning that there are risks that their needs are not adequately, or only perfunctorily, met. Medical and social services are unevenly distributed, and the quality of care varies both spatially and socially. Rural and sparsely populated areas are particularly afflicted, with long distances to healthcare and social service infrastructure. Deprived urban areas are also vulnerable. There is a need of reducing the risk of poverty, especially preventing poverty in old age, since this is directly related to health and social well-being. Such a development would entail great perils of growing divides between the richer and poorer parts of the population in general and in the ageing population in particular, leading to marginalisation and more pronounced social stratification. Both cases will increase the pressure on social- and healthcare services.

2.4 The Increasing Burden of Communicable and Non-Communicable Diseases

An ageing population will also cause changes in somatic and mental health patterns. There will be a growth in lifestyle-related diseases, and hence a more complex clinical picture. New types as well as an increase in multi-resistant bacteria will emerge. Today 86% of deaths and 77% of the disease burden in the WHO European Region are caused by non-communicable diseases such as cardiovascular diseases, cancer, diabetes and chronic respiratory diseases. This will cause increased expectations and demands on the social services and health systems. Preventive strategies and actions will play an increasing role to reduce premature mortality and morbidity, both at an institutional and individual level.

2.5 Financial Pressure on Healthcare and Social Service Systems

Economic constraints together with demographic pressure limit the possibilities to increase social- and healthcare funding and to ensure sustainable and equitable social- and healthcare. The rising costs are increasingly a result of a rising need for treatment of the ageing population, but also of medical innovation and progress. The number of recipients of social benefits grows, while the number of payers to the social insurance systems decreases. New models for funding of social- and healthcare systems are needed. NGOs and non-state actors might get a stronger role in social- and healthcare.

2.6 Ensuring High Quality and Evidence-Based Treatment and Care

New IT and biotechnology solutions must be introduced and integrated within existing care systems, recognising i.e. their ethical and equality dimensions. There will be a growth of e-health development and implementation. Alternative forms of service infrastructure and institutional social care, such as home care, will be developed. Effective social- and healthcare provision requires thorough quality control. There will also be growing demands of including and empowering patients in health and social care, which will require legislative reforms.

2.7 Progress and Ethics

A challenge, which is also an opportunity, is posed by the breakthroughs and innovations that are made in medical and psychological fields. They have resulted, and will result, in new medicines, cures, therapies and treatments. They will lead to an improved and broadened capability to diagnose, prevent, treat and remedy various existing ailments, but also to an expanded ability to provide a more qualified and patient-adapted treatments over a broader spectrum of stages of an illness. The challenge of such a development is that the enhanced therapeutic capacity is likely to drive costs upwards, which in turn necessitates difficult but necessary ethical, medical and social considerations on how to prioritise scarce resources among different illnesses, patient groups and other competing internal and external interests.

2.8 Social- and Healthcare Workforce Development

There is a rising shortage of skilled workers and difficulties in recruiting new generations for the tasks of healthcare. The lack of qualified personnel is mainly caused by unattractive conditions. The care of the elderly will require a growing availability of multi-professional staff to work with prevention, activating and rehabilitation. There is a problem of brain-drain and out-migration of social and health professionals.

2.9 Vested Interests

The vested interests of the pharmaceutical and medical industries pose another kind of challenge. It is a well-known fact that e.g. the pharma industry is extremely lucrative, and it is reason to believe that this goes for the medical industry as well. Innovation in these fields has indeed produced more efficient and widely available medicines and therapies, which can cure illnesses better and remedy previously incurable diseases. The development has also escalated the costs of medicines and treatments. There is, to put it bluntly, sizable profits to be made from curing people´s illnesses, and it is important to ensure that production and innovation is primarily devoted to the improvement of people´s health and not to the enrichment of companies. Public authorities must ensure fair and sound competitive rules and conditions for the pharma and medical industries, that monopolistic practices are banned and prosecuted, and that public procurement rewards transparent competition, high quality and low costs.


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3. Innovation in Social- and Healthcare

3.1 Definition

An established overriding and generic definition of innovation is the one found in the OECD Oslo Manual on Guidelines for Collecting and Interpreting Innovation Data (2005):

"An innovation is the implementation of a new or significantly improved product (good or service), or process, a new marketing method, or a new organisational method in business practices, workplace organisation or external relations."

Innovation in social- and healthcare can be seen as a way of adapting to changing conditions for the social welfare and the healthcare systems. Demand for social welfare and health services is escalating and changing character, while the resources for such services are becoming more constrained. Hence, there is a need to use resources more efficiently and creatively, in order to secure a continued and fair distribution and access to social and health services.

The view by the Working Group is that innovation in social welfare and healthcare is a means of securing the provision of qualitative and equitably available social and medical services to the citizens in a situation of changing demographics, altering patterns of somatic and mental ailments, and constrained financial resources.

3.2 Potentials

As the changing global economy generates further fiscal and social pressures, continued reform approaches will be necessary. A comprehensive Health Economy approach should be fostered in order to promote the strategies, products and services that are conducive to an efficient and equitable social- and healthcare system, as well as the political, legal economic and organisational infrastructure that is needed to support it.

Policymakers have already introduced a considerable range of institutional reforms in response to the financial and organisational pressures that their health systems confront. There are already numerous

practical examples of strategies, programmes, plans and projects on ISHC. Experiences and lessons have accumulated, and new potentials are constantly identified. These can be grouped in clusters such as care philosophies and policies, care practices, care organisation and management, and R&D and business opportunities.

3.3 Best Practice

The WG has through study visits, expert presentations and exchange of knowledge, collected and compiled examples of **best practices** gleaned from Working Group meetings, the study trip and visits to different institutions and actors.

E-health Estonia

The Estonian e-health system is used for health information, digital prescription, health insurance, public health and quality registers, and for telemedicine tools. The central system is built on a common platform with one-entry configuration, making security a prime concern. It was decided early on that the system should be a stand-alone structure and not be subordinated to a ministry. Currently, about 93% of the population has documents in the central system, and e-prescription is used in 97% of the cases. The central system consists of a number of sectorial sub-systems for various kinds of patient information. The information in the sub-systems can be combined, but there are different levels of authorisation in order to define the level and extent of access by different users. In other words, everyone does not have access to all the information. The insurance system, for example, does not have automatic access to patient information. A patient can also choose to block information from external access. Spouses, however, can automatically access each other's patient information, and it is not possible for one partner to block the information from the other. Patient information for persons up to 18 years of age is automatically accessible by his/her parents. By permission of a patient, his/her information can be made available for others. A patient can follow the log of his/her journal.

The perceived benefits of the system so far are greater efficiency in patient handling and care, lower health costs, better quality of care, and raised patient awareness. Some of the lessons learned are that

user-friendliness is of decisive importance that data quality is central for the functioning if the system, and that there is a precarious balance between usability and security. Certain reluctance from hospitals to implement the system has been noted, and therefore it is important to use both carrots (funding) and sticks (legislation) to propagate it.

HUNT

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 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 members at HUNT Research Facility

The Norwegian Competence Centre for Arts and Health

The Centre is based on Government White Paper 29 Future Care (2012-2013), entered into Care Plan 2020. It is managed by the Norwegian Directorate of Health, and is a partnership between HUNT Research Centre (NTNU), Nord-Trøndelag Health Trust, Levanger Municipality, Nord-Trøndelag County and the University College in Nord-Trøndelag (HiNT).

The background is recent research and practical experiences which show that systematic use of song, music and other cultural expressions seems to work positively in treatment, quality of life, use of medicines and personnel resources within the health field. This applies both to care for the elderly/patients with dementia, to mental health work and towards other vulnerable groups.

The main agenda for the Competence Centre is to contribute to the development and use of cultural activities in daily nursing and care and promote/initiate research, competence and development of good practice. The Centre shall further develop the interaction between research, education, and practice and shall be a resource for municipalities, research organisations, educational institutions, hospitals, and other interested parties. The Centre has developed a separate continuing education study course in arts and health at HiNT (7.5 ECTS) which will start autumn 2015 and new study programmes are under development. The centre works with rhythmic training for persons with a diagnosis of Parkinson's disease, and they have artists who work with people suffering from dementia, etc.

The Competence Centre will collaborate with other disciplines and research environments in the field and has established formal co-operation with Norwegian National Advisory Unit for Ageing and Health (*www.aldringoghelse.no/english*). The Centre also participates in international networks.

See further *www.kulturoghelse.no/english/*

Steno Diabetes Centre, Denmark

Steno is a world-leading institution within diabetes care and prevention. Steno is owned by Novo Nordisk A/S and is a not-for-profit organisation working in partnership with the Danish healthcare system. Steno treats around 5600 people with diabetes. Steno's

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

In 2014 Steno Diabetes Centre was awarded the prestigious 'Golden Scalpel' award by Dagens Medicin, the leading medical newspaper in Denmark. The prize was given to Steno Diabetes Centre for innovating and improving the quality of care for the individual diabetes patient in a way that is adapted to the life of the patient.

Steno Diabetes Centre is organised in four areas that work closely together: 1. Steno Clinic, 2. Research, 3. Health Promotion Research and 4. Education.

1. Steno Clinic: Steno is one of the few centres globally that focus on diabetes only and have research, education and health promotion closely connected to the clinical care of patients. Steno Clinic has a unique position in Denmark offering:

- All-in-one service through multidisciplinary team-based care
- Diabetes specific electronic medical record enabling constant focus on quality of care
- Specialised clinics to personalise treatment and prevent complications
- Fully integrated clinical research unit to optimise care
- Day hospital with a focus on the newly diagnosed and patients in need of extra support
- Foodlab - a nutritional laboratory and hands on training facility for patients
- Online service through 'My Steno' and 24h nurse counselling telephone service.

The patient base of around 5600 patients is from the Capital Region of Denmark. The centre serves as an integrated part of the public health care system and is under contract with the Capital Region. The clinical staff of 90 in the centre includes doctors, nurses, dieticians, patient coordinators, podiatrists and lab technicians.

2. Research: Biomedical Research at Steno Diabetes Centre is translational. The aim is to apply knowledge and findings from research in the clinic to improve outcomes for patients with type 1 and type 2 Diabetes. Research is organised in the areas:

- Complication research: Understanding the prevention and treatment of diabetic micro- and macrovascular complications of diabetes

- Clinical epidemiology: Developing preventive strategies for persons with reduced glucose metabolism and early treatment strategies for persons with type 2 diabetes
- Translational patophysiology: Understanding genetic, cellular, physiological and behavioural mechanisms that lead to diabetes and its complications
- Systems Medicine: System-level understanding of metabolism and translation of this knowledge into novel solutions to benefit human health

3. Health Promotion Research: Health Promotion is a humanistic research and development department focusing on Patient Education and Prevention. The aim is to establish cross-disciplinary cooperation with partners at Steno as well as with external institutions in Denmark and abroad. The focus is on research with the potential to promote health in real life settings and practices. Research in Health Promotion is based on five principles for social and human change that permeate all research projects and ensure a clear direction for the methods and knowledge developed:

- Active involvement and participation of the target group as a basis for development of ownership and sustainable health promoting change
- A positive and broad concept of health, which focuses on the person as a whole instead of just risk factors and the disease
- Development of people's competence to take action to control their own life as well as their living conditions
- Acknowledging the context in which people live and to include this in the intervention carried out
- Increasing equity in health by paying attention also to the least resourceful members of the community

Currently, more than 25 different projects are on-going. Due to this increase of activity and substantial external funding during 2012, the number of overall staff is now at 35 people, covering a broad range of academic fields such as public health, anthropology, psychology, pedagogy, social science and design.

4. Education: The main focus of Steno Education is to disseminate the clinical competencies, front-line research results, and patient focused treatment- and care practices that are present at Steno Diabetes Centre. This is done through educational collaboration with Novo Nordisk affiliates and international recognised key

opinion leaders. The target audience for education is endocrinologists, nurses, dieticians and other health care professionals and teams who treat diabetes on a daily basis. The teaching is performed as state-of-the-art knowledge sharing at seminars, symposiums, or interactive workshops. The teaching faculty consists of experts from Steno and, often, skilled endocrinologists and healthcare professionals (HCP) from the host country, thereby ensuring that all key core competencies necessary for optimal treatment of diabetes are covered.

National Centre of Integrated Care and Telemedicine (NST) in Tromsø, Norway

NST is the world's largest centre for research and development in telemedicine and e-health. The centre has strong interdisciplinary expertise, and aims to shape the healthcare of the future. Through user-oriented research and development, NST has contributed to integration of care between levels in the health sector since 1993. Telemedicine solutions and e-health give patients easier and better access to health services. Effective collaboration makes the skills and services of health personnel available to more people, and society's resources are used more effectively.

Telemedicine, e-health and welfare technology are very important tools in the realisation of the Integrated Health Care Reform. The NST has valuable knowledge and experience in this field, and has a responsibility to ensure that the reform will have the best possible outcomes for both patients and health professionals.

NST's core expertise is defined as knowledge, solutions and technology that will support interaction with and collaboration between patients and health professionals. Through research and service development, NST contributes to competence and knowledge sharing between health professionals, and between the health service and the user.

New technology can simplify, but may also change the development of skills and knowledge sharing both across disciplines and levels in the health service, and between health professionals and users. NST has knowledge, methods and models for the organisational changes needed in connection with the introduction of e-health and telemedicine services.

Projects where the university hospital in Tromsø is involved:

www.slutta.no – a website for smoking cessation – part of the national health portal.

www.sjekkdeg.no – a website for youth about sexual health, contraception and how to avoid sexually transmitted diseases. Information is provided through text, short videos and gaming.

Electronic Welfare report, Finland

The healthcare actors in Finland follow a holistic understanding of "health promotion" as spelled out in the Ottawa Charter for Health Promotion, 1986, according to which it comprises health promotion policy and management, living environments, cooperation and participation, competencies, services, and monitoring and assessment of health promotion; health determinants are understood to also include living and working conditions. One of the greatest challenges in healthcare has been the fact that health

Expert presentation about Pirkanmaa Hospital District, Finland

inequalities between men and women by income have increased. The problem is further complicated by the fact that 20% of patients use 80% of the resources in healthcare. To reduce health inequalities the National Development Programme for Social Welfare and Healthcare (Kaste) was introduced in Finland; a strategic steering tool that is used to manage and reform social- and health policy. The targets of the Kaste programme are 1) that inequalities in well-being and health will be reduced, and 2) that social welfare and healthcare structures and services will be organised in a client-oriented and economically sustainable way. To this end, an electronic welfare report was introduced to support local strategic management, which is used by over 250 local authorities in Finland. The report includes a welfare evaluation of both the outgoing and incoming local council, spelling out priorities, national, municipal and regional plans and programmes, as well as a plan for health promotion and well-being during the council office. The report is approved as part of the operating and financial plan of the municipality. As a consequence, 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; and all administrative branches take more responsibility for the welfare of residents. The presentation clearly demonstrated that the definition of "public health" in Finland includes more aspects than merely the absence of illness; local authorities are very involved in the way healthcare and welfare are organised and implemented in Finland.

Municipality of Sastamala, Finland – focusing on men's health

Once a year the male personnel of the municipality organise a seminar for men. It has been a real success with more than 300 participating at each event. They arrange competitions, impart diet information, organise physical activities and invite celebrities to motivate and attract. The municipality also organises different campaigns such as "one cent of your waist for the health" and health promotion events and well-being weeks.

The WG members are briefed on sustainable Nordic welfare

Dealing with the challenges of non-communicable diseases in the Nordic countries

Tobacco and alcohol are two socially accepted stimulants in much of the world, even though they contribute to poorer public health. The renewed national public health policy bill in Sweden particularly recognises the challenges of non-communicable diseases (NCDs). The Swedish government has also approved a five-year national action plan on alcohol, illicit drugs, doping and tobacco. The Swedish National Institute of Public Health is assigned by the government to support implementation of the action plan at local and regional levels by doing various tasks. The increase in Swedish life expectancy over the past decades is due mainly to decreased mortality from non-communicable coronary and respiratory diseases, and recent policies such as the ban on smoking in public places and initiatives to counteract physical inactivity aim to maintain this trend.

A number of studies, among them the aforementioned Könberg report, point out an association between life expectancy in the Nordic

countries and the consumption of alcohol and tobacco. The Nordic region generally has lower alcohol and tobacco consumption than the rest of Europe – one major determinant of the higher life expectancy rates in the Nordic countries. Still, the Könberg report asserts that much is to be done to improve public health in the Nordic region, despite the strong increase in life expectancy and despite what also seem to be healthy years added to life. According to the report, the two most important areas, and which can also be influenced by political decisions, are the use of tobacco and the misuse of alcohol.

The importance of this issue was also highlighted by the European Commissioner for Health and Consumer Policy, Mr Vytenis Andriukaitis, at the meeting of the BSPC Standing Committee on 23 January 2015 in Brussels. Among others, the Commissioner identified the use of alcohol and tobacco as the main issues in healthcare. Regarding alcohol consumption the Commissioner informed that he had set himself a five-year action plan, in which he would like to address, amongst others, questions of taxation policy and customs cooperation in order to reduce the use of alcohol in the Union.

Diabetes Prevention in Finland

The Finnish Diabetes Prevention Study DPS has shown that diabetes incidence was 58% lower after mean follow-up of 3.2 years among individuals at high risk for type 2 diabetes (T2D), who had successfully achieved goals regarding weight reduction, moderate fat, low saturated fat, high fibre intake and physical activity. These encouraging results led to the Finnish Development Programme for the Prevention and CARE of Diabetes, DEHKO 2000-2010, which was implemented by the FIN-D2D project, 2003-2007. Five hospital districts are partners in the FIN-D2D project, along with 400 healthcare centres, 200 occupational health centres and over 2000 healthcare professionals, covering 1.5 million people. Funding came from all levels, including the Finnish Diabetes Association, totalling 8.4 million euros. Goals of the project included the identification of individuals with T2D, the generation of new models for the prevention of T2D, the evaluation of the effectiveness, feasibility and cost-effectiveness of the project and awareness-raising for T2D and its risk factors among the population. As one of the projects results, a diabetes risk assessment form (FINDRISC) was introduced, which became an integral part of routine healthcare check-ups. The questionnaire was supplemented with various interventions on weight management, exercise, healthy cooking etc. Healthcare centres and occupational health units received resources

and needs for the prevention of T2D, working methods, tools, materials, education and training. A protocol for the prevention and care of T2D was set up in order to know what unit takes responsibility for the treatment and care of T2D. Among the lessons-learned and results are: there are a lot of people with pre-diabetes and a lot of people not being aware of their illness; the more weight people lost during one-year follow-up, the less likely they were to show incidences of diabetes; the D2D model has been adopted in most healthcare centres and some occupational health units for screening and intervention, and has been included into the local and regional T2D prevention care protocols; large-scale screening and effective lifestyle intervention for preventing T2D are possible in primary healthcare settings.

Expertise in tick-borne diseases in Åland

Åland is very experienced in the fight against tick-borne infectious diseases. For instance, it has started a mass vaccination programme against tick-borne encephalitis (TBE); About 70% of the Ålandic population has used the free service of basic vaccination against TBE provided through the programme. One of the most important actors in the field of infectious diseases in Åland is Bimelix Biomedical Laboratory, which provides laboratory services in microbiology for healthcare in Finland and other Nordic countries. It provides services for hospitals, laboratories, clinics in the private sector etc. Most importantly, it possesses high-level expertise in the field of tick-related diseases and specialises in borreliosis (Lyme disease). The Bimelix test algorithm for borreliosis is the result of decades of research and clinical experience, and combines different commercially available test systems for optimal results. For the clinical side of borreliosis management and research, Bimelix relies on a close connection with Åland's Medimar Borrelia Clinic. The Medimar Borrelia Clinic offers a comprehensive care package including the services of specialised physicians, nurses, physiotherapists and CBT therapist, as well as blood tests, treatment, rehabilitation, follow-up and further investigations regarding differential diagnoses if needed. The clinic also attracts patients from outside of Åland.

The Danish delegation deliberating scope & mandate of the WG

3.4 Barriers and legal aspects

Many efforts are being made to further innovation in social- and healthcare, though as with most sweeping reforms this does not occur without a number of obstacles. They consist for instance of weak public awareness and a political reluctance to invest in innovation in healthcare, lack of knowledge about new solutions for social- and healthcare issues, unclear or inadequate legislation, lack of fiscal and financial incentives or poor resources for Research and Development. The Working Group has, through study visits, expert presentations and exchange of knowledge, collected examples of such barriers. They are compiled here from the input provided by the responsible government bodies of the member states, and reflect the barriers that can be found in some of the countries and regions across the Baltic Sea Region.

First and foremost, many member states face financial difficulties in achieving their goals. The scope of the reforms that have to be realised across the Baltic Sea Region are without a doubt substantial, and making the systems fit for the increasingly daunting task will be taxing on many a budget. Some member states are forced to rely on European funds, and worry about the moment those funds run dry, fearing that they will face difficulty replacing them with a national source.

The lack of funds does not only lead to slow innovation in a moment where time is of the essence, it also leads to a cap on human resources. Many member states need a large infusion of skilled labour and hence need to make healthcare an attractive field of profession again – something that is (amongst other aspects) strongly related to better remuneration.

In some cases, the lack of sufficient funds stems from weak political support and reluctance to back indispensable plans. There seems to exist a poor understanding of the potential technological solutions offered, and hence a hesitancy to support them. Communicating the necessity of these innovations and reforms is crucial in raising political attention and thus in securing funding. However, the control of the purse strings is not they only reason political attention is warranted. It will also be highly necessary in order to dissolve current legal obstacles that block the road to successful remodelling of the social- and healthcare landscapes, for instance in the case of further integrating different types of care.

Drawing the attention of the political class alone is not enough. The problems with cooperation and communication can be detected in different layers of social- and healthcare. A number of governments point out there is poor exchange between the R&D departments of the innovation industry, the healthcare professionals and the different government agents. Some member states agree that even within the healthcare sector there are too many actors, each with their own agenda. Furthermore, innovation in social- and healthcare needs to be brought to the attention of the general public. It is pointed out that there is public resistance to innovation schemes, simply because misunderstandings exist about their use and potential abuse. The different examples of poor communication lead to weak and unstable support for the overhaul beyond necessary.

4. WG Composition and Activities

4.1 Composition (as of June 2015)

Ms Olaug Bollestad, MP, Norway, Chair of the WG
Mr Wolfgang Waldmüller, MP, Mecklenburg-Vorpommern, Vice Chair of the WG
Ms Liselott Blixt, MP, Denmark
Mr Andre Sepp, MP, Estonia
Ms Hanna Tainio, MP, Finland
Mr Franz Thönnes, MP, Germany
Mr Uwe Lohmann, MP, Hamburg
Mr Romualds Ražuks, MP, Latvia
Ms Giedrė Purvaneckienė, MP, Lithuania
Ms Sonja Mandt, MP, Norway
Ms Irina Sokolova, MP, Russian Federation
Mr Bernd Heinemann, MP, Schleswig-Holstein
Mr Roland Utbult, MP, Sweden
Ms Annette Holmberg-Jansson, MP, Åland Islands

Substitutes:
Mr Julian Barlen, MP, Mecklenburg-Vorpommern
Ms Agneta Börjesson, MP, Sweden

Former members:
Mr Raimonds Vējonis, President of Latvia, former WG Chair September 2013 - February 2014
Mr Atis Lejiņš, MP, Latvia
Mr Jānis Vucāns, MP, Latvia

Secretariat / staff:
Mr Bodo Bahr, WG Secretary, BSPC
Ms Julie Helmersberg Brevik, WG Secretary, Norway
Mr Florian Lipowski, WG Secretary, Mecklenburg-Vorpommern

Substantive input at secretary level was also provided by
Ms Beate Christine Wang, Senior advisor, Nordic Council
Mr Dan Alvarsson, International advisor, Sweden

The WG at the Latvian parliament

4.2 Activities

The BSPC Working Group on Innovation in Social- and Healthcare (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.

The BSPC Working Group on Innovation in Social- and Healthcare 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 Mr Vējonis was 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

Tromsø, Norway

implementation, flexible e-learning in healthcare, homecare and prevention, and barriers and legal aspects of cross-border telemedicine.

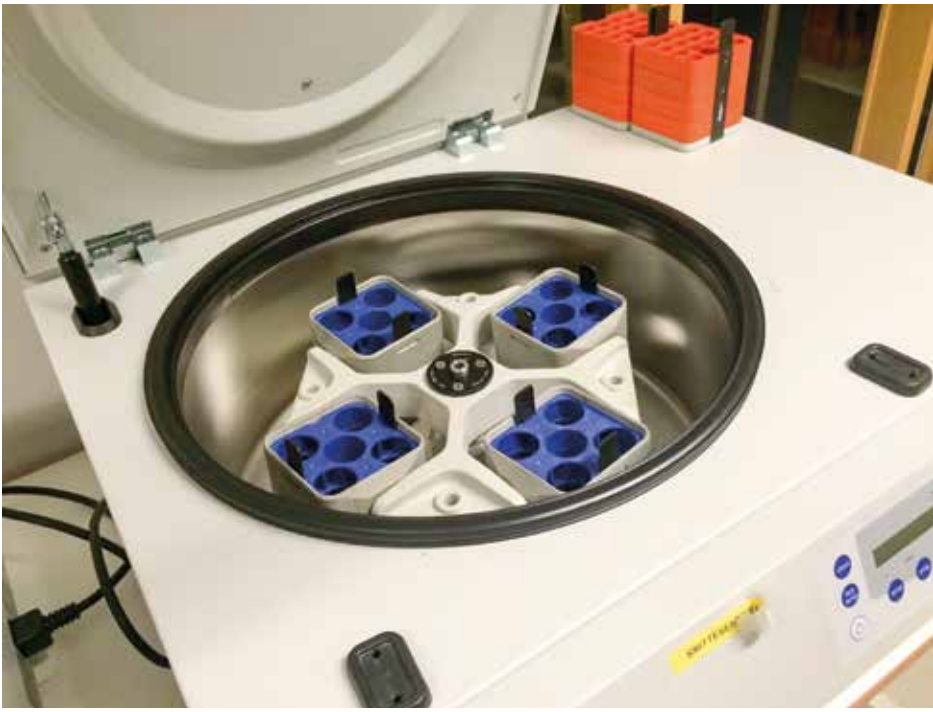
The BPSC Working Group on Innovation in Social- and Healthcare convened its **third meeting** in Birštonas, Lithuania, on 19-20 June 2014. The meeting itself was preceded by an extensive study tour of the balneological and rehabilitation resort of Birštonas, with several sanatoriums and a wide range 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.

The BSPC Working Group on Innovation in Social- and Healthcare held its **fourth meeting** in Copenhagen on 13-14 November 2014. The meeting itself was preceded by a visit to Steno

The WG at the Danish parliament

Diabetes Centre with the focus on lifestyle-related diseases / diabetes and innovation. Steno Centre 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 partnerships 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.

The BSPC Working Group on Innovation in Social- and Healthcare 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



HUNT Research Facility

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.

The BSPC Working Group on Innovation in Social- and Healthcare 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

The WG in Tampere, Finland

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.

The BSPC Working Group on Innovation in Social- and Healthcare held its **sixth meeting** on the Åland Islands on 11-12 June 2015. The meeting itself was preceded by a study tour of Healthcare 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 healthcare in Finland and other Nordic countries. Most importantly, it possesses unique expertise in tick-related diseases and specialises 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

The WG after the final two-day debate on its Final Report on the isle of Silverskär, Åland Islands

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.

Finally, the members of the Working Group have 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.

A summary of the homework follows below under section 4.3. Both the complete answers to the homework as well as the WG meeting programmes and the slides of the expert presentations can be found in Volume II of this report, published on the BSPC website.

Further information about the Working Group and its activities can be retrieved from the WG homepage at *http://www.bspc.net/page/show/694*

4.3 WG homework

As noted above, the following section summarises responses by the WG members to 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.

4.3.1 Homework assignment 1

The member states offer their perspective on the main challenges faced by social- and healthcare now and in the future.

By far the widest concern is expressed over the consequences of the democratic shift that will occur in the Baltic Sea Region over the next fifty years. The growing share of elderly within the populations of the member states will result in a higher demand of social- and healthcare and a more limited supply, since the workforce will shrink significantly and costs will go up. Existing care structures will have to bear more pressure, both practically and financially.

One of the results of an older population is the disease landscape. Lifestyle diseases, cardio-vascular diseases and cancer will require more attention in the future, as will the rise of multi-resistant bacteria. The percentage of multi-morbidity will amount to more intensive and complex care for a larger part of the populations.

A significant share of the responding members expresses uncertainty about the future of the workforce in healthcare. The percentage of the population willing to be active as healthcare professionals declines due to unattractive work conditions and poor payment. This only increases the pressure on the existing professionals.

Access, especially socio-economical, is a concern of almost all responding member states and regions. An increasing pressure on pension funds and climbing costs for patients may prove to be prohibiting when it comes to access, especially to those with a weaker socio-economic background. Member states and regions with sparsely populated areas, such as Estonia, Mecklenburg-Vorpommern, and Schleswig-Holstein express concern about the physical access to care. The lack of physicians in rural areas ensures that patients have to travel longer distances in order to receive necessary care.

In order to improve the current situation and make healthcare continuously available to all in need in the future, the responding member states and regions agree that the care system needs restructuring in order to keep being effective. An important example is the shift from inpatient to outpatient care, and the consequential increase of home care. A great majority of the responding member states further agree that medical innovation is necessary in order to deal with rising and changing challenges. At the same time, they agree that restructuring and innovation will increase the financial burden, and that a balance has to be found in moving the quality of healthcare forward, while keeping an eye on the costs.

A number of responding member states also recognises the increasing burden on local government, which in many member states is largely responsible for the delivery of healthcare as well as social services. Concerns about the ability to further deliver such services to a growing group of recipients as well as the increasing financial burden they will face can be gleaned from a number of responses.

The changing demographic is indicated as an important challenge for the future, perhaps because it has a direct effect on the unanimously addressed result: costs. All member states indicate that the cost of innovation, the cost of restructuring and the cost of increase demand will form perhaps the most significant challenge to suitable future healthcare.

The member states reflect on the new public strategies and programmes that have been launched for ISHC and on any planned initiatives.

Quite naturally, the answers to the second questions have been far more diverse than the relative unanimity regarding the first question. The member states have reacted, and will react in many different ways to the challenges presented to ISHC. Nonetheless, some patterns can be discovered.

First, it must be noted that the member states are not only launching new programmes and public strategies, but are making a fair consideration if it is necessary to start a new programme, or if it is more sensible to modernise existing structures and thereby making them newly equipped to conquer future challenges. An example can be found in the widespread attempts to further support local governments in dealing with the increasing pressure on the services they offer. Trainings and additional funding are assigned to allow

local governments and care institutions to make highly informed and effective decisions. In some cases this is an attempt to level the quality of care between municipalities, since differences do occur. The local level is furthermore a testing ground for new models and innovations. Municipalities around the Baltic Sea Region participate in numerous trial projects, in order to assert which new programmes are worth adopting nation-wide.

Another common denominator in the responses to the question is the new programmes involving the digitalisation of medicine. Member states are actively pursuing the opportunities offered by ICT advancements in order to enable easier (digital) access for both patients and medical staff. A majority of the responding members are now or soon will be actively involved in e-health or telemedicine.

Furthermore, there are several member states that have started or will start programmes for the advancement of human genome and biological research. This is in an attempt to map personal risk, as well as the ability to produce personalised medicine.

A large number of the governments that reported have created public-private platforms in order for medical suppliers and innovators, the healthcare sector and government to come together and advance efficient care. Such platforms stimulate demand-led innovation in the healthcare and social care sectors, but also provide an opportunity to keep such new innovations affordable and hence implementable. Government strategies regularly focus on solutions that make implementing the latest innovations affordable and manageable for local care institutions.

In addition to these common themes, the member states have created a host of programmes focussing on regional health needs. These vary from healthy nutrition in schools (Latvia) and vaccination programmes (Åland) to helpdesks and facilities for those dealing with dementia (Schleswig-Holstein).

The member states reflect about public awareness campaigns that have been launched or are planned, regarding ISHC.

With regard to the raising of public awareness concerning ISHC, it is fair to say that in most member states this is in the early stages of development.

In about a third of the responses, member states indicated that public awareness campaigns are not (yet) being realised or that they are not at the top of the list of priorities.

The respondents that have answered in the affirmative can be divided into two categories. There are the member states that have (thus far) decided to focus on informing the general public. Mecklenburg-Vorpommern, for instance, has launched campaigns focussed on sexual health or alcohol prevention. Schleswig-Holstein's campaign Land.Artz.Leben, attempts to interest physicians in settling in rural areas.

Then there are the member states that focus their attention within the healthcare community. Denmark for instance, has created so-called 'healthcare promotion packages', meant to help Danish municipal and healthcare decision makers set priorities and organise care on a myriad of subjects, from alcohol and tobacco to good nutrition and physical activity. Finland, in turn, awards prizes for innovative solutions. The internal focus on awareness also results in additional attempts to build networks between the different care actors.

The member states discuss the public economic support mechanisms for ISHC that have been developed, such as dedicated funding, seen money or tax incentives.

Economic support is granted to social- and healthcare in a number of ways. It is rarely identical among the responding member states, mostly due to the fact that the legal structures for granting such money (and which money to grant) are different between states. Tax incentives for instance, are offered by Finland to organisations that invest in R&D&I (Research and Development and Innovation), whereas options for offering tax incentives is relatively complicated for members such as Mecklenburg-Vorpommern and Schleswig-Holstein, seeing that taxation is organised federally in Germany.

Although some governments argued that they don't offer direct funding to any programme, there seems to be not one member state that does not offer funds in one way or another. A relatively common way of providing funding to social- and healthcare is through subsidies offered by local, regional or federal government, and through research grants offered by (national) foundations. In this

manner, many member states are capable of steering the flow of money and therefore the development of the social- and healthcare to the programmes they deem to be most vital and necessary at the time. Examples of such recipients can be found across the board, from research initiatives to centres that counsel in case of abuse or addiction or the strengthening of outpatient care.

Public-(semi-)private cooperation is again a common phenomenon when it comes to funding innovation in social- and healthcare. States, for instance, seek the financial partnership with medical associations or state-led insurance companies.

These are the main obstacles in promoting and implementing ISHC. The following forms of political support and measures are conceivable to overcome these obstacles.

A large majority of the member states have indicated that financial constraints will form the most considerable obstacle to a successful implementation of ISHC. Many have pointed out that financial resources are already limited, and partially stem from the European Union. These funds will be difficult for the member states to substitute from national sources, should the EU source discontinue. This is combined with the rising costs of providing high quality healthcare, especially in the light of continued innovation and a higher demand on the healthcare systems across the Baltic Sea Region.

Poor communication and prohibiting bureaucracy have been indicated as a further obstacle. Member states are confronted with this in different ways. The delegations from Germany for instance, indicate that the strict separation between inpatient and outpatient care forms a barrier for those patients with complex medical requirements, who are in need of different forms of care from different sectors. They often face significant hindrances when communicating with different providers across different sectors. Denmark on the other hand has indicated that a lack of clear communication to its population forms a hindrance to a smooth implementation of e-health. This results in a resistance to the digitalisation of medicine for privacy reasons. Norway in turn has pointed out that communications between different healthcare sectors, the government and the research branch have been troubled, hampering its potential power in reforming its healthcare system.

The member states are in the process of evaluating these obstacles in order to remove them in the future. For example: in light of the

difficulty of procuring financial support, Estonia proposes a national action plan to form financial support instruments. This way they aim to provide stable and sustained financing for a time when EU funds may run out.

4.3.2 Homework assignment 2

These are the major ethical issues and dilemmas caused by the progress in medical and social treatment methods and therapies, according to the member states.

Several responding member states have replied to this question by pointing out that although new innovation could give rise to significant ethical dilemmas, it could also form the solution to current ethical issues.

That said some ethical conundrums were highlighted in the responses. Access to healthcare will continue to be a question, especially in the light of rising costs. Each member state will have to determine whether it is ever acceptable to terminate treatment due to high costs, for instance when the treatment itself will only bring moderate improvement, or if certain patients should be prioritised considering potential success rates, for instance in the case of organ transplants.

In the previous homework assignment, we have seen that several member states have started investigating the options of genome research, and the potential predictive capabilities it holds. That does not mean the ethical question is ignored. The member states have pointed out that being aware of someone's potential illnesses should not become a factor in the willingness to treat those illnesses. This is perhaps an example of the more general concern about data protection, and which medical actor is permitted to access patient's medical information.

Finally some member states wonder about the power of decision-making. When illness, costs and perhaps lifestyle choices of a patient are weighed in the balance, politicians and even insurance companies might claim a role in the ultimate decision-making regarding treatment options. Decisions, that can be argued, should stay with the medical experts.

These policies and methods have been applied or planned in order to guide the prioritising between different patient groups (different kinds of diseases and ailments), in a situation where treatment potentials are growing by practical resources are scarce. The member states answer which body or person has the responsibility for setting and making priorities.

A large majority of the responding governments have answered that equal access for all patients is paramount and that prioritising may in some cases even be unconstitutional.

That said, most member states have indicated that it has governmental bodies that decide on what is medically and economically necessary and appropriate. Often, these boards are made up by a cross-section of the medical community and produce a set of guidelines meant to improve effectiveness and stimulate evidence-based medical decisions. Depending on the member state, they also advise on medical ethical issues, or make decisions regarding expensive treatment.

In most cases, however, it is the medical professional that has the final say in the ultimate treatment of his or her patient.

The member states weigh to what extent a patient's lifestyle, behaviour and self-responsibility will influence the choice of treatment/therapy for him/her, especially when it comes to new and more expensive treatments.

All responding member states agree about the fact that a patient's lifestyle cannot play a role in the creation of a treatment plan. Although it is acknowledged that lifestyle and behavioural decisions can have a significant impact on the rise and development of an illness, it is believed that one should not be treated differently because of it. An exception is only made when such changes are required for medical reasons, for instance in the case where severe obesity or alcohol dependence have a real impact on the treatment results.

The stance on equal healthcare despite negative lifestyle choices does not stop the member states from trying to influence behaviour that could lead to ill health. This approach is often many-fold. Education of the general population on healthy living is the first logical step in this attempt. However, most states aim to move beyond mere informing and hope to mould their population into a group of empowered patients. This includes informing them on the possible treatment plans, and involving them into the decision-making. This often stems from the belief that informed and involved patients are more driven to take responsibility during the treatment process, not just undergoing it.

The member states disclose 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.

A patient's right to privacy of medical records is in most instances covered under general privacy legislation. In a majority of the cases, acting medical professionals are only allowed to access the information in line with their care duties. It is not a free for all for the medical community, to browse as they please. A level of professional integrity is expected from those employed in the medical professions. In most member states, a log is kept of the medical professionals accessing it, and fines or even jail sentences attached to potential abuse.

The degree of digitalisation and access is varied among the member states. Some are still in the process of digitalising the medical information, whereas other have made the information available not only to the medical community, but to the patients themselves. The inhabitants of Finland and Denmark, for instance, are able to view their medical records online, in an e-health environment. Most of the populations of the Baltic Sea Region, however, have a right to their own medical information, even if it is not (yet) available with the click on the home computer.

Security is ensured in different ways, for instance by providing both the physicians and the patients with a password or key card, which unlocks the access to the files. How the files are protected against wilful attacks for e.g. hackers or what will be done in the case of a larger leak is not further specified in the respondents' answers.

The member states illuminate to what extent ethical issues are taught and incorporated in the education, training and continuing education of health workers.

Ethical training is a valued section of each of the respondents' medical training. It is either formed by a merely theoretical programme or by a combination of theory and practice. Denmark, for instance, has formed a competence-based ethics section as part of its post-graduate education, including amongst others "management of professionalism in compliance with the Hippocratic Oath and legislation" and "knowledge of conflict resolution". Finland has increasingly focussed on sensitivity towards other cultures within the medical sphere.

Generally speaking, broad parameters for ethical behaviour are set out by national governments. Most member states have a national body that is involved with providing guidelines on ethical issues, like the National Advisory Board on Social Welfare and Healthcare Ethics in Finland or the Centre for Medical Ethics in Norway.

Often, however, they are built upon in detail by local government, institutions and higher education. This causes different professional groups or even different institutions to have varying guidelines on medical ethical dilemmas.

4.3.3 Homework assignment 3

The member states shed light on the demographic perspectives in the respective countries.

The responses from the member states are in a certain way difficult to compare because different statistics are used to demonstrate the demographic perspectives for the different entities. What can be deduced is that to a greater or lesser degree all member states are ageing significantly, resulting in a reduced workforce and hence more pressure on the social- and healthcare structures.

The peak of this ageing process is likely to strike different countries in the Baltic Sea Region sometime between 2025 and 2040. Member states indicate that roughly a quarter of their population will be over 65 somewhere within this timeframe. Rural areas are generally more vulnerable to ageing than urban areas. The countryside of

Mecklenburg-Vorpommern will have to face a population of which 40 percent will be over 65. This compared to a percentage of 22-30 percent in the rest of the state.

In some member states however, it is not all grim. Norway's population is currently rapidly ageing, but the country predicts that this trend will flatten in the future, due to relatively positive birth rates and a steady influx of young immigrants. Lithuania today is in a good shape when it comes to ageing, and has a relatively young population. This will face some change in the future, for instance due to emigration rates.

Nonetheless, the dependency rates of the population in the Baltic Sea Region will continue to rise in the coming decades.

This is how the member states prepare for the approaching elderly boom.

Sweeping reforms are planned across the Baltic Sea Area, in order to conquer the demographic challenges. A large majority of the member states is currently preventing a further shrinking of its workforce by postponing the retirement age and incentivising healthy and energetic elderly to keep working after the national retirement age, be it perhaps in an adapted form.

Naturally, the healthcare sector will face reform. In several member states, hospitals and other healthcare institutions will be restructured in order to accommodate the changing illnesses and needs. Often this will mean an increased focus on chronic diseases, cancer and cardio-vascular diseases. There will also be an attempt to integrate cure and care, and to make especially care options accessible close to home, if not in the home.

Finally, there are multiple examples of member states that will not only aim at prolonging life in a healthy fashion, but also keeping those lives active and socially engaged, thus reducing the years of dependency.

This is how the mobility of elderly people, both at home and outside of their homes, is organised in order to allow for a self-determined life.

The range of care options is the different member states are wide, from home care to complete institutionalised living. The member states are adamant to prolong independent home living in each country. Being able to live at home is presumably most pleasant for the populations, though the consideration is also largely financial. Supported home care is the more cost effective option when compared with care in a nursing home.

In most member states, home care is organised and often financed by the municipal government. NGOs, private-for-profit organisations or local governmental institutions offer a range of services that can be divided in practical care (grocery shopping, meal services and cleaning) and personal care (help with personal hygiene or nursing). In some states there is a reliance on informal care (provided by the family), which is then supported and supplemented by public services.

A relatively new aspect of home care is the virtual care services now or soon to be offered by a number of the member states. Sweden offers its elderly citizens a range of digital solutions designed for users with an advanced age, such as reminders to take medication and alarm units, but also mobile phones designed for elderly users and even Nintendo WII sport for personal activity. It is likely that more and more member states will rely on such digital advances in order to further enable home care. It is also a step towards activating care, moving patients toward an active lifestyle, even if they require care options.

In addition to home care there are options for (semi-) institutionalised living. These options of long term, constant care are usually exclusively for those who have a medical necessity.

The care options are paid for in different manners around the Baltic Sea Region. The Åland islands use a voucher system to pay for services rendered, while many other states financially subsidise their population in order to pay for home care. In some cases the healthcare options are entirely free for the patients, in other cases a (small) amount has to be paid privately.

5. Political Recommendations

A diversity of supportive measures at different societal levels and in a broad range of sectors is necessary to address the challenges and promote ISHC. Such measures could consist of, for example, political strategies and programmes for the benefit of ISHC, fiscal measures to facilitate ISHC, information and awareness-raising campaigns, enabling legislation and removing legal obstacles, economic incentives, novel organisational and operational strategies for providing social- and healthcare services, reform and re-thinking on social- and healthcare practices, new concepts and methods of providing medical treatment and social care, allocating resources to promote research and education on ISHC, et cetera.

5.1 Recommendations from the Midway report, 23rd resolution and governmental reactions

Some political recommendations were already elaborated in the Midway report in 2014, a number of them was integrated in the 23rd resolution of the BSPC (cf. 5.1.1 and 5.1.2). A part of them is reflected on in the follow-up reports by the Governments (5.1.3).

5.1.1 Recommendations from the Midway report

The WG Midway Report included the following political demands:

The BSPC Working Group on Innovation in Social- and Healthcare calls on the Governments, and where appropriate the Parliaments, of the Baltic Sea Region to:

1. develop and implement strategies and action plans to promote innovations in social welfare and healthcare, based on a preventive philosophy and closely involving the health economy, and to integrate healthcare and social welfare issues in other growth strategies;

2. promote the development and deployment of new ways for the provision of social welfare and healthcare services, including innovative methods for treatment and therapies as well as organisational and structural reforms, and placing great weight on secure e-health solutions;

3. put in place fiscal incentives to encourage and support entrepreneurs, SMEs and business incubators in the health economy;

4. support favourable financing conditions and models in the health economy, such as seed money, venture capital and foundations

5. support competence centres as regards the transfer of scientific results into commercial products and services in the area of health promotion and prevention;

6. utilise and devise public procurement rules and procedures in a way that favours smart and innovative social welfare and healthcare services and products;

7. ensure that new solutions for social- and healthcare provision are incorporated in the education, training and competence enhancement of personnel;

8. take strong measures to ensure equitably available healthcare and social welfare services, e.g. between urban and rural areas and between socio-economic groups;

9. against the background of the demographic shift, to work towards a greater focus on the needs of the elderly, including e.g. the promotion of qualified health tourism;

10. strengthen and systematise cooperation within the Baltic Sea Region on social welfare and healthcare, promoting the exchange of best practices among stakeholders and exploring the possibilities of elaborating and implementing joint strategies for social welfare and healthcare;

11. provide continued support to the Northern Dimension Partnership in Public Health and Social Well-being.

5.1.2 23rd resolution – recommendations from the Midway report

The following compilation shows, in how far the recommendations from the Midway report were implemented in the final resolution of the 23rd BSPC:

a) Recommendation 1 equals Call 23 from the 23rd resolution, changed wording is marked

23. develop and implement strategies and action plans to promote innovation and entrepreneurship in social- and healthcare, based on a preventive philosophy and closely involving the health economy*, and to consider the social welfare and healthcare dimension also in the innovative health economy when developing growth strategies;*

b) Recommendation 10 forms the first part of call 24 from the 23rd resolution, "promoting the exchange of best practices among stakeholders" is deleted;

24. strengthen and systematise cooperation within the Baltic Sea Region on social welfare and healthcare, including e.g. the exploration of the possibilities of elaborating and implementing joint strategies for social welfare and healthcare,…

c) Thoughts of Recommendations 2 and 6 are used in the second part of call 24 from the 23rd resolution

24. …transferable models for the provision of social welfare and healthcare, public procurement models and quality standards, and joint research and development endeavours;

d) Recommendation 8 forms the first part of call 25 from the 23rd resolution

25. further strengthen measures to ensure equitably available healthcare services, e.g. between urban and rural areas and between socio-economic groups;…

e) Parts of Recommendations 2 and 6 form the second half of call 25 from the 23rd resolution

25. …the development and application of modern communication technologies such as telemedicine is especially relevant in this regard;

f) Recommendation 11 equals call 26 from the 23rd resolution

g) 26. provide continued support to the Northern Dimension Partnership in Public Health and Social Well-being;

5.1.3 Follow-up

In this passage the answers about the implementation of the 23rd resolution from the governments (as of 1 June 2015) with regard to the recommendations on innovation in social- and healthcare are compiled. They have been summarised in order to provide an overview of the state of social-and healthcare in the Baltic Sea Region. The interested reader searching for the complete responses by the member states and regions is referred to the Volume II of this report, which contains the full-text reactions to the 23rd resolution by the responding member states.

In the responses to the 23rd BSPC resolution, a large number of member states have included extensive remarks on innovation in social- and healthcare. Even if it is difficult make general remarks about what can only be described as a wide array of policy proposals and programmes currently being executed in the different member states. Nonetheless, the Working Group decided to develop a survey of the different reports.

A large theme in overcoming the significant challenges of a healthcare system under pressure is international cooperation. A majority of the governments that have reported sought partnerships either bilaterally or multilaterally in the search for innovative solutions. This is often many facetted, varying from practical cooperation on concrete projects to the more theoretical cooperation regarding education and knowledge exchange. One of the often-mentioned vehicles for such cooperation is the Northern Dimension Partnership in Public Health and Social Well-being, currently chaired by Germany.[2]

2 The NDPHS, as a highly valued and innovative regional network, significantly contributes to the improvement of peoples' health and social well-being in the Northern Dimension area.

A large part of the healthcare tasks are usually delegated to the local level, referring to the different health systems of the countries within the Baltic Sea Region. However, national and regional governments are actively involved in strengthening local institutions and government and assisting them in performing their tasks under increasing duress. This involves providing the institutions with the scientific and practical information they need in order to use and disseminate it, but also fostering relationships between different organisations and actors in a region (e.g. public and private-for-profit) in an attempt to help them supplement each other. Estonia, for instance, supports the creation of new social enterprises to serve such a purpose.

An important step in making the healthcare sector resistant and allowing it to continue to provide high quality services, is bringing it into the digital age. Most governments implemented IT innovations in the social- and healthcare sectors in order to support its various functions. Social- and healthcare benefit from such developments by being able to monitor secure living, offering e-ambulance services and online medication prescription services. Telemedicine, however, is by far the most mentioned. The ability to monitor or even diagnose patients from a distance is considered worth pursuing because it increases the efficiency of healthcare, but most of all because it increases the access to healthcare, especially for those patients either physically too far removed or incapacitated by poor health. It is understood, however, that telemedicine will remain a helpful tool in distributing healthcare further, and will not become a replacement for a face-to-face appointment with a physician.

Another step into the future are the genome projects underway in a number of member states. When successful, they will harness the ability to forecast a person's illnesses. This will have the benefit of being much more proactive on a treatment path, even though perhaps some ethical and practical issues would have to be considered.

Finally, the responses to the 23rd resolution involve many projects, both proposed and currently active, meant to battle different health threats. Regular screenings for common (lifestyle related) diseases such as cardiovascular diseases and cancer are widely introduced, as are a number of vaccination programmes. Various member states attempt to reduce the intake and especially the abuse of alcoholic beverages and tobacco. This may include a stricter policy on advertisement and sales, but also on where and when use is allowed. Latvia for example goes beyond the restriction of smoking in public (which is becoming the norm in many countries) and will consider restricting smoking in private, for instance when children are present. It is

also taking an active stance on other aspects of healthy living, aiming to ban sugary, salty and other unhealthy foods from schools and hospitals.

These are a selection of the many ways in which the member states push their social- and healthcare systems towards higher adaptability to the challenges of the 21st century.

5.2 *Political recommendations for the 24th Baltic Sea Parliamentary Conference*

On the basis of its mandate, the Baltic Sea Parliamentary Conference Working Group on Innovation in Social- and Healthcare proposes the following political recommendations as a result of its work. The recommendations also are a result of deliberations and proposals of the meetings of the Standing Committee of the BSPC in Brussels (21 January 2015 and Stralsund (29 May 2015) and include the contribution of the BSPC to the 4th# Northern Dimension Parliamentary Dialogue with regard to the Northern Dimension Partnership in Public Health and Social Well-being.

These political recommendations will be conveyed to the 24th BSPC in Mecklenburg-Vorpommern on 30 August – 1 September 2015:

The BSPC Working Group on Innovation in Social- and Healthcare calls on the Governments, and where appropriate the Parliaments, of the Baltic Sea Region:

Regarding Cross-border Cooperation in Healthcare

- to expand and deepen cross-border cooperation in healthcare in the Baltic Sea Region because of the common challenges all Baltic Sea Region countries face in the field of social- and healthcare, and therefore
- to support the Northern Dimension Partnership in Public Health and Social Well-being (NDPHS) as a highly valued and innovative regional network, significantly contributing to the improvement of peoples' health and social well-being in the Northern Dimension area, including its efforts to coordinate the new NDPHS 2020 Strategy and its Action Plan and
- to launch and develop concrete cross-border healthcare initiatives, such as ScanBalt or the WHO's Healthy Cities project;
- to improve the borderless cooperation and medical specialisation in treatment of rare diseases, bearing in mind the cost-effective usage of medical equipment;
- to broaden the scope of the *Könberg report* to the entire Baltic Sea Region, in order to gain a comparable overview of the status of health and care in the Baltic Sea Region and
- to intensify exchanges of experience and the cooperation with the aim of fighting multi-resistant microbes and to implement research in this area;
- to spread innovative practices throughout the Baltic Sea Region to become a model region in healthcare and continue the development of the Baltic Sea Health Region;
- to strive to introduce same standards in the treatment of contagious infectious diseases on a high level all around the Baltic Sea Region;

Regarding Health Economy

- to use synergies with existing strategies, such as the ScanBalt Strategy 2015-2018;
- to improve the support for the development of innovations in healthcare to undertake measures in order to prevent a brain drain;
- to improve the conditions to support the development of innovations in healthcare, especially in the fields of e-health and telemedicine;
- to improve early intervention to strengthen a good public health through social investment like vaccine programmes, and work towards a stronger alcohol, tobacco and illicit use of drugs prevention, diabetes and other lifestyle illnesses;

- to support the usage of cost-reducing methods for better life quality, like cultural and physical health-related activities in treatment;
- to foster the development of health-related services within the tourism strategies of the Baltic Sea Region countries;

Regarding Sustainable and Accessible Social- and Healthcare

- to ensure affordable healthcare for everybody and emphasise the focus on the needs of the patient;
- to raise the awareness of the people living in the Baltic Sea Region to support approaches for more responsibilities of the patients;
- to take strong measures to ensure equitably available social welfare and healthcare services, e.g. between urban and rural areas and between socio-economic groups;
- to develop and strengthen strategies addressing the demographic change, an important issue affecting all partner regions;
- to carry out studies with the aim of developing prevention strategies in healthcare, such as the *North-Trøndelag Health Study* (HUNT);
- to create incentives to improve the conditions of the nursing and care professions;
- to install geriatric healthcare centres and modify social rehabilitation centres to ensure healthcare in rural areas as well as to improve age-appropriate medicine;
- to recognise that strong social partners in the social- and healthcare professions exist, and to protect their activities;
- to consider health in all policies;
- to commission a regular report on the status of health in the countries of the Baltic Sea Region.

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