



**World Health
Organization**

REGIONAL OFFICE FOR **Europe**



Regions for Health Network

Catalogue of Regions 2019



Abstract

This catalogue is a compilation of profiles of the regions participating in the Regions for Health Network (RHN), and of regions that are in the process of joining or have expressed an interest in joining RHN. The purpose of the catalogue is multifaceted, namely to: (a) present information related to each region in a clear, homogeneous and structured manner; (b) illustrate the potential of the Network by showcasing its greatest asset – the diversity of its participating regions; (c) enable useful comparison of the strengths, challenges and aspirations in the regions; (d) act as a tool to foster bilateral and multilateral collaboration between the regions; and (e) help WHO identify best practice in the regions, and challenges faced at the regional level.

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Regions for Health Network

Catalogue of Regions 2019

WHO WE ARE

Our many faces – a mosaic of experiences and voices.

- Collaboration
- Participation
- Dynamic innovation
- Effective change
- Sharing of best practice
- Peer-to-peer-learning

These are only few words to describe our motivation.

The WHO Regions for Health Network (RHN) is a growing movement, a platform for bringing regions across the WHO European Region together.

This catalogue is a compilation of crucial information about what we are, what we do, and what we strive for.

Speak up, team up, join us!

The RHN Secretariat is hosted by the WHO European Office for Investment for Health and Development, Venice, Italy, of the WHO Regional Office for Europe.

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Lower Austria, Austria

Wachau Cultural
Landscape



General overview

Lower Austria is situated in the middle of Europe in the north east of Austria. A border of 414 km connects this federal province with its neighbouring countries, the Czech Republic and Slovakia. With a land area of 19 174 km² and a population of 1.6 million, it is the largest province in Austria (1). The main economic sectors are those for industry, commerce, company services, catering/tourism, agriculture and forestry. In 2016, life expectancy at birth was 78.8 years and 83.6 years for males and females, respectively (2).

The Austrian health-care system is characterized by the federal structure of the country, the delegation of competencies to stakeholders in the social-insurance system, and cross-stakeholder structures in the federal regions, which possess competencies in cooperative planning, coordination and financing. Competencies in the health-care sector are generally regulated by law. The health system is financed through health-insurance contributions and deductibles, as well as subsidies provided to hospitals at the federal, regional and municipal levels.

The Government of Lower Austria is responsible for the provision of health care and social services in the province. The Niederösterreichischer

Gesundheits- und Sozialfonds (Lower Austrian Health and Social Fund) (NÖGUS), which is a body governed by public law, is responsible for planning, controlling, funding and assuring the quality of the health-care and social systems in Lower Austria. Since 2008, all 27 hospitals in Lower Austria have been part of the Niederösterreichische (NÖ) Landeskliniken-Holding (the Lower Austrian State Hospital Holding).

Lower Austria is the only Austrian province in which all hospitals are legal entities of the province itself. NÖ Landeskliniken-Holding offers clinical health-care services, from basic to specialist, and handles the operative management of the hospitals.

Lower Austria's geographic location is favourable to cross-border cooperation due to its long border with the Czech Republic and Slovakia. Since 2008, the province has conducted six projects in the field of cross-border health care (co-funded by the European Union (EU)) and is currently running two EU projects started in 2016; it also participates in three transnational networks. To ensure long-term sustainability, in 2017, NÖGUS set up "Initiative Healthacross", which combines

all cross-border health-care activities in Lower Austria.

The first EU-cofinanced cross-border project, entitled “Healthacross” (2008–2010), involved the border areas of Lower Austria and South Bohemia (Czech Republic). Its aim was to ensure optimum usability of the health services by, and equal accessibility to health care for, the population living in these border areas through the close cooperation of their health-service providers. A follow-up project entitled “Healthacross in practice”, initiated in 2012, has to date enabled more than 4000 Czech patients in the border region to access medical treatment at the hospital in Gmünd, Austria, in a simple, uncomplicated way. A new EU-cofinanced project, “Healthacross for the future” (2017–2020), is focused on ensuring that Czech patients receive outpatient treatment in the Gmünd hospital on a permanent basis. It expands on the initial projects (“Healthacross” and “Healthacross in practice”) to include the provision of inpatient care and the search for opportunities of long-term cooperation by establishing a cross-border health-care centre in the border region of Gmünd–České Velenice.

Cross-border cooperation on the provision of health care has also been established between Lower Austria and the Czech regions of South Moravia and Vysocina. A project entitled “Health without borders” was set up in 2012 with the aim of elaborating strategic opportunities for cross-border cooperation between hospitals and organizing a cross-border contract for emergency services. The project addressed language barriers by providing language courses in health-care facilities and publishing a phrasebook. A follow-up project entitled “Unlimited Health Together” is focusing on cross-border cooperation between hospitals in the areas of radiotherapy and gynaecology (endometriosis). It is also aiming to develop software that links emergency coordination centres on the cross-border scheduling of emergency vehicles.



Strengths

In Lower Austria:

- ✓ all hospitals are legal entities of the federal province;
- ✓ there is vast experience in running cross-border health projects co-funded by EU;
- ✓ in addition to the Czech Republic, cross-border cooperation has been initiated with a second EU Member State (Slovakia).



Aspirations

Lower Austria is interested in:

- ✓ finding new possibilities for networking;
- ✓ gaining new input in the field of public health;
- ✓ identifying examples of good practice for new projects in the field of cross-border health care.



Challenges

These are:

- ✓ an ageing population (demographic change);
- ✓ a lack of health professionals in hospitals in rural areas; and
- ✓ regional disparities (increasing/decreasing population development).



Potential areas of collaboration

Lower Austria is interested in collaborating with other regions on:

- ✓ cross-border health care in general;
- ✓ building new cross-border projects; and
- ✓ sharing experience in the field of cross-border health care.



Working groups

Lower Austria is interested in participating in working groups on:

- ✓ women's/men's health;
- ✓ health systems/primary health care;
- ✓ the all-of-government approach/intersectoral action.



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References

1. Lower Austria – Facts and Figures. In: Land Niederösterreich [website]. St.Pölten: Office of the Provincial Government of Lower Austria International & European Affairs; 2018 (http://noe.gv.at/noe/Topics-in-English/Lower_Austria_-_Facts___Figures.html, accessed 21 February 2018).
2. Statistisches Handbuch des Landes Niederösterreich, 41. Jahrgang 2017 [Statistical Handbook of Lower Austria, Vol. 41. 2017]. St Pölten: Office of the Provincial Government of Lower Austria; 2017:85 (http://www.noe.gv.at/noe/Zahlen-Fakten/NOeSTAT_2017_www200dpi.pdf, accessed 21 February 2018).

Lower Austria, Austria



Flanders, Belgium

City Hall of Ghent



General overview

Flanders is the most populated region in Belgium. Of the 11 million inhabitants of Belgium in 2017, 6 million were living in Flanders, which covers 13 500 km² (1). In 2013, life expectancy in the region was 78.9 years and 83.6 years for men and women, respectively (2).

Belgium has a complex state structure whereby the competencies are divided between the federal level and the regional level (the 3 Communities (person-related issues) and the 3 Regions (land-based issues, such as environment and agriculture). Flanders decided to merge the different competencies into one governance structure, with a Regional Government, Parliament and Administration.

In Belgium, the federal and regional levels are on an equal footing. Since 1980, political responsibilities, such as those related to health care, have been increasingly devolved to the regional level. The federal level is responsible for: the regulation and financing of the compulsory health insurance; the financing of hospital budgets; legislation related to the qualification of professionals; and the registration and price control of pharmaceuticals. The regional level is responsible for issues, such as: financing

the health infrastructure and heavy medical equipment; quality control of emergency hospitals; health promotion and disease prevention; defining the recognition norms for hospitals; planning the health workforce; mental-health care; rehabilitation; maternity and child health care; coordination in primary care; and long-term care.

The Belgian health system is characterized by a compulsory health-care insurance system. Health policy is the responsibility of both the federal and regional levels.

To facilitate collaboration and conclude cooperation agreements between the federal and regional levels, interministerial conferences are organized on a regular basis. The topics of discussion at these conferences relate to competencies (for example, chronic diseases) that are divided among the different governance levels. The conferences agree on the approach to action on these topics. For example, the Interministerial Conference on Health, which gathered the different ministers of health at the federal and regional levels, resulted in an action plan on e-health in Belgium in 2015. The ministers agreed to set up a common governance structure

that would ensure the political and operational coordination of the action plan. Specialized working groups follow up on this at a more detailed and technical level.

The Belgium Health Interview Survey carried out in 2013 identified a small increase in the satisfaction of the Flemish population with the health-care system compared to 2008. The social gradient was apparent in all surveys conducted in this period, however, whether they were on chronic diseases, mental-health issues, suffering, long-term functional limitations, quality of life, or health perception (3).

In December 2016, Flanders adopted the multiannual health goal that “every citizen in Flanders lives healthier in 2025”. The approach to this goal involves a change in the way of thinking of policy-makers and field workers. Previous multiannual health goals have focused on problem-driven action to tackle health-related issues, such as nutrition, tobacco use and physical activity.

The overarching concept of the new health goal to extend life expectancy is proportioned universalism with a focus on vulnerable

groups. To achieve it will require the actors involved to consider the different settings that are important in people’s daily lives, such as workplaces, leisure-time settings, environments, neighbourhoods and sports settings.

Since the Sixth State Reform in Belgium in 2014, Flanders has made progress in implementing new competencies in areas, such as primary care, mental-health care, rehabilitation, home care and care of the elderly.

Demographic changes and population ageing are generating an epidemiological shift towards chronic diseases, which is putting pressure on health-care organization in Flanders.

Since February 2017, Flanders has been implementing primary-care reform based on the *WHO framework on integrated people-centred health services* (4). The organization of integrated primary-health and social care focuses on a patient-centred approach, which combines self-care and home care with primary and outpatient care in conjunction with hospital and residential care.



Strengths

The strengths of the Flanders health-care system include:

- ✓ long-term health targets in prevention (vaccination, suicide, cancer, nutrition), which provide a solid basis across several legislatures;
- ✓ the involvement of stakeholders in the process to reach a health target (quadruple helix model);
- ✓ the outsourcing of action towards health targets and other policy initiatives to partner organizations, which creates a critical mass of field workers in support of the policies in question (for example, the Expertise Center Dementia in Flanders helps increase the expertise of care workers and offers citizens and professionals a forum for the exchange of knowledge about dementia).



Aspirations

The Flanders region is aiming to:

- ✓ work on inclusion of the Health in All Policies (HiAP) approach (5,6) in the Flanders Vision 2050 strategy, which is based on the circular economy concept and part of the long-term vision to achieve the Sustainable Development Goals (SDGs) (7) in Flanders;
- ✓ empower its citizens by increasing health literacy in prevention and health care.
- ✓ continue to focus on the social gradient in health and prevent lower levels of health and well-being among citizens of lower socioeconomic status (increasing healthy life expectancy).



Challenges

These include:

- ✓ a lack of sustainable cross-sectoral governance at the regional level (the HiAP approach) (5,6);
- ✓ insufficient cooperation between the regional and local levels on issues of environment and health (biomonitoring);
- ✓ bringing changes to the organization of care by integrating social and health care and introducing a patient-centred approach.



Potential areas of collaboration

The Flanders region is interested in collaborating with other regions on the:

- ✓ development of an HiAP approach (5,6) (by exchanging strategies on and evidence related to its implementation), including an all-of-government, all-of-society approach;
- ✓ development of strategies on and interventions for tackling the social gradient in health and monitoring their effect;
- ✓ development of a geographical tool for mapping differences in socioeconomic status;
- ✓ development of approaches to introducing behavioural change and increasing health literacy with a view to shared decision-making, for example, on cancer prevention and screening and primary care;
- ✓ implementation of the 2016 multiannual health goal, "in 2025 every citizen in Flanders lives healthier", by exchanging information on HiAP (5,6) approaches and, particularly, on developing healthy conditions in workplaces, leisure-time settings, the environment, neighbourhoods and sports settings.



Working groups

The Flanders region is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs)(7)/equity;
- ✓ environment;
- ✓ health systems/primary health care.

Flanders, Belgium



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References

1. Belgie in Cijfers. Structuur van de bevolking [Statistics Belgium. Structure of the population, 2017. In: StatBel [website]. Brussels; Statistics Belgium; 2017 (<https://statbel.fgov.be/nl/themas/bevolking/structuur-van-de-bevolking> (accessed 20 February 2018)).
2. Vrijens F, Renard F, Camberlin C, Desomer A, Dubois C, Jonckheer P et al. Performance of the Belgian Health System. Report 2015. Brussels: Belgian Health Care Knowledge Centre (KCE); 2016 (KCE reports 259CD/2016/10.273/03; https://kce.fgov.be/sites/default/files/atoms/files/KCE_259C_performancereport2015_0.pdf, accessed 21 February 2018).
3. HISIA: Belgian Health Interview Survey – Interactive Analysis [website]. Brussels: Scientific Institute of Public Health, Operational Direction Public Health and Surveillance; 2013 (<https://hisia.wiv-isp.be/SitePages/Home.aspx>, accessed 6 April 2018).
4. WHO framework on integrated people-centred health services. In: Service and delivery [website]. Geneva: WHO; 2018 (<http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>, accessed 21 February 2018).
5. Leppo K, Ollila E, Peňa S, Wismar M, Cook S, editors. Health in All Policies. Seizing opportunities, implementing policies. Helsinki: Ministry of Social Affairs and Health; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf, accessed 17 April 2018).
6. WHO, Ministry of Social Affairs and Health of Finland. The 8th Global Conference on Health Promotion, Helsinki, Finland, 10–14 June 2013. The Helsinki Statement on Health in All Policies. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.who.int/healthpromotion/conferences/8gchp/en/>, accessed 17 April 2018).
7. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

Flanders, Belgium



Burgas Region, Bulgaria

Burgas Sea Garden

General overview

Burgas is one of the fastest-growing metropolitan regions of south-east Bulgaria (1). Influenced by the Black sea, three large lakes (Mandra Lake, Atanasovsko Lake and Burgas Lake) and the Strandja Mountain, the climate is mild in winter and moderate in summer. The Region's main city, Burgas, is an important commercial and transport hub, its international airport serving more than 2.5 million passengers annually and its port being one of the biggest on the Black Sea coast. Pan-European Transport Corridor N°8, which is the shortest land connection between the Adriatic and the Black Sea coasts, passes through the Burgas Region. The city of Burgas is also a growing cultural and educational centre (2).

Because of its many facilities and connections to resorts along the southern coast of the Black Sea, the Burgas Region is a favourite among tourists. The Burgas Mineral Baths, which comprise one of the most ancient balneotherapy centres in the Balkans, are located 15 km from Burgas city, further enhancing the resort complex.

According to data for 2016: the Burgas Region covers an area of 7748 km²; it had a population of 412 684 (5.8% of Bulgaria's population); the average population density was 53/km²; infant mortality was 5.8‰ while the average for the

country was 6.5‰; and the crude death rate was 13.2‰ with two leading causes: cardiovascular diseases and neoplasms. The average life expectancy in the Burgas Region in the period 2014–2016 was 74.9 years (71.6 for males and 78.20 years for females) (3).

In 2015, Bulgaria spent €1117 per head on health care, less than half the European Union (EU) average (€2797). Only half of the total health expenditure is publicly financed, and out-of-pocket payments in Bulgaria are the highest in the EU – 48%. Around 12% of the population lack insurance coverage. The revenue base for the Social Health Insurance remains narrow due to low incomes, many uninsured individuals and a large informal sector (4). The Ministry of Health in Bulgaria is responsible for health-policy decisions at the national level. At the regional level, political and financial autonomy and responsibility for health and health care are delegated to the municipal level. For example, in the Burgas Municipal Development Plan 2014–2020, improving health-related quality of life is a strategic goal. There are 20 medical centres in the region, including 9 multiprofile hospitals and 11 specialized hospitals, as well as 3 hospices and more than 70 outpatient medical-care centres.

Public health covers the implementation of activities related to children and school health care, involving over 119 medical specialists attached to more than 90 medical offices in kindergartens and educational institutions.

In the Municipality of Burgas, there are 10 municipal medical centres of which 5 are outpatient centres and 5 are specialized hospitals. The medical centres are owned by the Burgas Municipal Council.

Other public health activities relate to providing services to vulnerable groups, which involves the intervention of health mediators. Caring for the elderly is also a public health priority. The regional authorities provide various types of social support to people with incomes below the minimum wage.

The Burgas Region is a metropolitan area full of dynamism and engagement. Public health is a priority in its municipal policies. The Region's inhabitants, community organizations and public authorities all contribute on a daily basis to assuring its healthy profile. As the city authority, Burgas Municipality has a social responsibility to, and statutory tasks associated with, protecting public health and building a sustainably healthy future for the Region.



Strengths

The strengths of the Burgas Region include:

- ✓ its upward development, which has prompted a lot of people seeking better living opportunities to settle in the Burgas metropolitan area;
- ✓ the touristic attraction of the Burgas metropolitan area (it is one of the most visited destinations in Bulgaria);
- ✓ natural prerequisites for healthy lifestyles and economic development in the form of its environment, climate and coast.
- ✓ the presence of the Faculty of Public Health of the Burgas University "Professor Dr Asen Zlatarov" and the support it provides to health-care services (higher medical education being a priority in the Region).



Aspirations

The Burgas Region is aiming to:

- ✓ strengthen prevention programmes;
- ✓ improve the health literacy and health culture of the population, adolescents in particular;
- ✓ improve demographic processes in the Region towards trends that are more favourable than those at the national level for all indicators – birth rate, mortality, natural growth.

Challenges

These are related to:

- ✓ the increasing population over working age and difficulties associated with ensuring the long-term care of people with chronic illnesses;
- ✓ finding ways of financing and sustaining public health-care activities, most of which are currently underfinanced;
- ✓ reducing health inequities among urban/rural inhabitants, and in socially marginalized groups.

Potential areas of collaboration

The Burgas Region is interested in collaborating with other regions on:

- ✓ benchmarking towards achievement of the Sustainable Development Goals (SDGs) (5) at the regional level;
- ✓ developing a telemedicine centre in the Region;
- ✓ developing innovative programmes on health promotion, urban health and health informatics;
- ✓ Collaboration in these areas could bring about improvement in, and novel approaches to, creating a healthy region, healthy settings, healthy families and healthy people.

Working groups

The Burgas Region is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs)(5)/equity;
- ✓ environment;
- ✓ participatory approaches/resilience.

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References

1. Nikolova D, Slavova Z, Aleksiev Y. Regional profiles. Indicators of development – 2017. Sofia: Institute for Market Economics; 2017 (<http://www.regionalprofiles.bg/bg/>, accessed 17 March 2018).
2. Burgas Municipality [website]. Burgas: Burgas Municipality; 2018 (<https://www.burgas.bg/en/index/index>, accessed 17 March 2018).
3. Population by districts, municipalities, place of residence and sex as of 31.12.2016. In: National Statistical Institute [website]. Sofia: National Statistical Institute; 2017 (<http://www.nsi.bg/en/content/6704/population-districts-municipalities-place-residence-and-sex> , accessed 17 March 2018).
4. Organisation for Economic Co-operation and Development (OECD), European Observatory on Health Systems and Policies. State of health in the EU. Bulgaria Country Health Profile 2017. Paris: OECD and World Health Organization (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies); 2017 http://www.euro.who.int/__data/assets/pdf_file/0006/355875/Health-Profile-Bulgaria-Eng.pdf?ua=1 , accessed 17 March 2018).
5. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

Burgas Region, Bulgaria



Varna Region, Bulgaria

Varna - Sea Garden



General overview

The Varna Region is situated in the north east of Bulgaria. Its capital city, Varna, the largest Black Sea port in Bulgaria, is an attractive touristic, cultural and educational centre.

Covering 3820 km², the Region has 12 municipalities with a total population of 472 654 (6.4% of the Bulgarian population). The average population density is 124/km² (1).

In 2016, the average life expectancy in the Varna Region was 75.3 years (72 years for men and 79 for women). Infant mortality in 2016 was 4.9‰ while the average for the country was 6.5‰. In the same year, the crude death rate for the Region was 12.9‰ with four leading causes: cardiovascular disease, neoplasms, and diseases of the digestive and respiratory systems (2,3).

In 2017, Varna received the European Youth Forum award, “European Youth Capital”, on the strength of the city’s five universities (Varna Medical University, the Technical University of Varna, Varna University of Economics, Varna Naval Academy and Varna Free University) with more than 40 000 students from more than 40 countries, six research institutes with highly qualified academic staff, and an extensive educational infrastructure with more than 100 schools.

In Bulgaria, health care is funded through social health insurance, although the main sources of health funding are out-of-pocket payments (47.7 % in 2015), followed by social health insurance (41.9 % in 2015) (4). The Ministry of Health of Bulgaria is responsible for health-policy decisions at the national level, which affect the Varna Region as much as the other 27 regions in the country.

A specific feature of the Bulgarian political structure is that the regions are not represented by governments at their level (elected by the population of the regions) and are not included in health-policy decision-making. Political and financial autonomy and responsibility for health and health care are delegated to the municipal level.

The health budget of the Varna municipality for 2016 was approximately 6% of the total municipal budget. The Varna municipality has an extensive health-care network, including hospitals for active treatment, centres for specialized and primary out-patient care, nurseries, and institutions for care of the elderly and adults and children with physical or mental disabilities. It is one of the few municipalities that provide health care in schools.

There are currently 19 hospitals in the Varna Region, 8 of which are multiprofile and 11 specialized. In addition, there are more than 600 centres for specialized outpatient care, 7 hospices and almost 400 primary-care practices.

Public health activities at the local level are focused mainly on child health, and funding is provided for: child care in nurseries (ages 1–3 years); child nutrition (food provided in kindergartens and schools, and through kitchens where lunches for children can be bought at a reduced price); health care in kindergartens and schools; the childhood obesity programme; screening for and the prevention of spinal deformities in children; screening for hearing problems in children; and tooth sealants for children aged 6–7 years.

Other public health programmes/activities at the local level relate to: health-care mediation (provision of services to ethnic minorities, especially the Roma population); the disinfection and deratization of public places; the provision of support for couples with fertility problems; and the prevention of health problems in women.



Strengths

The strengths of the Varna Region include its:

- ✓ sound economy (it has one of the strongest economies of all regions in Bulgaria);
- ✓ well-developed, well-equipped health-care establishments, the staff of which are highly professional;
- ✓ natural resources, including the Black Sea, an enormous number of mineral-water and thermal-water sources, and specific spa-related resources, such as mud (used in treatment therapies);
- ✓ pleasant moderate climate in the long summer season (June–September);
- ✓ active participation and involvement in the public health initiatives of Varna Medical University and several university hospitals.



Aspirations

The Region is aiming to:

- ✓ develop a regional health strategy for reducing social/health inequalities, based on Health in All Policies (HiAP) (5,6);
- ✓ strengthen health-system integration in the region;
- ✓ integrate health and social services.

Challenges

These include:

- ✓ hidden, but existing, health inequities among ethnic, urban, rural, and socially disadvantaged groups;
- ✓ the lack of a political process at the regional level;
- ✓ the current strong sectoral approach towards health.

Potential areas of collaboration

The Varna Region is interested in collaborating with other regions on:

- ✓ benchmarking towards achievement of the Sustainable Development Goals (SDGs) (7) at the regional level;
- ✓ the development and improvement of local health-information systems;
- ✓ the development of innovative programmes on the promotion of public health, financed at the local level.

Working groups

The Varna Region is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (7)/ equity;
- ✓ the all-of-government approach/intersectoral action;
- ✓ participatory approaches/resilience.

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References

1. Population by districts, municipalities, place of residence and sex as of 31.12.2016. In Statistical data [website]. Sofia: National Statistical Institute; 2018 (<http://www.nsi.bg/en/content/6704/population-districts-municipalities-place-residence-and-sex>, accessed 21 February 2018).
2. Population (demography, migration and projections). In Statistical data [website]. Sofia: National Statistical Institute; 2018 (<http://www.nsi.bg/en/content/6593/population-demography-migration-and-projections>, accessed 21 February 2018).
3. Mortality by causes, sex, statistical regions and districts. In Statistical data [website]. Sofia: National Statistical Institute; 2018 (<http://www.nsi.bg/en/content/5623/mortality-causes-sex-statistical-regions-and-districts>, accessed 21 February 2018).
4. OECD, European Observatory on Health Systems and Policies. Bulgaria: Country Health Profile 2017. Paris: OECD Publishing/Brussels:European Observatory on Health Systems and Policies; 2017 (<http://dx.doi.org/10.1787/9789264283305-en>, accessed 5 February 2018).
5. Leppo K, Ollila E, Peña S, Wismar M, Cook S, editors. Health in All Policies. Seizing opportunities, implementing policies. Helsinki: Ministry of Social Affairs and Health; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf, accessed 17 April 2018).
6. WHO, Ministry of Social Affairs and Health of Finland. The 8th Global Conference on Health Promotion, Helsinki, Finland, 10–14 June 2013. The Helsinki Statement on Health in All Policies. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.who.int/healthpromotion/conferences/8gchp/en/>, accessed 17 April 2018).
7. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

Varna Region, Bulgaria

Saskatoon, Canada

Canola

General overview

The province of Saskatchewan in Canada covers an area of 651 900 km² and has about 1.17 million inhabitants (2017). The largest city in the province is Saskatoon with a population of approximately 250 000 (2017) (1).

Currently, life expectancy is 83.4 years for women and 78.7 years for men; there is a 9-year gap between the most and least well off (1).

According to recent data, the top causes of death are circulatory diseases, cancer and respiratory diseases, and 57.6% of the population is overweight or obese. The self-rated health status is reported as very good or excellent for 65.2% of the population (1).

Further information on health status in Saskatoon can be found in the reports under “Community views” on the CommunityView Collaboration website (1).

The Saskatchewan Health Authority is responsible for the delivery of health services for the entire province of Saskatchewan. It is the largest organization in the province, employing over 44 000 people.

Health services delivery in Saskatchewan is organized into six integrated service areas

(ISAs), providing a comprehensive range of services and programmes, including – but not limited to – hospital and long-term care, public health, home care, mental-health and addiction services, and prenatal and palliative care.

Located in the western prairies of the south-central part of the province, the city of Saskatoon, along with its surrounding area, form one of the ISAs. Saskatoon is the main referral centre for the central and northern part of the province, providing specialized care to thousands of people from across Saskatchewan.

Together with the Health Sciences Colleges of the University of Saskatchewan, the hospitals and community health services in Saskatoon form an academic health sciences centre supporting more than 394 research studies within the health area. They provide training opportunities to more than 2000 health sciences students and take part in health education and research for the benefit of the province as a whole.

The Public and Population Health Department of the Saskatchewan Health Authority receives 2% of the health budget to deliver a wide range of programmes spanning the following areas: healthy families (immunizations, well

child clinics, oral health, older-adult wellness, parenting support); communicable disease control; international travellers' health; sexual-health; street health/harm reduction; HIV and TB prevention and treatment; population-health promotion; health inspection; and environmental health services. All of the programmes involved are supported by a public health observatory, the primary focus of which is to build health equity.



Strengths

Saskatoon's strengths include:

- ✓ health status monitoring and health equity reporting, monitoring and evaluation (2,3);
- ✓ intersectoral collaboration through priority projects, such as: the Saskatoon Poverty Reduction Partnership; the Plan to End Homelessness; the Aboriginal Employment Strategy; the Early Childhood Development Strategy; and the HUB/Centre of Responsibility (COR) model (4,5);
- ✓ research on population health intervention, including topics, such as comprehensive school health, equitable immunization coverage for low-income neighbourhoods, and the HIV reduction strategy;
- ✓ adaption of quality improvement and management tools to public health and community services;
- ✓ auditing of health-care equity in the health system, and application of a health-equity gauge to health services;
- ✓ translation of knowledge on health equity and the social determinants of health for use in the health system and by intersectoral partners;
- ✓ public health leadership at the subnational level (Saskatoon's Medical Health Officer is co-founder and president of the Urban Public Health Network (UPHN) in Canada, which comprises the public health departments of the 23 largest cities/regions in Canada) (6).



Aspirations

Saskatoon is aiming to:

- ✓ integrate population-health approaches in the health system;
- ✓ develop comparative health-status and health-performance indicators;
- ✓ conduct collaborative and comparative health-equity and health-policy research and monitoring with other regions of Canada and the Regions for Health Network (RHN);
- ✓ develop cultural competencies and safety approaches to reduce health inequities.

Challenges

These are:

- ✓ lack of cultural diversity in the health workforce;
- ✓ low level of public health and prevention among government funding priorities;
- ✓ lack of surge capacity in times of public health crisis.

Potential areas of collaboration

Saskatoon is interested in collaborating with other regions (through RHN and UPHN) on:

- ✓ comparative research and monitoring projects (6);
- ✓ poverty-reduction planning;
- ✓ and in acting as the liaison with and collaboration link to other UPHN members for any RHN-member initiatives.

Working groups

Saskatoon is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (7)/ equity;
- ✓ health systems/primary health care;
- ✓ the all-of-government approach/intersectoral action.

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References

1. CommunityView Collaboration [website]. Saskatoon: Saskatoon Health Region; 2018 (www.communityview.ca, accessed 9 April 2018).
2. Our population, our health. In: CommunityView Collaboration [website]. Saskatoon: Saskatoon Health Region; 2018 (www.communityview.ca/communityviews.html, accessed 9 April 2018).
3. Our population and poverty reduction. In: CommunityView Collaboration [website]. Saskatoon: Saskatoon Health Region; 2018 (www.communityview.ca/communityviews.html, accessed 9 April 2018).
4. Saskatoon Poverty Reduction Partnership [website]. Saskatoon: Saskatoon Poverty Reduction Partnership; 2018 (www.saskatoonpoverty2possibility.ca, accessed 9 April 2018).
5. Saskatchewan's Building Partnerships – Hub and COR (Centre of Responsibility) Model. In: Observatory of Public Sector Innovation [website]. Paris: Organisation for Economic Co-operation and Development; 2018 (<https://www.oecd.org/governance/observatory-public-sector-innovation/innovations/page/saskatchewansbuildingpartnerships-hubandcorcentreofresponsibilitymodel.htm>, accessed 9 April 2018).
6. Urban Public Health Network [website]. Saskatoon: Urban Public Health Network; 2018 (www.uphn.ca, accessed 9 April 2018).
7. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

Saskatoon, Canada



Dubrovnik-Neretva County, Croatia

Korčula Island

General overview

Dubrovnik-Neretva is the southernmost county in Croatia, located in south Dalmatia; it is also the county that is furthest from the capital, Zagreb. Its seat is Dubrovnik; other large towns in the county are Korčula, Metković, Opuzen and Ploče. The Dubrovnik-Neretva County borders with Bosnia and Herzegovina in the north, Montenegro in the south east, and Italy in the south. The Municipality of Neum, which belongs to neighbouring Bosnia and Herzegovina, divides the Dubrovnik-Neretva County, rendering its southern part an exclave. The County has a land area of 9272.37 km² with a population of 122 568, which is diminishing, specially on the islands and the Pelješac Peninsula. There are more women than men in the County (51,4% and 48,6%, respectively), the ratio being similar to that at the national level (51.8% women and 48.2% men) (1). Life expectancy is 75 years and 82 years for men and women, respectively (2).

The Croatian state is responsible for the overall provision of health-care and social services and for the Croatian Health Insurance Fund. Medical care in the Dubrovnik-Neretva County is organized at the primary and secondary levels. There are two hospitals in the County: (i) General Hospital Dubrovnik with the 299 beds; and (ii)

Kalos Hospital in the municipality of Vela Luka, which specializes in medical rehabilitation. Both hospitals are financed mainly by the state from county funds with income from private patients covering a small part of the expenditure.

There are large distances between some areas of the County and General Hospital Dubrovnik and between Dom Zdravlja (the Regional Health Centre) in Dubrovnik and the closest medical centres that provide additional medical care (for example, Clinical Hospital Split). During the summer months, the presence of tourists increases the need for medical care and the County and cities finance tourist-related medical teams themselves. Currently, there is no cross-border cooperation with non-European Union (non-EU) countries although a project is underway to make life-saving invasive procedures available to neighbouring countries without this possibility. The WHO Country Office in Croatia has initiated a pilot project to promote healthy diet for tourists, as well as a project entitled “The heart is the best medicine for the heart”, the aim of which is to reach the most distant parts of the County, the islands and the rural areas with cardiology diagnostic medical tools. The latter project entails the organization of weekly one-day missions to

Konavle in the very south of Croatia during which people living on the islands and in the villages have an opportunity to undergo cardiological check-ups. The Regional Health Centre, which is financed by both state and county funding, is responsible for the provision of primary health care in the County. Recognizing the needs of patients receiving palliative care, the Centre has initiated a project, which involves visiting and treating them in their homes. This project is sponsored completely by the County and needs supplementary resources and support from the state. The Centre is also planning to offer specialist medical care to patients residing in rural areas and on the islands, thus, providing new services in the field of public health.



Strengths

The strengths of the Dubrovnik-Neretva County are:

- ✓ its hospitals and the Regional Health Centre, which are legal public entities financed by both the State and the County;
- ✓ the opportunity provided by tourism for intersectoral cooperation, the development of new programmes and the strengthening of medical institutions;
- ✓ the well-preserved ecosystem of the Adriatic Sea (off the coast of the County), which makes healthy-food production possible;
- ✓ its Mediterranean-type forests, which are well preserved and play a significant role in preserving the ecological and aesthetic values of the whole area;
- ✓ the relatively high number of nature-protected areas in the County, which contribute to increasing the quality of life of the population.



Aspirations

The Dubrovnik-Neretva County has the following aims:

- ✓ cross-border cooperation with non-EU states in the field of medical care;
- ✓ cross-border cooperation to protect the County from transborder pollution, especially in underground springs;
- ✓ the availability of healthy food for tourists, for example, by supporting the ecological sustainability of the local food system;
- ✓ further development of palliative care in the County;
- ✓ access to specialist medical help in rural areas and on the islands.

Challenges

These include:

- ✓ an ageing population;
- ✓ transport problems in general (maritime, air and road);
- ✓ lack of health professionals in Dubrovnik Hospital, as well as in rural areas and on the islands;
- ✓ the mass influx of tourists during the summer season, slowing down border control;
- ✓ the pollution of fresh and sea water by industrialized parts of the neighbouring countries, which can cause extensive ecological and economic damage.

Potential areas of collaboration

The Dubrovnik-Neretva County is interested in collaborating with other regions on:

- ✓ cross-border health care (exchange of experience; development of education programmes);
- ✓ cross-border projects to combat air, soil and water pollution;
- ✓ problems related to global warming (floods, fires).

Working groups

The Dubrovnik-Neretva County is interested in participating in working groups on:

- ✓ environment;
- ✓ women's/men's health.

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References

1. Demographic data. In: Dubrovačko-Neretvanska Županija [Dubrovnik-Neretva County] [website]. Dubrovnik: Dubrovnik-Neretva County; 2011 (<http://www.edubrovnik.org/en/demographic-data/>, accessed 16 February 2018).
2. Akrap A, Čipin I. Demografske promjene [Demographic changes]. NUTS2. Zagreb: In: Studija: Definiranje razvojnih prioriteta širih regija (NUTS 2) [Study: Defining the development priorities of wider regions "(NUTS 2)]. Zagreb: Ministry of Regional Development, Forestry and Water Management; 2008:69–118.

Dubrovnik-Neretva County, Croatia



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Split-Dalmatia County, Croatia

The Island of Vis

General overview

Split-Dalmatia is the largest county in Croatia. Located centrally on the Adriatic coast, it covers a total area of 14 106.40 km² of which 4523.6 km² is land surface (8% of that of the country) and 9576.4 km² is sea surface (30.8% of that of the country) (1). Most of the land-surface area consists of the hinterland (59.9%) and the islands (19%). The Split-Dalmatia County stretches from Vrlika in the north to the furthest-reaching Croatian island of Palagruza in the south, and from Marina in the west to Vrgorac in the east. According to the Census of Population, Households and Dwellings 2014, 48.7% of the population of the County (454 798), were men and 51.3% women. The average age of the population was 40.8 years; 23.1% were over 60 years of age (2). In 2012, overall life expectancy at birth in Croatia was 78 years (3).

The Split-Dalmatia County borders to the north with the Republic of Bosnia and Herzegovina, to the east with the Dubrovnik-Neretva County, and to the south with Croatian territorial waters. It is divided into three geographical subunits: (i) the hinterland, a sparsely populated and economically poor area in the continental part of the County, which is criss-crossed by mountains running parallel to the coastline; (ii) the coastal

area, a narrow strip along the coast between the mountain ranges and the sea, which is highly urbanized and economically developed compared to the hinterland; and (iii) the islands, which – though sparsely populated – are economically more developed than the hinterland, but, due to various circumstances, have experienced permanent emigration. The County has 74 islands and 57 islets and reefs. The largest, most populated of the islands are Brač, Dugi Otok, Šolta, Hvar and Vis; other inhabited islands are Veli Drvenik, Mali Drvenik, St. Clement, Scedro Bisevo and St. Andrew.

The Croatian State is responsible for the overall provision of health care and social services and for the Croatian Health Insurance Fund. Medical care in the Split-Dalmatia County is organized at the primary and secondary levels. There are two hospitals in the County: Clinical Hospital Centre Split and Biokovka Hospital in the municipality of Makarska, the latter specializing in medical rehabilitation. Both hospitals are financed mainly from State county funds; income from private patients covers a small part of the expenditure.

Through participation in various initiatives and associations, Split-Dalmatia County, has

established coordinated, systematic cooperation with regions in Croatia's neighbouring countries and other countries in the European Union. Bilateral relations with influential regions and membership of important international organizations has led – over time – to fruitful collaboration in the economic domain, as well as to the development of specific projects related particularly to cross-border cooperation. Thanks to this collaboration, the Split-Dalmatia County and the Public Institution of RERA SD for the Coordination and Development of the Split-Dalmatia County participate actively in the preparation and implementation of EU projects carried out through partnerships among neighbouring regions (4).



Strengths

The strengths of the Split-Dalmatia County are:

- ✓ its Mediterranean climate and food (the well-preserved ecosystem of the Adriatic Sea enables the production of healthy food);
- ✓ its various natural resources (the sea, islands, mountains, lakes and rivers);
- ✓ its hospitals and Regional Health Centre, which are legal public entities financed by both the State and the County;
- ✓ the opportunities provided by tourism for intersectoral cooperation on tourism, health and sport;
- ✓ the large number of fitness clubs and gyms in the cities and tourist facilities across the County (especially on the islands and in the rural area by the sea).



Aspirations

The Split-Dalmatia County has the following aims:

- ✓ to enhance physical activity among elderly people by increasing their involvement in organized forms of physical activity aimed at improving their overall health status, their posture and ability to move and, thus, their self-confidence, independence and contribution to the community (5);
- ✓ to provide access to primary health care in rural areas and on the islands.

Challenges

These include:

- ✓ an ageing population;
- ✓ substantial differences in lifestyle between elderly people in rural areas and those in urban areas (the lack of fitness clubs and gyms in rural areas represents a big challenge);
- ✓ the need to further invest in transport facilities between the mainland and the islands.

Potential areas of collaboration

The Split-Dalmatia County is interested in collaborating with other regions on:

- ✓ cross-border health care for elderly people (exchange of experience; development of education programmes);
- ✓ cross-border exchange of good practice in increasing physical activity in elderly people;
- ✓ cross-border exchange of good practice in the establishment of optimal primary care in the rural areas and on the islands.

Working groups

The Split-Dalmatia County is interested in participating in working groups on:

- ✓ women's/men's health;
- ✓ health systems/primary health care.

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References

1. Splitsko-dalmatinska županija [Split-Dalmatia County] [website]. Split: Split-Dalmatia County; 2018 (www.dalmacija.hr, accessed 25 March 2018).
2. Census 2011. In: Croatian Bureau of Statistics [website]. Zagreb: Croatian Bureau of Statistics; 2015 (https://www.dzs.hr/default_e.htm, accessed 25 March 2018).
3. Croatia: data and statistics. In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/countries/croatia/data-and-statistics>, accessed 25 March 2018).
4. International activities. In: Splitsko-dalmatinska županija [Split-Dalmatia County] [website]. Split: Split-Dalmatia County; 2018 (www.dalmacija.hr, accessed 25 March 2018).

Split-Dalmatia County, Croatia

Ústí Region, Czech Republic

Central Bohemian
Highlands

General overview

The Ústí Region is an administrative unit of the Czech Republic located in the northwest of the country. It borders on the Free State of Saxony, Germany, to the north, the Liberec Region in the northeast, the Karlovy Vary Region and, partly, the Pilsen Region in the west, and the Central Bohemian Region in the southeast. It is the fifth largest of the 14 regions in the Czech Republic and has a population of 821 377. It is the fourth most densely populated region in the country (154/km²), its population density being higher than the national average (133/km²). The Region's 339 km² account for 6.8 % of the total area of the country. The town of Ústí nad Labem (92 984 inhabitants) is the largest municipality in, and the seat of, the Region (1).

In the Ústí Region, 80.7 % of the population live in 59 cities and 295 villages; 54 % of the villages have populations of up to 500 inhabitants but these populations total only 5.8 % of the inhabitants of the Region (1). The different locations of the Ústí Region are distinguishable from each other in terms of natural and environmental conditions, economic structure and population density. Historically, the economic importance of the Region is the result of mineral wealth and developed industrial production. The

Region's gross domestic product (GDP) accounts for 6.0 % of the national GDP (the fifth highest of the country's 14 regions) (1). Although the Ústí Region is highly developed industrially, it has many beautiful natural areas, cultural monuments, and tourist sites.

One of the Region's characteristics is its relatively young population with an average age of 41.4 years (the average age in the Czech Republic is approximately 42 years). The Ústí Region ranks third lowest with respect to number of live births per 1000 inhabitants (10.3); its mortality rates are, however, among the highest in the country (11.2 deaths/1000 inhabitants) (2).

The most common diseases in the Region are ischemic heart disease (the rates for which rank among the highest in the Czech Republic), brain vascular diseases, malignant tumours, diabetes mellitus, and infectious diseases. The most common causes of death are circulatory diseases and cancer. Other main causes of death are diseases of the digestive and respiratory systems. Life expectancy at birth is 73.9 years for males and 79.6 years for females; both values are constantly about two years below the national average. The health indicators for the Ústí Region rank among the worst in the country.

The provision of health care in the Czech Republic is based mainly on compulsory public health insurance, which is funded by the mandatory contributions of entrepreneurs, employers and employees, as well as state funds provided to cover seniors, students, unemployed people, women on maternity leave, among others (1).

The public-services network is regulated by independent health-insurance companies contracted at the regional and municipal levels. In turn, the health-insurance companies contract medical services to provide health services. Citizens are liable for payment of only certain expenditures related to health care and medicine.

Urgent medical care is provided in 11 hospitals with approximately 3856 beds. The most important health-care establishment in the Region is Krajská zdravotní, Plc., a company with five associated hospitals (the Děčín, Ústí nad Labem, Teplice, Most and Chomutov hospitals). These include highly specialized departments, such as those for neurosurgery, thoracic surgery, robotic surgery, cardiology, oncology, and nuclear medicine. After, long-term and rehabilitation care is ensured in 17 specialized therapeutic institutions with 1444 beds; hospice/palliative care is provided in two institutions in the region with 41 beds. Basic health care is provided by a network of outpatient-care establishments and pharmacies.

Since 2015, the Ústí Region has provided financial support for the creation of a public network of automated external defibrillator (AED) devices. These have gradually been placed in public places with high concentrations of people, such as train stations, city squares, public offices, and tourist sites.

There are 21 emergency medical services (EMS) stations and 1 air medical services base in the Ústí Region.

In 2015, the Ústí Region entered into an agreement with the Free State of Saxony on mutual cross-border EMS cooperation. The project allows the emergency medical services of both countries to intervene in case of emergencies on either side of border.



Strengths

The strengths of the Ústí Region include:

- ✓ a full range of primary and outpatient care;
- ✓ equal availability of health care for all insured people;
- ✓ several highly specialized departments, such as those for neurosurgery, thoracic surgery and nuclear medicine.



Aspirations

The Ústí Region is interested in:

- ✓ gathering examples of good practice in health-care organization at the regional level,
- ✓ participating in cooperative projects within the frame of public health and prevention (involving all age groups, screening programmes, elimination of health-risk behaviour, etc.);
- ✓ obtaining resources for hospital modernization and the training of health-care professionals;
- ✓ improving the quality of life of the citizens in the Region.



Challenges

The Region is challenged by:

- ✓ a lack of medical professionals in hospitals (young physicians leave to work abroad or in private ambulances);
- ✓ a growing deficit in public finances intended for health care;
- ✓ an ageing population of physicians providing primary and outpatient care and a lack of interest among young physicians.



Potential areas of collaboration

The Ústí Region is interested in collaborating with other regions, especially cross-border regions, on:

- ✓ sharing experiences, knowledge and mutual challenges related to health care and prevention;
- ✓ providing cross-border health care;
- ✓ work/study exchange programmes for health-care professionals.



Working groups

The Ústí Region is interested in participating in working groups on:

- ✓ health systems/primary health care;
- ✓ the all-of-government approach/intersectoral action;
- ✓ cross-border cooperation in providing health care.



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References

1. Statistical yearbook of the Ústecký region 2017. In: Czech Statistical Office [website]. Prague: Czech Statistical Office; 2017 (<https://www.czso.cz/csu/czso/regional-yearbooks>, accessed 25 February 2017).
2. Population change for 1st–3rd quarter of 2017 in the Usti Region. In: Czech Statistical Office. Krajská správa ČSÚ v Ústí nad Labem. [website]. Prague: Czech Statistical Office; 2017 (<https://www.czso.cz/csu/xu/pohyb-obyvательства-za-1-az-3-ctvrtleti-2017-v-usteckem-kraji-predbezne-vysledky>, accessed 20 February 2017).

Ústí Region, Czech Republic

Estonia

Tallinn Old Town

General overview

Estonia, known as “the most advanced digital society in the world” (1) is the smallest of the three Baltic States. In 2018, 1 318 705 people (2) were living in Estonia, the territory of which covers an area of 45 227 km². In 2016, life expectancy at birth was 73.2 years and 81.9 years for men and women, respectively (3).

Estonia is a democratic parliamentary republic. Administratively, the country is divided into 15 counties. Until January 2018, each county was run by a county government led by a governor. An administrative reform removed this level of government and the responsibilities were divided among county-level associations of municipalities and county development centres, or were moved to the Regional Administration Department in the Ministry of Finance (4). The second political tier in Estonia consists of 64 municipalities, which have budgetary autonomy and local tax-raising powers. The largest municipality is the capital city, Tallinn.

The Estonian health system is based on compulsory, solidarity-based insurance and almost universal access to the health services is provided by entities that operate under private law. Stewardship and supervision, as well as health-policy development, are the duties of the Ministry

of Social Affairs and its agencies. The financing of health care is mainly organized through the independent Estonian Health Insurance Fund (EHIF). Local municipalities play a minor, rather voluntary role in organizing and financing the health services.

The health system is mainly publicly financed. The largest share is funded through social health-insurance contributions in the form of an earmarked social payroll tax. Other public sources of health-care financing include the state and municipal budgets. Private expenditure constitutes approximately a quarter of all health expenditure, mostly in the form of copayments for medicines and dental care. Voluntary health insurance, as well as external sources and revenues from private companies, play a minor role.

In 2017, 84.9% of the 20–59 year-old population and 94.1% of the whole population were covered by mandatory health insurance offered by the EHIF (5). In 2016, Estonia spent 6.7% of its gross domestic product on health (6). The main policy document, the National Health Plan, sets out the goal for a significant rise in life expectancy and healthy life years in the Estonian population. For men, it aims to raise life expectancy from 67.7

years (in 2006) to 75.0 years (by 2020) and for women from 78.6 to 84.0 years over the same period (7). In 2016, the achieved rate was 73.2 years for men and 81.9 years for women. On a positive note, life expectancy in Estonia has risen more rapidly than in any other European Union (EU) country, gaining more than 6.6 years between 2000 and 2016. Less positively, the gender gap is one of the highest in Europe though it has been declining since 2011 (8). The National Health Plan also aims to raise the rate of healthy life years for men from 48.1 (in 2005) to 60 (by 2020) and for women from 52.1 to 65.0 years in the same period. In 2015, the achieved rate was 53.8 for men and 56.2 for women (9).

Amenable mortality rates for both men and women in Estonia have almost halved since 2000, the largest reduction in EU, pointing to the strong contribution of the health system to life-expectancy gains over the years through preventive and treatment action. The mortality rate for cardiovascular diseases for males and females combined is nearly double the EU average. Mortality from cancer is the second-leading cause of death, accounting for 22% and 27% of all deaths among women and men, respectively, in 2016. External causes are the third-leading cause of death for men and women combined (10). These numbers illustrate that there is still room for improvement.



Strengths

The strengths of the health system in Estonia are:

- ✓ almost universal health coverage;
- ✓ high level of vaccination coverage;
- ✓ strong primary-health-care system;
- ✓ prevention programmes (screenings, education);
- ✓ e-health services (e-prescription, electronic health record, e-consultation, patient control over their data).



Aspirations

The aims of the health system in Estonia are to:

- ✓ further strengthen the role of primary health care;
- ✓ introduce medical liability insurance (move from a fault-based to non-fault-based system);
- ✓ develop transparent, quality monitoring systems;
- ✓ introduce further innovations in the field of IT;
- ✓ further develop the national personalized medicine programme (to include the use of genotyping for prevention).



Challenges

The challenges of the health system in Estonia are:

- ✓ an ageing workforce;
- ✓ ensuring continuity of insurance coverage;
- ✓ integrating health and social care;
- ✓ adaption of health-care providers to need to provide care-delivery models of higher quality at lower cost;
- ✓ further development of e-health services (popularize them among health-care workers).



Potential areas of collaboration

Estonia is interested in collaborating with other regions on:

- ✓ increasing health literacy;
- ✓ integrating health and social care;
- ✓ sharing know-how on patient-centredness.



Working groups

Estonia is interested in participating in working groups on:

- ✓ health systems/primary health care;
- ✓ the all-of-government approach/intersectoral action.



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References

1. Hammersley, Ben. "Concerned about Brexit? Why not become an e-resident of Estonia". Wired. 27 March 2017 (<http://www.wired.co.uk/article/estonia-e-resident>, accessed 15 May 2018).
2. Population at beginning of year (2018). In: Statistics Estonia [website]. Tallinn: Statistics Estonia; 2018 (<https://www.stat.ee/stat-population-at-beginning-of-year>, accessed 15 May 2018).
3. Life expectancy at birth, years (2016). In: Statistics Estonia [website]. Tallinn: Statistics Estonia; 2018 (<https://www.stat.ee/34279>, accessed 15 May 2018).
4. Ülesanded, mis lisanduvad 1. jaanuarist 2018 kohalikele omavalitsustele ja omavalitsuste ühisasutustele seoses maavalitsute tegevuse lõpetamisega. Ministry of Finance (2018) Haldusreform [Tasks to be added from 1 January 2018 to local governments and joint municipalities in connection with the decommissioning of county governments. Ministry of Finance (2018) Administrative Reform]. In: Rahandusministeerium [Ministry of Finance]. Tallinn: Ministry of Finance; 2018 (<https://haldusreform.fin.ee/2017/12/ulesanded-mis-lisanduvad-alates-1-jaanuarist-2018-kohalikele-omavalitsustele-ja-omavalitsuste-loodud-uhisasutustele-seoses-maavalitsute-tegevuse-lopetamisega/>, accessed 15 May 2018).
5. RA01: Residents aged 20-59 with health insurance and health insurance coverage by sex, age group and county: health insurance. In: Health Statistics and Health Research Data [database]. Tallinn: National Institute for Health Development; 2018 (http://pxweb.tai.ee/PXWeb2015/pxweb/en/04THressursid/04THressursid__12Ravikindlustatud/RA01.px/table/tableViewLayout2/?rxid=7902f9fb-cd20-4a82-8d1c-7f9bcd5c782d, accessed 15 May 2018).
6. KK05: Indicators of current health care expenditure: the share of current health expenditure in GDP, % (2016). In: Health Statistics and Health Research Data [database]. Tallinn: National Institute for Health Development; 2018 (http://pxweb.tai.ee/PXWeb2015/pxweb/et/04THressursid/04THressursid__10THKogukulud/KK05.px/table/tableViewLayout2/?rxid=a4311630-f2c8-4065-bb62-da29f42f6077, accessed 15 May 2018).
7. National Health Plan 2009–2020. Tallinn: Ministry of Social Affairs; 2008 (http://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Aruanded/rta_2009-2020_2012_eng.pdf, accessed 15 May 2018).
8. Lai T, Leinsalu M. Trends and inequalities in mortality of noncommunicable disease. Case study for Estonia. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0020/316154/Trends-inequalities-mortality-NCD-case-study-Estonia.pdf?ua=1, accessed 15 May 2018).
9. Healthy life years statistics. In: Eurostat statistics explained [website]. Brussels: Eurostat; 2017 (http://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthy_life_years_statistics, accessed 21 May 2018).
10. Organization for Economic Co-operation and Development (OECD), State of health in the EU. Estonia. Country health profile 2017. Brussels: European Commission, 2017 (<http://dx.doi.org/10.1787/9789264283350-en>, accessed 15 May 2018).



Baden-Württemberg, Germany

Countryside in
Baden-Württemberg

General overview

Baden-Württemberg is Germany's third-largest federal state, covering an area of 35 751 km². It is located in south-west Germany and shaped by varying landscapes (1). Commitment in the state to the economy, sciences, education, culture, and society has contributed to making southwest Germany one of the most successful regions in the world. The population (10.8 million) has grown steadily over time, attributable in present times mainly to immigration (1). The population structure is changing fundamentally; in addition to longer life expectancy and a slow growth in birth rate (1.51 children per woman in 2015), migration is a key factor. Roughly 1.2 million people (approximately 11%) with non-German passports currently live in Baden-Württemberg (2).

The State Government of Baden-Württemberg wishes to ensure the best possible health and medical care for its population. The Baden-Württemberg Ministry of Social Affairs and Integration has introduced health guidelines, focusing on ensuring a patient-centred, regionally available and well-networked health-care system and its continuous improvement, (3). The health guidelines, which were developed with extensive citizen participation, represent the Baden-Württemberg Government's understanding

of a modern health-care system that caters for its patients and their preferences. Baden-Württemberg recognizes that a health-promoting environment means one in which there is universal access to the best possible medical and long-term care. This recognition, fortified by cross-sector supply structures, has contributed to improving care, especially of the chronically ill, and to making transitions easier. Individual areas of care are continually being developed to ensure the provision of services on a long-term, universal basis. In addition to inpatient, outpatient, psychiatric and long-term care, the state places great importance on prevention and health promotion activities.

The health-care sector in Baden-Württemberg employs more workers than any other sector in the state. More than one eighth of employees contributing to social security in Baden-Württemberg work in health-care-related areas. Over €44.1 billion were spent on health-care-related goods and services in Baden-Württemberg in 2015, averaging €4088 per person. This was €125 below the average per capita health-care expenditure in Germany, and partially due to the different demographic development in Baden-Württemberg (4). Baden-Württemberg's health-

care expenditure ratio in 2015 was close to 10%, still almost 2% lower than that for Germany as a whole. This was due primarily to the above-average economic performance and below-average unemployment rate in the south-west region, compared to federal figures.

Statutory framework conditions for health care in Baden-Württemberg are shaped by the German health-care system. Its organization and financing are based on the traditional principles of decentralization, self-regulation and social solidarity. There are different levels of health policy. National-level policy establishes a framework for the delivery of inpatient and outpatient care, which is planned, financed, and regulated separately by different agencies. The Association of Statutory Health Insurance Physicians is responsible for the planning and provision of outpatient medical care by private-practice physicians. This is financed through a complex formal negotiation process between the health-insurance companies and the physician and dentist associations.

The hospital landscape is dominated primarily by independent non-profitable hospitals, although the number of private hospitals is growing. The federal states are responsible for hospital planning. The hospitals are financed through a dual system, which provides for state coverage of investment costs and coverage of operating costs by statutory health-insurance companies.



Strengths

The strengths of Baden-Württemberg are as follows.

- ✓ “Health dialogue” is used to improve prevention and health promotion in the state, as well as in counties, districts, cities, and communities.
- ✓ The “Health guideline Baden-Württemberg” is structured in three action areas: prevention and health promotion; medical care (including cure and rehabilitation); and long-term care.
- ✓ Baden-Württemberg’s health-care industry is growing steadily, and good health-care services are available to everyone free of charge.
- ✓ Medical and long-term-care advisory facilities and service providers work alongside companies dealing with pharmaceuticals, medical technology and biotechnology, as well as research institutions, to ensure maintenance of the high level of health care available and to improve it further over time.



Aspirations

Baden-Württemberg is aiming to:

- ✓ develop health-care provision as patient-focused, networking, participatory structures;
- ✓ strengthen prevention and health promotion by promoting collaboration among participating institutions and promoting healthy lifestyles;
- ✓ develop integrated care for chronically ill patients and patients with multiple illnesses;
- ✓ support local communities in providing care and companionship to citizens wishing to stay in their own homes as long as possible.



Challenges

These are:

- ✓ fragmentation between inpatient and outpatient care and between curative, rehabilitative, and long-term care services;
- ✓ the increasing number of patients suffering from chronic illness as a result of the growing number of older people that require specialized advisory services and structured case management;
- ✓ the need for coordination and networking among stakeholders and services involved in prevention and health promotion activities at the state and local levels.



Potential areas of collaboration

Baden-Württemberg is interested in collaboration with other regions on:

- ✓ ways of integrating family-health centres into the local communities;
- ✓ intersectoral health policy/health care;
- ✓ digitalization of health files;
- ✓ prevention and health promotion.



Working groups

Baden-Württemberg is interested in participating in working groups on:

- ✓ health-care systems/primary health care;
- ✓ governmental approaches/intersectoral measures;
- ✓ prevention and health promotion.



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References

1. Geografie [Geography]. In: Baden-Württemberg.de [website]. Stuttgart: State Government of Baden-Württemberg: 2018 (<https://www.baden-wuerttemberg.de/de/unser-land/land-und-leute/geografie>, accessed 23 May 2018).
2. Bevölkerung [Population]. In: Baden-Württemberg.de [website]. Stuttgart: State Government of Baden-Württemberg: 2018 (<https://www.baden-wuerttemberg.de/de/unser-land/land-und-leute/bevoelkerung/>, accessed 23 May 2018).
3. Gesundheitsleitbild – Baden-Württemberg [Health Mission Statement – Baden-Württemberg]. Stuttgart: Ministry of Labour and Social Affairs, Families, Women and Senior Citizens; 2014 (<https://sozialministerium.baden-wuerttemberg.de/de/gesundheitsleitbild/>, accessed 23 May 2018).
4. Gesundheitsökonomische Indikatoren für Baden-Württemberg [Health economy indicators for Baden-Württemberg]. Stuttgart: Baden-Württemberg State Statistical Office; 2017 (<https://sozialministerium.baden-wuerttemberg.de/fileadmin/redaktion/m-sm/intern/downloads/Publikationen/Gesundheitssoekonom-Indikatoren-BW-2017.pdf>, accessed 23 May 2018).

Baden-Württemberg, Germany



Cologne Cathedral and
Hohenzollern Bridge

North Rhine-Westphalia, Germany

General overview

The federal state of North Rhine-Westphalia (NRW) covers an area of more than 34 000 km² in the western part of Germany and has a population of approximately 18 million (1). Of the 16 federal states (Länder) in Germany, NRW is the most densely populated with more than 500 inhabitants/km² (2). Situated in the heart of Europe, NRW has several neighbours: Lower Saxony to the north, the state of Hessen to the east, Rhineland-Palatinate to the south, and Belgium and the Netherlands to the west. Average life expectancy in NRW (2015) is 82.5 years for women and 77.9 years for men (3). The Rhine–Ruhr area belongs to the European Megalopolis, the corridor of urbanization in Western Europe. The City of Essen, located in the particularly densely populated Ruhr region with more than 2000 inhabitants/km², was designated by the European Union as a European Capital of Culture for 2010.

The German health-care system is characterized by its system of mandatory health-insurance coverage, either private or public (sickness funds). About 10% of the German population, mainly public officials and servants, have private health insurance (4). Employees' contributions to the sickness funds are 15% of their income, half of the amount being paid by their employers. For the

unemployed, the costs for health insurance are covered by the state and financed through taxes. In 2016, national health expenditure accounted for 11.3% of Germany's gross domestic product (5).

One of the fundamental aspects of the German health-care system is the sharing of decision-making powers among the federal states, the federal Government and legitimized civil-society organizations. In health care, governments traditionally delegate competencies to membership-based, self-regulated payer and provider organizations. These corporatist bodies constitute the structures that operate the financing and delivery of benefits covered by the statutory health insurance within the legal framework.

Two major responsibilities at state level are governmental regulation of capital investments, which are based on hospital plans, and public health services, which in NRW are regulated according to the Public Health Act of 1995. Other responsibilities are undergraduate medical, dental and pharmaceutical education and the supervision of the regional chambers of physicians, the regional associations of physicians, and the sickness funds operating in the state (6).

In NRW, responsibility for health lies with the Ministry of Labour, Health and Social Affairs, the focus of which is not on “structures” or “systems”, but on helping people to preserve or regain their health through good medical care. The Ministry sees its remit as organizing the legal framework and social conditions in such a way to allow everyone to find their place in the community; it is committed to:

- strengthening patients’ rights;
- ensuring effective and efficient prevention measures; and
- providing area-wide, quality health-care coverage, appropriate to people’s needs and accessible to all.

The Ministry cooperates with the five provincial governments and 53 institutions in NRW that are responsible for health in the counties and cities of the state. Its work is supported by the NRW Centre for Health (Landeszentrum Gesundheit Nordrhein-Westfalen), an agency falling under the Ministry.



Strengths

The strengths of NRW include:

- ✓ the presence of a high-level, modern, well-financed social health-care system;
- ✓ support provided to promote people’s ownership of their health and their lives;
- ✓ a high level of health literacy in the population.



Aspirations

NRW’s is aiming to:

- ✓ safeguard sufficient human resources for health (particularly general practitioners and nursing staff);
- ✓ ensure good hospital care;
- ✓ strengthen disease prevention (through children’s health programmes dealing with early recognition and control, vaccination, addiction, non-smokers’ protection);
- ✓ implement the new Prevention Act (the NRW Centre for Health participates in and coordinates the national cooperation network, Equity in Health, at the federal level).

Challenges

These are:

- ✓ an acute crisis with respect to human resources for health;
- ✓ a high density of hospitals in urban areas simultaneously with a decrease in the number of hospitals in rural areas;
- ✓ the possibility of ensuring medical treatment and health care in rural areas in general, and in the face of demographic ageing in particular.

Potential areas of collaboration

NRW is interested in collaborating with other Regions for Health (RHN) (7) members on:

- ✓ health reporting;
- ✓ health impact assessment (8);
- ✓ urban health.

Working groups

NRW is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (9)/ equity;
- ✓ participatory approaches/resilience;
- ✓ the all-of-government approach/intersectoral action.

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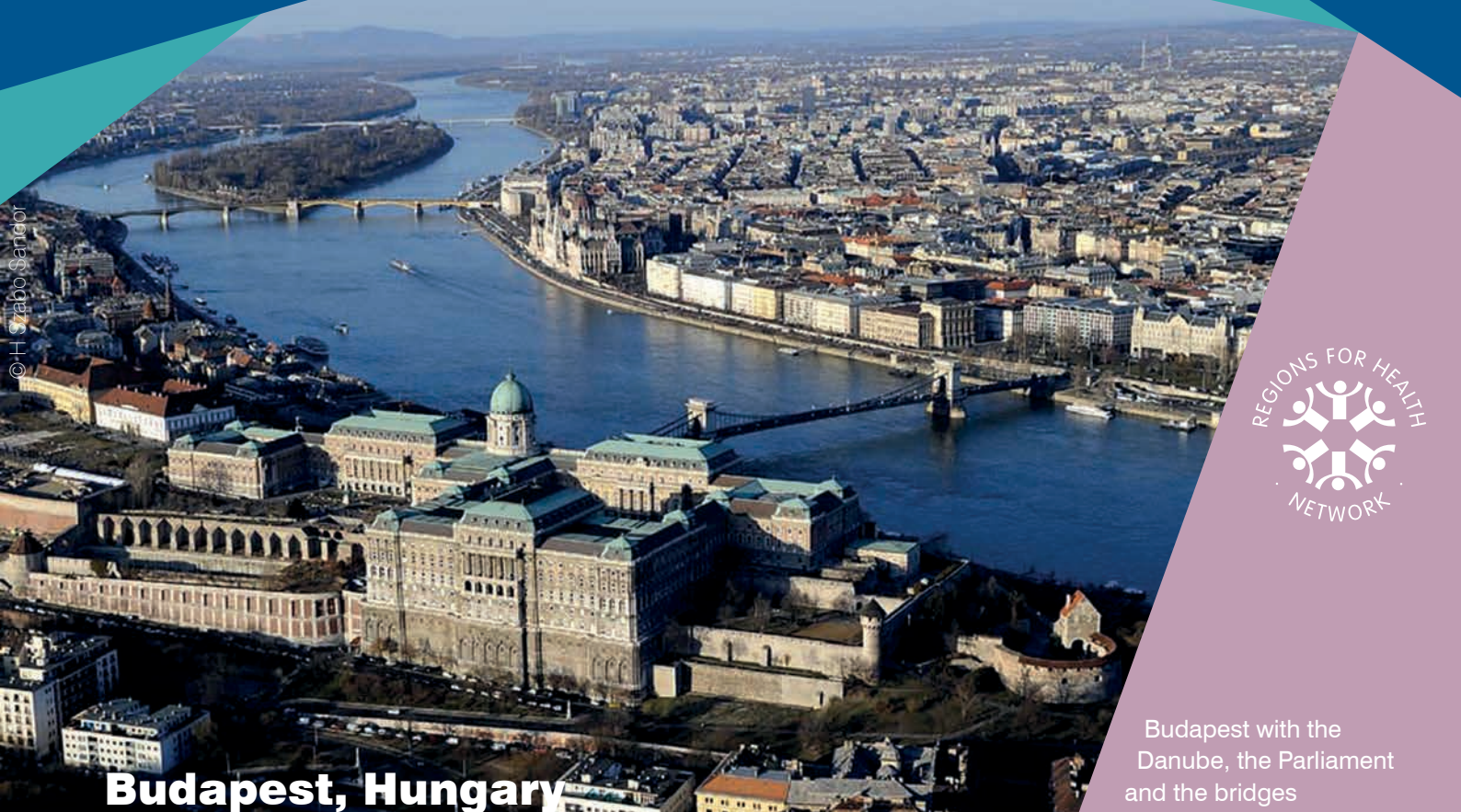
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North Rhine-Westphalia, Germany

References

1. Statistische Berichte. Bevölkerungsstand in Nordrhein-Westfalen September 2016 [Statistical reports. Population in North Rhine-Westphalia September 2016]. Düsseldorf: Information und Technik Nordrhein-Westfalen; 2017 (<https://webshop.it.nrw.de/gratis/A119%20201609.pdf>, accessed 17 April 2018).
2. Statistikatlas NRW 2018 [Statistics Atlas NRW] [website]. Düsseldorf: Information und Technik Nordrhein-Westfalen; 2018 (<https://www.statistikatlas.nrw.de/>, accessed 17 April 2018).
3. Landesgesundheitsbericht 2015. Informationen zur Entwicklung von Gesundheit und Krankheit in Nordrhein-Westfalen [State health report 2015. Information on the development of health and illness in North Rhine-Westphalia]. Düsseldorf: Ministerium für Gesundheit, Emanzipation, Pflege und Alter des Landes Nordrhein-Westfalen [Ministry of Health, Equalities, Care and Ageing of North Rhine-Westphalia]; 2016 (https://www.lzg.nrw.de/_media/pdf/ges_bericht/landesgesundheitsberichte/landesgesundheitsbericht_2015.pdf, accessed 17 April 2018).
4. Busse R, Blümel M et al. Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition. *The Lancet*. 2017;390:882–97 ([http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(17\)31280-1.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)31280-1.pdf), accessed 17 April 2018).
5. Organisation for Economic Co-operation and Development (OECD). Health at a glance 2017: OECD indicators. Paris: OECD Publishing; 2017 (http://dx.doi.org/10.1787/health_glance-2017-en, accessed 17 April 2018).
6. Busse R, Blümel M. Germany: health system review. Copenhagen: World Health Organization (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies); 2014 (*Health Systems in Transition*. 2014;16(2):1–296 (http://www.euro.who.int/__data/assets/pdf_file/0008/255932/HiT-Germany.pdf?ua=1, accessed 16 April 2018).
7. Regions for Health Network (RHN). In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/about-us/networks/regions-for-health-network-rhn>, accessed 17 April 2018).
8. Health impact assessment. In: World Health Organization [website]. Geneva: WHO; 2018 (<http://www.who.int/hia/en/>, accessed 12 April 2018).
9. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

North Rhine-Westphalia, Germany



Budapest with the Danube, the Parliament and the bridges

Budapest, Hungary

General overview

Budapest is the capital of and the biggest city in Hungary with a land area of about 525 km² (203 mi²) and a population of 1.7 million (1). The Budapest metropolitan area is accountable for almost half of the Hungarian gross domestic product (GDP).

Until 31 December 2017, the Budapest metropolitan area and Pest County in which it is situated constituted one of the seven Hungarian regions of the European Union (EU) Nomenclature of territorial units for statistics, level 2 (NUTS2). These Hungarian regions are very inhomogeneous with a gap in development between the capital cities and the rural areas in their peripheries. As a consequence, on 1 January 2018, the Budapest metropolitan area was separated from the rest of the region (Pest County) and became the eighth Hungarian region of NUTS2. The following information relates to the Budapest city and its metropolitan area.

Budapest is known as one of the most beautiful cities in Europe, running along both sides of the River Danube. The central area of the city, which has been classified as a UNESCO World Heritage Site, has many impressive monuments and buildings, including the Parliament (the second

largest in Europe), home to the unique Holy Crown of Hungary dating back to the 11th century, and the Castle from which there is a breathtaking view of the city. The main synagogue has survived history as the second largest in the world. Budapest is famous for its museums and wonderful Art Nouveau buildings, and not least for its thermal baths, which are supplied from 80 geothermal springs and the largest geothermal water-cave system in the territory.

Health-care system

The Hungarian health-care system is a social health-insurance system covering almost 100% of the population (approximately 10 million people). The country has an ageing population and a high dependency ratio (50%) driven by low fertility and high rates of migration. The average life expectancy in Hungary is 72.4 years for males and 79.0 years for females; in Budapest, the perspectives are better, namely, 74.3 for males and 80.1 for females. The educational level in Budapest (as in the rest of the country) has an enormous impact on health status and life expectancy, especially for men. Around 70% of the health expenditure in Hungary is covered from public sources; in 2016, this amounted to approximately 5.2% of GDP (1).

With rates of smoking in Hungary that were among the highest in Europe, in 2012, the Parliament passed a very strict anti-tobacco law aimed at decreasing tobacco use and the negative health effects associated with the habit in the shortest possible time frame.

Hungary is one of the main medical-tourism destinations in Europe, the most popular treatments being in the areas of dentistry, cosmetic surgery, orthopaedic surgery, rehabilitation, fertility treatment and balneotherapy.

In recent years, Hungary has moved towards a centralized health-care system, most hospitals now falling under one authority (the National Health Care Centre). Most of the provider capacities are located in the Budapest area, which also includes the Semmelweis University, one of Hungary's four famous medical universities. Hospital-bed numbers are still high in Hungary (70 beds per 10 000 people); in the Budapest region, there are 68 acute beds and 42 long-term beds per 10 000 people (2).

The diagnosis-related-group system of payment and the "German points system" (a fee-for-service payment mechanism for ambulatory-care physicians) have been in use since 1993. A unique patient identifier (social insurance number) introduced in 1997 makes it possible to trace a patient's history back across all types of care (primary care, outpatient and inpatient specialist care, prescriptions, etc.) and facilitates the execution of real-world-evidence longitudinal studies. Due to the single-payer system, the National Health Insurance Fund has an outstanding health database.

The "Healthy Budapest Programme" (2017–2026), one of the largest health-care development programmes in the country, was launched in 2017 with the aim of strengthening the health-care system in the Budapest region. Within the framework of this Programme, it is expected that approximately €2.5 billion will be spent on the development of regional and nationwide hospitals and outpatient clinics to serve the capital and the central region. The Programme will cover three central hospitals (one of which will be opened within the next five years), 25 partner hospitals and 16 outpatient clinics.



Strengths

The strengths of the health-care system in the Budapest region are:

- ✓ a concentration of capacities in the form of infrastructure and trained professionals (the region is responsible for approximately 40% of the Hungarian health-care output);
- ✓ a concentration of trained professionals;
- ✓ very good access to health-care providers for the population of Budapest and the surrounding area;
- ✓ innovative training initiatives, such as unique training programmes (master's programmes in English) on health policy, planning and financing for professionals in health-care administration (at the Eötvös Lóránd University).



Aspirations

The Budapest region is aiming to:

- ✓ strengthen regulatory mechanisms on the provision of private and public health services;
- ✓ examine strategies related to health-needs assessment and health-services management in other countries, especially regarding functions at the regional and central levels;
- ✓ introduce new methods of provider payment;
- ✓ improve health data with respect to the connection between administrative data and those in electronic health records and registries;
- ✓ promote health education to reduce health inequalities;
- ✓ develop patient-centred care, using new technologies and telemedicine.



Challenges

These are:

- ✓ an ageing population;
- ✓ brain drain (human resources) for economy reasons;
- ✓ centralization of services coupled with the need to enhance the coordination of health-care capacity at the hospital level;
- ✓ out-of-pocket payments;
- ✓ the need for more transparency in communications between the health and social services involving patients (which is especially problematic for older people);
- ✓ the need to integrate care through intersectoral cooperation.



Potential areas of collaboration

The Budapest region is interested in collaborating with other regions on:

- ✓ ways of achieving well-integrated care;
- ✓ new methods of provider payment, including reimbursement for quality outcomes and integrated care;
- ✓ observing confidentiality in the collection and provision of health data.



Working groups

The Budapest region is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (3)/ equity;
- ✓ women's/men's health;
- ✓ health systems.



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References

1. Regional Statistical Yearbook of Hungary. Budapest: Hungarian Central Statistical Office; 2016.
2. Magyar Egészségügyi Rendszer Teljesítményértékelési Jelentése 2013–2015 [Health System Assessment Working Group: Health System Assessment Report of Hungary 2013-2015], Budapest: Állami Egészségügyi Ellátó Központ [National Health Care Service Center]; 2016 (<https://mertek.aek.hu/documents/68031/186704/10.Strukt%C3%BAra-egyben.pdf/fccc9ab2-6e21-2098-1469-abaad109dac9>, accessed 23 May 2018).
3. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 27 May 2018).

Budapest, Hungary

Northern Region, Israel

Acre

General overview

The Northern Region of Israel covers approximately 4500 km², 21% of the total territory of the country (22 000 km²) (2016). The Region borders Lebanon to the north, Syria and Jordan to the east, and the Palestinian Authority to the south. In 2016, the population in the Region counted approximately 1 401 300, about 20% of the whole Israeli population (8 628 600), with an almost equal distribution of Arab and Jewish citizens. The Arab population includes: Muslims, Druses (a separate religion descending from Islam), Circassia's (Muslims originating from Caucasia in the south of Asia), and a minority of Christian Arabs (1,2).

The Northern Region includes 437 settlements

in 94 authorities: 17 cities, 15 regional councils and 62 local councils (with various settlement modalities: cities, villages, kibbutzim, agricultural communities).

In 2016, life expectancy in Israel was 84.1 years (80.7 years for men and 84.2 years for women). Among the Jewish population, life expectancy was 84.5 years (80.9 years for men and 84.5 years for women) and for the Arab population it was 81.1 years (76.9 years for men and 81.1 years for women) (1).

Table 1 allows a comparison of the mortality and fertility rates for the Northern Region with those for the whole of Israel in 2016 (1).

Table 1. Life expectancy and mortality and fertility rates, Israel and the Northern Region, 2016

Area	Rates Israel			Rates Northern Region		
	Overall	Arab	Jewish	Overall	Arab	Jewish
Infant mortality	3.1	6.4	2.2	2.2	4.4	3.0
Standardized death rate	5.0	6.3	6.3	6.3	5.9	5.3
Crude death rate	5.2	2.7	5.8	5.8	2.7	6.8
Fertility rate	3.1	3.3	3.2	3.2	2.7	3.0

Some of the unique characteristics of the Northern Region are the following.

- The Region is relatively large with a multicultural society, but there is a lack of work, health and educational services, roads and

public transport. The birth rate is high (5–7 and more children among orthodox families) and congenital birth defects are not uncommon.

- The Region has many tourist attractions and recreational destinations.
- It has coped successfully in absorbing an influx immigrants from Ethiopia and countries of the former Soviet Union, and refugees from South Lebanon, Sudan and Darfur.
- The Northern Region is a health-promoting Region, its public health vision being to create a healthy and supportive environment (through programmes such as: “Northern Region – Smoke Free Region”, “Healthy Lifestyle” (focusing on physical activity and nutrition), and “One Stop Shop” (health preparedness for preschool children).
- The Region participates in the WHO Regions for Health Network.

The Israeli Health Ministry is decentralized to 6 Regional Health Offices. In the Northern Region there are 5 District Health Offices: Acre, Kinneret, Nazareth, Safed and Yizrael.

The Public Health Services of the Ministry of Health have adopted the WHO approach to enhancing global health security and preventing chronic diseases by creating a healthy and supportive environment for the benefit of individuals and communities. The Northern Region seeks in practice to prevent and control morbidity and improve the quality of life of its citizens through maintenance of and improvement in collaboration between the various health and medical organizations (governmental, nongovernmental, public, private, international) and between these organizations and communal groups.

The Regional Health Office is viewed as a “mini ministry”, employing about 700 people (equal percentage of Arabs and Jews), including 55 medical doctors (specialists in public health, psychiatrists, dentists, gynecologists and pediatricians), 400 nurses, and lawyers, engineers, pharmacists, psychologists, physiotherapists, technicians and clerks/

secretaries. It participates in determining national and local health policy and measures needed to implement and execute it. To this end, it collects information on the health needs of the population for use in building, implementing and evaluating tailor-made health-promotion programmes. The Regional Health Office also coordinates and supervises various medical and health providers, such as individual preventive services, health-maintenance organizations, private clinics, hospitals, nursing homes, dental clinics and pharmacies, as well as educational institutes, sewage and water systems, beaches and swimming pools, food-producing factories and businesses, and non-medical treatment centres.

In addition, the Regional Health Office is responsible for preparedness to respond in emergencies, such as outbreaks of war and disease and natural disasters, and for ensuring immediate access to adequately equipped medical services.

The Northern Region is running two successful programmes related to maternal and child health: “Tipat halav” (“A drop of Milk”) and the “One stop shop” programme, which is a subprogramme of the first mentioned.

The “A drop of milk” programme involves 320 mother/child clinics spread out in the Region, which deal mainly with prevention. These conduct: follow up of pregnant women and newborns; screening tests for and the follow up of genetic and congenital diseases and malformations, phenylketonuria and hypothyroidism, among others; and routine childhood vaccinations. The programme also includes health-education consultations in the areas of physical activity, nutrition, breastfeeding/ substitutes and contraceptives.

The “One stop shop” programme focuses on children about to enter the first grade who are invited to their nearest Tipat Halav location with their parents for a series of screening tests. Fifty children are invited to each session (out of a total of 26 000 in the Region). The sessions include: eye examinations (by an optometrist); hearing tests; vaccinations (given by school nurses

specializing in first and second graders); and height and weight measurement. All children participating in the programme are given a certificate stating that they are about to enter the first grade, a modest gift and a refrigerator

magnet with tips about “healthy sandwiches”. The screening tests and preventive measures ensure that each child entering the first grade does so under optimal conditions.



Strengths

The Northern Region’s strengths include:

- ✓ highly qualified, skilled and devoted human resources;
- ✓ creativity and “thinking outside the box”;
- ✓ multi-year work plans.



Aspirations

The Northern Region is aiming to:

- ✓ establish a “golden age clinics” network for the older population (with a similar concept to that of the “Tipat Halav” programme mentioned above) to maintain and improve health and well-being in this age group;
- ✓ reinforce and enhance preventive health care in all the schools in the Northern Region (there are approximately 784 schools with about 230 000 children in the 6–18-years age group with risk-behaviour issues, such as alcohol, drug and tobacco use, unsafe sex, etc.);
- ✓ confront the trend in overweight and obesity to reduce the increasing rate of diabetes mellitus, especially among the Arab population (the incidence rate among adult Arab citizens in Israel compared to adult Jewish citizens is significantly higher (2)).



Challenges

These are the need to:

- ✓ enhance collaboration between governmental and nongovernmental organizations dealing with public health;
- ✓ disseminate real-time data and information to the public on the sanitary status of food factories businesses and restaurants;
- ✓ establish an information and guidance centre for all issues related to the elderly population (morbidity, hospitalization, social services and others).

Potential areas of collaboration

The Northern Region is interested in collaborating with other regions on:

- ✓ developing software to inform the public about the sanitary status of food factories, restaurants and businesses;
- ✓ developing a model information-and-guidance centre for the elderly population;
- ✓ increasing health literacy and improving shared decision making;
- ✓ facilitating brainstorming in the Regions for Health Network on developing healthy conditions in workplaces, leisure-time settings, etc.

Working groups

The Northern Region is interested in participating in working groups on:

- ✓ women's/men's health;
- ✓ health systems/primary health care;
- ✓ the all-of-government approach/intersectoral action.

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References

1. The Israel Central Bureau of Statistics [website]. Jerusalem: The Israel Central Bureau of Statistics; 2018 (http://www.cbs.gov.il/reader/?Mlval=cw_usr_view_Folder&ID=141, accessed 28 May 2018).
2. State of Israel Ministry of Health. Health status in Israel 2008. Publication 333. Ramat Gan: The Israel Center for Disease Control (ICDC); 2011.

Northern Region, Israel



Autonomous Province of Trento , Italy

Adige Valley

General overview

The Autonomous Province of Trento (also called Trentino) is a mountainous region located in the northern part of Italy. It spans over 6214 km² and has about 500 000 inhabitants. In 2016, the financial requirements for health services in the Province were calculated at €1 238 000 000 (1).

Health services are provided by the National Health Service through the Local Health Unit, which is divided into five smaller health districts. The regional health authorities are responsible both for establishing autonomous health policies and for implementing/adapting national guidelines (national health plans).

Compared to the rest of Italy, almost all the health and socioeconomic indicators in Trentino are above average (1):

- life expectancy at birth has improved to 81.2 years for men and 85.9 years for women;
- 77% of the adult population perceive their health as good or very good;
- the performance of the health sector is better than elsewhere in Italy;
- compared to the Italian averages, there is less unemployment in Trentino, and people earn more, smoke less, eat more fruit and vegetables

and are leaner and more physically active;

- the Gini index is 0.281 (2014), a value closer to that for the Netherlands (0.264 in 2015) than for Italy (0.324 in 2015); and
- Trentino's natural environment (the Dolomites) is health promoting and attracts many tourists from Italy and abroad at all times of the year.

Nevertheless, there are several social- and health-related problems:

- unemployment, specially among youth, is increasing;
- there is a gender gap in income and working status;
- the number of people completing a university degree is below the EU target;
- there are social inequalities in health and health behaviours;
- whereas all other risk factors are lower in Trentino compared to the Italian average, alcohol consumption is higher.

In December 2015 the Trentino Government adopted a strategic health plan, which involves the application of a participatory approach (2).

The Trentino health plan (2015–2025) addresses the challenge of the triple burden of disease: communicable, newly emerging and re-emerging, and noncommunicable diseases. It calls for governmental and nongovernmental institutions, civil-society organizations and the public to take mutual responsibility for community health and well-being, underlines the importance of health promotion, and supports the adoption of the HiAP approach in planning at the provincial level.



Strengths

The strengths of Trentino include:

- ✓ good health-information systems;
- ✓ improved health reporting, focusing more on the social determinants of health and health inequalities;
- ✓ comprehensive experience in participatory processes and intersectoral action for community health and well-being;
- ✓ the Trentino health plan, which supports the use of the HiAP approach in strategic planning.



Aspirations

The Trentino region intends to:

- ✓ draft more specific and practical operational plans on priority issues in connection with the implementation of the Trentino health plan;
- ✓ address newborn, child and adolescence health as a first priority;
- ✓ intensify work in the field of health inequalities (prison health, health and gender, and health of refugees and other minority groups).
- ✓ establish (in 2018) collaboration with other departments of the local government (mainly those for environment and education) on implementing a selection of the Sustainable Development Goals (SDGs) at the provincial level.



Challenges

These are that:

- ✓ intersectoral collaboration and interinstitutional dialogue continue to be very difficult and are mainly related to the integration of the health and social services, which address only specific health needs;
- ✓ the health sector is still regarded mainly as the authority responsible for dealing with diseases rather than one that works according to the salutogenic model of HiAP;
- ✓ not all life-years gained in the region in recent decades are healthy years free of disability, which is an issue of increasing importance in the light of the ageing population.

Potential areas of collaboration

Trentino is interested in collaborating with other regions on:

- ✓ the social determinants of health and strategies to address health and social inequalities;
- ✓ how to strengthen public health systems and PHC strategies and, in particular, how to establish greater integration of services related to hospital and primary care;
- ✓ how to promote women's and men's health;
- ✓ how to work with gender-related issues in health.

Working groups

Trentino is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (3)/ equity;
- ✓ women's/men's health;
- ✓ health systems/primary health care.

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References

1. Profilo di salute della Provincia di Trento, aggiornamento 2016 [Health profile of the Province of Trento, 2016 update]. Trento: Government of the Autonomous Province of Trento; 2017 (<https://www.trentinosalute.net/Pubblicazioni/2017/Profilo-di-salute-della-provincia-di-Trento>, accessed 6 April 2018).
2. Adopting a broader concept of health and well-being in the development of the Trentino health plan (2015–2025): a participatory process. Copenhagen: WHO Regional Office for Europe; 2016 (<http://www.euro.who.int/en/publications/abstracts/adopting-a-broader-concept-of-health-and-well-being-in-the-development-of-the-trentino-health-plan-20152025-a-participatory-process-2016>, accessed 6 April 2018).
3. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

Autonomous Province of Trento, Italy



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Emilia-Romagna Region, Italy

Piazza Maggiore, Bologna

General overview

The Emilia-Romagna Region in north-eastern Italy is the sixth-largest in Italy. Covering an area of 22 451 km² (7.4% of the national territory), it is divided into 8 provinces and 1 metropolitan city, Bologna, the capital of the Region.

The Emilia-Romagna Region is home to the oldest university in the Western world, the University of Bologna, which was founded in the year 1088 and counts almost 100 000 students today (1). The Region is also known for its medieval cities, rich gastronomy and seaside resorts.

In 2016, the Region had a population of 4 454 000, among whom, 12% did not have Italian citizenship. In the same year, the Region was characterized by a “zero growth” rate compared with the rates for the previous ten years. The demographic data show a steadily ageing population; in 2016, the number of people aged over 75 was 560 835, representing approximately one in ten.

The forecasts up to 2020 predict a moderate growth rate in the Region with a marked change in its composition, which will become increasingly heterogeneous and multicultural: almost one child in three born today in the Emilia-Romagna Region is of a non-Italian mother (2).

After the economic crisis in Europe in 2008–2013, the Region’s economy is now experiencing a period of moderate growth. The level of relative poverty in Emilia-Romagna Region (4.8%) is the third-lowest in the country (after Trentino-Alto Adige and Lombardy, followed by Veneto and Tuscany (2)). The economy is based on small and medium-sized family-run businesses and large industrial companies; cooperatives are also very widespread.

In 2016, the average life expectancy was 81.2 years for men and 85.3 years for women. Life expectancy at age 65 was 19.6 years for men and 22.5 years for women (3).

The Italian National Health Service is statutorily required to guarantee the uniform provision of comprehensive care throughout the country, covering all citizens and legal foreign residents. It is regionally based and organized at the national, regional and local levels. Under the Italian Constitution, the central Government controls the distribution of tax revenue for publicly financed health care and has defined a national statutory health-benefits package – LEA (“livelli essenziali di assistenza” (essential levels of care)) – to be offered to all residents in every region. The 19

regions and two autonomous provinces are responsible for organizing and delivering health services, through local health units (LHUs), and enjoy a significant degree of independence in determining the macro structure of their health systems. LHUs are managed by a general manager appointed by the governor of the region in question, and deliver primary care, hospital care, outpatient specialist care, public health care, and health care related to social care (4,5). They operate through their health districts at which level requirements are determined, services planned, health-care and social-health care provided, and results assessed.

The Health Service of Emilia-Romagna Region comprises:

- 8 local health units
- 4 university hospitals
- 1 hospital trust
- 4 research hospitals
- 38 health districts (6).

The Emilia-Romagna Region is historically characterized by a strong system of public, territorial and community welfare: an “engine of development”. Over time, the system has created good employment opportunities and reduced social and health inequalities, redistributing resources and fostering social inclusion. In recent times, the economic crisis and sociodemographic changes have put the whole system on trial.

The new Regional Social and Health Plan 2017–2019 (2), is the result of a huge participatory process, involving more than 500 stakeholders. These included representatives of health and social institutions, the third sector, trade unions, associations and citizens. Shared by institutional and community actors alike, its main purpose is to guide innovation and strengthen an inclusive and participatory welfare system. People-centred and deeply rooted in their needs, it reaffirms the importance of the fundamental principles of universalism and equity in counteracting the social consequences of the economic crisis.

The key objective of the Regional Social and Health Plan is to tackle social challenges, such as exclusion, frailty and poverty, through intersectoral approaches and the integration of different policies (social, health, housing, work, mobility and education).

The Region has adopted the WHO vision of a world free of the avoidable burden of preventable diseases, and the preventable burden of morbidity, mortality and disability with the aim of eliminating these barriers to well-being and socioeconomic development (7). According to the Regional Social and Health Plan, the enhancement of primary health care services through the Houses of Health (community health centres) and the health districts, and the development of intersectoral, participative initiatives in close collaboration with schools, local associations and local authorities, strongly contribute to the pursuit of these objectives.



Strengths

The Emilia-Romagna Region has the following strengths:

- ✓ a strong system of public, territorial and community welfare, and orientation towards reducing inequality and promoting empowerment and social inclusion;
- ✓ the Regional Social and Health Plan 2017–2019, an innovative and appropriate tool to strengthen the role of public and participative governance in the field of health;
- ✓ integrated programmes to tackle exclusion, frailty and poverty, supported by legislation on labour social inclusion and solidarity income;
- ✓ interinstitutional and intersectoral cooperation at the national and international levels on responding to public health challenges in the fields of health services’ organization and health professionals’ training.

Aspirations

The Emilia-Romagna Region is aiming to:

- ✓ develop regional programmes and initiatives to tackle poverty and promote social inclusion;
- ✓ strengthen the role of the health district as a strategic hub for primary health care and social integration;
- ✓ support the development of territorial and community health-care services, providing citizens with integrated care in easily accessible locations, such as the Houses of Health and community hospitals.

Challenges

These are:

- ✓ an increasing older population (proportion of old to young people was 175.5 in 2016 compared to 168 in 2012);
- ✓ the increase in frailty among the population owing to the economic crisis, particularly among immigrants and large families, which include minors and/or elderly people;
- ✓ the high prevalence of the main modifiable and intermediate risk factors (such as, hypertension, tobacco smoking, sedentary lifestyle, high consumption of alcohol, obesity and low consumption of fruit and vegetables) leading to a large proportion of life years lived with disabilities (2).

Potential areas of collaboration

The Emilia-Romagna Region is interested in collaboration with other regions on:

- ✓ establishing policies to strengthen home-care and community-care settings;
- ✓ reducing inequalities and promote health;
- ✓ promoting empowerment and social participation;
- ✓ improving the quality of health services and health expertise (including the skills needed to work in multiprofessional teams).

Working groups

The Emilia-Romagna Region is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (8)/ equity;
- ✓ women's/men's health;
- ✓ health systems/primary health care;
- ✓ participatory approaches/resilience;
- ✓ the all-of-government approach/intersectoral action.



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References

1. Geoportale [website]. Bologna: Regione Emilia-Romagna; 2018 (<http://geoportale.regione.emilia-romagna.it/applicazioni-gis/regione-emilia-romagna>, accessed 27 May 2018).
2. Piano Sociale e Sanitario 2017–2019 della Regione Emilia-Romagna [Social and Health Plan 2017–2019 of the Emilia-Romagna Region]. Bologna: Emilia-Romagna Region; 2017 (<https://salute.regione.emilia-romagna.it/ssr/piano-sociale-e-sanitario/piano-sociale-e-sanitario-la-programmazione>, accessed 27 May 2018).
3. Sistema informativo territoriale su sanità e salute. Versione di dicembre 2017 [Health information system on health. December, 2017 version]. In: ISTAT [website]. Rome: National Institute of Statistics; 2018 (<https://www.istat.it/archivio/14562>, accessed 27 May 2018).
4. Donatini A. The Italian Health-Care System. In: International Health Care System Profiles. New York, NY: The Commonwealth Fund; 2018 (<http://international.commonwealthfund.org/countries/italy/>).
5. France G; Taroni F; Donatini A. The Italian Health-care System. Health Economics. 2005;14(Suppl 1):S187–202.
6. The Emilia-Romagna Regional Health Service. Facilities, expenditure, activities as of 31.12.2013. Report on 4 years of activity (2010–2013). Bologna: Emilia-Romagna Region; 2014 (http://salute.regione.emilia-romagna.it/documentazione/rapporti/ssr/2014the-emilia-romagna-regional-health-service-facilities-expenditure-activities-as-of-31-12-2013-report-on-4-years-of-activity-2010-2013-2014/at_download/file/SSR-ER_2014_ENG_bassa.pdf, accessed 27 May 2018).
7. Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. Geneva: WHO; 2013 (http://www.who.int/nmh/events/ncd_action_plan/en/, accessed 27 May 2018).
8. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 28 May 2018).

Emilia-Romagna Region, Italy



Friuli Venezia Giulia, Italy

Miramare Castle, Trieste

General overview

Friuli Venezia Giulia (FVGR) is an autonomous region with special statute situated in the extreme north east of Italy, bordering Austria to the north, Slovenia to the east and the Adriatic Sea to the south. Its strategic position for communication with both northern and eastern Europe is enhanced by appropriate infrastructures, such as motorways, railways and port networks.

FVGR covers a geographical area of 7862 km² (2.6% of the total area of Italy). The landscape of the region is very varied: the Alps mountain range, where only 5.2% of the population lives, stands out to the north (42.6% of the territory) and slopes down to the hills (19.3 %), plains (38 %) and coast to the south. Biodiversity adds value to the region and is strongly protected: 17.1% of the territory comprises parks, nature reserves and biotypes (1).

FVGR has a population of 1 217 872 (2% of the total for Italy) distributed among 216 municipalities, most with fewer than 5000 inhabitants (71.3%). There is a very large proportion of older people (Table 1) in connection with which a law has been passed in favour of developing policies for this group. The birth rate in the region is very low, but the gradual ageing of the population is partly offset

by the presence of young foreign residents (8.6% of the population) (1).

Annual investment in research and development is quite substantial. FVGR hosts several internationally acknowledged scientific institutes, such as the International Centre for Theoretical Physics, the International School for Advanced Studies, the Area Science Park and two universities.

In Italy, the health system is based on the Beveridge model (2). In FVGR, five local health authorities provide health care in all the provinces through an integrated and capillary network of services, including: three tertiary hospitals (specializing in oncology, paediatrics and rehabilitation); long-term care; home care; mental health and addiction services; palliative care; paediatric care; and public health centres. The regional health system, the social services of the municipalities, various associations, nongovernmental organizations and agencies in the region are well integrated and constitute an effective network, providing adequate care for people suffering from acute and, especially, chronic diseases.

Table 1. Socioeconomic indicators, FVRG and Italy, 2017

Indicators	FVGR	Italy
Gross domestic product (GDP) (euros per capita)	28 600	26 700
GINI index	0.27	0.33
Unemployment rate (%)	6.9	11.3
Research and development (euros per capita)	457.4	366.7
Life expectancy at birth (years)	82.4	83.1
Male	80.3	80.6
Female	85.4	85.1
Gender gap	5.1	5.5
Old-age index (%)	208.8	165.1
Structural dependency ratio (%)	61.4	55.8
Old-age dependency ratio	41.5	34.8
People at risk of poverty/social exclusion (%)	16.7	29.9
Severe material deprivation rate	6.5	12.1
Total annual health spending (euros per capita)	2 474	2 418
Out of pocket expenses (euros per capita)	561	569

Source: Regione in cifre 2017 [Region in figures 2017] (1).

As in most developed countries, the top three causes of death in FVGR are cardiovascular, oncological and respiratory diseases and, therefore, much effort is spent on health-promotion programmes (Table 2). The budget for health care, health promotion, prevention and

social policies is equivalent to 55% of that of the Regional Government.

In FVGR, there is a strong orientation towards the voluntary sector and 1196 voluntary organizations are actively engaged in voluntary activities.

Table 2. Health indicators, FVRG and Italy, 2017

Indicators	FVGR	Italy
Self-rated health status (at least "very good") (%)	82.7	81.2
Overweight (%)	35.3	31.7
Obesity (%)	10.6	10.5
Average use of tobacco (a day)	10	11.5
Habitual excess consumption of alcohol (%)	11.9	10.4
People who practise sport (%)	39.5	34.8

Source: Regione in cifre 2017 [Region in figures 2017] (1).

FVGR has been working for years towards being a "region for everyone" with a friendly and supportive environment suitable for children, people with disabilities and older people. It has also been engaged for a very long period in efforts to reduce inequities in health and pursue an equity-in-all-policies approach.



Strengths

The strengths of FVGR are the following:

- ✓ high respect for the environment;
- ✓ quality health and social services that are easily accessible to everyone;
- ✓ well-integrated health-care and social services;
- ✓ intersectoral programmes involving institutions, local agencies, nongovernmental organizations and volunteers working towards creating a friendly environment in the region;
- ✓ awareness at the political level of the importance of investing in health promotion and primary prevention;
- ✓ the dedication of a high percentage of the regional budget to health and social services.



Aspirations

It is the aim of FVGR to:

- ✓ keep politicians interested in investing in prevention projects;
- ✓ increase the budget for health promotion and prevention;
- ✓ reduce inequities in health and meet citizens' needs, within the available budget;
- ✓ reduce out-of-pocket expenses.



Challenges

These relate to:

- ✓ an ageing population;
- ✓ a low birth rate;
- ✓ a high unemployment rate;
- ✓ increased poverty in the fragile segments of the population.



Potential areas of collaboration

FVGR is interested in collaborating with other regions on:

- ✓ empowering and educating people, using a life-course perspective from childhood;
- ✓ projects related to "ageing in place" and "silver economy" to tackle the challenges of an ageing society;
- ✓ gender-transformative health promotion;
- ✓ building citizens' resilience and increasing their participation in health-related decision-making processes.



Working groups

FVGR is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (3)/equity;
- ✓ women's/men's health;
- ✓ participatory approaches/resilience;
- ✓ the all-of-government approach/intersectoral action.



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References

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2. Beveridge W. The Beveridge report, 1942. In: Internet Archive [website]. San Francisco, CA: Internet Archive; 2018 (https://archive.org/stream/in.ernet.dli.2015.275849/2015.275849.The-Beveridge_djvu.txt, accessed 25 February 2018).
3. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

Friuli Venezia Giulia, Italy



Ostuni, the White City –
jewel of Puglia

Puglia Region, Italy

General overview

The Puglia Region, with about 4 million inhabitants distributed over 19 345 km², is situated in southern Italy, bordering the Adriatic Sea to the east, the Ionian Sea to the south east, and the Strait of Otranto and Gulf of Taranto to the south. It extends from Mount Gargano in the northern part of the Region to Santa Maria di Leuca in the southernmost part, known as the Salento Peninsula, which forms the heel of the boot of Italy. Puglia has direct borders with three other Italian regions: Molise in the north, and Campania and Basilicata in the north west. Across the Adriatic and Ionian Seas, Puglia faces Albania, Bosnia-Herzegovina, Croatia, Greece, and Montenegro. The capital city of the Puglia Region is Bari (in the Bari Province). The other five Provinces are Foggia, Lecce, Brindisi, Taranto and Barletta-Andria-Trani, with a total of 258 municipalities.

Puglia has a coastline of 829 km, a wonderful sea and an exceptional cultural heritage from the Messapi and Japigi to the Ancient Greeks and Romans, and from the Byzantines to the Normans and Angevins. In addition to its beautiful “masserie” (manor farms) and “casali” (rural homes), it has three Unesco World Heritage sites: Castel del Monte, the mysterious fortress of Fredrick II (near Andria); the “trulli”, characteristic

drystone huts, unique in the world; and the Sanctuary of San Michele Arcangelo in Monte Sant’Angelo, a masterpiece of Templar medieval art and an international pilgrimage destination, very close to San Giovanni Rotondo, where the Tomb of Padre Pio attracts millions of pilgrims from all over the world.

The quality of life in the Puglia Region is excellent. Because of its warm climate, however, the Region is prone to water shortages, a problem that has been addressed through the construction of Europe’s largest aqueduct (Acquedotto Pugliese). The large-scale production of extra virgin olive oil in the Region is the basis of the Mediterranean diet (MD) traditionally adopted by the people living there. MD was inscribed in the United Nations Educational, Scientific and Cultural Organization (UNESCO) Representative List of the Intangible Cultural Heritage of Humanity in 2013.

Although the quality of life in the Region is high, there is a high unemployment rate (as a result of the emigration, over the last ten years, of 250 000 young people on finishing their education) and the number of people living on low incomes is increasing. Problems related to the ageing population are being addressed through further

welfare policies, such as “Reddito di Dignità” (Minimum Salary for Dignity) (RED) (1), and the Regional Healthcare System; the latter is committed to delivering “Livelli Essenziali di Assistenza (Essential Levels of Care) (LEA), in the fields of prevention (primary prevention and screening), treatment (diagnosis and cure) and rehabilitation. The regions are responsible for the delivery of health-care services to their populations within the framework of LEA.

The Italian health-care system, which was designed to provide health-care services to the whole population, is funded through citizen taxes.



Strengths

The strengths of the Puglia Region are:

- ✓ a universally accessible health-care system;
- ✓ a focus on public health issues, environmental protection and sustainable development;
- ✓ use of a participatory approach with citizens' involvement.



Aspirations

The Puglia Region aims to:

- ✓ achieve the goals of the “Long and happy life” programme of the current regional government;
- ✓ pursue the application of the precautionary principle in the promotion of public health (for example, in connection with the implementation of the Puglia Region Road Map towards Decarbonization (2–7);
- ✓ enhance people's well-being.

Challenges

These are to:

- ✓ tackle social and health inequities by addressing the social and environmental determinants of health;
- ✓ adequately cope with population ageing;
- ✓ increase commitment in research and innovation.

Potential areas of collaboration

The Puglia Region would be interested in collaborating with other regions on:

- ✓ assessing the impact of carbon-fired coal and steel plants on environment and health;
- ✓ the monitoring of air and water quality;
- ✓ climate change and health.

Working groups

The Puglia Region is interested in participating in working groups on:

- ✓ environment;
- ✓ women's/men's health;
- ✓ participatory approaches/resilience.

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References

1. Reddito di dignità pugliese [Minimum salary for dignity, Puglia Region] [website]. Bari: Puglia Region; 2018 (<http://red.regione.puglia.it>, accessed 27 May 2018).
2. Emiliano M, Valenzano B, Piscitelli P, Surico G, Missoni E. Decarbonisation, climate change, and human rights: a road map for the future of Puglia region. *The Lancet Planetary Health*. 2018;2(2):e60–e61.
3. Landrigan PJ, Fuller R, Acosta NJR, Adeyi O, Arnold R, Basu N et al. The Lancet Commission on pollution and health. *The Lancet*. 2018;391(10119):462–512 ([https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(17\)32345-0.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)32345-0.pdf), accessed 16 May 2018).
4. The unpaid bill of carbon. How coal power plants make us sick. Brussels: Health and Environment Alliance (HEAL); 2013 (http://www.env-health.org/IMG/pdf/heal_report_the_unpaid_health_bill_how_coal_power_plants_make_us_sick_final.pdf, accessed 16 May 2018).
5. WHO. Air quality guidelines–global update 2005. Particulate matter, ozone, nitrogen dioxide, sulfur dioxide.. Copenhagen: WHO Regional Office for Europe; 2006 (<http://www.euro.who.int/en/health-topics/environment-and-health/air-quality/publications/pre2009/air-quality-guidelines.-global-update-2005.-particulate-matter,-ozone,-nitrogen-dioxide-and-sulfur-dioxide>, accessed 16 May 2018).
6. IARC monographs. Outdoor air pollution. Volume 109. Lyon: International Agency for Research on Cancer; 2016 (<http://monographs.iarc.fr/ENG/Monographs/vol109/mono109.pdf>, accessed 16 May 2018).
7. Communication from the Commission on the precautionary principle. Brussels: European Commission; 2000 (<http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex:52000DC0001>, accessed 16 May 2018).



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Veneto Region, Italy

Canal Grande, Venice

General overview

The Veneto Region is the eighth largest region in Italy with a total area of 18 398.9 km². Located in the north-eastern part of the country it is one of the most affluent in terms of per-capita income; only 5.5% of families live in relative poverty in the Veneto Region, the averages for the northern regions and the entire country being 5.7% and 10.6%, respectively (1).

On 1 January 2017, the Region had 4 907 529 inhabitants. Having increased steadily until 2014, population growth became stable, also taking lower birth rates and migration to and from the region into consideration. In 2016, the birth rate was below 8/1000 inhabitants, whereas in 2011 the number of deaths exceeded the number of births (2).

Ageing is a big challenge and has led to a change in the needs profile. Some 20% of the Veneto population is over 65 years, 10% is over 75, and there are around 7 people over 65 for every 5 under 15. A quarter of the population has a chronic health problem, including 65% of those over 65; over 25% of those aged 75–84 and over 57% of those above that age group are disabled (3).

To manage resources and meet the needs, the Veneto Region uses the Johns Hopkins Adjusted Clinical Groups® (ACG®) system (4,5) to

understand, map and measure what is needed across its territory. This system entails analysing data related to people's diseases and the services and costs involved; people are grouped according to the constellation of diseases they experience and the support they require, from those in good health, for whom the appropriate interventions are health promotion and screening, through to those requiring end-of-life care.

Multimorbidity is the norm in Veneto Region's ageing population. Care for those affected is often fragmented and expensive. Traditional care programmes fail when many chronic conditions are prevalent at the same time. Patient expectations are changing, needs are increasing, and resources are decreasing. Integrating care can help improve health, the care experience and value for money.

The collection and analysis of data through the ACG® system provides retrospective information on the population and supports individual care, allowing a better understanding of the burden of disease, how it is distributed and, therefore, the resources needed to deal with it (6).

According to WHO, 86% of deaths and 75% of health costs in Europe and Italy are caused by chronic disease in part related to poor lifestyle

choices, namely, unhealthy nutrition, lack of physical activity, smoking and alcohol use, the main risk factors connected with chronic degenerative disease (7). The monitoring of these risk factors in relation to individual behaviour is carried out through specific surveillance programmes, such as Progressi delle Aziende Sanitarie per la Salute in Italia (Progress by local health units towards a healthier Italy) (PASSI) (8).

The national health budget is divided among the regions and autonomous provinces of Italy on a weighted, differentiated, per-capita basis, taking the ages of the local populations into account. According to a common set of criteria, the regions assign funding to their local health units (LHUs) to provide health-care services.

In recent years, the needs and challenges (including funding) of the health-care system in terms of assistance to citizens have significantly increased. To resolve this situation, the Region is currently implementing Regional Law 19/2016, which defines the reengineering of the LHUs, reducing their number from 21 to 9. Azienda Zero is the governance mechanism, which is centralizing some of the important functions

previously assigned to the LHUs, such as responsibility for procurement, human resources, training, legal services, health technology assessment, health information technology, epidemiological services and cash-flow management. This not only streamlines the use of the resources available, avoiding unnecessary duplication of cost, but also improves cost-efficiency in care delivery.

Health-care facilities, professionals, and health and social services are highly integrated in the Veneto health-care system, which has among its key objectives to provide all patients with access to the best, most timely and appropriate forms of care, and to ensure, at the same time, continuity of care by overcoming fragmentation.

Health-care facilities are run according to a hub-and-spoke scheme, which assigns all stakeholders a specific role and structural mandate based on health-care standards. The clinical networks coordinated within the scheme comply with quality, structural, technological and quantitative standards (defined by Ministerial Decree No. 70 of 2 April 2015), taking demographic conditions into account.



Strengths

The Veneto Region has the following strengths:

- ✓ a strong tradition of investment for health promotion and the prevention of risk factors;
- ✓ strong intersectoral focus, fostering the sharing of good practice in and a mutual understanding among the different sectors about the determinants of health;
- ✓ a positive balance in managing available funds without lowering standards;
- ✓ life-expectancy indicators for both men and women that are higher than the national average;
- ✓ a constant focus on integrating surveillance mechanisms and risk factors;
- ✓ the integration of social and health aspects;
- ✓ diversified solutions to the provision of assistance and care, according to the degree of care needed;
- ✓ economic recovery (many indicators show that as of 2016, Veneto has managed to overcome the recent financial crisis);
- ✓ tourism (in 2015, Veneto ranked fourth among European regions regarding number of visitors and sixth regarding number of nights spent in tourist facilities).



Aspirations

The Veneto region is aiming to:

- ✓ strengthen public health strategies to address environmental risk factors, such as water contamination;
- ✓ increase research into and development of care from both a medical/clinical and a management point of view;
- ✓ optimize the network of regional hospitals according to the hub-and-spoke system, taking the local context into consideration;
- ✓ promote the role of health professionals through intersectoral collaboration;
- ✓ support equity in the regional health sector by ensuring access to quality care;
- ✓ encourage the implementation of valuable health-systems financing by learning from European and international best practice;
- ✓ maximize the benefits of digital tools;
- ✓ develop useful comparisons with other European regions;
- ✓ continue to contribute to the fruitful process of “internationalizing” regional health through joint health-sector action with other regions.



Challenges

These are:

- ✓ an ageing population and multimorbidity;
- ✓ the considerable number of people (many elderly) living on their own (11%) who are deprived of a support network;
- ✓ an increase in the number of people prone to addiction (for example, drugs, alcohol) and in the number of younger people experimenting with substances;
- ✓ an increase in smoking among youth (while adults are tending to smoke less).



Potential areas of collaboration

The Veneto Region is interested in collaborating with other regions on:

- ✓ the training of health professionals and decision-makers in the health sector;
- ✓ primary health care;
- ✓ environment and health;
- ✓ new and innovative forms of governance;
- ✓ promoting patient-centred care;
- ✓ encouraging intersectoral and formative initiatives for health professionals.



Working groups

The Veneto Region is interested in participating in working groups on:

- ✓ environment;
- ✓ health systems/primary health care;
- ✓ the all-of -government approach/intersectoral action.

Veneto Region, Italy



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References

1. Istituto Nazionale di Statistica [National Institute of Statistics][website]. Rome: National Institute of Statistics; 2017 (<http://dati.istat.it>, accessed 25 May 2018).
2. Demografia in Cifre [Demography in numbers][website]. Rome: Istituto Nazionale di Statistica; 2018 (<http://demo.istat.it/>, accessed 23 May 2018).
3. AUR – Anagrafe Unica Assistiti Regionale. In: Portale Sanità Regione del Veneto [website]. Venice: Veneto Region; 2011 (<https://salute.regione.veneto.it/web/bando-ssi/aur-anagrafe-unica-assistiti-regionale>, accessed 14 January 2018).
4. The Johns Hopkins ACG® System [website]. Baltimore, Md: The Johns Hopkins University; 2018 (<https://www.hopkinsacg.org/>, accessed 23 May 2018).
5. Starfield B, Kinder K. Multimorbidity and its measurement. *Health Policy*. 2011;103(1):3–8.
6. Corti MC, Avossa F, Schievano E, Gallina P, Ferroni E, Alba N et al. A case-mix classification system for explaining healthcare costs using administrative data in Italy. *Eur J Intern Med*. 2018 (<https://doi.org/10.1016/j.ejim.2018.02.035>, accessed 23 May 2018).
7. Gaining health. The European Strategy for the Prevention and Control of Noncommunicable Diseases. Copenhagen: WHO Regional Office for Europe; 2006 (EUR/RC56/8 + EUR/RC56/Conf.Doc./3; http://www.epicentro.iss.it/focus/guadagnare_salute/pdf/Strategia_europea_italiano.pdf, accessed 23 May 2018).
8. Progressi delle Aziende Sanitarie per la Salute in Italia: la sorveglianza Passi [Progress of local health units in Italy: the surveillance Passi]. In: Epicentro [website]. Rome: Istituto Superiore di Sanità; 2018 (<http://www.epicentro.iss.it/passi/>, accessed 23 May 2018).

Veneto Region, Italy



The Kyzylorda Oblast
Medical Center,
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Kyzylorda Oblast, Kazakhstan

General overview

Kyzylorda Oblast (region) is situated along the Syrdariya River in the south-western part of the Republic of Kazakhstan in central Eurasia. The region covers an area of 226 000 km² with a distance of 1000 km between its northernmost and southernmost borders (1). Comprising seven districts and the capital city – also called Kyzylorda – the region is more than 190 years old, one of the oldest in the country. It borders on Aktobe Oblast in the north-west, Karaganda Oblast in the north, South Kazakhstani Oblast in the south-east, and the Republic of Uzbekistan in the south. It has a wide range of mineral resources, the most important being hydrocarbons, non-ferrous metals (lead and zinc), uranium, vanadium, white salt and underground mineral waters. The gross domestic product per capita was T 839 300 in the first half of 2017 (approximately US\$ 2632 as of 21 February 2018). The total population of the region is 780 235 (390 857 men and 389 378 women), more than the half of which lives in rural areas. According to 2015 data, total life expectancy is 71.9 years (67.8 for men and 76.3 for women) (1).

One of the challenges in the region is its very pronounced continental climate with great variations in temperatures, which in summer can reach 46 °C and in winter drop to -37 °C. In

summer, precipitation generally evaporates, and it is only in winter that the soil receives moisture. There are many days with strong wind, and dust storms can occur in summer. The remaining part of the shrinking Aral Sea – the Small Aral Sea – is located in the southern part of the region. The Aral Sea has been described as “one of the worst environmental disasters of the world” (2). The salinity of the remaining water exceeds 100 g/l. In 2008, a project to construct a seawall made it possible to increase the water level slowly in the northern part of the Aral. Currently, the level of salinity is decreasing, which has resulted in the appearance of some species of fish. Fishing in the Sea, as an industry, is reviving and again becoming a source of income.

The Region hosts the space-launch complex, Baikonur Space Base.

The main challenge in the Region is to improve quality of life, particularly in rural areas. Considering the high level of environmental and health risks resulting from the Aral Sea disaster, the adaption of the population to climate change, particularly in summertime, is of the utmost importance. Other key challenges to the sustainable development of population

health include limited access to clean water and sanitation, especially in villages. Efforts have been made to build networks of drinking-water supplies in the rural areas, but problems relating to access to improved sanitation and the implementation of water, sanitation and hygiene (WASH) standards, especially in educational and health-care facilities, require special attention and are yet to be resolved.

The aim of the current National Health Development Programme, “Densaulyk” (2016–2019), is to improve population health and achieve sustainable socioeconomic growth in the country. The regional health system is an integral part of the national health system, which is controlled by the Ministry of Health of the Republic of Kazakhstan. The Ministry takes all the policy decisions regarding health at the national level, while health-care facilities have a certain degree of independency at the local level. Health-care services are provided free of charge by the state and private specialized diagnostic centres licensed by the Regional Health Department. The health system is financed through national and local budgets.

Historically, the rate of morbidity from communicable diseases in Kyzylorda Oblast has been high since it is home to several zoonotic infections, such as plague, Congo-Crimean hemorrhagic fever, anthrax and brucellosis. Through the effective organization of sanitary and epidemiological welfare services, epidemiological surveillance is being carried out successfully in all communities of the Oblast.

On the other hand, the level of morbidity from noncommunicable diseases (NCDs) is high despite the health-system reform, which is in progress at the national level to improve population health with a focus on prevention. The reform, which is being managed at the national level, is the shared responsibility of the Government, the health system and the population. Tackling prevention and promoting healthy lifestyles are challenging for health-care facilities at the regional level. Primary-health-care (PHC) professionals lack sufficient competencies in the field of NCDs. Improvement is also needed in the promotion of healthy lifestyles, healthy eating and physical activity.



Strengths

The strengths of Kyzylorda Oblast include:

- ✓ high investment in the health sector, including the provision of resources for health-care facilities and human resources' capacity-building;
- ✓ the National Programme 2016–2019, “Densaulyk” ;
- ✓ effective organization of epidemiological and health monitoring.



Aspirations

The Oblast is interested in:

- ✓ learning about new ways of accessing information about best practice at the global level;
- ✓ sharing its experience in the development of public health and PHC;
- ✓ introducing the health-for-all approach.

Challenges

These are:

- ✓ an excessive load on PHC doctors;
- ✓ need to increase NCD-related competencies;
- ✓ need to better motivate health professionals;
- ✓ difficulties in the delivery of preventive services;
- ✓ too few NCD-prevention programmes;
- ✓ insufficient access to safe water and sanitation;
- ✓ need to promote the rational use of fresh-water ecosystem.

Potential areas of collaboration

Kyzylorda Oblast is interested in collaborating with other regions on:

- ✓ improving health behaviour and health literacy among the population with a view to NCD prevention;
- ✓ protecting women's health, particularly women of childbearing age;
- ✓ combatting the effects of climate change and providing access to clean water and sanitary services.

Working groups

Kyzylorda Oblast is interested in participating in working groups on:

- ✓ environment;
- ✓ women's/men's health;
- ✓ health systems/primary health care.

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References

1. Official data of the Department of Statistics of Kyzylorda Oblast. Kyzylorda: Department of Statistics of Kyzylorda Oblast; 2017.
2. Shrinking Aral Sea underscores need for urgent action on environment – Ban. In: UN News [website]. New York: United Nations; 2010 (<https://news.un.org/en/story/2010/04/334402>, accessed 8 May 2018).

Kyzylorda Oblast, Kazakhstan



“Girl” on Central Park Sculpture Trail, Birštonas, Kaunas Region (by Sculptor Romas Kvintas)

Kaunas Region, Lithuania

General overview

The Kaunas Region is located in the centre of Lithuania and covers an area of 8086 km². It is subdivided into eight municipalities: Birštonas town, Kaunas city, and the Jonava, Kaišiadorys, Kaunas, Kėdainiai, Prienai and Raseiniai districts. The municipalities vary considerably in size, the largest being Kaunas city with 292 691 citizens (1). The total population of the Kaunas Region is 569 875.

Life expectancy in the Kaunas region is 75.6 years (80.6 years for women and 70.2 years for men) (2). The main reasons for death in the Kaunas region are similar to those for the country as a whole, namely, cardiovascular diseases (Kaunas region: 690.2/100 000; Lithuania: 718.8/100 000), malignant tumours (Kaunas region: 261.5/100 000; Lithuania: 246.7/100 000) and external causes of death (Kaunas region: 120.0/100 000; Lithuania: 123.1/100 000) (3).

Other indicators listed in the Health Indicators of Lithuania database are also important in rating health disparities in the Kaunas Region. A detailed analysis carried out in 2016 showed noticeable differences between the municipalities. For example:

- the lowest rates of morbidity from type II diabetes mellitus were found in the Kaunas and Kaišiadorys districts (39.2–41.6/10 000), the highest rates were found in Kaunas city and the Jonava district (61.5–62.5/10 000), while the average rates for the Kaunas Region and the whole country were, respectively, 50.3/10 000 and 45.6/10 000;
- the lowest rates of social-risk families were found in Kaunas city (1.5–2.5/1000 population), the highest rates in the districts of Raseiniai and Prienai (6.2–6.8/1000), and the average rates for the Kaunas Region and the whole country were, respectively, 4.5/1000 and 3.4/1000 (3).

There are five universities in the Kaunas Region, three of which are involved in activities related to health promotion: the Lithuanian Sports University, the Aleksandras Stulginskis University (both directly involved as members of the Health Promoting Universities network in Lithuania), and the Lithuanian University of Health Sciences (indirectly involved).

The Kaunas Region is not an administrative unit as there are no regional decision-making administrative authorities in Lithuania, and there are no regional taxes. The Kaunas Regional

Development Council, a collegial body comprising representatives of the public and the local authorities, has the legal authority to take decisions on important problems relating to the municipalities, or the Region as a whole, approve the regional development plan, and provide recommendations to the Ministry of Interior and other national institutions. The Council is approved by the Minister of the Interior within three months of the municipal council elections that take place every four years.

In 2012, the Kaunas Regional Development Council made the decision to participate in Regions for Health Network (RHN) and, to this end, established the Health Promoting Kaunas Region Working Group. The Group is comprised on a parity basis, each municipality having the right to delegate two representatives (physicians, representatives of public health bureaus, politicians).

Since 1996, Lithuania has had compulsory national health insurance, which consists of employers', state-budget and personal payments. It is the responsibility of the National Health Insurance Fund, which is a state institution under the Ministry of Health. The State Patient Fund has five units called Territorial Health Insurance

Funds; the Kaunas Region is served by the Kaunas Territorial Health Insurance Fund. All health-care services provided by private or public institutions in possession of signed agreements with Territorial Health Insurance Funds are free of charge to patients.

In the Kaunas Region, PHC centres (policlinics, dispensaries and family-doctors' offices) are arranged so that their services are also available to residents living more remotely. In addition, each municipality has ambulance stations, mental-health centres, and nursing hospitals. All these services are provided by both municipality-subordinate and private institutions.

Second-level health-care institutions (hospitals and consulting clinics) operate in the municipalities as well. The largest hospital in Lithuania (approximately 2000 beds) – the Hospital of the Lithuanian University of Health Sciences (Kauno Klinikos) – is found in Kaunas city. It provides third-level health-care services (including highest-level specialization in heart, lung and liver transplantations).

The Kaunas Region does not have a separate budget, or health foundation.



Strengths

The strengths of the Kaunas Region include:

- ✓ its being one of the economically strongest regions in Lithuania (this includes the support of EU structural funds and investments in its development);
- ✓ highly qualified academic staff (the Region has five universities, including the Lithuanian Sports University, the Lithuanian University of Health Sciences and the Aleksandras Stulginskis University, which lead initiatives related to health-promotion programmes and projects, such as Health Promoting Kindergartens, Health Promoting Schools, Health Promoting Universities, Health Promoting Hospitals and Health Services);
- ✓ the presence of active public health bureaus in each municipality in the Region;
- ✓ municipal physicians responsible for the coordination of the health services delivered in each municipality in the Region;
- ✓ the Health Promoting Kaunas Region Working Group, which coordinates the implementation of measures to reach the goals of RHN and the Kaunas Region.



Aspirations

The Kaunas Region aims to:

- ✓ decrease health inequalities;
- ✓ develop good practice in intersectoral collaboration on solving health-related problems;
- ✓ implement the Health 2020 strategy (4) (including the Health in All Policies approach (5)), and the Sustainable Development Goals (6).



Challenges

These are the need to:

- ✓ strengthen leadership competencies for positioning the Kaunas Region as a "healthy region";
- ✓ strengthen the administration and management of the Kaunas Region as the Health Promoting Kaunas Region;
- ✓ enhance understanding of the added value of intersectoral collaboration for solving health-related problems in the Region as a whole and in each municipality.



Potential areas of collaboration

The Kaunas Region is interested in collaborating with other regions on:

- ✓ developing effective methods of intersectoral collaboration at the municipal level;
- ✓ joint research projects on health inequalities;
- ✓ developing good practice in primary health care (PHC) involvement in health promotion and the prevention of noncommunicable diseases;
- ✓ the involvement of nongovernmental organizations and the community in health-promotion activities.



Working groups

The Kaunas Region is interested in participating in working groups on:

- ✓ the all-of-government approach/intersectoral action;
- ✓ women's/ men's health;
- ✓ health systems/PHC.



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References

1. Oficialiosios statistikos portalas [Official statistics portal] [online database]. Vilnius: Department of Statistics of the Government of the Republic of Lithuania; 2017 (https://osp.stat.gov.lt/statistiniu-rodikliu-analize?region=all#/, accessed 10 May 2018).
2. Oficialiosios statistikos portalas [Official statistics portal] [online database]. Vilnius: Department of Statistics of the Government of the Republic of Lithuania; 2016 (https://osp.stat.gov.lt/statistiniu-rodikliu-analize?region=all#/, accessed 10 May 2018).
3. Lietuvos sveikatos rodiklių sistema [Lithuanian health indicator system] [online database]. Vilnius: Lithuanian Health Information Center, Institute of Hygiene; 2016 (<http://sic.hi.lt/webdps/?lang=lt>, accessed 10 March 2018).
4. Health 2020: the European policy for health and well-being. In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being>, accessed 10 March 2018).
5. Sustainable Development Goals. In: Sustainable Development Knowledge Platform. New York: United Nations; 2015 (<https://sustainabledevelopment.un.org/sdgs>, accessed 10 March 2018).
6. Leppo K, Ollila E, Peňa S, Wismar M, Cook S, editors. Health in all policies. Seizing opportunities, implementing policies. Helsinki: Ministry of Health and Social Affairs; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/health-in-all-policies-final.pdf, accessed 10 March 2018).

Kaunas, Lithuania

Klaipėda Region, Lithuania

Sailing-boat Meridianas,
Klaipėda city

General overview

The Klaipėda Region, situated in the western part of Lithuania, includes seven municipalities and has a population of 317 471 (beginning 2018), representing 11.3% of the Lithuanian population. The territory of the Region covers 5209 km² and the average population density is 61/km² (1).

The main city in the Region, which is also called Klaipėda, is the third-largest in Lithuania and has the only sea port in the country. One of the three largest health-care centres in Lithuania is also found in Klaipėda city where four multiprofile hospitals provide the highest level of qualified, specialized services. The city participates actively in international health projects, such as the WHO European Healthy Cities Network, which it joined in 2011.

Klaipėda city is the first in Lithuania to be awarded the European Capitals and Cities of Sport Federation (ACES Europe) title, “European City of Sport 2018”. Currently, it has almost 100 facilities for sport, leisure and wellness, 5 professional sports clubs, and 5 sports schools for children. The Klaipėda City Municipality was the first in the country to introduce swimming lessons for pupils in the second grade.

The average life expectancy in the Region is 75.6 years (70.4 years for men and 80.5 years for women) (1). In 2016, the infant mortality rate was 3.6‰ while the average for the country was 4.5‰. The crude death rate for the Region was 13.7‰, the three leading causes being cardiovascular diseases, malignant neoplasms and external causes (2).

The health system in Lithuania is funded through the Compulsory Health Insurance Fund, which comprises contributions from employers and employees, as well as revenue created through state and social insurance activity. Public health is funded from state and municipal budgets. The municipalities support health care in their respective territories by providing additional funding for basic medical aid and health care for pregnant women, unemployed people, people with disabilities, children under 16 years of age, orphans under 18 years of age, and people who have reached retirement age. Lithuania provides free state-funded health care to all citizens and registered long-term residents. Private health care is also available.

The Ministry of Health is responsible for implementing government policy and controls

Lithuania's health-care system at the central level. Expenditure related to health care accounts for 6.7% of the gross domestic product (3). Political and financial autonomy and responsibility for health care have been delegated to the municipal level. In the Klaipeda Region, the municipal councils are responsible for health care, which is administered by the Health Care Department and implemented either by public health bureaus or primary-health-care centres, depending on which is responsible for the type of health care in question. Public health services at the municipal level are provided by the public health bureaus, their main functions being: health monitoring at the municipal level; health promotion in kindergartens, schools and communities; and the provision of youth-friendly health-care services.



Strengths

The strengths of the Klaipeda Region include:

- ✓ its favourable geographic location for economic development as the northernmost ice-free port on the east coast of the Baltic Sea;
- ✓ its well-developed physical and social infrastructure;
- ✓ the high recreational potential of its natural resources: geothermal water and the Baltic Sea;
- ✓ the presence of highly qualified health-care professionals in the Region, from specialists in public health to those working in personal health care.



Aspirations

The Klaipeda Region is aiming to:

- ✓ increase the involvement of the private sector and nongovernmental organizations in health politics;
- ✓ strengthen public health at the municipal level;
- ✓ develop integrated health and social services.

Challenges

The main challenges in the Klaipeda Region are:

- ✓ the insufficiency of the resources allocated for health care and, especially, public health;
- ✓ health inequality in urban/rural areas, gender-related inequality, inequality related to socially disadvantaged groups, and socioeconomic inequality in access to health care;
- ✓ a decline in the population growth rate and stagnant birth rate.

Potential areas of collaboration

The Klaipeda Region is interested in collaborating with other regions on:

- ✓ strengthening cross-sectoral partnership for health at the local level and public participation in planning and implementing health interventions;
- ✓ reducing health inequalities and improving access to comprehensive, quality health-care services;
- ✓ developing innovative programmes on promoting public health at the municipal level.

Working groups

The Klaipeda Region is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (4)/equity;
- ✓ women's/men's health;
- ✓ the all-of-government approach/intersectoral action.

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References

1. Oficialiosios statistikos portalas [Official statistics portal] [online database]. Vilnius: Department of Statistics of the Government of the Republic of Lithuania; 2016 (<https://osp.stat.gov.lt/statistiniu-rodikliu-analize?hash=bd3d3cb3-e789-4bf4-ba4c-6797c2c1d8f6#/>, accessed 27 February 2018).
2. Lietuvos sveikatos rodiklių sistema [Lithuanian health indicator system] [online database]. Vilnius: Lithuanian Health Information Center, Institute of Hygiene; 2016 (<http://sic.hi.lt/webdps/?lang=lt>, accessed 27 February 2018).
3. European health for all database [online database]. Copenhagen: WHO Regional Office for Europe; 2014 (<http://data.euro.who.int/hfad/>, accessed 27 February 2018).
4. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

Klaipeda Region, Lithuania



Meuse-Rhine Euroregion

Old Bridge, Maastricht

General overview

The Meuse-Rhine Euroregion (EMR) is one of the oldest cross-border regions in the European Union; it was created in 1976 and achieved legal status in 1991. For the past 35 years, EMR has brought together five partner regions in three countries with different languages and cultures. Since 1976, the southern and central parts of the Dutch Province of Limburg, the German Zweckverband (specific administration union) of the Aachen Region, the German-speaking community of Belgium, and the Belgian provinces of Liège and Limburg have joined forces in tackling cross-border issues. The Euroregion covers a geographical area of approximately 11 000 km² around the city corridor of Aachen–Maastricht–Hasselt–Liège. This cross-border partnership creates new opportunities for the population, thus making an important contribution to the quality of life of the approximately four million inhabitants living in EMR. The seat of the Euroregion has been in Eupen, Belgium, since 1 January 2007 (1).

EMR hosts around 150 municipalities, 49 of which have one or more borders with another country. It has more than 50 hospitals, 22 universities and higher educational colleges, and around 43 000 daily commuters (1).

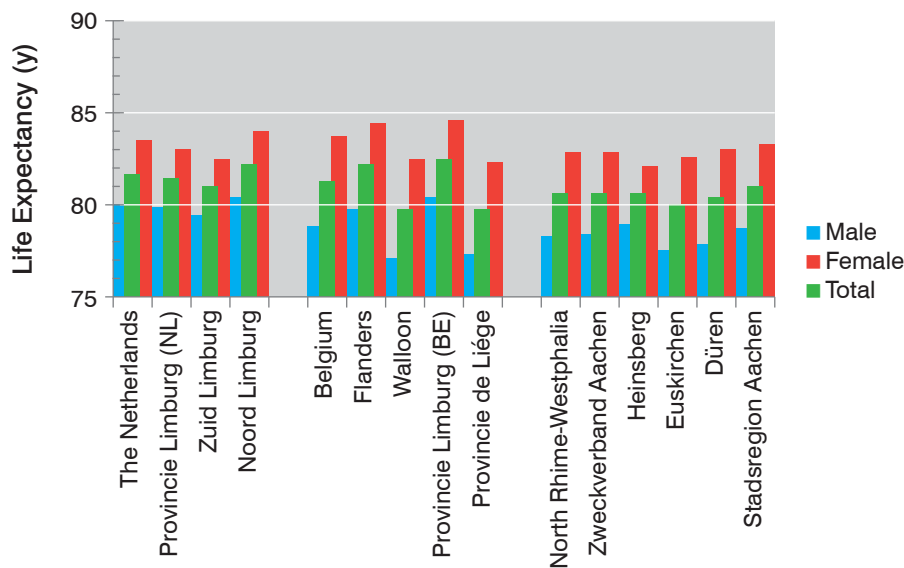
The regions in EMR share a partly common history (for example, in relation to mining) and their health statuses have many similarities. There are, however, wide differences between the regions' public health structures and health-care systems, not only across the different countries, but also within the countries. For example, the health-care systems of all of the regions involve insurance companies, although the conditions under which these companies function differ.

The health-care sector in EMR is changing rapidly: social trends are enforcing a fundamentally different approach to health-care activities, health-care professionals and patients. For example, population ageing, health inequalities, environmental challenges, increasingly sophisticated medical technology (health technology), the growing need for a comprehensive people-centered public health approach and greater patient autonomy means that the concept of health care has become much broader. There is a clear need and wish to focus more on public health. This is especially important in EMR, where not only the population, but also the (public) health-care professionals, organizations, etc., must deal with the above-mentioned changes relative to three different health-care systems.

Regarding the topic of health, EMR has delegated action to achieve its objectives in this area to the euPrevent | EMR Foundation (2). EuPrevent initiates, supports, stimulates and facilitates cross-border cooperation between professionals and organizations working to promote and preserve the health of the population. It brings together partners from the different countries in EMR to work on these challenges and create opportunities for the population (2). This is done

through a collaboration programme, entitled “Crossing borders in health”, which uses the approaches of two frameworks: Positive health (3) and Health in All Policies (4,5). One of the aims of this programme is to collect and compare data at the euregional level for use by both health-care professionals and policy-makers. An example of this is the overview of life expectancy in EMR provided in Fig. 1 (2).

Fig 1. Life expectancy in EMR, 2014



Source: euPrevent, 2018 (2)

Another result of EMR collaboration in public health, executed through euPrevent (2), is a support system aimed at helping communities to become “senior friendly”, that is, to focus on being care friendly, carer friendly and inclusion friendly, allowing senior citizens to continue to live normal lives from both an economic and a social perspective. The focus of the support

system so far has been on dementia and depression in the elderly. One of its concrete results is the creation of online assessment tools that enable communities to examine their (euregional) collaboration on dementia or depression. These tools, which can be used by everyone free of charge, can be found on the euPrevent website (2).



Strengths

EMR's strengths include:

- ✓ a wealth of experience in and knowledge about how to make best use of three different (public) health-care systems, including patient accessibility to all services in the Euroregion;
- ✓ a broad euregional network of health-care providers, health-care insurance companies, public health authorities, patient organizations, university departments related to health care, and governments, among others;
- ✓ the ability to transform abstract and more theoretical topics into practical implications for (public) health care in EMR.



Aspirations

EMR is aiming to:

- ✓ improve the quality of life of EMR citizens by ensuring (public) health care without borders;
- ✓ deal with practical problems related to the changing demography, technology, life patterns and health-care systems, as well as health inequality and patient autonomy;
- ✓ extend the extent of EMR's service as a test zone for a wide range of cross-border policies and activities related to public health care;
- ✓ direct more attention to (public) health-care economy in the broad sense, including innovations in the fields of technology and marketing.



Challenges

These are:

- ✓ differences in legislation, (public) health-care systems and structures across the Euroregion;
- ✓ differences in governmental responsibilities concerning (public) health care and topics related to health care;
- ✓ shortages of health-care professionals;
- ✓ low health status in some parts of EMR.



Potential areas of collaboration

The Euroregion is interested in working with other regions on topics related to:

- ✓ environmental health;
- ✓ Health in All Policies (4,5);
- ✓ changing demography, technology, life patterns and public health-care systems, as well as health inequality and patient autonomy;
- ✓ cross-border cooperation related to public health;
- ✓ cross-border cooperation on citizen empowerment, health care and cultural innovation.



Working groups

EMR is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (6)/ equity;
- ✓ environment;
- ✓ participatory approaches/resilience;
- ✓ the all-of-government approach/intersectoral action.



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References

1. Euregio Maas-Rhein | Maas-Rijn | Meuse-Rhin [website]. Eupen: Euregio Maas-Rhein | Maas-Rijn | Meuse-Rhin; 2018 (<http://euregio-mr.info/euregio-mr-de/wer-wir-sind/organisation/>, accessed 26 April 2018).
2. euPrevent | EMR [website]. Heerlen: euPrevent | EMR; 2018 (www.euprevent.eu/tools/, accessed 26 April 2018).
3. Institute for Positive Health [website]. Utrecht: Institute for Positive Health; 2017 (<https://iph.nl/>, accessed 26 April 2018).
4. WHO, Ministry of Social Affairs and Health of Finland. The 8th Global Conference on Health Promotion, Helsinki, Finland, 10–14 June 2013. The Helsinki Statement on Health in All Policies. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.who.int/healthpromotion/conferences/8gchp/en/>, accessed 17 April 2018).
5. Leppo K, Ollila E, Peña S, Wismar M, Cook S, editors. Health in All Policies. Seizing opportunities, implementing policies. Helsinki: Ministry of Social Affairs and Health; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf, accessed 17 April 2018).
6. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

Meuse-Rhine Euroregion



Province of Utrecht, Netherlands

Fort Ruigenhoek

General overview

Founded by Bishop Willibrord in the 7th century, the Province of Utrecht is the oldest of the 12 provinces in the Netherlands. It lies in the centre of the country as part of the Randstad Region (a megalopolis in the west-central part of the Netherlands, comprising the 4 largest Dutch cities, Amsterdam, The Hague, Rotterdam and Utrecht). The Province of Utrecht itself consists of 26 municipalities and their surrounding areas.

Described as “the beating heart of the Netherlands”, the Province of Utrecht spans an area of 1449 km² and has a total population of 1 200 000 (1). The Province owes its strong economic position to its central geographic location, which links the west of the Netherlands (often called the Randstad Region) with the German Ruhr Area. Its largest cities are Amersfoort, Nieuwegein, Zeist and Utrecht (capital of the Province).

The Province of Utrecht combines urban living facilities in natural and green areas with the busiest rail/water/road networks in the Netherlands. Utrecht’s central railway station processes 57 million travellers each year – as many as Amsterdam Schiphol Airport. It is also one of the most densely populated regions in

the Netherlands with 904 residents per km², compared to 513 residents per km² for the whole country (2).

In the Netherlands, the provinces represent the middle level of government and as such work in close cooperation with the municipalities and central Government. The Government of the Province of Utrecht has a tier comprising officials elected to serve on the Provincial Council and Provincial Executive; it employs roughly 800 civil servants.

The Province of Utrecht uses its constitutional powers to develop and implement integrated programmes and strategies on spatial planning, mobility, regional public transport, energy, housing and the environment. It does so, focusing on promoting a healthy living environment (especially the reduction of noise and air pollution) and a positive health approach among its citizens, which means actively promoting healthy life choices.

The Province does not have direct responsibility for public health. In the Netherlands, overall responsibility for the Dutch health-care system is at the national level. Central Government sets the health-care priorities, introducing legislative change when necessary and monitoring access,

quality and costs. It also partly finances social-health insurance. Prevention and social support are not part of social-health insurance but are financed through general taxation. Municipalities and health insurers are responsible for most outpatient long-term services and all youth care, using a provision-based approach (with a high level of freedom at the local level).

To achieve its health-and environment-related goals, the Province must work with public, private and knowledge-related partners alike. Luckily, it has an abundance of knowledge institutes, private-sector companies and start-ups from which it can profit.

According to WHO data (2018), the average life expectancy of residents in the Province of Utrecht is 82.6 years, compared to 80.6 years for those in the city of Utrecht. In 6 of the 26 municipalities, the average life expectancy, ranging between 84 and 85 years, is quite a bit higher than the national average of 81.4 years, which ranks the Netherlands seventeenth at the global level (3).



Strengths

The strengths of the Province of Utrecht include:

- ✓ strong regional cooperation with knowledge and research institutes dealing with public health, health care and environment, such as the National Institute for Public Health and the Environment, the University Medical Centre Utrecht, the Hubrecht Institute, the Royal Netherlands Academy of Arts and Sciences, the "Princess Maxima Centre" for child cancer and the Royal Netherlands Meteorological Institute;
- ✓ Health Hub Utrecht, a multiple helix network working to promote positive health and attainable health care, comprising – among others – the City of Utrecht, the Province of Utrecht, the Economic Board Utrecht, the University of Utrecht, Utrecht University of Applied Sciences and the above-mentioned knowledge institutes, as well as private-sector practitioners;
- ✓ being a living lab in terms of healthy urban living, known for education, innovation and economics within health care in the Netherlands;
- ✓ having the most highly educated and practically trained workforce in the Netherlands (44% with a university degree) and +/- 60.000 students of which 85% speak at least 3 languages (4);
- ✓ being the fastest growing economic region in the Netherlands and the second most competitive region in Europe and an innovation leader, according to the EU Commission (5);
- ✓ having the tenth-best incubator in the world: UtrechtInc (university business incubator) (6).



Aspirations

The Province is aiming to:

- ✓ become the healthiest region in Europe in terms of housing, working, living and mobility (which means working towards a healthy environment, a healthy economy and an inclusive recreational society focused on connectivity in the broadest terms);
- ✓ become an international living lab for innovative healthy urban living and find sustainable energy solutions for healthy growth and urbanization;
- ✓ reduce air and noise pollution towards meeting – by 2030 – the WHO standards for air quality and for noise pollution in new noise-sensitive buildings (such as, schools, hospitals, etc.) (7,8);
- ✓ increase joint initiatives between the government, knowledge institutes, private-sector companies and citizens.

Challenges

These include:

- ✓ meeting housing needs (resulting from a population increase of +/- 160 000), which will demand roughly 30% more dwellings in 2050, while maintaining the Province as an attractive place to live, work, recreate and interact;
- ✓ preserving citizens' quality of life through affordable housing, clean energy, good infrastructure and a healthy living environment;
- ✓ finding better ways to equip health-care students for the needs of the future labour market and its challenges;
- ✓ finding ways of avoiding health-care issues, resulting from busy waterways, railroads and highways, while taking the rising mobility needs of the Province into account;
- ✓ finding the right form of effectively working together in a multiple helix network – a participatory and multidisciplinary approach, involving governmental institutions, knowledge institutions, private-sector companies and citizens;
- ✓ finding the spatial-planning arrangements (including green/recreational areas) in which citizens can lead healthy lives.

Potential areas of collaboration

The Province of Utrecht is interested in collaborating with other regions on:

- ✓ finding ways of influencing policy-makers and integrating a healthy-living approach in all policy areas (Health in All Policies (HIAP)) (9, 10);
- ✓ developing a cross-border exchange of strategies, as well as best practice in healthy planning in urban and rural areas;
- ✓ further improving air quality and reducing noise pollution in accordance with the WHO guidelines (7,8);
- ✓ finding proven ways of effectively collaborating in a multiple helix, using a participatory and multidisciplinary approach.

Working groups

The Province of Utrecht is interested in participating in working groups on:

- ✓ environment;
- ✓ participatory approaches/resilience;
- ✓ the all-of-government approach/intersectoral action.



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References¹

1. Province of Utrecht. In: Provincie Utrecht [website]. Utrecht: Province of Utrecht; 2019 (<https://www.provincie-utrecht.nl/algemene-onderdelen/serviceblok/english/provincie-utrecht/>).
2. Metatopos [website]. The Hague: The Koninklijke Bibliotheek; 2019 (http://www.metatopos.eu/provincies_eu.php).
3. Netherlands: life expectancy. In: WorldHealthRankings. Le Duc Media; 2018 (<https://www.worldlifeexpectancy.com/netherlands-life-expectancy>).
4. Bright and talented workforce. In: Utrecht Region – Invest Utrecht [website]. Utrecht: Utrecht Region; 2017 (<https://www.investutrecht.com/en/smart>).
5. Utrecht City In Business [website]. Utrecht: Utrecht Region; 2017 (<https://utrechtcityinbusiness.com/en/home-2/>).
6. Ranking: Top Business Incubator – Affiliated with University – 2017/2018. In: UBI Global [website]. Stockholm: UBI Global; 2017 (<https://ubi-global.com/ranking-top-business-incubator-managed-university-2017-2018-2/>).
7. Air pollution. Guidelines. In: World Health Organization [website]. Geneva: WHO; 2019 (<https://www.who.int/airpollution/guidelines/en/>).
8. New WHO noise guidelines for Europe released. In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2019 (<http://www.euro.who.int/en/media-centre/sections/press-releases/2018/press-information-note-on-the-launch-of-the-who-environmental-noise-guidelines-for-the-european-region>).
9. Leppo K, Ollila E, Peňa S, Wismar M, Cook S, editors. Health in All Policies. Seizing opportunities, implementing policies. Helsinki: Ministry of Social Affairs and Health; 2013 (<http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/health-in-all-policies-seizing-opportunities,-implementing-policies-2013>).
10. WHO, Ministry of Social Affairs and Health of Finland. The 8th Global Conference on Health Promotion, Helsinki, Finland, 10–14 June 2013. The Helsinki Statement on Health in All Policies. Copenhagen: WHO Regional Office for Europe; 2013 (https://www.who.int/healthpromotion/conferences/8gchp/8gchp_helsinki_statement.pdf).

¹ All URLs accessed 25 May 2019.

Akershus County, Norway

Autumn, Akershus

General overview

Akershus County, Norway, borders the capital from the east, west and north and is often referred to as “the green belt of Oslo”. Although its geographic area is relatively small (4918 km²), Akershus is one of the largest counties in Norway comprising 600 000 inhabitants (11.5% of the total population). It is divided into four districts and has 22 municipalities. While some areas are densely populated (nine out of ten people live in urban areas), there are large distances between neighbours in rural areas (1).

The overall health level in Akershus County is high, and the average life expectancy is 82 years (2). The population is young and well educated compared to the rest of the country. Children thrive in their schools, and businesses provide adequate possibilities for young people seeking apprenticeships. Unemployment rates are low, and the general level of income is high; however, health inequality is increasing because of social inequities, for instance, in living conditions.

Akershus County has the highest level of net migration within Norway and attracts many people in the age group 30–39 years from both Oslo and abroad. Over the most recent 20 years, as a result of immigration from abroad and migration within

Norway, the County has seen a 35.4% increase in population and a further increase of 200 000 is foreseen by 2040 (2). Young adults attracted to living and working in the capital tend to move to Akershus County when they start a family. They are typically of immigrant background, are in their thirties and have young children. This means that the population of Akershus is becoming more ethnically diverse and multicultural. More than 120 000 people commute daily from Akershus to Oslo and other counties. Housing prices in Akershus have increased by more than 50% since 2010; a record-high number of new houses were constructed in 2017 (1).

Akershus County Council is a democratically elected body with regional responsibilities in areas such as education, transport, dental care and regional development. Using its development funds, the County Council aims to promote public health through all service areas. Norway is currently undergoing a regional reform that may influence the way in which the County will be organized in the future.

The Norwegian health-care system was developed as part of the welfare state after the Second World War to ensure access for all inhabitants to quality

care, independent of their place of residence and socioeconomic status. While the system is financed through taxes stipulating certain payment conditions, all residents are covered by the National Insurance Scheme. Health-care policy is controlled centrally, while responsibility for the provision of health care is decentralized. The Norwegian Government has overall managerial and financial responsibility for the hospital sector. After the latter was restructured in 2002, responsibility for running public hospitals was transferred from the county level to four regional health authorities overseen by the Ministry of Health and Care Services.

The aim of the *Norwegian Public Health Act* passed in 2011 was to contribute to social development that promotes public health and reduces social inequity in health. The Act stipulates that public health work shall promote population health and well-being, as well as good social and environmental conditions, and contribute to the prevention of mental-health

problems and somatic diseases. It aims to facilitate long-term, systematic public health work and lists responsibilities at the local (municipality), regional (county) and national (country) levels. It specifies that the local and regional levels are the key stakeholders, but that it is the responsibility of the national level to support them.

Akershus County Council has the overarching responsibility for promoting good public health in the County. This includes monitoring the status and key determinants of the health of the population and ensuring that health is included in all regional policies. This work is organized through partnerships with the County's municipalities and financed through grants and subsidies. The Council also cooperates with and supports several nongovernmental organizations in various fields. Responsibility for implementing measures to meet public health challenges lies with the municipalities, most of which have a designated public health coordinator.



Strengths

Akershus County:

- ✓ has a well-funded, well-functioning health-care system;
- ✓ takes a broad, holistic, intersectoral approach rooted in the *Norwegian Public Health Act*;
- ✓ enforces focus on public health in municipal planning through the *Planning and Building Act*;
- ✓ applies the precautionary principle and a participatory approach.



Aspirations

Akershus County is aiming to:

- ✓ develop sustainability, for example, through health-promoting urban areas;
- ✓ introduce a systematic public health approach;
- ✓ enhance public well-being.

Challenges

These include:

- ✓ increasing health inequality resulting from social inequities in living conditions;
- ✓ the rise in the rate of mental-health issues;
- ✓ the sectoral focus on public health;
- ✓ a large ageing population.

Potential areas of collaboration

Akershus County is interested in collaborating with other regions on the development of:

- ✓ health-promoting urban areas;
- ✓ social sustainability;
- ✓ preventive measures and life-coping skills.

Working groups

Akershus County is interested in participating in working groups on:

- ✓ development goals/equity;
- ✓ participatory approaches/resilience;
- ✓ the all-of-government approach/intersectoral action;
- ✓ health-promoting urban development/sustainable development and well-being.

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References

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2. Akershusstatistikk nr 3-2016 – befolkningsprognoser for Akershus 2016–2031 [Akershus statistics no. 3-2016 – population prognoses for Akershus 2016–2031]. In: Statistikkhefter og grunnlagsdokumenter [Statistics and foundation documents] [website]. Oslo: Akershus fylkeskommune; 2016 (<http://www.akershus.no/ansvarsomrader/statistikk-og-kart/om-statistikkjenesten/statistikkhefter/>, accessed 5 February 2018).

Akershus County, Norway



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Østfold County, Norway

Old town in Fredrikstad

General overview

Located in south-eastern Norway between Oslo, the capital, and Sweden, Østfold County has a population of about 293 000 (5.6% of the total of Norway) and a population density of 70/km² (1). It covers an area of approximately 4000 km² (5.6% of the country) and has a total of 18 municipalities (2). The administrative seat of the County is Sarpsborg. With its highways, railways and ports, it is a transport hub in Norway.

Norway is a well-developed welfare state in which overall public health is good. Life expectancy in Østfold County is 79.3 years for men and 83.1 years for women (averages for 2010–2016). This is below the averages for the country, which are 79.6 years and 83.7 years for men and women, respectively. Compared to the other regions in Norway, Østfold County has more public health challenges. Historically, the region was highly industrialized: hence, the overall education level there is lower, fewer people are in paid employment, and there are more health problems than in other regions (3). For many years, the County has prioritized public health work at the political level.

The Norwegian Government is responsible for providing health care to the population in

accordance with its stated goal of equal access to health care regardless of age, race, gender, income, or place of residence. Responsibility for primary health and social care lies with the municipalities, the Ministry of Health and Care Services playing an indirect role through legislation and funding mechanisms. The Ministry plays a direct role in the provision of specialist care through its hospitals and directives to the boards of the regional health care authorities. Responsibility for public dental care lies with the county councils in the country.

As regards publicly financed health care, in 2015, health expenditure represented 9.9% of the gross domestic product, slightly above the 8.9% average for countries participating in the Organisation for Economic Co-operation and Development (OECD). Norway ranks highest among OECD countries in terms of absolute expenditure per capita (NOK 60 000, or US\$ 6122.1, in 2015); public financing (85% of this expenditure), which is covered through national and municipal taxes, is universal and automatic for all residents (4). Social-security contributions finance public retirement funds, sick-leave payment, and, for some patient groups, reimbursement of extra health-care costs.



Strengths

Among the strengths of Østfold County are:

- ✓ the Norwegian statutory foundation for public health at all levels;
- ✓ Norway's labour law, which secures the rights of workers to influence their own working conditions;
- ✓ innovations in the field of health profiling at the international level;
- ✓ a successful public health approach, which has attracted attention at the national level;
- ✓ the County's participation in national pilot schemes to test new methods of health promotion.



Aspirations

The Østfold County is aiming to:

- ✓ increase knowledge about public health work and create innovative solutions relative to this area;
- ✓ participate in networks and joint projects;
- ✓ tackle the social determinants of health and social inequality in environment and health, and to enhance urban health.



Challenges

These include:

- ✓ the small size of the County, which limits its capacity to work internationally;
- ✓ social inequalities in health;
- ✓ the need to invest more in public health at the community level;
- ✓ the lack of tools and authority at the county level to handle regional development;
- ✓ the necessity for people outside the labour market, or with lower incomes, to move from Oslo to areas with lower housing costs, such as Østfold;
- ✓ the lack of jobs in the County for highly educated persons, resulting in the emigration of skilled, well-educated individuals;
- ✓ the decline in the proportion of people with high levels of education and income, resulting in fewer tax payers and high social-welfare costs.

Potential areas of collaboration

Østfold County is interested in:

- ✓ forming public health partnerships aimed at resolving wicked problems;
- ✓ collaborating on finding ways of reducing health inequities at the regional and local levels;
- ✓ setting up statistics-based profiles that provide an overview of health in the region;
- ✓ participating in joint projects, for example, under programmes funded by the European Union (EU).

Working groups

Østfold County is interested in participating in working groups on:

- ✓ participatory approaches/resilience;
- ✓ the all-of-government approach/intersectoral action;
- ✓ the Sustainable Development Goals (SDGs) (5)/equity.

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References

1. Statistics Norway [website]. Oslo: Statistics Norway; 2017 (<http://www.ssb.no/en>, accessed 4 February 2018).
2. Fakta om Østfold [Facts about Østfold]. In: Østfold Flykeskommune [website]. Sarpsborg: Østfold Flykeskommune; 2018 (<https://www.ostfoldfk.no/om-fylkeskommunen/om-ostfold/>, accessed 4 February 2018).
3. Norhealth [database]. Oslo: Norwegian Institute of Public Health; 2017 (<http://norgeshelsa.no/norgeshelsa/>, accessed 4 February 2018).
4. Lindahl AK. The Norwegian health care system. In: International health care system profiles [website]. New York, NY: The Commonwealth Fund; 2018 (<http://international.commonwealthfund.org/countries/norway/>, accessed 4 February 2018).
5. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

Østfold County, Norway



Autonomous Region of Madeira, Portugal

North Coast,
Madeira Island, Portugal

General overview

The Archipelago of Madeira is located in the Atlantic Ocean between latitudes 30 °W and 33 °N (approximately the same latitude as Casablanca), 978 km south west of Lisbon, about 700 km west of the African coast, and 450 km north of the Canary Islands. The Archipelago comprises the Island of Madeira with an area of 740.7 km², the Porto Santo Island with 42.5 km², the Desertas Islands, three uninhabited islands with a total of 14.2 km², and the Selvagens Islands whose three islands and sixteen uninhabited islets make up an area of 3.6 km². Of the eight islands, only the two largest (Madeira and Porto Santo) are inhabited (1).

Thanks to their excellent geographical location and mountainous relief, these islands enjoy surprisingly balmy weather, with moderate humidity and pleasant average temperatures of 25 °C in summer and 17 °C in winter (1).

In 1976, the Archipelago of Madeira became an autonomous region. It has about 270 000 inhabitants and a population density of 267 inhabitants/km². Although its population density is higher than the national average, 75% of the population of Madeira Island dwells in only 35% of the territory, mainly on the south coast. Funchal, the capital of Madeira Island (and the Archipelago), with a population density of 1500

inhabitants/km² is home to 45% of the population of the Archipelago (130 000 inhabitants) (2).

Governance of the Autonomous Region of Madeira is provided by the Legislative Assembly of Madeira and the Regional Government. The Region is an integral part of the European Union (EU) with the status of one of the outermost regions of the EU.

Currently, tourism is the main driver and largest source of revenue in Madeira.

In the scope of their devolved powers, the Autonomous Regions of the Azores and Madeira created their own regional health services (Serviços Regionais de Saúde (SRS)), managed by the respective regional governments (3).

Madeira is responsible for the provision of health-care services, which are managed by the Regional Government of Madeira. The Health Service of the Autonomous Region of Madeira (Serviço de Saúde da Região Autónoma da Madeira – SESARAM) comprises three public hospitals located in Funchal and 48 health-care centres, which cover the whole Region (3). In addition, the Regional Health System has agreements with private entities for the provision of complementary health-care services to its users (4).



Strengths

The strengths of the Autonomous Region of Madeira are the following.

- ✓ The Regional Health Service provides differentiated and quality hospital and primary care to the population and visitors.
- ✓ Great improvements have been made to the health indicators in recent decades.
- ✓ Clinical records for primary and secondary care and integrated.
- ✓ An excellent disaster-response training network provides prompt response to major incidents.
- ✓ Clinical and nonclinical training programmes are offered at the Madeira Clinical Simulation Centre.



Aspirations

The Autonomous Region of Madeira is aiming to:

- ✓ identify examples of good practice with a view to establishing new projects in health and civil protection;
- ✓ introduce new projects related to health promotion and disease prevention;
- ✓ increase networking with other RHN regions and keep abreast of the latest developments in the WHO European Region.



Challenges

These are:

- ✓ an ageing population;
- ✓ lack of certain categories of health professionals, primarily doctors, therapists and diagnostic technicians;
- ✓ the needs to strengthen capacity to ensure universal access to health care, based on equity;
- ✓ lack of data for use in assessing and organizing services;
- ✓ budgetary constraints;
- ✓ the need to ensure the sustainability of the regional health system.



Potential areas of collaboration

The Autonomous Region of Madeira is interested in collaborating with other regions on:

- ✓ the provision of continuous care;
- ✓ disease-screening programmes;
- ✓ medical-emergency programmes;
- ✓ public health-care programmes.



Working groups

The Autonomous Region of Madeira is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (5)/ equity;
- ✓ health systems/primary health care;
- ✓ the all-of-government approach/intersectoral action.



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Autonomous Region of Madeira, Portugal

References

1. Madeira. In: Madeira Islands [website]. Funchal: Madeira Regional Tourism Board; 2018 (<http://www.visitmadeira.pt/en-gb/madeira/madeira>, accessed 21 May 2018).
2. Regional Directorate of Statistics [website]. Funchal: Regional Directorate of Statistics; 2017 (<https://estatistica.madeira.gov.pt/>, accessed 21 May 2018).
3. ALRAM – Assembleia Legislativa da Região Autónoma da Madeira [ALRAM (Legislative Assembly of the Autonomous Region of Madeira)] [website]. Funchal: Legislative Assembly of the Autonomous Region of Madeira; 2018 (<http://www.alram.pt/>, accessed 21 May 2018).
4. SESARAM – Serviço de Saúde da Região Autónoma da Madeira [Health Service of the Autonomous Region of Madeira] [website]. Funchal: Health Service of RAM; 2018 (<https://www.sesaram.pt/>, accessed 21 May 2018).
5. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 27 May 2018).

Autonomous Region of Madeira, Portugal



Centro Region Rural
Village

Centro Region, Portugal

General overview

Situated in the geographic centre of Portugal, the Centro Region occupies a strategic position in the country, with the city of Coimbra serving as its main educational, cultural and health-services centre. The city prides itself on being the location of one of Europe's oldest and most distinguished universities (the University of Coimbra, established in 1290), Portugal's largest hospital (Coimbra University Hospital Centre, which belongs to the National Health Service), the oldest and largest Portuguese nursing school (Coimbra's Nursing School), and one of the best science-based incubators in the world (Pedro Nunes Institute). These institutions share a long history of delivering much admired education, research and transversality in the fields of medicine, health-care services, and health sciences and technologies. Since 2015, the consortium, Coimbra Health, established by the University of Coimbra and the Coimbra University Hospital Centre, has been a member of the world network, M8 Alliance of Academic Health Centers, Universities and National Academies.

The national health-care system in Portugal, established in 1971, comprises three complementary parts: (i) the National Health Service, the functions of which are the financing, regulation, management and provision of health-care services; (ii) the social and private sectors, which provide health-care services; and (iii) subsystems of public and private insurance, which deal with the financing and provision of health care. In 2016, national health expenditure was

8.9% of the gross domestic product (1).

Portugal is not regionalized (except for the Autonomous Region of the Azores and the Autonomous Region of Madeira) and its health system follows a strong model of central governance and financing, according to which five administrative health regions were established in 1993. Each region has its own health administration board, answerable to the Minister of Health, and assumes responsibility for the management of population health and the provision of health-care services. The regional health administration of the Centro Region is carried out by the Central Regional Health Administration, which is responsible for the implementation of national health policies and the coordination of all levels of health care at the regional level, in accordance with the current National Health Plan.

With a land area of 23 671 km² and a population of 1 674 660 inhabitants (2011) (population density 71/ km²), the Centro Region comprises 78 municipalities, which are home to 17% of the population of mainland Portugal. The average life expectancy in the Region is 81.7 years (78.5 years for men and 84.6 for women); infant mortality (2016) is 2.1 per 1000 (mainland Portugal: 3.2 per 1000). The Region hosts an ageing population: in 2015, it recorded one of the highest ageing indices (190.4) and one of the lowest fertility rates (1.17 births per woman) in Europe (2). As these challenges have been recognized as major

societal issues for the Centro Region, and taking into account the performance of the consortium, Ageing@Coimbra (a partnership among the University of Coimbra, the Coimbra University Hospital Centre, the Central Regional Health Administration, the Pedro Nunes Institute and the Coimbra City Council), the European Commission considers it as one of the 74 European reference sites for active and healthy ageing.

Currently, in the Centro Region, the National Health Service has 85 primary-health-care centres, 18 hospitals (corresponding to 4695 beds), and 101 long-term health-care units (corresponding to 2427 beds) (3). They are all administered by the Central Regional Health Administration and work alongside an extensive health-care network, including hospitals for active treatment, centres for specialized and primary outpatient care, nurseries, and institutions

providing care of the elderly and adults and children with physical or mental disabilities.

The Central Regional Health Administration – in cooperation with relevant stakeholders, such as municipalities and schools – manages several public health programmes and health-promotion activities in different areas. Examples of these are child immunization, screenings (cervical cancer, breast cancer and diabetic retinopathy, the last-mentioned being pioneered at the national level), child and maternal health, children’s oral health, healthy eating, childhood obesity, adolescent mental-health and suicide prevention. Environmental-health activities are developed at the local level by public health units and include waste management and water surveillance (the use of water for drinking and recreational purposes) in cooperation with municipalities, regional environmental authorities and water-pipe suppliers.



Strengths

The Centro Region’s strengths are:

- ✓ its diversified regional economy, encompassing both low-technology-level industrial sectors and sectors with medium- and high-technology levels, such as those dealing with health services, biotechnology and IT;
- ✓ a relevant critical mass for high-quality research activities and regional competencies related to health services (several hospitals have gathered leading national and international knowledge on various health topics and are supported by the universities in the region, for example, the consortiums, Coimbra Health and Ageing@Coimbra);
- ✓ the “health hub” in Coimbra, which brings together resources, professional competencies and quality services (the University of Coimbra and the Coimbra University Hospital Centre work in close collaboration with the regional health network and charities administered by the Central Regional Health Administration);
- ✓ EU’s recognition of the Region as one of the 74 reference sites for active and healthy ageing;
- ✓ the Region’s extensive, quality network of health-care services (in both the National Health Service and the private sector);
- ✓ the presence of quality education and research centres, the Region being the location of several public universities, medical and nursing schools, and numerous incubators for innovative businesses (the University of Coimbra is the reference point for higher education and research and development in Portugal).



Aspirations

The Centro Region is aiming to:

- ✓ develop an ecosystem of good practice in health care associated with active and healthy ageing, and in monitoring the social determinants of health in relation to the Sustainable Development Goals (SDGs) (4);
- ✓ develop an effective regional health strategy for promoting health gains in accordance with the national and regional health plans;
- ✓ strengthen health-system integration and health information systems at the regional level;
- ✓ develop an intersectoral health approach according to the Health in All Policies (HiAP) (5,6) model.

Challenges

These are:

- ✓ demographic and societal challenges related to an increasingly ageing population;
- ✓ low population density: there is an asymmetry in the Region characterized by a desertification of the "inland" areas (apart from the urban centres located there) in contrast to the coastal areas, which are mostly populated and urbanized;
- ✓ health inequalities among urban/rural and socially disadvantaged groups;
- ✓ lack of political decision-making at the regional level (regional resources for health policies depend on national policies/decisions);
- ✓ the proneness of the Region to natural disasters (namely wildfires) due to its extensive forested area, in combination with the factor that the elderly population resides mostly in rural areas.

Potential areas of collaboration

The Centro Region is interested in collaborating with other regions on:

- ✓ establishing health-promotion/public health programmes;
- ✓ tackling health planning and health-policy implementation and evaluation with a view to achieving the SDGs (4) at the regional level, based on the principles of HiAP (5,6);
- ✓ ensuring highly qualified health-care/health-services staff and exchanging experience on working in international projects, for example, on international public health care and health management/administration;
- ✓ addressing environmental health (including health-impact assessment and health-contingency planning for heat-waves and extreme cold).

Working Groups

The Centro Region is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (4)/equity;
- ✓ environment;
- ✓ the all-of-government approach/intersectoral action.

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References

1. PORDATA [website]. Lisbon: Francisco Manuel dos Santos Foundation; 2018 (<https://www.pordata.pt/en/Portugal/Current+expenditure+on+healthcare+as+a+percentage+of+GDP-610>), accessed 7 March 2018).
2. Statistics Portugal [website]. Lisbon: Statistics Portugal; 2016 (https://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_cont_inst&INST=53884, accessed 28 February 2018).
3. Relatório de Atividades – 2016 [Report of activities – 2016]. Coimbra: Central Regional Health Administration; 2017 (http://www.arscentro.min-saude.pt/Institucional/Documents/monitoriza%C3%A7%C3%A3o%20e%20avalia%C3%A7%C3%A3o/Relat%C3%B3rio%20de%20Atividades%202016_%20ARS%20Centro_03.08.2017_aguarda%20homologa%C3%A7%C3%A3o%20da%20Tutela.pdf, accessed 28 February 2018).
4. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).
5. Leppo K, Ollila E, Peña S, Wismar M, Cook S, editors. Health in All Policies. Seizing opportunities, implementing policies. Helsinki: Ministry of Social Affairs and Health; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf, accessed 17 April 2018).
6. WHO, Ministry of Social Affairs and Health of Finland. The 8th Global Conference on Health Promotion, Helsinki, Finland, 10–14 June 2013. The Helsinki Statement on Health in All Policies. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.who.int/healthpromotion/conferences/8gchp/en/>, accessed 17 April 2018).

Centro Region, Portugal

Orhei Rayon, Republic of Moldova

The archaeological and tourist complex, Old Orhei

General overview

Orhei Rayon (district) is one of the 39 territorial administrative units of the Republic of Moldova. Located in the centre of the country, it covers a total area of 122.83 km². The Rayon consists of 75 localities, which are organized into 38 municipalities, including Orhei city, and 37 villages (communes). The town of Orhei is located in the centre of Orhei Rayon, 50 km north-east of Chisinau, the capital of the Republic of Moldova.

Since half of the territory is covered by arable land, the economy of Orhei Rayon is based on agricultural activities. These focus primarily on growing vegetables and fruits, cultivating cereal crops and raising livestock. The trend in agricultural tourism (agritourism) has been increasing in recent years.

On 1 January 2017, the population of the region counted 124 802, 62% of which was of working age. Population density was 102 inhabitants/km². The evolution of the demographic indicators for the latest five years is characterized by a continuous decrease in the population: a drop of 800 was registered in 2017 as compared to 2013 (implying a 0.6% reduction of the stable population). In 2016, life expectancy at birth had reached 69.3 years and the trend is increasing.

It is lower, however, than life expectancy for the whole country, which was 72.2 years in the same year. The gender gap in life expectancy is quite high; women outlive men by 8.9 years in Orhei Rayon (1).

Overall mortality in the Rayon is similar to that at the national level, cardiovascular diseases being the leading cause (57%), followed by cancers (14%), disorders of the digestive system (13%), etc. Many of these deaths can be attributed to alcohol use, tobacco smoking and unhealthy diet (2).

The health system of the Republic of Moldova is organized according to the principles of universal health coverage, which include access to basic health services, equity and solidarity in health-care financing. The health system includes public agencies and authorities involved in the provision and administration of health services, as well as a mix of public and private medical facilities. In the Republic of Moldova, health insurance is mandatory and covered from a single pool of funds combining payroll contributions and budget transfers. The health system, which is governed by the Ministry of Health, Labour and Social Protection, is funded jointly by the State and the National Health Insurance Company.

Medical assistance is provided to the population of Orhei Rayon through a wide network of public medical institutions. Currently, the population benefits from health-care services provided by the Orhei Rayon Hospital, which has a capacity of 325 beds, six emergency health-care units and 65 autonomous, self-financing, non-profit primary-health-care (PHC) institutions contracted by the National Health Insurance Company.

Public health services in the Rayon are coordinated by the Orhei Center of Public Health, which is currently responsible to and financed by the Ministry of Health, Labour and Social Protection. As of 2017, the Center is part of the National Public Health Agency, which falls under the Ministry of Health, Labour and Social Protection.

A decreasing trend has been registered in the number of medical personnel in medical institutions, especially at the PHC level and particularly in rural districts. At the same time, a number of private medical institutions across the country provide services in the respective rayons. In Orhei Rayon, the Center of Medical Diagnosis, dental clinics and gynecology clinics, among others, contribute to increasing population access to medical services. All private medical institutions must adhere to the protocols, guidelines and recommendations of the Ministry of Health, Labour and Social Protection.

Public health is among the priorities of local public administration. At the end of 2016, the Orhei Rayon Council endorsed the Orhei Rayon Public Health Action Plan 2016–2020: Health

2020, the main objectives of which are to reduce the prevalence of noncommunicable diseases (NCDs) and the major modifiable NCD risk factors. To this end, the public authorities of Orhei city increased local taxes on tobacco and alcohol products. This means that companies selling these harmful products have to charge twice as much for them as for other products.

As part of the memorandum of collaboration in the field of health and medical sciences signed by the Ministry of Health, Labour and Social Protection of the Republic of Moldova and the Ministry of Health and Care Services of Norway for 2015–2017, Orhei Rayon and the Municipality of Drammen, Norway, initiated a joint project on public health at the local level. The aim of the project is to reduce the prevalence of alcohol, tobacco and drug use among youth (14–18 years) in the Rayon by raising their awareness of the dangers of the use of these products.

The health and harmonious development of youth comprise one of the key objectives of the strategic development programme of Orhei Rayon. Since 2016, new stadiums, sports grounds and children's playgrounds have been built in various parts of the Rayon, including Orhei city.

With the support of development partners, new youth centres have been opened; these include the Youth-Friendly Health Center founded within the framework of the Moldovan–Swiss Healthy Generation Project to promote youth-friendly health services.



Strengths

The strengths of Orhei Rayon are:

- ✓ its strong intersectoral collaboration in the area of public health;
- ✓ its participation in collaborative projects, which enables not only an exchange of experience, but also the possibility of receiving support in the area of public health;
- ✓ the universal access of the population to basic medical services (PHC).



Aspirations

These are:

- ✓ to develop collaborative partnerships with other regions in European Union (EU) Member States;
- ✓ to exchange best practice in public health with other regions in EU Member States and launch new projects in this area;
- ✓ to introduce innovations in public health.



Challenges

In Orhei Rayon, the main challenges relate to increases in:

- ✓ the burden of NCDs, especially from cardiovascular diseases, cancer and diabetes;
- ✓ the migration of the population to other countries;
- ✓ population ageing.



Potential areas of collaboration

Orhei Rayon would be interested in collaborating with other RHN participants on:

- ✓ NCD prevention and the reduction of NCD risk factors;
- ✓ projects related to public health, in particular NCD prevention and the reduction of NCD risk factors.



Working groups

Orhei Rayon is interested in participating in working groups on:

- ✓ environment;
- ✓ health systems/primary health care;
- ✓ the all-of-government approach/intersectoral action.



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2. National Center for Health Management [website]. Chisinau: National Center for Health Management: 2018 (www.cnms.md, accessed 4 February 2018).

Orhei Rayon, Republic of Moldova



Romania



The Sphinx, Bucegi Natural Park in the Bucegi Mountains of Romania

General overview

The eighth largest country in the European Union, Romania is situated in the south-eastern part of central Europe. According to the National Statistics Institute, in January 2018 Romania had a population of 22.1 million inhabitants, a 0.2% decrease compared to January 2017. A 0.3% increase in the population over 65 years of age was observed in the same period, resulting in 350 000 more people in this age group than in the 0–14-years age group. There are more Romanian women (51.2%) than men, and more women than men live in urban areas (56.4%) (1). Historical trends reveal that there has been a population constriction since the 1990s because of declining fertility and birth rates, relatively high death rates and outward migration (2).

According to the World Bank classification, Romania is an upper-middle income country with a gross domestic product (GDP) per capita of US\$10 000 (2016) (3). Romania has the second highest score for poverty and the fifth-highest score for income inequality in the European Union (EU) (4).

The basic administrative unit of Romania is the county (“județ” in Romanian). The country is divided into 41 counties, plus the municipality of

Bucharest as a separate entity. The 42 districts are divided among eight development regions: North-East, North-West, Center, South-East, West, South-West Oltenia, South Muntenia and Bucharest-Ilfov. Since the regions are not territorial-administrative units, they do not have any type of autonomy, or legal power (2).

The Romanian health-care system

Romania has a social health insurance system, which is highly centralized despite consistent efforts to move away from the previous Semasko type of organization. It provides a comprehensive benefits package to those insured (85%); those who are not covered have access to a minimum benefits package. While – in theory – every insured person has access to the same health-care benefits, regardless of their socioeconomic situation, inequities in accessing health care exist across many dimensions, such as rural vs urban, and health outcomes also differ across these dimensions (2).

Public sources account for over 80% of total health financing, leaving a considerable margin for out-of-pocket payments, which cover almost a fifth of the total expenditure (2). The share of informal payments also seems to be substantial though,

given the sensitive nature of the issue, its size is not known. According to data of the Organization for Economic Development, in 2015, health expenditure per capita in Romania was the lowest among the EU Member States (5).

The Romanian population has seen increasing life expectancy and declining mortality rates, but both remain among the worst in the EU. Life expectancy at birth has increased over recent decades but, at 75.1 years, it is considerably lower than the EU average of 80.9 years (5,6). Mortality from cardiovascular diseases is among the highest in the EU. There are differences in mortality rates among the geographical areas (higher in the south) and between the urban and rural areas (higher in rural areas). Infant and maternal mortality rates are the highest among the EU Member States: 8.8 per 100 000 for infant mortality in Romania compared to the EU average of 3.8; and 13 per 100 000 for maternal mortality compared to the EU average of 4.9 (2).



Strengths¹

The strengths of the health-care system in Romania are:

- ✓ a social health insurance system that covers a significant proportion of the population;
- ✓ highly assessable health-care services;
- ✓ strong emergency-care services.



Aspirations¹

Romania aims to:

- ✓ strengthen primary and secondary care;
- ✓ improve health promotion and disease prevention by increasing vaccination coverage, among others;
- ✓ increase health-system responsiveness;
- ✓ increase the effectiveness of noncommunicable-diseases management.

Challenges¹

These are to:

- ✓ increase health-system financing;
- ✓ enhance the management of human, material and financial resources;
- ✓ better manage the mobility of health professionals within and outside the country;
- ✓ improve coordination among key actors at the central and county levels.

Potential areas of collaboration

Romania is interested in collaboration with other regions on:

- ✓ the design and management of health service delivery;
- ✓ training opportunities in health-care management;
- ✓ evidence-informed policy-making;
- ✓ health promotion and disease prevention, including vaccination.

Working groups

Romania is interested in participating in working groups on:

- ✓ health systems/primary health care;
- ✓ the all-of-government approach/intersectoral action;
- ✓ the Sustainable Development Goals (SDGs) (7)/equity.

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¹ According to the National Health Strategy 2014–2020 Health for Wealth (8).

References

1. National Statistics Institute. Romanian population at 1 January 2018 (<http://www.insse.ro/cms/ro/content/popula%C5%A3ia-dup%C4%83-domiciliu-la-1-ianuarie-2018>, accessed 16 May 2018)
2. Vlădescu C, Scîntee SG, Olsavszky V, Hernández-Quevedo C, Sagan A. Romania: Health system review. *Health Systems in Transition*, 2016;18(4):1–170 (http://www.euro.who.int/__data/assets/pdf_file/0017/317240/Hit-Romania.pdf?ua=1, accessed 16 May 2018).
3. GDP per capita, PPP (current international \$). In: World Bank [database]. Washington DC: The World Bank Group; 2018 (https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD?locations=RO-MD-HU-RS-BG-UA&name_desc=true, accessed 31 May 2018).
4. People at risk of poverty or social exclusion. In: Eurostat: statistics explained [website]. Brussels: European Commission; 2016 (http://ec.europa.eu/eurostat/statistics-explained/index.php/People_at_risk_of_poverty_or_social_exclusion, accessed 31 May 2018).
5. Organization of Economic Co-operation and Development (OECD), European Observatory on Health Systems and Policies. State of health in the EU: Romania country health profile 2017. Brussels: OECD and World Health Organization (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies; 2017 (https://ec.europa.eu/health/sites/health/files/state/docs/chp_romania_english.pdf, accessed 16 May 2018).
6. Organization of Economic Co-operation and Development (OECD), European Commission. Health at a Glance: Europe 2016. State of Health in the EU cycle. Paris, OECD Publishing; 2016 (https://ec.europa.eu/health/sites/health/files/state/docs/health_glance_2016_rep_en.pdf, accessed 16 May 2018).
7. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 28 May 2018).
8. Strategia Nationala de Sanatate 2014–2020. Sănătate pentru prosperitate [National Health Strategy 2014–2020. Health for Wealth]. Bucharest: Ministry of Health of Romania; 2014 (<http://www.ms.ro/strategia-nationala-de-sanatate-2014-2020/>, accessed 16 May 2018).

Botoșani County, Romania

The Ipotești Lake, source of inspiration for the Romanian national poet, Mihai Eminescu (1850 – 1889)

General overview

Botoșani County, situated in the north of Romania, is part of the north-east development region. The County borders the Urkainain Cernăuți Region to the north, the Briceni, Edineț, Rîșcani and Glodeni Rayons in the Republic of Moldova to the east, Iași County to the south, and Suceava County to the west. The territory of Botoșani County covers 4965 km² (2.1% of that of the whole country) (1).

According to the 2011 census, the population of Botoșani County counted 412 626, with a density of 83 inhabitants per km² and 59.3% of the population living in rural areas. A large part of the population (25%) lives in the town of Botoșani, the history of which goes back to the year 1439 (1,2). After Romania joined the European Union (EU) in 2007, increasing numbers of people emigrated to other EU Member States, mainly Italy and Spain. Recently, however, a reverse trend has been observed, and many are returning to their home towns or villages.

Due to a challenging economic environment, the birth rate is low. Moreover, many people who leave the County to complete their higher education in other counties do not return. Life expectancy in the county is 75.3 years and the share of people over 65 years of age is increasing.

Health care

Romania has a social health insurance system, which is highly centralized despite consistent efforts to move away from the previous Semasko type of organization. It provides a comprehensive benefits package to those insured (85%); those who are not covered have access to a minimum benefits package.

Health care in Botoșani County is provided by a network of primary-care offices, ambulatory offices, hospitals and social health-care units. The largest health-care provider is the Mavromati County Hospital (which has external units for obstetrics and gynecology, pediatrics and psychiatry). The link between the different types of providers could be improved, since many of them work separately with poor connections to and communication with other providers. There are inequalities between the quality of care for people in rural areas versus those in urban areas (3,4).

Community health care is also provided at the county level. Its beneficiaries are usually people of low socioeconomic status, unemployed people, people with disabilities and chronic illnesses, and people with terminal illnesses in need of palliative care. Transportation – when needed – is provided

by the County Ambulance Service, which has a main station in the town of Botoșani, as well as five sub-stations (in Darabani, Dorohoi, Nicolae Bălcescu, Săveni and Trușești), which together cover the entire County.

Regarding hospital infrastructure, most of the hospitals are in a good shape, having benefitted from massive investments during 2013–2017. A shortage of health professionals, however, poses some challenges. Of the 516 doctors working in the County, 83% do so in urban areas. People living in rural areas have access to primary-care physicians (family physicians), but it is often difficult for them to avail themselves of this service because of the distance to be covered and poor infrastructure.

According to data from the County Public Health Authority, in 2011, there were 174 family physician offices, 63 ambulatory offices, 122 dentistry offices, 6 laboratories and 127 pharmacies in Botoșani County.



Strengths

In Botoșani County:

- ✓ access to health-care services is provided for all medical specialties;
- ✓ all health-care institutions are accredited by the national accreditation body (Agenția Națională pentru Managementul Calității în Sănătate (National Agency for Quality Healthcare Management) (ANMCS));
- ✓ the Botoșani County Council provides support to the health-care institutions;
- ✓ transnational partnerships in disease epidemiology.



Aspirations

Botoșani County is aiming to:

- ✓ improve accessibility to health-care services;
- ✓ invest more in research (delivery of clinical and health-service research);
- ✓ establish public–private partnerships in health-care-service delivery;
- ✓ increase the overall quality of care and patient satisfaction.

Challenges

These are:

- ✓ to further develop end-of-life and palliative care;
- ✓ to improve the integration of services;
- ✓ population ageing;
- ✓ to enhance retention strategies for health professionals.

Potential areas of collaboration

Botoșani County is interested in collaboration with other regions on:

- ✓ health promotion and disease prevention at the population level;
- ✓ the development of palliative-care services;
- ✓ ways of integrating the work of nongovernmental organizations;
- ✓ the development of retention strategies for the health workforce.

Working groups

Botoșani is interested in participating in working groups on:

- ✓ health systems/primary health care;
- ✓ Sustainable Development Goals (SDGs) (5)/equity;
- ✓ participatory approaches/resilience.

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References

1. Poclid M. Judetul Botoșani in 2013 – Monografie geografică [Botoșani County in 2013 – Geographic monography]. Iași: Taida Publishing House; 2013.
2. Populația stabilă pe sexe și grupe de vârstă - județe [Stable population based on sex and age groups – counties] [database], Bucharest: National Institute of Statistics; 2011 (http://www.recensamantromania.ro/wp-content/uploads/2013/07/sR_Tab_31.xls, accessed on 18 May 2018).
3. Strategia de dezvoltare a județului pentru perioada 2014–2020 [Botoșani County Development Strategy 2014–2020]. In: Consiliul Județean Botoșani [Botoșani County Council] [website]. Botoșani: Botoșani County Council; 2018 (<http://www.cjbotosani.ro/portal.html?pid=980>, accessed 16 May 2018).
4. Decizia de aprobare a strategiei de dezvoltare socio-economică a județului Botoșani pentru perioada 2014-2020 [Decision to approve the socio-economic development strategy of Botoșani County for 2014–2020]. Botoșani: Botoșani County Council; 2014 (http://www.cjbotosani.ro/portal/files/h043_27.03.2014.pdf, accessed 16 May 2018).
5. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 27 May 2018).

Botoșani County, Romania



San Marino

View of San Marino



General overview

The Republic of San Marino is an enclave located between the regions of Emilia-Romagna and Marche in Italy. It has a population of approximately 33 000 and covers a total area of 61 km² (1).

San Marino is one of the countries in the world with a very high life expectancy (81.9 for males and 86.4 for females) (1). One of the oldest sovereign states and constitutional republics in the world, it is a parliamentary representative democracy headed by two captains regent (coheads of state). The Congress of State (Government) exercises executive power. The Grand and General Council (Parliament) is a unicameral legislature comprising 60 members. Legislative power is vested in both the Parliament and the Government. The Judiciary is independent of both the executive and the legislative branches.

San Marino is divided into nine municipalities: Acquaviva, Borgo Maggiore, Chiesanuova, City of San Marino, Domagnano, Faetano, Fiorentino, Montegiardino and Serravalle. Each municipality has a local community council, chaired by a captain, to control and manage local services. The duties and functions of the councils are deliberative, consultative and promotional.

San Marino is recognized as high-income and developed country. Its economy relies heavily on industry and tourism, as well as on the service and financial sectors. Cross-border workers are very important since they make up 26% of the total work force (1). In terms of education, a key social determinant of health, almost 50% of the population has a secondary education and more than 10% has a university diploma (1).

Since 1955, San Marino has based its health system on the principles of solidarity, universalism and equity, and established the Institute for Social Security (ISS) to find ways of meeting the health needs of its population. ISS is a public organization financed by the state budget. Its aim is to ensure that all citizens and residents of San Marino have access to health and social services, priority being given to the most vulnerable citizens. ISS offers a social security system, which includes retirement benefits and support to people with disabilities.

San Marino took up a new challenge in 2012 when it adopted the new European health policy framework, Health 2020 (2). The country also participates in the WHO small countries initiative (established in 2013), acting as coleader along

with the European Office for Investment for Health and Development, Venice, Italy, of the WHO Regional Office for Europe. The countries participating in the initiative all have populations of less than one million: these are Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro and San Marino.

The Second national health plan (2015–2017) (3), approved in 2015, is based on Health 2020 objectives and oriented to achieving the Sustainable Development Goals (SDGs) (2,4).

In 2016, the leading causes of all-age mortality in San Marino were cardiovascular diseases (32.2%), neoplasms (28%) and respiratory tract infections (10%). Mortality from dementia and diseases of the nervous system have increased recently (10% in 2017 vs 7% in 2015 and 2016); this is attributable both to an ageing population and to endocrinology-diabetes (5%) (1). These data demonstrate the burden of noncommunicable diseases (NCD) (1). Lifestyle-related interventions and empowering people to take responsibility for their own health are central to the Second national health plan (2015–2017) (3). The Second national health plan also emphasizes the importance of addressing reemerging communicable diseases (HIV, hepatitis, etc.).

Health development measures in San Marino include a continuum of health promotion, health protection, disease prevention, diagnosis, acute treatment, rehabilitation, palliative care, treatment of chronic diseases, and a system of delivering coordinated, integrated health services with people and the community centre stage. San Marino considers an intersectoral (whole-of-government, whole-of-society, Health in All Policies (5,6)) approach – engaging other sectors by allowing them to identify how they could contribute to improving health – fundamental to tackling NCDs and lifestyle issues.



Strengths

The strengths of the health system in San Marino are:

- ✓ universal health coverage;
- ✓ cross-sectoral working groups (for example, on education, road safety, gender violence, climate change);
- ✓ strong social cohesion;
- ✓ prevention programmes (screenings, education);
- ✓ voluntary associations.



Aspirations

San Marino's aims include:

- ✓ improving health promotion;
- ✓ introducing innovations (both organizational and of health/non-health information systems);
- ✓ strengthening internal and external networks;
- ✓ enhancing quality in ageing;
- ✓ building community capacity for action on the social determinants of health;
- ✓ tackling exclusion (vulnerable groups/people);
- ✓ achieving sustainability.



Challenges

These are:

- ✓ recruitment of human resources for health;
- ✓ purchase of technologies;
- ✓ evidence-based working;
- ✓ improved data collection.



Potential areas of collaboration

San Marino would be interested in collaborating with other regions on:

- ✓ research and policy development;
- ✓ sharing know-how on promoting/improving health equity;
- ✓ creating a specific database/dataset for small countries/regions with common indicators (Health 2020 (2));
- ✓ continuing education in medicine and public health.



Working groups

San Marino is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (4)/ equity;
- ✓ environment;
- ✓ women's/men's health;
- ✓ health systems/primary health care;
- ✓ participatory approaches/resilience;
- ✓ the all-of-government approach/intersectoral action;
- ✓ investment for health and well-being.



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References

1. Supplemento al Bollettino di Statistica – Anno 2016 [Supplement to the Statistics Bulletin – Year 2016]. In: Ufficio Informatica. Tecnologia e Statistica [Office of Economic Planning, Data Processing and Statistics] [website]. San Marino: Office of Economic Planning, Data Processing and Statistics of the Republic of San Marino; 2018 (<http://www.statistica.sm/on-line/home/pubblicazioni/bollettino-di-statistica.html>, accessed 13 March 2018).
2. Health 2020: the European policy for health and well-being. In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being>, accessed 9 March 2018).
3. Piano Sanitario e Socio-Sanitario della Rep. di San Marino 2015-2017 [Health and Social-Health Plan of the Republic of San Marino 2015-2017]. In: Segreteria di Stato Sanità e Sicurezza Sociale, Pari Opportunità, Previdenza e Affari Sociali [State Secretariat Health and Social Security, Equal Opportunities, Social Security and Social Affairs] [website]. San Marino: Secretariat of State Health and Social Security; 2018 (<http://www.sanita.sm/on-line/home/authority-sanitaria/pianificazione-e-programmazione/piani-sanitari-e-sociosanitari/2015-2017.html>, accessed 13 March 2018).
4. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).
5. Leppo K, Ollila E, Peña S, Wismar M, Cook S, editors. Health in All Policies. Seizing opportunities, implementing policies. Helsinki: Ministry of Social Affairs and Health; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf, accessed 17 April 2018).
6. WHO, Ministry of Social Affairs and Health of Finland. The 8th Global Conference on Health Promotion, Helsinki, Finland, 10–14 June 2013. The Helsinki Statement on Health in All Policies. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.who.int/healthpromotion/conferences/8gchp/en/>, accessed 17 April 2018).

San Marino

Žilina Self-Governing Region, Slovakia

Natural beauty in
the Western Tatras in
Slovakia

General overview

The Žilina Self-Governing Region is situated in the north-western part of Slovakia, bordering the Czech Republic and Poland. The Region comprises 5 subregions (Horné Považie, Kysuce, Liptov, Orava and Turiec) that are divided into 11 districts. Covering an area of 6809 km² (14% of the territory of the Slovak Republic), the Region has a total population of 690 778 and a population density of 101.4 inhabitants/km² (1).

Of the total population of the Žilina Region, 19% are over the age of 60 and 12.5% are over 65. The average age of the population is 38.9 years. The proportion of people of working age (15–64 years) is 74.5%. In the period 2003–2013, the number of people in this age group increased by 8030 (1.5%). Average life expectancy in the Žilina Region is 73.7 years for men and 80.4 years for women. The most common cause of death in the Region for both sexes is cardiovascular disease (54.5%), followed by cancer and respiratory diseases (2).

Nature in the Region is pristine and there are many places of interest to tourists, including national parks, landscape areas, nature reserves, natural monuments, national natural landmarks and protected areas. The Region also has several

thermal and mineral springs that are used in spas and regenerative treatment centres. The health-enhancing (preventive) treatment offered in these centres is often included in post-surgery rehabilitation programmes. The springs are considered a natural wealth in the Region owing to their beneficial effects on human health (1).

The health-care system in Slovakia is administered by the Ministry of Health of the Slovak Republic. The core values of the health system are the principles of solidarity, responsibility and equality regarding access to health care for every citizen. Article 40 of the Constitution of the Slovak Republic guarantees the right to free health care under conditions stipulated by law. Health care is financed through compulsory health insurance (3,4).

The Žilina Region has seven hospitals and a polyclinic. Two of the hospitals are directly managed by the Ministry of Health, one falls under the Ministry of Defence, and the remaining four hospitals and the polyclinic are under the direct administration of the Žilina Self-Governing Region (5). The Region has 3919 hospital beds, 1262 health-care providers and 236 pharmacies.

One of the medical faculties in the Region, the Jessenius Faculty of Medicine located in

Martin city, is a leader in post-graduate medical education in Slovakia and one of the top medical schools in Central Europe. Its programme includes English-language master's and PhD courses for foreign students.

There is one national insurance company in Slovakia with a market share of about 60%,

and two private insurance companies. Health care includes outpatient, institutional and pharmaceutical care, as well as nursing care in assisted facilities. It is provided either by the state, or by private providers and health-care professionals, according to specified conditions (3,4).



Strengths

The Žilina Self-Governing Region has the following strengths:

- ✓ a strategic geographical position in relation to the important corridors of the international road network that lead to the Region;
- ✓ a clean environment and atmosphere (influenced by the mountains), many natural springs and spas;
- ✓ a well-developed network of university education;
- ✓ screening programmes for newborns;
- ✓ highly qualified health professionals.



Aspirations

The key priorities of the health care system in the Žilina Self-Governing Region are to:

- ✓ improve population health;
- ✓ provide affordable, quality and effective health care as one of the basic public services;
- ✓ influence national health policy, taking regional specificities into account;
- ✓ ensure the adherence of health insurance companies to the provisions in their insurance agreements;
- ✓ create intelligent health care in information technology;
- ✓ implement measures to support young doctors and nurses at the start of their working lives;
- ✓ set an effective minimum network of health-care providers, taking demographic trends into account;
- ✓ contribute meaningfully to the work of the Ministry of Health and interdepartmental groups.

Challenges

These are:

- ✓ significantly increasing morbidity rates and decreasing birth rates;
- ✓ decreasing interest in working in the health care system at the regional (and national) level;
- ✓ high average age of doctors and nurses;
- ✓ decreasing numbers of health-care professionals;
- ✓ low remuneration of health-care professionals.

Potential areas of collaboration

The Žilina Self-Governing Region is interested in collaborating with other regions on:

- ✓ monitoring morbidity and mortality, establishing prevention programmes and comparing the Region's prevention outcomes with those of the other regions;
- ✓ setting up a full range of health and medical care from prevention, through diagnosis to treatment and therapy, and from primary through secondary to tertiary care;
- ✓ analysing successful preventive measures implemented in other regions to set targets for the Region;
- ✓ increasing prevention in Slovakia;
- ✓ stabilizing human resources by reducing the fluctuation of health professionals among regions.

Working groups

The Žilina Self-Governing Region is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (6)/ equity;
- ✓ health systems/primary health care;
- ✓ the all-of-government approach intersectoral action;
- ✓ women's/men's and children's health

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References

1. Žilina Self Governing Region [website]. Žilina: Žilina Self Governing Region; 2016 (<http://www.regionzilina.sk/en/zilina-selfgoverning-region/regions/>, accessed 22 May 2018).
2. Statistical Office of the Slovak Republic [website]. Ljubljana: Statistical Office of the Slovak Republic; 2018 (https://slovak.statistics.sk/wps/portal/ext/home!/ut/p/z1/hY9LD4lwEIR_Cweu7BJAqrdqDI8Ql0Qj9mLAIKAI-pK3w923Um6-57c43mx1gkAJrs6EuM1l3bdaoec8mh9gNyHxuUiSrZlnBhq69JLRNtB3Y_QOYsvGLKKo8eyALj_q2Gy-GSyHMwoP42mcaWhdR6AT9uhMDKpsuf79l2t0gJjBenghfcuHG1rqTsZzrqOl6jlaRqJ2R9Fla46PgpVHVCQvoGQ-39N8ew0Q0Q17Q4ejO71/dz/d5/L2dBISEvZ0FBIS9nQSEh/, accessed 22 May 2018).
3. Regionálna integrovaná územná stratégia – RIÚS [Regional Integrated Territorial Strategy – RIUS]. In: Žilina Self Governing Region [website]. Žilina: Žilina Self Governing Region; 2018 (<http://www.zilinskazupa.sk/sk/samosprava/odbor-so-ro-rop/odbor-implementacie-so/ro/aktuality-oznamy/regionalna-integrovana-uzemna-strategia-rius.html>, accessed 25 May 2018).
4. Organisation for Economic Co-operation and Development (OECD). OECD Economic Surveys: Slovak Republic 2017. Paris: OECD Publishing; 2017 (https://read.oecd-ilibrary.org/economics/oecd-economic-surveys-slovak-republic-2017_eco_surveys-svk-2017-en#page3, accessed 22 May 2018).
5. Samospráva [Local Government]. In: Žilina Self Governing Region [website]. Žilina: Žilina Self Governing Region; 2018 (<http://www.zask.sk/sk/samosprava/urad-zsk/odbor-zdravotnictva/>, accessed 25 May 2018).
6. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 30 May 2018).

Žilina Self-Governing Region, Slovakia



Nordic walking in a rural area of the Pomurje Region with Danilo Türk, former President of the Republic of Slovenia

Pomurje Region, Slovenia

General overview

Pomurje is one of 12 regions in Slovenia. Located in the north-eastern part of the country, it borders Austria, Croatia and Hungary. Covering an area of 1337 km², it has around 117 000 inhabitants (roughly 5% of the Slovenian population), including a Hungarian minority and a Roma population. Pomurje is one of the most deprived regions in Slovenia: it has the highest unemployment rate (12,5% in 2015) and a gross domestic product (GDP) per capita (€12 437 in 2015), which is 66.5% of the national average (€18 693) (1).

In Slovenia, there are no regional governments. The regions are statistical areas and there is no level of authority between the municipalities and the national Government. The regions do, however, have regional development councils that take decisions on their future development and the allocation of certain development resources. Primary health care (PHC) falls under municipal authority, and secondary and tertiary care under national authority; all are funded through the Universal State Insurance Fund and private insurances. High unemployment, unhealthy lifestyle and a low level of education are the main drivers of health inequity in the Pomurje Region where a tradition of agriculture prevails (2).

Data and statistics in the *Regional development programme for Pomurje region 2014–2020* illustrate that life expectancy in the Pomurje Region is three years below the national average for men and two years below the national average for women (3).

According to data of the National Institute of Public Health of the Republic of Slovenia, the Region also presents the highest rate of mortality caused by cardiovascular diseases and the highest premature-death rate for men in Slovenia (4).

The unemployment rate in Pomurje has been high since the transition period in the nineties. The global financial crisis (2007–2008) hit the Region harder than the rest of Slovenia, causing a decline in GDP growth. Although Pomurje was fairly industrialized in the 20th century, mainly producing textiles, agricultural machinery, food and beverages, and tourism services, the Region was and still is traditionally agricultural with a large share of the farmers in a low-income bracket. In addition, the Region's share of older people is above the national average. One of the main reasons for the high unemployment rate in Pomurje is the collapse of the textile industry in Europe in the nineties, the aftermath of which

is still being felt. The Region was not prepared for structural unemployment and it took several years to close most of the textile factories. Because of the loss of markets in former Yugoslavia and the inability of European Union (EU) countries to replace them adequately, other traditional industries also suffered, if not as hard, significantly enough to contribute to raising the unemployment rate.

Nevertheless, Pomurje was one of the first regions to put health on the regional agenda as a development opportunity. The Centre for Health and Development Murska Sobota represents the Region in many international projects and was designated as a WHO collaboration centre for cross-sectoral approaches to health and development. A number of projects have

been carried out through the cross-sectoral Regional Action Group established to tackle health inequities, helping to introduce positive changes in how institutions, decision-makers and the population perceive health. As a result, different sectors began to work together to better the health of the population. For example, in recognizing their influence on and interest in each other, the sectors for agriculture, tourism and health set out to develop tourism in the traditionally agricultural region. Its small size makes it possible for the Pomurje Region to be very flexible in piloting or introducing new ways of tackling health inequities, which proved necessary in connection with the most recent demographic changes, economic crises and natural disasters.



Strengths

Pomurje's strengths include:

- ✓ universal health-care insurance and a health system based on decentralized, accessible health care centres and regional hospitals;
- ✓ investment in building regional stakeholder capacity for tackling the social determinants of health;
- ✓ investment in intersectoral communication on the connection between the social determinants of health and the health outcomes and well-being of the population;
- ✓ a history of strong investment in social cohesion, particularly at the local level;
- ✓ recognized wellness centres as part of a strong tourism infrastructure for active leisure time;
- ✓ the location of the Region in the centre of Europe, which is easily accessible by road and air (Graz and Vienna, Austria; Zagreb, Croatia; Budapest, Hungary; and Ljubljana, Slovenia).



Aspirations

Pomurje aims to:

- ✓ further reduce persistent health inequities between regions and different population groups as a result of socioeconomic conditions;
- ✓ prevent new inequities, especially those connected with ageing;
- ✓ introduce the Health in All Policies (HiAP) approach (5,6) in efforts at the regional level towards the well-being of the population;
- ✓ introduce palliative care and integrated health-/social-care services;
- ✓ encourage active mobility among the population;
- ✓ enhance tourism-health/agriculture-health opportunities for sustainable growth;
- ✓ increase the physical-activity and healthy-eating habits of different target groups;
- ✓ increase the use of locally produced food in public-sector institutions (kindergartens, schools, hospitals, homes for the elderly, etc.);
- ✓ exchange best practice in reducing health inequities with other regions.

Challenges

These are:

- ✓ lack of autonomy and limited financial resources at the regional level;
- ✓ lack of resilience in changing behaviours, habits and ways of thinking, and in taking action;
- ✓ low morale among the population regarding the economic situation in the Pomurje Region;
- ✓ emigration (brain drain) of highly skilled workers (mainly to Austria) in recent years, and the resulting limited human resources;
- ✓ lower (or the lowest) income, education and employment rates compared to the national averages.

Potential areas of collaboration

The Pomurje Region would be interested in collaborating with other regions on:

- ✓ tackling health inequities in local communities;
- ✓ health promotion (nutrition and physical activity);
- ✓ cross-sectoral approaches to health and development.

Working groups

The Pomurje Region is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (7)/ equity;
- ✓ health systems/primary health care;
- ✓ participatory approaches/resilience;
- ✓ the all-of-government approach/intersectoral action;
- ✓ health promotion/nutrition and physical activity.

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References

1. Statistical Office of the Republic of Slovenia [website]. Ljubljana: Statistical Office of the Republic of Slovenia; 2015 (<http://www.stat.si/obcine/en/2015/Region/Index/1>, accessed 5 February 2018).
2. Buzeti T et al. Health inequalities in Slovenia. Ljubljana: National Institute of Public Health; 2011 (http://www.euro.who.int/__data/assets/pdf_file/0008/131759/Health_inequalities_in_Slovenia.pdf, accessed 5 February 2018).
3. Regionalni razvojni program Pomurje 2014–2020 [Regional development programme 2014–2020]. Murska Sobota: Regional Development Agency Mur; 2012:19 (http://www.rcms.si/sites/default/files/datoteke/staticne/RRP%202014-2020_1.0_maj%2015%20FINAL.pdf, accessed 27 February 2018).
4. Zdravstveno stanje prebivalstva [State of health of the population]. In: Zdravstveni statistični letopis 2015 [Health statistics yearbook 2015]. Ljubljana: National Institute of Public Health; 2017:13–15 (http://www.nijz.si/sites/www.nijz.si/files/uploaded/publikacije/letopisi/2015/2.4.1_szb_2015.pdf, accessed 27 February 2018).
5. Leppo K, Ollila E, Peňa S, Wismar M, Cook S, editors. Health in All Policies. Seizing opportunities, implementing policies. Helsinki: Ministry of Social Affairs and Health; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf, accessed 17 April 2018).
6. WHO, Ministry of Social Affairs and Health of Finland. The 8th Global Conference on Health Promotion, Helsinki, Finland, 10–14 June 2013. The Helsinki Statement on Health in All Policies. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.who.int/healthpromotion/conferences/8gchp/en/>, accessed 17 April 2018).
7. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

Pomurje Region, Slovenia



Andalusia, Spain

Charles V Palace in Alhambra

General overview

The region of Andalusia, which covers an area of 87.5 km² in the south of Spain, has a population of 8.4 million (18% of the total population of the country) (1). Life expectancy in the region is 81.9 years (79.2 for males and 84.6 for females) (1). The Andalusian Regional Ministry of Health is responsible for public health, health policy, planning and regulation, and the provision and management of health care in the region. It also provides leadership of the Andalusian Public Health System (APHS). As stated in the *Andalusian Health Act (1998)* and the *Andalusian Public Health Act (2011)*, APHS's driving principles are based on equity, guaranteed rights related to health care, territorial homogeneity, accessibility, transparency and participation.

APHS is responsible for the provision of universal health care in the region, also to undocumented migrants. It comprises a wide network based on accessible, high-quality, patient-centred care. There are two levels of care: (i) primary health care, which forms the backbone of the system and is provided in 1500 centres grouped in health districts (the managerial unit for this level of care) throughout the region; and (ii) specialized care of varying complexity, which is available in 49 public hospitals. There are other dependent entities that

foster research and innovation in the field of public health and health care in the region, such as the Biobank Network, a specific public enterprise for emergency care, the Andalusian School of Public Health, and the Progress and Health Foundation.

As part of the Spanish health system, APHS is funded by taxes and operates predominantly in the public sector. Health care is provided free of charge at the point of care; medication is covered in part. There are 96 500 health-care professionals working in the public-health-care system in the region.

The overarching goals of the region's health policy are stated in the Andalusian Health Plan, which is passed by the Regional Government. The Plan defines the action to be taken by the different departments, using the Health-in-All Policies (HiAP) approach (2), as well as the funding each department shall allocate to this end. It specifies objectives for each of the eight provinces in connection with which local health-related action plans are drawn up in each municipality. Health impact assessment (HIA) (3) is compulsory for all sectoral plans and programmes passed by the Regional Government that could have an impact on health, general urban planning, and activities related to environmental control.

To further develop the action lines included in the Andalusian Health Plan, several transversal plans have been designed to tackle the most relevant health-related issues. Examples of these are the Plan on Comprehensive Health Care for Patients with Chronic Diseases and the Andalusian Comprehensive Care Strategy.



Strengths

The strengths of the Andalusia region are:

- ✓ the *Andalusia Public Health Act*, which is based on HiAP principles (2);
- ✓ the Andalusia Regional Health Plan, including commitments from all departments, passed by the Regional Government;
- ✓ the obligation to include HIA (3) in regional initiatives;
- ✓ the continuity of political will for, and commitment to, the development of the Public Health Strategy;
- ✓ the coordination of the activities of the Andalusian Health Care System and other sectors, particularly those related to health protection and promotion.



Aspirations

The region is aiming to further develop:

- ✓ successful public health programmes and activities at the local level, using the HiAP approach (2);
- ✓ regional policies on the reduction of health inequities;
- ✓ HIA (3), particularly of government plans, industrial projects and urban planning.



Challenges

These are:

- ✓ budgetary restrictions;
- ✓ finding ways of increasing equity across the whole region.

Potential areas of collaboration

Andalusia is interested in working with other regions on the:

- ✓ inclusion of a health-assets approach, according to the HiAP strategy (2,3);
- ✓ further development of HIA (4);
- ✓ development of a public health research programme oriented to decision-makers' needs;
- ✓ development and implementation of public health programmes and activities at the local level;
- ✓ identification and implementation of efficient regional policies to reduce historical health inequities.

Working groups

Andalusia is interested in participating in working groups on:

- ✓ environment;
- ✓ women's/men's health;
- ✓ participatory approaches/resilience;
- ✓ the all-of-government approach/intersectoral action.

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References

1. Portal de la Junta de Andalucía [website]. Seville: Regional Government of Andalucía; 2016 (<http://juntadeandalucia.es/andalucia.html>, accessed 4 February 2018).
2. Leppo K, Ollila E, Peña S, Wismar M, Cook S, editors. Health in All Policies. Seizing opportunities, implementing policies. Helsinki: Ministry of Social Affairs and Health; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf, accessed 17 April 2018).
3. WHO, Ministry of Social Affairs and Health of Finland. The 8th Global Conference on Health Promotion, Helsinki, Finland, 10–14 June 2013. The Helsinki Statement on Health in All Policies. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.who.int/healthpromotion/conferences/8gchp/en/>, accessed 17 April 2018).
4. Health impact assessment. In. World Health Organization [website]. Geneva: WHO; 2018 (<http://www.who.int/hia/en/>, accessed 12 April 2018).

Andalusia, Spain

Catalonia, Spain

General overview

Catalonia, one of the 17 autonomous communities in Spain, covers 6.4% of the territory of the country in which 16.1% of the population is concentrated. It has its own official language and strong cultural identity.

Catalonia has full powers in the area of health care, including public health. Table 1 lists relevant health-related data for Catalonia in the period 2016–2018.

Table 1. Health-related data, Catalonia, 2016–2018

Factors (year)	Data
Population (2017)	7 496 276 (1)
Life expectancy (2015)	83.2 years (males 80.4; females 85.9) (2)
Healthy life expectancy (2014)	68.4 years (males 67.9; females 68.8) (3)
Birth rate (2016)	9.2 (4,5)
Crude mortality rate (2016)	8.47 (males 8.7; females 8.3) (2)
Infant mortality (2016)	2.47 (5)
Immigrant population (2017)	13.8% (compared with 4.4% in 2001, 11.4% in 2005, and 15.9% in 2009) (6)
Unemployment rate (2017)	13.4% (7)
Population over 65 years (2017)	18.6% (8)
GDP per capita (2016)	€30 078 (9)
Public expenditure on health, per capita, US\$ purchasing power parities (PPP) (current prices, current PPP) (2014)	US\$ 1930.4 (10)
High urban concentration (2017)	Average 234.3 inhabitants/km ² ; range from 5.1 in Pallars-Sobirà to 15 319.6 inhabitants/km ² in Barcelonés Country, which includes Barcelona (8)

Important issues to mention in relation to health and society in Catalonia are the following:

- ageing society with low fertility rates and high life expectancy (epidemiological profile: noncommunicable diseases);
- social and health inequalities between the urban and rural areas;

- emerging populations (immigration);
- emerging (global) health threats arising from obesity, chronic diseases, infectious diseases, and climate change;
- health effects of economic crisis and increasing sense of vulnerability (individual and collective);
- increasing positive influence of the media regarding health-related issues;
- growing demand for citizen empowerment;
- increasing expectations of the population regarding (public health) services requiring:
 - ability to anticipate health problems/risks to prevent them;
 - ability to deal with them rapidly and transparently when they occur.

The Catalan health model within the content of the Spanish national health system

The Catalan Government created the Catalan Health Service in 1991 as the official entity for planning, assessing and purchasing health services, separating the functions of providing and financing health services. As a result, all health-care providers are contracted by the Catalan Health Service.

In Catalonia, public and private bodies that finance/provide health services coexist. Although the whole population is covered by publicly financed health services, in Catalonia, about 20% of the population opt for private coverage or use both systems. Universal care is provided by primary-care centres where family physicians and nurses work in teams with other health professionals and administrative staff.

In 2016, the Department of Health of Catalonia launched the 2016–2020 Health Plan for Catalonia (10) that includes the framework for and strategic objectives of the Catalan Health System. Among these objectives, top priority was placed on the Interministerial Public Health Plan (PINSAP) 2017–2020 (11).

In 2009, Catalonia's Public Health Law (No. 18/2009), establishing PINSAP (11) as the basic tool for implementing public health action in Catalonia, and a Government commitment, was passed unanimously by all political parties.

Since 2014, PINSAP (11) has been included

in all government plans. Elaborated by the Interministerial Health Commission, comprising representatives of all government ministries, approved by the Government and presented to Parliament, it seeks to involve the local administration and the society at large, through collaborative work with their representatives. The Plan, which is the only one in Spain to be based on the Health-in-All-Policies strategy recommended by WHO, promotes a whole-of-government, whole-of-society approach, and requires evaluation of the health impact of its main policies and strategies.

Focusing on the living conditions of the population, the first stage of PINSAP (2014–2016) (11) involved 1266 activities of different departments of government, local administration and other sectors of society to improve population health and address the health determinants. The most important of these related to the promotion of community health, the elaboration of social prescribing projects, the development of a map of assets, the development of a health impact assessment screening test ("Test Salut"), and collaboration with the Health and Crises Observatory of The Agency for Health Quality and Assessment of Catalonia (AQuAS).

The second stage of PINSAP (2017–2020) (11) focuses on the concept of health as a fundamental human right and on tackling health inequality through action on the social determinants. PINSAP emphasizes that evaluation of the impact of its activities on health is included in all government policies and proposes that it also be included in municipal policies at the local level. It also underlines the relationship between health and sustainable development within the framework of the 2030 Agenda.

The second stage of PINSAP (11) seeks to better interdepartmental and intersectoral collaboration in continuing implementation of the activities started in the first phase. To this end, it focuses on eight new priority topics that require a whole-of-government, whole-of-society approach if they are to be addressed effectively. These topics (obesity, environment and climate change, addiction, smoking, vulnerability and social exclusion, emerging diseases, ageing, mental health and well-being, and traffic injuries) were

identified by WHO as challenges for the 21st century. They are major causes of premature mortality or disability in Spain (according to the Global Burden of Disease Study), and complex (“wicked”) problems that require effective public health interventions. It is planned to include further topics, such as sexual and reproductive health, and early childhood in the near future.

Another important feature of the second stage of PINSAP (11) is its emphasis on the different levels of governance for health. The previous stage had only one level: Catalonia. The present has four: Catalonia, regional, municipal, and community. The intersectoral approach will be applied at each of these levels, and committees and intersectoral groups will work together to this end.



Strengths

The Catalan Health Service has the following strengths:

- ✓ PINSAP (11), which is based on the Health-in-All-Policies approach and fully supported by the Government;
- ✓ universal health care provided by the Catalan Health Service;
- ✓ multidisciplinary primary-health-care teams;
- ✓ integration of activities of the health promotion and preventive services in PINSAP (11), and in primary health care (working together with public health teams);
- ✓ the Chronicity Prevention and Care Programme set up by the Health Plan for Catalonia in 2011 (10) the results of which have shown some impact in reducing the rate of emergency admissions and readmissions related to chronic conditions and to better outcomes of chronic disease control;
- ✓ initiatives, like the Catalan Expert Patient Programme, that have obtained good results and appropriate service utilization (12).



Aspirations

Catalonia is aiming to:

- ✓ fully implement health-in-all-policies strategies and improve the evaluation of intersectoral actions, including health-impact assessment;
- ✓ implement action towards achievement of the Sustainable Development Goals (SDGs);
- ✓ enhance intersectoral action to tackle obesity, tobacco use and mental ill health.



Challenges

These are:

- ✓ aging population (demographic change, increased rates of noncommunicable diseases (NCDs));
- ✓ the long terms effects of the economic crisis on health;
- ✓ over-medicalization in the health system;
- ✓ inequalities between urban and rural areas;
- ✓ emerging health threats (NCDs, infectious diseases, effects of climate change);
- ✓ increasing costs of the health system – sustainability of the model.



Potential areas of collaboration

Catalonia is interested in collaboration with other regions on:

- ✓ health in all policies/SDGs (13)/intersectoral action;
- ✓ equity in health/application of universal proportionalism to public health action;
- ✓ primary health care / community health;
- ✓ migration.

Catalonia, Spain



Working groups

Catalonia is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (13)/ equity;
- ✓ environment;
- ✓ the all-of-government approach/intersectoral action.



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References

1. IDESCAT [website]. Population on 1 January. 1900–2018. Provinces. Barcelona: Statistical Institute of Catalonia; 2018 (<https://www.idescat.cat/pub/?id=aec&n=245&lang=en>, accessed 17 May 2018).
2. IDESCAT [website]. Death rate indicators. 2012–2016. Barcelona: Statistical Institute of Catalonia; 2018 (<https://www.idescat.cat/pub/?id=aec&n=245&lang=en>, accessed 17 May 2018).
3. Informe de salut 2016 [Health report 2016]. Barcelona: Department of Health of Catalonia; 2017 (http://salutweb.gencat.cat/ca/el_departament/estadistiques_sanitaries/dades_de_salut_i_serveis_sanitaris/Informe-de-salut-de-Catalunya/, accessed 17 May 2018).
4. IDESCAT [website]. Birth statistics. Barcelona: Statistical Institute of Catalonia; 2018 (<https://www.idescat.cat/pub/?id=naix&lang=en>, accessed 17 May 2018).
5. IDESCAT [website]. Population estimates. Barcelona: Statistical Institute of Catalonia; 2018 (<https://www.idescat.cat/pub/?id=ep&lang=en>, accessed 17 May 2018).
6. IDESCAT [website]. Total and foreign population series. 2000–2017 Catalonia. Barcelona: Statistical Institute of Catalonia; 2018 (<https://www.idescat.cat/poblacioestrangera/?geo=cat&nac=a&b=0&lang=en>, accessed 17 May 2018).
7. IDESCAT [website]. Unemployment rate. 2001–2007. By sex. Provinces. Barcelona: Statistical Institute of Catalonia; 2018 (<https://www.idescat.cat/pub/?id=aec&n=318&lang=en>, accessed 17 May 2018).
8. IDESCAT [website]. Population density. Counties and Aran, areas and provinces. Barcelona: Statistical Institute of Catalonia; 2018 (<https://www.idescat.cat/pub?id=aec&n=249&lang=e>, accessed 21 May 2018).
9. IDESCAT [website]. GDP per inhabitant. 2012–2016 In purchasing power parity (PPP). Barcelona: Statistical Institute of Catalonia; 2018 (<https://www.idescat.cat/pub/?id=aec&n=356&lang=en>, accessed 17 May 2018).
10. Despesa sanitària a Catalunya [Health Plan for Catalonia]. Barcelona: Department of Health of Catalonia; 2017 (<http://catsalut.gencat.cat/ca/coneix-catsalut/informacio-economica/despesa-sanitaria-catalunya/>, accessed 17 May 2018).
11. Pla Interdepartamental i Intersectorial de Salut Pública (PINSAP) [Interministerial and Intersectoral Public Health Plan]. Barcelona: Department of Health of Catalonia; 2016 (http://salutpublica.gencat.cat/web/.content/minisite/aspcat/sobre_lagencia/pinsap/01Els_Plans/PINSAP_2017-2020/PINSAP-2017-2020-web.pdf, accessed 17 May 2018).
12. Contel JC, Ledesma A, Blay C, Mestre AG, Cabezas C, Puigdollers M et al. Chronic and integrated care in Catalonia. *Int J Integrated Care*. 2015;15:e025 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4491324/>, accessed 19 May 2018).
13. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 27 May 2018).

Catalonia, Spain

Västra Götaland, Sweden

Västra Götaland – winter

General overview

Västra Götaland is one of the three most populated regions in Sweden. Situated on the west coast, it encompasses forests and agricultural land, a coastline and an archipelago with small villages, 49 middle-sized municipalities and one large city, Gothenburg (population 564 034 in 2017) (1).

Västra Götaland, home to the largest port in the country, is one of the leading regions in Sweden as far as industry and transportation are concerned. The population of the geographical area of Västra Götaland is 1.6 million. Life expectancy is 83.9 years for women and 80.3 years for men, equivalent to the national figures. The proportion of foreign-born people is 21%, slightly lower than the average for Sweden (22%) (2).

The Swedish health-care system is mainly government-funded and decentralized, financed primarily through taxes levied by county councils and municipalities. All three levels of Swedish government are involved in the health-care system: at the national level, the Ministry of Health and Social Affairs is responsible for overall health and health-care policy, working in concert with eight national government agencies; at the regional level, 12 county councils and nine

regional bodies are responsible for financing and delivering health services to citizens; and at the local level, 290 municipalities are responsible for care of the elderly and people with disabilities (3).

Region Västra Götaland (VGR) (4), one of Sweden's largest organizations with 55 000 employees and an annual turnover of SEK 60 billion, is responsible for public organization in the Region. Its governing bodies are the Regional Council (comprising 149 political members) and the Regional Executive Board (comprising 15 political members). Elections to these councils are held every four years.

VGR's main responsibility relates to the health-care sector, which includes 17 hospitals, 200 primary-care centres and 170 dental clinics. Research, innovation and education are also major responsibilities of VGR. The region is home to the renowned Sahlgrenska University Hospital and several science centres. VGR has a national mandate to take the lead in the regional development of several areas, such as business, culture, environment, public transport, public health promotion and human rights.

The political vision of VGR is currently "to provide a good life". In 2003, the Swedish

Parliament decided on a public health policy with the overarching goal, “to create the societal conditions for good health on equal terms for the entire population”. The policy had a clear focus on public health promotion and all sectors of society were required to recognize their responsibilities in reaching the goal. The policy was reviewed in 2008 and minor changes made. In 2017, the Swedish Commission for Equity in Health published the report entitled, *The next step towards more equity in health in Sweden – how can we close a gap in a generation? (5)*, which could lead to further amendments of the policy, including a stronger focus on health equity.

Several VGR committees are formally responsible for public health, namely, the five health and medical care committees and the Public Health Committee. Together with the municipalities, the health and medical care committees coordinate and agree on frameworks for local public health work, which is financed by both VGR and the municipalities on an equal basis. The Public Health Committee acts as a strategic engine in relation to public health promotion in the region, creating policy frameworks, initiating new methods of working and monitoring the development of population health.

Public health promotion focuses on creating equal access to preconditions for good health throughout the life-course.

Reducing school failures – an overall priority

The *Regional development strategy of Region Västra Götaland 2014–2020 (VG2020) (6)* stipulates that skills and competencies in the population are crucial for the future development and growth of people, companies and institutions. The link between education and health is strong, representing a visible social gradient. One of VGR’s overall priorities is, therefore, to reduce school failures and increase the number of school leavers eligible to study at a higher level. It is obvious that finding the right solution is the responsibility not only of the municipal school system but also of VGR, both as a leading partner in regional development and as a health authority and health-service provider. To achieve long-lasting, sustainable commitment, VGR needs to acknowledge the importance of cross-sector cooperation both within the organization and with relevant statutory and non-statutory stakeholders. It is important that action taken in this area be both generic and specific. Cross-sectoral action has been identified in five areas, namely:

1. promotion of sustainable cross-sector cooperation;
2. promotion of mental health and fight against the consequences of mental illness;
3. stimulation of the joy of studying;
4. reduction of the negative impact of migration on school achievement;
5. reduction of the impact of social determinants and risk factors for disease.



Strengths

Västra Götaland’s strengths include:

- ✓ strong development potential (the business sector is highly influenced by research and development);
- ✓ fast-growing tourism, cultural and creative industries;
- ✓ a high standard of health and steadily increasing life expectancy;
- ✓ health indicators with positive trends (fewer people smoking, fewer people drinking alcohol and no increase in obesity).



Aspirations

VGR is aiming to:

- ✓ fight exclusion and segregation, and strengthen the link between education and working life;
- ✓ strengthen the possibilities for children and teenagers to take part in cultural activities;
- ✓ strengthen primary-care services in addressing mental health.



Challenges

These are:

- ✓ the persistent problem of matching the demand for a skilled, experienced and highly educated workforce while many seeking work today have low levels of education and no experience of being in the Swedish labour market;
- ✓ the need for continued strong and forceful innovation to maintain sustainable development in the region;
- ✓ increasing inequity throughout the region, particularly that resulting in failure to graduate from school to institutions of further education.



Potential areas of collaboration

VGR is interested in collaborating with other RHN regions in the following areas:

- ✓ health and education (with a view to implementing the region's strategy and action plan, "Joint action for reducing school failures");
- ✓ the Sustainable Development Goals (SDG's) (7) and regional development (particularly in connection with the process of establishing a new regional development strategy for Västra Götaland);
- ✓ health equity (in particular, the importance of addressing gaps in knowledge, trust and language that affect people's access to health-care services and treatment).



Working groups

VGR is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (7)/ equity;
- ✓ the all-of-government approach/intersectoral action;
- ✓ education and health.



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References

1. Statistik och analys [Statistics and analyses]. In: Göteborgs Stad [Gothenburg City] [website]. Gothenburg: 2018 (<http://statistik.goteborg.se/>, accessed 16 April 2018).
2. Populär statistik [Popular statistics]. In: SCB [website]. Stockholm: Statistiska centralbyrån; 2018 (www.scb.se, accessed 15 April 2018).
3. Gelngård AH. The Swedish health care system. In: International Health Care System Profiles [website]. New York, NY: The Commonwealth Fund; 2018 (<http://international.commonwealthfund.org/countries/sweden/>, accessed 15 April 2018).
4. Västra Götalandsregionen [Västra Götalands region] [website]. Vänersborg: Västra Götalandsregionen; 2018 (www.vgregion.se, accessed 15 April 2018).
5. Lundberg O. The next step towards more equity in health in Sweden – how can we close a gap in a generation? Stockholm: Kommissionen för Jämlig Hälsa [Commission for Equal Health]; 2017 (<http://kommissionjamlikhalsa.se/publikationer/next-step-towards-equity-health-sweden>, accessed 15 April 2018).
6. Regional development strategy of Region Västra Götaland 2014–2020 (VG2020). In: Growth – internal market, industry, entrepreneurship, and SMEs [website]. Brussels: European Commission; 2018 (<https://ec.europa.eu/growth/tools-databases/regional-innovation-monitor/policy-document/strategy-growth-and-development-v%C3%A4stra-g%C3%B6taland-vg2020>, accessed 15 April 2018).
7. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 15 April 2018).

Västra Götaland, Sweden

Ticino Canton, Switzerland

Monte Bre over Lugano

General overview

Located in the southern part of Switzerland, Ticino is one of the 26 cantons of the country. It covers an area of 2812 km² and has almost 350 000 inhabitants (1). Ticino is the only canton where Italian is the official language, while in the other Swiss cantons it is French, German, or Romansh. Ticino benefits from its strategic geographic position between the Swiss Alps and Italy, representing a crucial corridor for road traffic along the European north–south axis. On the other hand, this situation negatively impacts the quality of the environment and mobility in the region.

Life expectancy in Ticino (83.8 years in 2015–2016) is above the national average (83.1 years in 2015–2016) (2), but, at the same time it has the greatest ageing index of all cantons (2016: Ticino – 164.2; Switzerland – 121.4) (3). In 2012, 74% of the population considered that their health was good, or very good, but data for health perception and physical activity indicators showed much lower rates for Ticino than for the rest of the country (4).

As a consequence of Swiss federal principles, all cantons have the privilege of shaping their own internal policies and regulations to some extent.

The health system is regulated by the Swiss Federal Law on Compulsory Health Care (LAMal) whereby every resident is provided compulsory health insurance. This is covered by private health-insurance companies, resulting in a market based on competition among these companies. Responsibility for financing, organizing and delivering health-care services lies, on the other hand, within the 26 cantons. Switzerland's health system is very well developed and peculiar to the country.

Despite this competition-based model, health costs continue to grow: in 2014, Switzerland allocated 11.6 % of its gross domestic product to health care compared to 9.6% in 2007. The trend also includes a steady increase in health-insurance premiums and, therefore, in total health expenditure per capita (in 2014, US\$ 7096 purchasing power parity (PPP) in Switzerland compared to an average of US\$ 3735 PPP in Organisation for Economic Co-operation and Development (OECD) countries). Unfortunately, the proportion of total health expenditure allocated to disease prevention and health promotion in Switzerland (2.5 % in 2014) is below the average of that allocated in the OECD countries (2.8% in 2014) (5).

Based on the national strategy against noncommunicable diseases adopted in 2016, the Ticino Canton has developed a health-promotion programme for 2017–2020, which includes programmes on nutrition, physical activity, tobacco and alcohol, as well as intersectoral projects related to migration, environment, mental health and sustainable mobility.



Strengths

The strengths of the Ticino Canton are:

- ✓ long life expectancy;
- ✓ high quality, accessible health services;
- ✓ a high level of democracy and participation;
- ✓ a low level of corruption;
- ✓ social security;
- ✓ environmental preservation.



Aspirations

Ticino Canton's aims include the development of:

- ✓ a strategy for and interventions on health promotion, focusing particularly on youth smoking, binge-drinking and physical activity;
- ✓ multisectoral approaches to developing slow mobility, green urbanism and climate adaptation;
- ✓ indicators on health status, health perception and healthy behaviour.



Challenges

The main challenges in the Ticino Canton are:

- ✓ high expenditure for basic health insurance;
- ✓ the presence of linguistic and cultural minorities;
- ✓ the social and political tension associated with increasing numbers of cross-border workers and immigration;
- ✓ public health policy too much health-care-system oriented;
- ✓ the absence of an evaluation culture (policies/ measures taken);
- ✓ poor intersectoral collaboration in public administration.

Potential areas of collaboration

Ticino would be interesting in collaborating with other regions on:

- ✓ promoting behavioural change in a life-course perspective;
- ✓ developing gender- and culture-oriented health-promotion interventions;
- ✓ adapting the environment and health strategy to include climate change;
- ✓ promoting health in small communities.

Working groups

Ticino would be interested in participating in working groups on:

- ✓ environment;
- ✓ women's/men's health;
- ✓ participatory approaches/resilience.

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References

1. USTAT [website]. Giubiasco: Cantonal Statistical Office of Ticino; 2018 (<http://www.ti.ch/USTAT>, accessed 21 February 2018).
2. Vital Statistics, BEVNAT. Neuchâtel: Federal Statistical Office; 2016 (https://www3.ti.ch/DFE/DR/USTAT/allegati/tabella/T_010302_29C.xlsx, accessed 21 February 2018).
3. Population and Households Statistics (STATPOP). Neuchâtel: Federal Statistical Office; 2016 (https://www3.ti.ch/DFE/DR/USTAT/allegati/tabella/T_010202_25K.xsl, accessed 21 February 2018).
4. Swiss Health Survey 2012. Neuchâtel: Federal Statistical Office; 2013 (<https://www.bfs.admin.ch/bfs/en/home/statistics/catalogues-databases/publications.assetdetail.349060.html>, accessed 5 February 2018).
5. OECD Health Statistics 2017 [database]. Paris: Organisation for Economic Co-operation and Development; 2018 (<http://www.oecd.org/health/health-data.htm>, accessed 21 February 2018).

Ticino Canton, Switzerland

Lebap Velayat, Turkmenistan

Amu Darya,
Lebap Velayat

General overview

The Lebap Velayat (region), one of the five velayats in Turkmenistan, is situated in the north east of the country, bordering Afghanistan and Uzbekistan. With an area of 93 730 km², it ranks third among the regions in terms of territory. The area runs alongside both sides of the Amu Darya (river) with the Gyzylgum Desert on the east side and the Garagum Desert on the west. The name Lebap is the Turkmen equivalent of the Persian بآب (lab-e āb), which means “riverside”. Thanks to a sunny climate and an abundance of water resources, the Velayat produces cotton and wheat, the quality of which ranks among the highest in the world. It is known for its natural parks, such as Repetek and Koytendag, and for being home to the country’s highest mountain, Ayrybaba (3137 m) (1).

The economy of Lebap Velayat is determined by its significant reserves of raw minerals and gas, and its water resources. Specializing in the extraction of natural gas and oil, as well as the processing of oil, and in chemical, electrical, food and light industry, Velayat produced 24.8% of the country’s industrial output in 2016. It produces 41.3% of all gas in the country, generating 6.4% of electricity (1). The Turkmenistan–China gas pipeline starts in the Lebap Velayat.

One of the main sources of the economy of the Velayat is light industry. The entire production of non-woven materials is concentrated there, as well as 30.8% of the country’s production of cotton fiber and 10.5% of its production of knitwear. The chemical industry in the Velayat is oriented to the production of mineral fertilizers from local raw materials. The construction industry has a significant local raw-material base and the prospects of further expanding production are favourable. The Velayat also produces 30.5% of the cement manufactured in the country (1). Traditionally, Lebap Velayat has a strong culture of farming. Its main agricultural products include cotton, grain (wheat and rice), and vegetables.

The Ministry of Health and Medical Industry of Turkmenistan is responsible for health policy on and the provision of health care for the whole population. The local government system comprises three levels: velayat (regional), etrap (district) and city/village. The last mentioned is the main unit of local self-governance for cities, settlements and villages. According to the legislation, local government undertakes socioeconomic planning, budgeting and taxation activities and makes rational use of the natural resources available. The health-care system is

organized at the national level as follows. While policy-making for the health sector falls within the scope of the Cabinet of Ministers, the Ministry of Health and Medical Industry is responsible for the actual operation of the health services. The provincial governor (velayat hakim), who is appointed by the President, finances the regional health services. The regional health administration reports to the provincial governor regarding the organization of the health services and to the Ministry on technical matters. Each velayat has a large number of health facilities. In the Lebap Velayat the total numbers of family doctors, mid-level medical personnel and hospital beds in 2016 were 659, 4600 and 5600, respectively (1).

Intersectoral mechanisms for health-related action are established at the national level in the form of coordination committees. These include representatives of different ministries, state organizations, civil society and international organizations. In 2014, Turkmenistan adopted a national strategy aimed at implementing the objectives of the *Ashgabat Declaration on the Prevention and Control of NCDs in the Context of Health 2020* and its plan of action. A national coordination committee, comprising representatives of 38 line-ministries, was established to oversee the implementation of the national strategy.

One of the best examples of multisectoral involvement in NCD control was the implementation of an information campaign on the early detection of breast cancer at the national level. This project was successfully implemented in all velayats of the country.

The National Programme for the Support and Development of Sports and Physical Education in Turkmenistan 2011–2020 has been approved. Its main objectives include the promotion of physical

education, sports and healthy lifestyles, and the active engagement of the population in physical education and mass sports. The Ministry of Health and Medical Industry is collaborating with the State Committee of Sports, other ministries, the municipalities of the regions and Ashgabat, and social organizations to ensure their active participation in fulfilling the objectives of the National Programme.

In the Lebap Velayat, there are many sports clubs for youth, among which the most active are judo and sambo clubs. The Velayat also boasts two women's football teams and often hosts women's football competitions and festivals. Among the most famous schools in the Velayat is Turkmenabat 5th Sports School of Gymnastics, which has great sports facilities and trains performance athletes. All the efforts to promote, and the investments made in, sports activities for youth were proven to have a positive effect by the success of the Lebap athletes who won the absolute majority of the olympic medals at the 5th Asian Indoor and Martial Arts Games, which took place in Ashgabat, Turkmenistan, in 2017, under the leadership of the Asian Olympic Council.

An initiative entitled "Improving access to regular physical activity among women affected by noncommunicable diseases, living in the Velayat (regional) area" has been developed, based on the findings of the Stepwise approach to surveillance (STEPS) survey on the prevalence of NCD risk factors in adults, conducted in Turkmenistan in 2013. The survey revealed that 58,9% of women do not comply with the WHO recommendations on physical activity with the highest proportion in the 55–64 age group. The regional initiative is aiming to improve access to regular physical activities for women aged 35 years and over living in the Velayat's urban and rural areas (2).



Strengths

The strengths of the Lebap Velayat are:

- ✓ strong will at the political level to succeed in NCD risk-factor control;
- ✓ availability of commitment documents, such as the National programme for the transformation of social and living conditions of the population of villages, towns, cities of etraps (districts) and etrap centers by 2020, and the National Strategy "Saglyk" for 2014–2020;
- ✓ readily available sports facilities;
- ✓ experience in the intersectoral implementation of a health-promotion project at the regional level;
- ✓ well-organized intersectoral collaboration for NCD prevention and control.



Aspirations

The Lebap Velayat aims include:

- ✓ finding new networking possibilities in the field of health promotion;
- ✓ contributing to the improvement of physical-activity indicators in the adult population;
- ✓ introducing innovative approaches in the field of public health;
- ✓ identifying examples of good practice for new projects in the field of health promotion.



Challenges

These are:

- ✓ many barriers to the participation of women in regular physical activity;
- ✓ low level of knowledge among the population about the importance of regular physical activity in preventing NCDs;
- ✓ low participation level of women in health-promotion activities.



Potential areas of collaboration

The Lebap Velayat is interested in collaborating with other regions on:

- ✓ initiatives in the areas of prevention and health promotion;
- ✓ women's health;
- ✓ intersectoral approach to health promotion.



Working groups

The Lebap Velayat is interested in participating in working groups on:

- ✓ women's/men's health;
- ✓ the all-of-government approach/intersectoral action;
- ✓ health systems/primary health care.

Lebap Velayat, Turkmenistan



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References

1. State Statistics. Ashgabat: State Statistics Committee; 2016
2. STEPwise approach to noncommunicable disease risk factor surveillance (STEPS). In: Noncommunicable diseases and their risk factors [website]. Geneva: WHO; 2018 (<http://www.who.int/ncds/surveillance/steps/en/>, accessed 14 May 2018).

Lebap Velayat, Turkmenistan

Wales, United Kingdom

Tryfan dominating the skyline of the Ogwen Valley in Snowdonia, North Wales

General overview

Wales is one of the four countries that make up the United Kingdom of Great Britain and Northern Ireland (the United Kingdom); it has its own government (the Welsh Government and democratically elected Parliament, the Senedd (the National Assembly for Wales)). The Senedd can pass laws for Wales in areas, such as health, education, economic development, transport, agriculture, housing, planning, and environment. Other sectors, such as those for defence and criminal justice, remain the responsibility of the Government of the United Kingdom. Wales covers an area of approximately 20 782 km², has an estimated population of 3 113 150 (1) and an average life expectancy of 65 years.

The health of the Welsh population is improving but there are still major challenges, including persistent health inequity (2). While life expectancy continues to increase, there is still a gap of as much as ten years between the most and least deprived areas in Wales. Health-care demand continues to increase as Wales' population grows, particularly among those in the over-65 and over-85 age groups (3). The National Health Service (NHS) is the largest of Wales' public services and the largest area of Welsh Government expenditure (4). It is responsible for health improvement,

promotion and protection and health care on an industrial scale for a population of just over 3 million (2). Every year, there are 18 million primary-care contacts, 400 000 emergency admissions, and around 500 000 ambulance calls; in addition, on average, 26 prescriptions per person are issued in Wales (5). The planning, organization and provision of preventive and treatment services are the responsibility of seven integrated health boards and three NHS trusts, which support the development of local solutions and encourage collaboration across services to meet shared objectives.

It is recognized that a wider set of social determinants, particularly poverty, poor education, and unemployment, have a bigger influence on the well-being of a population than the direct provision of health or social care. New sustainable-development legislation in Wales now requires the health system to work effectively with other sectors to address the root causes of ill health. *The Well-being of the Future Generation (Wales) Act 2015* focuses on improving social, economic, environmental and cultural well-being (6). It requires public bodies to work towards seven well-being goals by applying "five ways of working": prevention, integration, long-

term action, involvement and collaboration. In addition, NHS bodies work according to the principles of Prudent Healthcare, a philosophy that encompasses health services' improvement to benefit the population, actively avoids wasteful care that does not benefit patients, and aims to create a truly person-centred system by remodelling the service user–service provider relationship, based on coproduction. Wales is currently identifying the most promising models of integrated health- and social-care services with the aim of developing a new set of care models, combining primary care, hospital care, community-health care and social care.

The national strategy, “Prosperity for All”, is intended to unite all public-sector organizations and drive coordinated action to address its key themes: “prosperous and secure”; “healthy and active”; “ambitious and learning”; and “united and connected”, along five priority areas: early years; housing; social care; mental health; and skills and employability (7).

In aiming to protect and improve health and well-being and reduce health inequity, the national public health agency (Public Health Wales), undertakes a range of action to drive system change and build capacity. This includes: setting up a primary and community care development and innovation hub; establishing a NHS Wales patient-safety quality-improvement programme; developing an integrated all-Wales health-protection system; making the case for investing in public health (8); focusing research on adverse childhood experiences and breaking the intergenerational cycle of adversity (9); and developing health impact assessment (HIA) tools. The Public Health Wales Observatory provides health intelligence and has developed the Public Health Outcomes Framework (10) to inspire, inform and monitor action to improve and protect health and well-being.



Strengths

Wales' strengths include:

- ✓ a devolved health policy agenda, enabling the planning and provision of all health and social services in Wales, and a highly integrated health-care system;
- ✓ forefront legislation, such as:
 - the *Well-being of Future Generations (Wales) Act 2015* (6), an enabling framework to implementing the 2030 Agenda for Sustainable Development (11);
 - the *Social Services and Well-being (Wales) Act 2014*, enabling people to have more of a say in the care and support they receive (12);
 - the *Housing (Wales) Act 2014* (13), aiming to improve housing in Wales;
 - the *Active Travel (Wales) Act 2013* (14), aiming to increase walking and cycling in Wales;
 - the *Environment (Wales) Act 2016* (15) to manage Wales' natural resources in a sustainable way; and
 - the *Public Health (Wales) Act 2017* (16) introducing a statutory requirement for HIA;
- ✓ a history of, and continued commitment to, involving citizens in decision-making, for example, through the national conversation, “the Wales we want” (17);
- ✓ established national cross-sector partnerships for health, such as:
 - Cymru Well Wales (18);
 - Healthy Working Wales(19); and
 - the Welsh Network of Healthy School Schemes (20);
- ✓ the designation of the Policy, Research and International Development Directorate of Public Health Wales as WHO Collaborating Centre on Investment for Health and Well-being (21).



Aspirations

Wales' aims are to:

- ✓ integrate health and social care, and achieve prudent health care;
- ✓ progress HIA and cross-sector governance for health;
- ✓ enhance skills and employability;
- ✓ ensure sustainable housing and protected environment;
- ✓ enhance mental health, well-being and resilience across the life course;
- ✓ achieve early-years well-being and break the intergenerational cycle of adversity;
- ✓ achieve sustainable investment for health and well-being;
- ✓ introduce innovation and new technologies; such as genomics and genetic sequencing.



Challenges

These are to:

- ✓ tackle health inequalities and the social determinants of health;
- ✓ manage the growing demand in health;
- ✓ create a sustainable workforce.



Potential areas of collaboration

Wales is interested in collaboration with other regions on:

- ✓ sustainable development and prosperity for all;
- ✓ investment for health and well-being, and innovation for health;
- ✓ reducing health inequalities and building resilience across the life course;
- ✓ cross-sector partnership and HIA



Working groups

Wales is interested in participating in working groups on:

- ✓ the Sustainable Development Goals (SDGs) (22)/ equity;
- ✓ resilience/participatory approaches;
- ✓ the all-of-government approach/intersectoral action.



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References

1. Facts about Wales. In: About Wales [website]. Cardiff: Welsh Government; 2018 (<http://www.wales.com/facts>, accessed 5 March 2018).
2. Health Statistics Wales. In: Welsh Government [website]. Cardiff: Welsh Government; 2018 (<http://gov.wales/statistics-and-research/health-statistics-wales/?lang=en>, accessed 5 March 2018).
3. National Population Projections. In: Welsh Government [website]. Cardiff: Welsh Government; 2018 (<http://gov.wales/statistics-and-research/national-population-projections/?lang=en>, accessed 5 March 2018).
4. Health in Wales. In: NHS Wales [website]. Cardiff: NHS Wales; 2018 (<http://www.wales.nhs.uk/>, accessed 5 March 2018).
5. Rebalancing healthcare. Working in partnership to reduce social inequity. Cardiff: Welsh Government.; 2016 (<http://gov.wales/topics/health/professionals/cmo/reports/?lang=en>, accessed 5 March 2018).
6. Wellbeing of the Future Generation (Wales) Act 2015. In: Welsh Government [website]. Cardiff: Welsh Government; 2018 (<http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en>, accessed 5 March 2018).
7. New national strategy for a more prosperous Wales. In: Welsh Government [website]. Cardiff: Welsh Government; 2018 (<http://gov.wales/newsroom/firstminister/2017/170919-new-national-strategy-for-a-more-prosperous-wales/?lang=en>, accessed 5 March 2018).
8. Making a difference: investing in sustainable health and wellbeing for the people of Wales. In: Public Health Wales [website]. Cardiff: Public Health Wales; 2018 (<http://www.wales.nhs.uk/sitesplus/888/page/87106>, accessed 5 March 2018).
9. ACE publications. In: Public Health Wales [website]. Cardiff: Public Health Wales; 2018 (<http://www.wales.nhs.uk/sitesplus/888/page/88517>, accessed 5 March 2018).
10. Public Health Outcomes Framework. In: Public Health Wales Observatory [website]. Cardiff: NHS Wales; 2018 (<http://www.publichealthwalesobservatory.wales.nhs.uk/phof>, accessed 5 March 2018).
11. Transforming our world: the 2030 Agenda for Sustainable Development. In: Sustainable Development Knowledge Platform. New York: United Nations; 2015 (<https://sustainabledevelopment.un.org/post2015/transformingourworld>, accessed 5 March 2018).
12. Care and support in Wales is changing. In: Welsh Government [website]. Cardiff: Welsh Government; 2017 (<http://gov.wales/topics/health/socialcare/act/?lang=en>, accessed 5 March 2018).
13. Housing (Wales) Act 2014. In: Welsh Government [website]. Cardiff: Welsh Government; 2015 (<http://gov.wales/topics/housing-and-regeneration/legislation/housing-act/?lang=en>, accessed 5 March 2018).
14. Active Travel (Wales) Act 2013. In: Welsh Government [website]. Cardiff: Welsh Government; 2013 (<http://gov.wales/topics/transport/walking-cycling/activetravelact/?lang=en>, accessed 5 March 2018).
15. Environment (Wales) Act 2016. In: Welsh Government [website]. Cardiff: Welsh Government; 2016 (<http://gov.wales/topics/environmentcountryside/consmanagement/natural-resources-management/environment-act/?lang=en>, accessed 5 March 2018).
16. Public Health (Wales) Act. In: National Assembly for Wales [website]. Cardiff: National Assembly for Wales; 2018 (<http://senedd.assembly.wales/mglssueHistoryHome.aspx?lId=16155>, accessed 5 March 2018).
17. The Wales we want national conversation. In: Sustain Wales [website]. Cardiff Bay: Sustain Wales; 2015 (<http://www.cynnalcymru.com/project/the-wales-we-want/>, accessed 5 March 2018).
18. CymruWellWales. In: Public Health Wales [website]. Cardiff: Public Health Wales; 2016 (<http://www.wales.nhs.uk/sitesplus/888/page/87835>. Accessed 5 March 2018).
19. Healthy Working Wales [website]. Cardiff: NHS Wales; 2018 (<http://www.healthyworkingwales.wales.nhs.uk/home>, accessed 5 March 2018).
20. Welsh Network of Healthy School Schemes. In: Cardiff: Welsh Government; 2015 (<http://gov.wales/topics/health/improvement/schools/?lang=en>, accessed 5 March 2018).
21. Designation of a new WHO collaborating centre in Wales. In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/countries/united-kingdom-of-great-britain-and-northern-ireland/news/news/2018/3/designation-of-a-new-who-collaborating-centre-in-wales>, accessed 6 April 2018).
22. Sustainable Development Goals. In: Sustainable Development Knowledge Platform [website]. New York: United Nations; 2018 (<https://sustainabledevelopment.un.org/sdgs>, accessed 21 February 2018).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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