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Regions for Health Network Twentieth Annual General Meeting

**Cardiff, Wales, United Kingdom
10–11 October 2013**

ABSTRACT

From 10 to 11 October 2013, 44 participants from 19 countries and 20 regions met at the Twentieth Annual General Meeting of the Regions for Health Network (RHN), hosted by Public Health Wales in Cardiff. This was the first RHN Annual General Meeting in the Network's new phase of development, characterized by the implementation of the European health policy framework, Health 2020, at regional level. The purpose of the meeting was to discuss the RHN workplan of activities for 2013 and 2014, as well as contribute to the collective decision-making process of the Network, share experiences, learn from colleagues and debate public health challenges. Understanding and knowledge were developed on how public health can influence key areas including: health, wealth and well-being; tackling inequalities at local, national and international levels; holistic approaches to wellness across the life-course; excellence in health services; and informing policy-making and practice.

Keywords

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1. Introduction

The Twentieth Annual General Meeting of the Regions for Health Network (RHN) was held at the Wales Millennium Centre in Cardiff, Wales, United Kingdom from 10 to 11 October 2013. The meeting was held in the context of the Welsh Public Health Conference 2013. Forty-four participants from 20 regions and 19 countries took part.

The Right Honourable Carwyn Jones Assembly Member, the First Minister of Wales, opened the meeting with a speech on public health. Dr Erio Ziglio, Head of the WHO European Office for Investment for Health and Development in Venice, Italy, of the WHO Regional Office for Europe, welcomed the participants and thanked the Government of Wales for hosting the meeting. The city of Cardiff, where the Regions for Health Network started in 1991, welcomed back members from RHN.

The Network adopted the programme (Annex 1).

The purpose of the meeting was to discuss the Network's new phase of development, which was linked to the implementation of the new European health policy framework, Health 2020, at regional level and to agree on the projects and activities RHN would undertake over the coming months and years (1). The term "regional level" was used throughout the report as the level of governance between national and local.

2. Göteborg, a year later

The Network reviewed progress made since its special meeting in Gothenburg, Sweden in 2012, when it adopted the Göteborg Manifesto to launch the RHN's new phase of development in support of Health 2020, the WHO European Region's framework for improving health in Europe (2).

In this new phase of development, it was said that a much larger network with a revised focus was necessary to move in the right direction and meet both the commitments of the Network and the priorities of Health 2020. Along these lines, the Network agreed on a workplan for 2013–2017 that included specific RHN products, which would be the result of an innovative cooperative approach between the members. Current and future plans would focus on the 10 know-how areas in which the Network could explore new approaches to action at regional level:

1. how to foster and sustain regional commitment
2. how to secure policy coherence
3. how to develop skilled human resources
4. how to scale up from isolated regional projects
5. how to foster long-term regional investment
6. how to strengthen regional health systems
7. how to increase capacity for regional health diplomacy
8. how to create incentives for a regional whole-of-government approach

9. how to develop knowledge transfer among regions
10. how to reposition health within regional development.

2.1 Summary of the history of RHN

The creation of RHN in 1992 was linked to three trends at the time:

1. the growing international importance of the health agenda from the Declaration of Alma-Ata (3) to the policy framework *Health for All* to the Ottawa Charter for Health Promotion (4);
2. the growth of WHO networks to support international collaboration; and
3. the growing importance of regions within European countries and the development of institutional arrangements to support them.

The timing of the creation of the Network might also have been linked to the fall of the Berlin Wall in 1989 and the sense of a new openness across Europe.

Following an initial meeting in Lugano, Switzerland, the idea of a network was developed in Cardiff in 1991, which led to the signing of the Declaration of Dusseldorf and the creation of the Network in 1992 (5). The RHN Secretariat was originally based at the WHO Regional Office for Europe in Copenhagen, Denmark and then outsourced on a rotational basis to RHN members, first to Szabolcs-Szatmár-Bereg county in Hungary and then to Sicily, Italy. Since 2012, the Secretariat operates from the WHO European Office for Investment for Health and Development in Venice, Italy.

It was recognized that the Network was dependent upon its members' degree of involvement and participation, which was more important than formal institutional links. Dr Anna Ritsatakis was acknowledged for her vital role in setting up and supporting the Network.

The development of the Göteborg Manifesto was related to recent changes in Europe. The changes included the recession and its impact on both health and public services; the continuing, intractable patterns of inequity in health; and the improved understanding of the role that social determinants play in causing poor health and of possible actions to tackle them. Health 2020 reflected the new situation and offered a way of responding.

2.2 How to capitalize on Västra Götaland's experience

A member from the Västra Götaland region of Sweden presented a project to address health inequities that was running in his region. The project demonstrated how to foster and sustain regional commitment – know-how area 1. A draft document based on experiences from the Västra Götaland region was available to RHN members for review. The document focused on processes for incorporating the issue of health inequities into regional plans on health and development.

The document would be published in 2014 as a RHN publication. The first RHN publication, launched in 2013, was *Health and environment: communicating the risks* (Section 4.1) (6).

Members from Belgium and the Euregio Meuse-Rhine region indicated that the work in Västra Götaland was of interest to their regions. A member from the Pomurje region in Slovenia noted that there was a lot of evidence on implementing initiatives at national level but not at regional level. The Pomurje region in Slovenia intended to publish case studies to help fill the gap.

It was never the intention to separate the 10 know-how areas, and it would be important to the Network to work out how to connect them. Mechanisms to ensure their linkage were:

- a faculty of experts;
- a platform – perhaps a meeting – to allow the presenting and sharing of ideas; and
- the development of skills needed to support political commitment and effective action on key issues, perhaps through 1–2 day(s) meetings on specific topics with other links outside the meetings.

A member from Scotland (United Kingdom) who had recently attended the Healthy Schools Network meeting highlighted the benefit of linking various WHO and other health networks as vehicles for achieving Health 2020. A member from the Northern District, Israel agreed and noted that each region had its own experts and the challenge was to bring them together.

2.3 Maastricht University: a fulcrum of European actions on health inequities research

A member from the Department of International Health, Faculty of Health, Medicine and Life Sciences, Maastricht University, the Netherlands presented a proposal to have his faculty be considered as a RHN collaborating centre. Maastricht University was located in Euregio Meuse-Rhine, a strategic location for a transboundary region. In addition to its location, other advantages included the strength of the research performed at the Faculty (on comparative health, European public health and global health), the quality of education provided by the bachelor and master programmes, problem-based learning and projects to create a collaborating centre on the theme “health and regional policies”.

Possible terms of references would be to assist WHO in the Network’s new phase of development by:

- assisting in the development of regional health policies aligned with Health 2020, with particular focus on documenting effective practices to improve population health and reduce health inequities; and
- assisting in the development of capacity-building events on public health, with specific focus on the social determinants of health and health inequities.

A programme of work and a time scale linking the 10 know-how areas and the 10 WHO effective public health services was presented.

3. Regional implementation of Health 2020: from theory to action

3.1 How RHN could have a key role

Suggestions for what regional governments could do to help implement Health 2020 were to:

- identify and use the levers for change within the areas that are under their local control;
- put health at the top of the agenda, emphasizing that health was much more than just hospitals and doctors; and
- fill gaps in local capability and capacity by finding partners with the same ambitions, using the fact that all across Europe people have the same problems but different local resources, experience and creativity.

In particular, RHN could:

- interpret WHO policy at regional level
- develop health policy literacy
- create a literature of regional experience
- demonstrate the importance of Health 2020 to regional policy-makers and implementers.

3.2 A report on regional implementation of Health 2020

Health 2020 was always intended to be applicable to all levels within countries. Members were asked to share experience implementing Health 2020 at regional level. The resulting information would be published in 2014 as a report aiming at serving as a practical tool for further implementation of Health 2020 in the regions. Information would be collected on four points.

The first point asked questions: What was the narrative in each region on health? What was the level of commitment to Health 2020? What were the drivers in each region?

The second point considered the institutional arrangements and mechanisms, such as legal foundations used to support regional implementation of Health 2020. An example was the recent Norwegian Public Health Act (2011) (7).

The third related to the appetite for innovation in responding to governance challenges in the regions. Were there new experiments in that area, possibly involving academia? For example, in Germany, there was competition between regions to attract elements of the health industry, which was a new development that could be explored further.

The fourth area was the state of the culture of collaboration and the willingness in each region to take the implementation of Health 2020 forward.

Ideas on the content of the report varied widely. The document aimed to be helpful both in the shorter and longer term. A member from Sweden said that it might not be politicians who were a block to broader action but high officials and the bureaucracy; they might prefer to avoid difficult issues and focus on other matters. Public health might not be the right focus and that attention to themes such as sustainability and social concerns might produce better results. In Wales, there was a focus on poverty, which would lead directly to better health though it was not communicated as a health initiative. Along the same lines, in Region Skåne, Sweden, a different language was needed to bridge the gap to other professionals such as economists and architects.

The contents of two documents on governance published by WHO could be easily applied to the work of the Network (8,9). Information from the *Report on social determinants of health and the health divide in the WHO European Region* (10), which would incorporate the work of 13

subgroups launched in London, the United Kingdom on 30 October 2013, was also relevant to the work of RHN. The challenge was to make governance a driving force for change, which would require practical tools.

An anti-discrimination platform was created in Belgium in 2013, and the questionnaire and information used to develop the platform could be shared with RHN members. The complexity of the language used in the discussions about the social determinants of health was one of the main obstacles to engage different stakeholders.

There were great challenges faced by central governments in passing information to regional level. There was a need to develop ways to reduce complex evidence to a form that a busy minister could read and understand in 10 minutes or less. Sometimes the governance arrangements were in place but perhaps not fully effective; practical help was needed to make change happen. A better understanding of how other elements, such as social benefits, worked in society was needed.

Members were asked to suggest what the document would be like. Suggestions included a section on how to interpret global themes and aspirations at regional level; advice on how to make progress without suggesting that health was the only issue that mattered; lessons learnt from the approach of South Australia to health-in-all policies; a theoretical framework with practical implementation advice; and a short, simple, jargon-free document that included checklists for self-assessment and possible next steps. A member who was the only politician present supported a simple and practical approach as many of the ideas and much of the language sometimes used was alien to politicians. Since the document addressed two groups, politicians and administrators, two chapters might be needed. The paper should reflect both values and evidence.

4. Health 2020: better health through strengthened capacity at regional level

The need to institutionalize progress across the Network was emphasized. There were many valuable and successful capacity-building events across the Network, but their linkage to each other and to the Network's strategy could be improved. That must be an aim for the future.

4.1 Making a capacity-building event a learning opportunity: the experience from the Autonomous Province of Trento

In Italy, regional health authorities were responsible for autonomous health policies and for interpreting and adapting national guidelines to regional level. The Autonomous Province of Trento had a local health unit with four health districts and an overall plan developed by the Health Authority. The Health Observatory from the Health and Social Solidarity Department of the Autonomous Province of Trento, established in 2011, was embedded into the Public Health Council and recognized health literacy as a major issue.

The region had a tradition of health reporting and public health planning, with epidemiological analysis and annual reporting rich in data, describing issues related to services provided by the Local Health Unit and public health planning. Analysis and reporting were based mostly on expert opinion, without systematic community participation or systematic epidemiological data

analysis and prioritization. The main challenges facing the Health Observatory were the need to draw attention to the determinants of health, highlight the importance of health promotion and support a shift to a health-in-all-policies approach in health planning. In addition, it was necessary to link capacity building to epidemiological analysis, prioritization, community participation and public health planning.

As a result, the structure of the report, Health Profile of the Province of Trento, had changed radically. The former health services status report was replaced by a population health profile with a strong focus on health determinants. Health profiling was used as a means of advocacy, which was relevant to know-how area 1 – how to foster and sustain regional commitment. Data were broken down by individual health districts in order to facilitate data use at local and sublocal levels. Careful attention was paid to language and wording to make the report, *Health Profile of the Province of Trento 2012*, more accessible, and it was sent to stakeholders, posted on the Internet, and presented in scientific meetings and public conferences and to the press (11).

Another area of interest was the local application of ideas developed elsewhere. An example was the so-called downscaling of public health objectives, such as the set of nine voluntary global noncommunicable diseases (NCDs) targets from the WHO NCD Global Monitoring Framework, which was relevant to know-how area 4 – how to scale up/down from isolated regional projects – and know-how area 9 – how to develop knowledge transfer among regions (12).

In terms of research, a project on “law as a tool for health promotion” started, in collaboration with the Faculty of Law at the University of Trento. Opportunities were identified for normative action in different government sectors, such as health, economy, environment, agriculture and city planning, helping to develop an intergovernmental table of health in all policies due in 2014. These mapped to know-how area 8 – how to create incentives for a regional whole-of-government approach.

In collaboration with RHN, three workshops that addressed key decision-makers operating at both regional and health district levels were held. The population health profile was used as a starting point for the prioritization and planning process to support the integration of policies and interventions across health and social services as a first step in the direction of a whole-of-government approach. Individual district health profiles were developed, prioritization criteria established and the main health-related problems and resources identified. A preliminary district health plan and a workplan on how to collect input from the community were drafted.

In addition, a workshop on environmental risk communication, jointly organized by the WHO European Office for Investment for Health and Development in Venice and the WHO European Centre for Environment and Health in Bonn, Germany, was held in Trento, Italy. The workshop provided an opportunity for participants to share experience in the management and communication of environmental risks and to reflect on the current state of affairs. Case studies from the environmental health domain that featured a range of Italian experiences in managing risk in contaminated sites were examined along with the lessons learnt.

Based on the workshop, a report, *Health and environment: communicating the risks*, was published (6). The report expanded on the theory and practice of risk communication for environment and health, illustrating through key messages lessons learnt and its applicability to other countries in the WHO European Region. The publication was identified as a useful tool for other members and linked to know-how area 3 – how to develop skilled human resources.

4.2 Developing skilled human resources: harmonizing capacity-building initiatives

The first Florence International Training (FIT) Course was held in Florence, Italy in 2012. Twenty-seven young professionals from twenty European regions attended the course aimed at developing skilled public health practitioners.

After the course, a framework of cooperation between the Tuscany region and the WHO European Office for Investment for Health and Development in Venice was agreed for 2013–2014, and a training centre was created. The International Training Centre for Health, Development and Sustainable Societies in Florence would serve as a strategic reference point for high-level continuous training in health policies in the regions and in Europe. It would build a scientific and capacity-building platform to foster debate and discussion on social and economic conditions, including poverty, social exclusion and lifestyle, and identify measures supporting resilient communities and sustainable societies. The centre became a tool for RHN by contributing to know-how area 3 – how to develop skilled human resources.

The FIT 2 course was planned to take place in November 2013 with 30 young professionals from 18 countries participating. It would provide evidence on the impact of the economic crisis on the determinants of health; address the different response strategies in Europe; and explore ways in which health, social and economic policies address this challenge at supranational, national, regional and local levels. It would share strategies to minimize the negative effects of the crisis on health through improving equity, solidarity and resilience, and strengthening governance for health, based around five modules:

- impact of the economic downturn on health across Europe
- policies at supranational and national levels
- what worked at regional level
- programmes at local level
- whole-of-government and whole-of society approaches in difficult economic times.

The Tuscany region would like to use this significant training experience to strengthen RHN and support the implementation of Health 2020. Referring to a previous discussion (Section 3.2), the training centre could offer support to politicians and become a platform for knowledge exchange.

A member from Sweden noted that the Network would need politicians to help communicate with people in the regions and to make progress. Public health experts spoke about the social determinants of health, but politicians were more likely to use words such as “culture”, “systems” and “tradition”. The suggestion to bring together a small group of 5–6 politicians to discuss how to help the Network achieve its objectives was accepted.

4.3 Filling a gap in technical capacity at regional level: summer school on health inequities and sustainable growth

A broad-based approach to improve health and quality of life was used in the Pomurje region in Slovenia. The region had 120 000 inhabitants but no single political administration; the 27 municipalities agreed on the regional development plan, which was an important element in securing national funding and structural funds.

Initially, discussion had been about “health development”, but the language more commonly used now was “sustainable society”. The approach allowed agencies to engage with each other and to identify aims and indicators for progress. Agencies listened carefully to each other, which helped them develop an approach that was no longer a collection of sectoral ambitions but together supported the development of a sustainable society.

Different interests were mapped, which clearly showed how they were connected. Public health professionals initially offered some resistance to the approach but joined in. This method could work within regions, particularly in south-eastern Europe. The Pomurje region and the WHO European Office for Investment for Health and Development in Venice, Italy would organize a summer school on health inequities and sustainable growth. It would include people from a range of professional backgrounds interested in disease prevention programmes, and members were asked to comment on the proposal.

It was said that Slovenia presented a very helpful example of what could be done. Like other parts of eastern Europe, the Pomurje region was largely agricultural, and the possibility of massive rural change as a result of agricultural modernization itself presented a threat to public health.

A member from Sweden showed interest in applying the mapping method used in the Pomurje region and wondered if it might draw out conflict between different sectors. In the Pomurje region, concerns about a plan to develop tourism with a focus on wine were resolved by going ahead with the project but reformulating it to emphasize active leisure rather than alcohol.

A member from Italy noted that failure to progress was often due to political factors, and creating a social movement would be a way to counter it. It was said that networks were the basis for progress, but they needed to be promoted and nurtured using constant stimulus through, for example, issuing bulletins to maintain interest.

4.4 Securing policy coherence: the experience from the Autonomous Community of Andalusia

The Autonomous Community of Andalusia in Spain had 8.5 million inhabitants and, since 1981, had political autonomy with its own Parliament, Government and Court of Justice. The region’s National Health System was publically funded, and the region had full control of health policy since 1984. It operated the same principles in its management approach as the Government of Spain did at national level, including the public provision of services based on cooperation and coordination, with a stress on equity, a guarantee of rights, territorial homogeneity, accessibility, transparency and participation. There was an integrated national health service and public health system, supported by Law 2/1998 on the Health of Andalusia and the Andalusian Public Health Law of 2011.

The Autonomous Community of Andalusia proposed to lead work on know-how area 2 – how to secure policy coherence. The initial goals proposed were to:

- agree on an operational definition of “policy coherence”;
- fix the scope of policy coherence at regional level;
- identify good practices for increasing policy coherence among members of the Network;

- strengthen knowledge among the participants on how to integrate or implement more coherent policies in their (sub) regions; and
- support RHN members to implement more coherent policies in their (sub) regions.

The objectives were to:

- map and analyse existing experiences of the participants for securing policy coherence at regional levels;
- identify the rationale for policy coherence in the different European Union regions;
- identify success factors for applying policy coherence strategies, from a regional/national/Euroregional/European point of view;
- analyse what was necessary to successfully integrate policy coherence strategies; and
- identify good practices for increasing policy coherence applicable to different European regions according to their contextual characteristics.

The activities proposed included building up a work team, agreeing the goals and objectives, and selecting the appropriate methodology for achieving the objectives. This included distance networking and at least two face-to-face workshops, with a website for communicating, sharing, and collecting information and experience. The end result would be the website and documents written by the participants. The timescale and the arrangements around sharing of costs between the participants and WHO were still to be agreed.

The presenters suggested that it might be possible to link the work and the outcomes to the FIT course and the summer school on health inequities and sustainable growth in Slovenia. The suggestion was welcomed as the initial agreement for 10 know-how areas was never intended as an inflexible framework, and it would certainly be possible to join up areas. A member from Slovenia pointed out the value in creating joint products from the different work streams and suggested that those leading the know-how areas could meet at international public health meetings held throughout the year.

5. Health 2020: approaches and tools for inclusive and targeted policies at regional level

5.1 Scaling up/down regional/national projects

A project related to know-how area 4 – how to scale up/down from isolated regional projects – was proposed. The project had three major elements.

The first milestone was the distribution of a questionnaire adapted from a model used in North Rhine-Westphalia. It would be sent in October 2013 to members of RHN, project Euregio 1 and 2, European regional and local health authorities, and personal contacts.

The second milestone was a workshop to identify the promoting and hindering factors affecting up- and/or downscaling projects, to agree on recommendations to overcome the hindering factors and to make better use of the promoting factors. The aim was to bring together 20–30 participants, such as regional policy-makers, project managers and scientific professionals.

The third milestone was the publication of a report, with a guideline for case studies. The first draft of case studies would be due in March, the draft report in September and the final report would be available in December 2014. Members were asked to disseminate the questionnaire in their region and identify relevant projects.

5.2 A whole-of-government approach

A questionnaire was presented as a tool to implement a whole-of-government approach. The approach involved multilevel (from local to global) government actions, though also increasingly involving groups outside government. It required building trust, common ethics, a cohesive culture, new skills and far better coordination and integration. Accountability was required at all levels and in all systems.

The questionnaire would ask certain questions.

1. Would you say that your country/region operates a whole-of-government approach?
2. If your answer was “no”, would you say that a health-in-all-policies approach was used?
3. If you answered “yes” to question 1, please describe your organization’s role.
4. What specific challenges do you and or/your organization face in relation to this whole-of-government approach?
5. If you answered “yes” to question 2, please describe your organization’s role.
6. What specific challenges do you and/or your organization face in relation to this health-in-all-policies approach?
7. What specific support would assist you in taking forward the whole-of-government approach?
8. If you are already engaged in whole-of-government approaches, would you be willing to work with us to support others, and if so, what specific support would you offer?

Discussion on the questions might lead to their revision, and comments were welcome on the content and the possible timescale for pursuing the initiative. It was suggested to hold a technical meeting in early 2014 to discuss the results and actions required to address the issues raised.

5.3 Health intelligence and regional comparisons

The outline of a work package on know-how area 9 – intelligence for health – was described. Intelligence was defined as the ability to answer questions such as – “Who is doing well? Why are others better than us? Where can I link with others?” – and the ability to know what was done well locally and what was not. To accomplish this it was necessary to know and use what was available, understand what was transferable and filter out what was valuable. Work on this regard had been previously done, including the European Union project, Health Inequalities Indicators in the Regions of Europe (I2SARE), and the WHO regional health profiles in the atlases of social inequalities (13). These could be supplemented by local knowledge, which every region had.

The intelligence process was defined as creating, translating and propagating knowledge, and a practical approach to begin work was outlined. It was suggested to use the data and a selection of indicators from the WHO regional health profiles as the basis of a report to be published

electronically. The report would be designed to help the political process and not just a tool for experts and enthusiasts. Using the WHO profiles meant that the results would not, in all cases, match the boundaries of RHN members, but it would be a valuable start. The quality of the report needed to be assured and advice on areas of good practice was welcomed.

6. RHN: the way forward

6.1 Communication aspects

There was a need to improve communications both internally, so that members were aware of each other's activities, and externally to inform the public and politicians.

The RHN communications strategy had four components. The first was the WHO RHN website, which was relocated within the WHO Regional Office for Europe website, thus increasing its visibility. The site would be updated on a regular basis. The second was the newsletter, which would be sent on a regular basis (probably bimonthly), and contributions from all members were welcome. The third was the use of social media, which would involve Twitter and Facebook, to allow stakeholders to follow RHN events and updates. The fourth was a specialized RHN community site to allow members to interact, share information and hold discussions on a daily basis.

Communication would both support the Network and draw from its activities. Participation was vital, including discussions and publications, and the use of social media, meeting materials and training courses.

6.2 Other business

The Memorandum of Agreement was changed substantially by the WHO legal department and revised into Terms of Reference for the Network. Members were asked to review the changes and provide comments. The new Terms of Reference became effective in January 2014 (three months' notice in accordance with the original Memorandum of Agreement).

6.3 Conclusions

The main conclusions from the Twentieth Annual General Meeting of RHN addressed its new phase of development in which the Network was revising its core activities to align them to Health 2020, thus supporting the implementation of the new European health policy framework at regional level.

The Network would be promoted as a special platform for Health 2020 implementation at regional level. RHN members agreed to use the new European health policy framework to place health at the top of the agenda in their regions, to draw attention to the determinants of health and health promotion, and to support a shift to a health-in-all-policies approach in health planning.

A practical tool to provide guidance on how RHN members could implement Health 2020 in their regions would be created. A publication would be developed for the Network to better

explain how Health 2020 could be implemented at regional level. The tool would contribute to the sharing of knowledge and best practices among regions.

Members' activities would be connected to the 10 know-how areas. In order to improve the Network's cohesion, members agreed on linking their activities, publications and capacity-building events to the 10 know-how areas. The areas would help the Network focus new activities and action at regional level. However, they were not designed to be separated and thus, must all fit in the Network's strategy in a cohesive way. The document mentioned above would be organized by and further strengthen the 10 know-how areas of the Network.

Members acknowledged the importance of language used when discussing the social determinants of health. Members discussed the difference between non-discriminatory language and terminology, and approaches designed to make information accessible and involve all stakeholders. Inclusive language practice was especially relevant when dealing with politicians and mixed audiences. Choosing the right words and delivery approach for messages about public health would help improve political commitment and participation.

The future of RHN depended on the commitment and active participation of its members. The rationale of a network was to contribute to the sharing of knowledge and best practices. In order to strengthen the Network's cohesion and increase the members' participation, a communications strategy would be implemented in 2014.

6.4 Closing remarks

In 2012, the Network agreed to link its work to Health 2020. Activities during 2013 included discussion on network enlargement and a new membership package; development of the workplan, website, logo and links with other networks; design of new products and services; and consideration of how to build RHN partners and a faculty of experts. The new opportunities included promoting RHN as a special platform linked to Health 2020; creating new products in the form of skills, capacities and practices; and facilitating the exchange of knowledge and experiences between members. This would require a new way of working. In particular there was great potential in the International Training Centre for Health, Development and Sustainable Societies in Florence and the need to develop regional literature, both of which were linked to the strategic objectives of Health 2020 – health promotion and the reduction of inequities, and strengthening governance for health.

There was an interest in a 21st century network, with a clear purpose but open and able to adapt to changing circumstances, and in engaging people from all backgrounds to improve health and reduce inequalities. Great progress was made on the 10 know-how areas, but the areas were not mutually exclusive.

The Network was more mature. There were many opportunities for co-consultancy to create good and practical tools, and the Network itself should be a tool to implement Health 2020, supporting its objectives and priority areas. RHN would organize working meetings and major WHO RHN conferences, with an open invitation to members to present RHN products. The events would take place every two years, with working meetings occurring in even-numbered years and conferences taking place in odd-numbered years. Israel would host the RHN conference in 2015.

The Co-chair thanked the teams from Cardiff and Venice for making the meeting possible and contributing to its success and thanked Dr Ziglio for his constant support and unflinching vision.

The Co-chairs thanked the participants and closed the meeting.

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Annex 1. Programme

The Göteborg Manifesto a year later: where we are, where we want to go, how we get there

10 October 2013

Session 1: Göteborg, a year later

Topic	Speaker
Introducing the RHN business meetings and Session 1, Adoption of the agenda	Erio Ziglio Francesco Zambon
Introduction of the participants	All participants
From Dusseldorf to Göteborg: summary of RHN to date	Chris Riley
Göteborg: how to capitalize on Västra Götaland experience <i>Discussion on know-how area 1</i>	Göran Henriksson Each contributor to know-how area 1 raises one point for discussion
Maastricht University: a fulcrum of European actions on health inequities research and an asset for RHN	Kai Michelsen
Discussion and summing up	Erio Ziglio Francesco Zambon

Session 2: from theory to action

Topic	Speaker
Introducing Session 2	Neil Riley
Subnational implementation of Health 2020: why RHN could have a key role and what the network needs to boost actions	
Presentation of the outline/first draft of a report on subnational implementation of Health 2020	Ilona Kickbusch Thorsten Behrendt
Discussion/feedback	All participants
Summing up	Erio Ziglio Francesco Zambon

11 October 2013

Session 3: Health 2020: getting to better health through strengthened capacity at subnational level

Topic	Speaker
Introduction Session 3	Erio Ziglio Francesco Zambon
How to develop skilled human resources (know-how area 3): harmonizing capacity-building initiatives offered to RHN members <i>Discussion on know-how area 3</i>	Alberto Zanobini Each contributor to know-how area 3 raises one point for discussion
How to make a capacity-building event a learning opportunity for a large audience: the experience from Trento	Pirous Fateh-Moghadam
Summer schools on health inequities and sustainable growth and health: filling a gap in technical capacity at subnational level <i>Discussion on know-how area 7</i>	Tatjana Buzeti Each contributor to know-how area 7 and 10 raises one point for discussion
How to secure policy coherence: the experience from Andalusia and preliminary ideas for sharing it with RHN members <i>Discussion on know-how area 2</i>	Alberto Fernández/Ana Carriazo All participants
Summing up	Erio Ziglio Francesco Zambon

Session 4: Health 2020: approaches and tools for inclusive and targeted policies at subnational level. RHN: the “pillars” for a solid future

Topic	Speaker
Introduction Session 4	Erio Ziglio Francesco Zambon
Whole-of-government approach <i>Discussion on know-how area 8</i>	David Pattison Each contributor to know-how area 8 raises 1 point for discussion
Scaling up/down regional/national projects <i>Discussion on know-how area 4</i>	Brigitte Van der Zanden Each contributor to know-how area 4 raises one point for discussion
Health intelligence and regional comparisons <i>Discussion on know-how area 9</i>	Neil Riley Each contributor to know-how area 9 raises one point for discussion
Administrative issues	Erio Ziglio
The “pillars” and the next steps	Erio Ziglio Francesco Zambon
Summing up	Erio Ziglio Francesco Zambon

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