



Germany 2009

# Ensuring a functioning health care system in regions with declining and ageing populations

Minutes



On behalf of the  
European Commission DG Employment, Social Affairs and Equal Opportunities



Peer Review:  
**Ensuring a functioning health care system in regions with  
declining and ageing populations**  
**Potsdam, 15-16 June 2009**

*The Peer Review was hosted by the German Federal Ministry of Health and  
the Brandenburg Ministry of Labour, Social Affairs, Health and Family*

## Day 1 - Morning session

### Welcome and introductory remarks

**Ortwin Schulte** welcomed the Peer Review participants, on behalf of the German Federal Ministry of Health. He recalled that a successful Peer Review has already taken place in Germany in July 2008, on the topic of cost-cutting in the pharmaceutical sector. He was also pleased about the cooperation with the federal state of Brandenburg, which has experience of implementing a model project on the issue under review. The next two days would afford opportunities to discuss follow-up at European level. Mr Schulte thanked all those involved in organising the Peer Review.

**Thomas Barta** from the Brandenburg Ministry of Labour, Social Affairs, Health and Family (MASGF) said that although Potsdam itself does not suffer from a declining or ageing population, Brandenburg covers a wide area, and the further one moves away from the capital, the more acute the problem becomes. Demographic change is creating demand for new services. Similar situations apply in the German states (*Länder*) of Mecklenburg-Vorpommern and Saxony-Anhalt. The European Social Fund (ESF) has already provided financial support, mainly for the training of health service personnel.

**Roland Bladh** from the Employment, Social Affairs and Equal Opportunities Directorate-General of the European Commission thanked the Peer Review hosts. He explained that the DG works on health issues within the context of social security and social protection systems. The Peer Reviews form part of the Commission's support to the Member States for modernising social protection and social security through the Open Method of Coordination (OMC), whereby Member States put forward their plans, and the Commission together with the Social Protection Committee analyse these plans and monitor the implementation.

Monitoring activities are supported by concrete actions:

1. Financial support for innovative projects to develop solutions, for example on long-term care and healthcare. The Commission has recently issued a call for proposals from Member States: <http://ec.europa.eu/social/main.jsp?catId=630&langId=en>
2. Organising conferences, aimed at larger numbers of people and more general debate. One such event took place in Prague two weeks ago on the topic of long-term care for elderly people, dignity and the risk of abuse. The Commission DG Health and Consumer Affairs also supported a French conference in autumn 2008 on Alzheimer's disease.

3. Organising Peer Reviews, enabling restricted groups of people to focus on specific topics in greater detail. In 2009, eight Peer Reviews in the field of social inclusion and social protection are taking place. This is the third one covering health-related issues: the first was in the Netherlands in February, on long-term care, the second in France in May, again on Alzheimer's.

Planning for the current Peer Review started a year ago in Brussels. Mr Bladh urged other countries to propose topics for future Peer Reviews, in 2010, on issues that are important to them.

### Experiencing the decline of populations in Brandenburg

Brandenburg State Secretary **Gerd Harms** said the *Land* is dealing with the impact of population decline and its impact on the health system. But statistics can also express beauty. Brandenburg has 3,000 lakes, 163 castles, and 14,000 sq. metres of nature preservation area. It is the fifth largest state in Germany, with a small population of 2.5 million people. Brandenburg has a 250 km border with Poland, its largest neighbour. Potsdam is the capital, while Berlin is a separate city state in its own right.

Brandenburg used to be the heart of Prussia. In the 17th century it offered a refuge for persecuted minorities such as the Huguenots from France, and others from the Netherlands and Switzerland. This inward immigration influenced the development of the area. In 1945, Schloss Cecilienhof was the setting for the Potsdam conference, where world leaders agreed to divide up Europe. The nearby Glienicke Bridge was used for the exchange of spies during the Cold War – it was re-opened to the public on 9 November 1989.

In 1952, the GDR abolished the *Länder* and set up districts, under central control. But exactly 20 years ago, mass demonstrations in cities brought about the peaceful reunification of Germany. This process was linked to developments in other countries such as Poland, and opened the door to the unification of Europe itself through the European Union, which represents a unique form of international cooperation. Mr Harms said that the presence today of Peer Review participants from many EU countries was witness to this ongoing change in Europe, and it was a privilege to be part of it.

Brandenburg is now no longer at the edge of Europe, but at the centre. "Our role in eastern Germany is to build bridges between different parts of Europe," declared Mr Harms. The former East German states were fortunate in becoming part of the EU "overnight", without having to deal with the exacting standards of the EU *acquis*, as new Member States did.

### Economic and social data

Brandenburg has received considerable EU funding, especially for infrastructure and health services (€3.2 billion in 2000-2006, €3.1 billion available in 2007-2013). The years after reunification brought major changes, with a drop in the number of jobs in eastern Germany from 10 million to 6 million within two years, leading to unemployment and emigration – of young women above all – to other parts of Germany. The well-educated found good jobs elsewhere,

while those with lower qualifications stayed in rural areas.

Few older people left the labour force in the new *Länder*. For example, during this time 50,000 workers retired, whereas 200,000 young people left school looking for jobs. The situation was similar in new EU Member States. All these developments had a strong influence on family life. The birth rate in the former East German fell to 0.7. It is now 1.3, but needs to rise to 2.1 to sustain population levels. In the EU, only Ireland and France approach a birth rate of 2.1 – all other countries are lower.

By 2030, Brandenburg's population will fall to an estimated 2.2 million. At the same time there will be more people over 65: one in three compared with one in five at present. In rural areas, some 40% of the population will be over 65 by 2030. Decision-makers face questions about how to organise infrastructure, health systems, and communications.

Mr Harms cited the example of Schwedt, on the river Oder, which used to be "the youngest town in the GDR". Since 1990 it has lost one third of its population: 17,000 people. By 2030 it will be the third-oldest town in Brandenburg, and local authorities have started to demolish apartment blocks. By contrast, in the Berlin and Potsdam areas, population levels continue to rise. Population density of 14,000 per sq. km in central Berlin contrasts with 20 per sq. km in far-flung rural regions.

One consequence is that Brandenburg will face a shortage of qualified, high-skilled workers, coupled with high unemployment in some areas. Greater investment in education plus training for older workers is needed. By 2015 the state will require 200,000 new skilled workers.

### Responding to the challenges

Brandenburg started to confront these problems early. Local administrations faced with the prospect of losing 30% of the population will tend to assume that setting up an enterprise zone is the answer. But this will not resolve the situation. We have to accept that we are facing a real change that will affect all sections of society, and we have to examine the next steps, insisted Mr Harms. The changes affect:

- infrastructure (water supply, waste water systems etc.) with fewer people to pay for existing services;
- Transport provision in areas of low population;
- Schools: avoiding closures by combining different age-groups in classes, for example;

Healthcare in sparsely populated areas with an ageing population: the quantity/quality dilemma. Berlin has one of the best hospitals in Europe, but how can services be extended to people living out of range?

Investment in new ideas such as information and communication technologies, new forms of cooperation.

There is no one-size-fits-all solution, concluded Mr Harms. A Europe-wide discussion is needed on these questions, with networks at EU level, which could evolve from the Peer Review meeting.

### **How to ensure healthcare in regions with declining and ageing populations: challenges and policy responses in the European Union**

Thematic expert **Alan Maynard**, Professor of health economics at the University of York, in the UK, pointed out that he is also the chair of a hospital trust serving 350,000 people, and combines teaching medical students with the practical problems of healthcare management.

Prof. Maynard expressed scepticism about the way funds are used for healthcare, because evaluation of impacts is inadequate. There is little proof of good value for money, or the benefit to be derived from spending more. Does the expenditure of billions of Euros improve the length and quality of patients' lives? Elderly people need "running repairs", treatment for multiple disabilities and support for dementia sufferers. Providing good services for ageing populations in rural areas means freeing up resources from elsewhere.

He said the papers presented at the Peer Review talk mainly about reorganising structures, but there is little evidence that this guarantees better processes, or even that better processes improve outcomes. The problem is that healthcare services are inefficient. 70% of hospital costs come from labour. Changing practices could create more flexible labour responses and release more resources for patient care. However, doctors and their professional 'trade unions' feel challenged and often oppose such measures.

The skill mix could be adjusted. Do we need nurses with degrees?, asked Prof. Maynard. Most primary care could be provided by well-trained nurses able to diagnose and prescribe. In this case, we would need fewer doctors per head of population. We should start measuring patients' 'health status'. People want interventions/care that improve their quality of life. Quality of life measurements exist and are used in clinical trials. They could be applied, for example, before and after a hip replacement operation.

What can be done to incentivise health workers to change? Financial incentives are one option. Studies show that nurses are equally as good as doctors at identifying problems. In Sweden and the Netherlands nurses can already carry out anaesthesia. Nurses could also be trained to do some surgical procedures, but restrictive practices keep them in the hands of surgeons. New technologies and robotics are also making advances. But Prof Maynard warned that most reforms amount to experiments on patients, and can damage them.

Pay for performance (P4P) is emerging in the US and is one way of incentivising change. Insurers and governments are becoming more demanding purchasers. Currently, errors affect 10% of hospital procedures, making this the "most efficient" way of killing people in hospital! They should not occur. There is an argument for collecting and publishing data on such cases, and for purchasers not to pay for bad practice. Prof Maynard referred to initiatives to promote good performance such as the US Medicare Premier programme, but said that recent evidence shows it does not change outcomes.

An English programme launched in April 2009 aims to measure patients' health gains before and after treatment. It started with four elective surgical procedures (hip and knee replacement, hernia

and varicose vein repair). The plan is to publish the results, so as to inform patient choice and to reduce expenditure if outcomes are poor. Prof. Maynard said research within the National Health Service indicates 82% of patients feel better after a hip replacement, 73% after knee replacement, 47% after hernia repair and 55% following varicose vein treatment. By contrast, 47% feel no improvement following procedures for cataracts and 26% feel worse. Such data could change the nature of the debate. New hips and knees could be regarded as 'good buys', based on patients' interests rather than hospitals'.

## Overview

**Prof. Maynard** raised a number of questions for the Peer Review, with regard to the improvement of healthcare systems in response to demographic change: Should we focus just on evaluating process, or on process and outcome? Should we place incentives on hospitals or on doctors? He admitted that if he were a doctor, he would be fearful at the thought that a nurse could perform his job. However, resources must be freed up for elderly patients, and evaluation is poor. The chances of getting more resources are remote, so how can existing ones be redistributed to improve population health?

To make the appropriate reforms, policy-makers need courage, better measurement and better management. There is scope for significant change, on data available for a number of years, but there is a reluctance to move. In England, the current economic crisis is likely to produce 5-10% cuts in NHS budgets. This represents an enormous opportunity for redistributing resources.

## Discussion

**Deborah Sturdy** from the Department of Health in England said that there is a danger in taking a reductionist approach to skills and dilution across professionals. Older people are some of the most vulnerable with both complex co morbidities and social care needs which require highly skilled intervention and management, as this group are often the most clinically challenging.

**Konstanty Radziwill**, vice-president of the Standing Committee of European Doctors (CPME), said the organisation is not a trade union, and it works hard to improve conditions for patients. He described Prof. Maynard as "brave" in arguing for the substitution of doctors by nurses, and queried whom patients would rather turn to with serious health problems. Reducing access to very well-trained practitioners would be moving in a "very dangerous direction", he warned.

Healthcare in the 21<sup>st</sup> century is one of the greatest achievements of civilisation, he argued. However it is impossible in such a complicated field to eliminate the chance of human error or even more often organizational disorders and inefficiency. Mistakes are relatively rare compared with the number of patients who gain a better quality of life as a result of treatment. Dr Radziwill insisted that doctors should be responsible for coordinating services for people in remote areas. However he welcomed the questions posed by the Peer Review and endorsed the need for reform of structures and processes in order to achieve better outcomes.

**Hartmut Reiners** from the Brandenburg Ministry of Labour, Social Affairs, Health and Family emphasised the difficulties policy-makers face in reforming healthcare services, due to the strength of professional interests. He described health policy as "water ballet in a sharks'

aquarium”.

**Friederike Botzenhardt** from the General European and International Health Policy Planning unit of the German Federal Ministry of Health said doctors and nurses must support reforms if they are to work. She wondered how the ideas on the table would apply in a German context.

**Prof Maynard** said for around half of medical procedures there is no data on effectiveness. Evaluation is now impossible, because it would be unethical to withdraw treatment from some patients. So a lot is based on consensus. Nevertheless, compared with many policy areas (social, education, justice) medicine is relatively scientific. Randomised clinical trials (RCTs) are available, although the data may be incomplete.

Doctors are important, but should not have total power. One way to open assessment would be to collect and publish information on individual performance, which would have an impact on the practitioner's reputation. 30% of errors are avoidable and should not happen. On the other hand, doctors are not trained to be coordinators or managers, and they probably need to improve these skills and apply them more responsibly. Some incentives serve to reward rigidity and maintain the *status quo*. But problems in low-populated areas such as Brandenburg, Scotland and Ireland will force change.

**Simo Kokko** from the Finnish National Institute for Health and Welfare said in an ideal world all procedures would be standardised, but in fact RCTs are not appropriate for evaluating everything. By rewarding only results, we reward elective procedures, and many other needs (elderly care, mental health etc.) are penalised.

**Brian Murphy** from the National Primary Care Transformation Dept of Ireland's Health Service Executive said the country is undertaking a huge reform of services. Three million people live outside Dublin. Under the reform money will follow patients, away from hospitals where highly-paid consultants sometimes perform minor tasks to primary healthcare teams. This will be more efficient ensuring that “the right person will provide the right service at the right time in the right place”.

Blood transfusions are already carried out by healthcare assistants, and nurses are moving towards a more advanced nurse practitioner role. There has been criticism, however, that the nursing profession is becoming too academic (degree qualification) and less “hands on”. Reform has been difficult as there has been resistance from professional interest. One solution could be to give GPs more incentives and appeal to their professional “competitive instincts” in developing their practices and providing a wider range of services.

### **AGnES project: description and evaluation**

**Neeltje van den Berg** from the University of Greifswald Institute for Community Medicine described the project, which ran from July 2006 to December 2008 – data is still being analysed. The concept was based on the delegation of General Practitioner (GP) home visits to AGnES-practice assistants in regions with an imminent shortage in primary healthcare. The aim of the Brandenburg project - one of a number of such initiatives in the eastern part of Germany - was to develop a practically relevant qualification for nurses for integrative and sustainable primary care.

The project was based on an ambulatory healthcare centre in the small town of Lübbenau, 150 km from Potsdam, and involved six GPs and three AGnES practice assistants/nurses.

The evaluation covered a number of questions, including

- What kind of patients did GPs select to take part?
- What services did they delegate?
- Did the patients accept home visits from practice assistants?
- What was the effect of the project on the total number of home visits?

It was difficult to compare project activities with normal ones because GPs do not document all their activities. The project wanted to show the service was not a “luxury”, and therefore the aim was not to increase the number of home visits. Standardised records were important, so visits were recorded directly in the patients' homes, and data sent to the institute every day.

**Results** (Brandenburg): 379 patients received 4471 home visits. Mean age: 76.8 years. 72% had restricted or no mobility. The complaint most frequently treated was hypertension (62%), and least frequently cancer (10%). 95% of patients were multimorbid with an average of six different diagnoses.

**Activities:** assistants carried out a standard state-of-health check on every visit. Among a wide range of some 200 services, some of the most frequent were blood pressure measurement (3957), blood samples (1199), ordering prescriptions (653) and injections (618).

Assistants made telephone contact with a doctor during 3.5% of visits, and by video-conferencing during 1%, for reasons ranging from problems with medication to requests for hospitalisation. Legally, a doctor must be consulted before hospital admission takes place, but the nurses' assessment was right in 100% of cases.

The project also set out to develop an AGnES qualification model. This consists of seven modules requiring 622 hours of theoretical learning and 200 hours of practical work. Not all AGnES assistants have to take all the modules. But the basic nursing education, coupled with professional experience and advanced training enables them to perform all the delegated tasks.

**Evaluation** was based on the reactions of 42 GPs taking part in delegation schemes: 90.5% found the concept helpful; 88% felt nurse home visiting had a positive impact on patient compliance. The quality of care was approved in 92% of cases.

**Patient evaluation:** 94% of the 667 patients surveyed accepted the practice assistants making home visits except in case of urgent medical need. 99% found the AGnES nurse capable of dealing with their health questions.

The Brandenburg project also collected economic data from the health centre and one of the health insurers. Throughout the duration of the project the total number of home visits did not alter, but visits by GPs went down by 23%. Statistics covering about half the participants showed that there was little overall change in the proportion of female patients legally assessed as 'in need of care' (lowest level) between 2005, before the project started, and when it ended in 2008, compared with a slight increase in the male rate. However there was a significant rise in the number of prescriptions for home care services following the assistants' visits to patients' homes. Calculation of the cost of reimbursement of an AGnES home visit reached an estimate of €21.58 per visit.

In March 2009 a change in the law incorporated the delegation of home visits into regular health services, but reimbursement was set at a maximum of €17, excluding driving costs, with a qualification requirement for practice assistants of only 220 hours compared with the 622 hours recommended by the AGnES project. Ms Van den Berg concluded that the project organisers are proud of bringing the legislation into being, but still have to see whether €17 will be a sufficient incentive to persuade doctors to take up the scheme.

### **Flexibilisation of outpatient services in primary healthcare: deployment of AGnES practice assistants from the political perspective**

**Dr Friederike Haase** from the Brandenburg Ministry of Labour, Social Affairs, Health and Family said the state faced the problem of ensuring adequate healthcare at a time of demographic change. The specific German healthcare system means that doctors alone, represented by their professional association, are responsible for guaranteeing primary healthcare. But services have to be rearranged to make better use of resources. Doctors disagree about the potential risks arising from substitution of carers.

The AGnES pilot was a simple idea aimed at guaranteeing the quality of healthcare in a large area with not enough doctors. It employed the principle of delegation, not substitution. The partners were the medical care centre in Lübbenau and the three recruited medical assistants, the University of Greifswald Institute for Community Medicine, and the MASGF, which coordinated several advisory committees and set up the project with ESF support. It also communicated with other *Länder* running similar projects and translated the results into a legislative proposal. This meant creating a mechanism for funding delegated outpatient medical services.

The law as adopted provides for a lump sum of €17 per visit, to be awarded on certain conditions. The patient must be chronically ill, over 65, and in an area of existing or imminent shortage of primary care provision. It does not cover the whole range of outpatient services. As a result, the statutory basis for the scheme fails to reflect the AGnES conclusions in that it reduces the level of qualification of practice assistants and the range of tasks they can perform. Implementation is now in the hands of the doctors' professional body and the insurers. "We still have a long way to go," noted Dr Haase.

The project finished at the end of 2008. The legal basis came into effect on 1 April 2009, leaving a three-month gap in funding. The MASGF tried to fill this through financial support from the insurers, to enable the AGnES assistants to continue working until they could be employed on a statutory basis. However, doctors have now raised additional problems relating to the interim funding and the assistants' qualifications.

This has created a very difficult situation for the assistants, who may not be able to continue their work. As a result, Gabriela Marx, one of the AGnES nurses who was due to address the Peer Review, had decided not to attend. "It was a good project and they want to go on with it," concluded Dr Haase. "This is a tricky situation for the Ministry of Health, since we cannot impose the system."

## Questions and discussion

Peer review participants asked whether GPs gain or lose time through the project. Who pays the nurses? What is the role of insurers in German healthcare policy-making?

**Ms Van den Berg** said doctors were found to gain 400 hours a year, on average. They pay the assistants, but are reimbursed. **Mr Reiners** said Germany has a very complicated funding system. Reimbursement for home visits in rural areas does not cover costs. The project encapsulates all the problems relating to outpatient care. Regional governments cannot influence doctors' remuneration policy: contracts are negotiated at federal level. Thus, although regional politicians are responsible for healthcare provision, they cannot control it. This is a "tragic situation" for policy-makers. Health reforms take place every four years. Doctors' conditions are agreed by a committee of doctors, providers and sickness funds, which sometimes have different interests and therefore find it hard to reach consensus. After reunification, the GDR's healthcare system was destroyed, and doctors imposed the west German model, giving them a monopoly on outpatient care and leading patients to believe that nurses offer inferior care.

**Mr Kokko** said there is plenty of evidence from other EU countries that nurses are competent to carry out home visits.

**Dr Radziwill** denied that doctors only act in their own interests. Professional associations are often statutory organisations that regulate and represent doctors, and share responsibility with policy-makers in many countries. There is a role for physicians, but also for nurses, midwives, dentists, social workers, and 'neighbourhood helpers' who may be paid by local authorities.

## European Federation of Nurses Associations (EFN)

EFN General Secretary **Paul de Ravee** said the federation has 32 national nursing organisations in membership and operates at European level to inform and influence the policy process of the the European Commission, Parliament and Council. It currently has three overarching priorities:

1. Education, which is being threatened by Member States' failure to comply with the revised Directive 36 on the recognition of professional qualifications. France and Germany are moving away from implementing the criteria as set out in the Directive and in Belgium nurses coming out of the nursing school do not have the required clinical practice as set out in the Directive (50 Clinical Placement). In Italy, the nursing profession is losing its own discipline, so moving back 30 years of development and coming again under the medical umbrella, like in the former Soviet Union countries. Some Education Ministries have the ambition to lower down nursing education standards, which is a threat for quality of care and patient safety.
2. The workforce: why are nurses leaving the profession? In some EU Member States nurses earn as little as €150 a month. If they have a family, it is inevitable that they will want to move to the UK or Ireland, so as to be able to send money home. Within this policy pillar, skill needs, skill mix and task shifting is high on the political agenda of EFN as when reforming health systems, we need to discuss and agree on innovative developments.

3. Finally, Quality of Care and Patient Safety are high on the political agenda of EFN. The crossborder patients' rights directive and the Council recommendation on Patient Safety are major steps forward according to EFN. Within this context, the EFN welcomes the stakeholder approach since many EU policies tend to be developed in the dark and Civil Society plays an crucial role in developing policies, not only implement policies. It is impossible implementing recommendations and policies if you are not part of the development: policies need to be fit for practice!

Mr De Raeve suggested that lessons can also be learned from new and future Member States. He was impressed by Croatia, where early in the 20<sup>th</sup> century Andrija Štampar developed a public healthcare system in Zagreb, and was a pioneer in the League of Nations' health organisation. In the Balkans, during the war, Mr De Raeve observed perfectly functioning primary healthcare, and he also admired developments in Romania.

His job exists to influence politicians assumptive worlds and actions towards improving the conditions for Europe's 6 million nurses, he concluded. A European perspective and EU investment in health are important, but it is not easy to apply for funds at local level. He thanked the Commission for its efforts to make things happen there where people live out their life and hoped that in future the Social cohesion funds would be more used in synergy and for health. To achieve this, the national management teams and civil society should meet to discuss needs and content. The Commission should take an active role to bring stakeholders together and share best practices.

### Standing Committee of European Doctors (CPME)

**Dr Radziwill** underlined that Europe has a growing problem of an ageing population, and a decline in population in some regions. This has never happened before. It is a challenge for society and politicians. It is hard to find enough staff to care for elderly people living in such regions, who may form up to half the population.

Europe has 10 times more doctors than in the 1930s, but there is still a shortage of doctors and nurses. This is due to changing standards. Primary care is one of the best examples of high quality and can play a much bigger role than in the past:

- fast diagnostics are possible
- outpatient interventions can save lives
- effective treatment is available for chronic diseases.

If Europe has an ideal of 'health for all', then every citizen has the right to the best possible medical care.

Primary care is complex since it has two components: medical and social. Provision of both differs from country to country. Home care may often be the best option, and family care should be assisted. In rural areas, elderly patients need dental, hospital, rehabilitation and psychiatric services, and all must be coordinated. He agreed that doctors are not trained enough to manage, and saw this as a challenge, since doctors must be leaders in teams of health professionals.

There is currently a shortage of primary care physicians, particularly being (family medicine)

specialists. Why do doctors and nurses not want to enter primary care, especially among ageing populations? Because it is not attractive. If it is important, society therefore needs to make these jobs more attractive through better pay, working conditions, continuous training possibilities and community support for housing etc. It is not fair, claimed Dr Radziwill, to tell doctors that *they* must pay for experiments like the AGnES project. If policy-makers want reforms, they should pay for them themselves. More health professionals are needed, and have to share their knowledge and experience. Teamwork is the only option, he concluded, not substitution.

**Training:** traditional views must change, to attract more young medical students into family medicine. Currently, primary care carries less prestige than specialist medicine in many countries. It should be a specific subject, coupled with a better offer to graduates to encourage them to choose. There is a need to reassess what kind of skills family doctors need, such as for example dealing with emergencies.

**Research** is required into the needs of ageing patients with multiple morbidity. They are often most difficult patients and demand special skills that are not easy to delegate to less qualified practitioners. Yet care for people who will be ill for the rest of their lives must be a social priority. Even though 70% of hospital budgets go on labour, this is not misspent. Patients need care, not money, and this has to be bought from care providers via expensive equipment, medicines and highly skilled physicians and other health professionals.

### Questions and discussion

Asked why old members states are now facing infringements by the Commission, **Mr De Raeve** said countries like France, Germany and Belgium are lowering down standards, probably for economic reasons. This is unacceptable as the past learned that this is the wrong decision. Under the upcoming patient mobility legislation, if a Finnish patient goes to Cyprus for treatment, s/he needs to know who is qualified as a nurse. According to European law a nurse has had 4,600 hours and three years' training – 50% theory, 50% practice and the entry to the nursing education is after 10 years basic education. Germany wants to lower down this last criteria. But also graduate nurses in Belgium, for example, have lesser clinical training as set out in the Directive. "We want nurses to be fit for practice." In healthcare the core group is the patients, doctors and nurses, who are working 24 hours a day, 7 days a week. It is important to take care of these core groups.

**Prof Maynard** said two things are certain: we die, and resources are finite. The rate of growth in funding health care is going to be small or negative in many countries, so we have to think about how to prioritise and switch resources. People are living longer largely due to changes in behaviour, not healthcare. How do we reduce the size of the hospital sector to free up resources for primary care?

**Mr Reiners** pointed out that GPs in Brandenburg get paid €20,000 pa. more than in Berlin, but there is still a shortage. In Germany, 70% of medical graduates are now women. "We have to address this problem," he remarked.

## Transformation of health services for an ageing population – virtually connected health service centres in rural areas – Annex 5

**Gerd Groh**, from the Ministry for Health and Social Affairs of Saxony-Anhalt, introduced the **Transage** project (linking 'transformation' and 'age') on *Innovative health care structures as response to a declining and ageing population*. Structural and demographic change goes hand in hand, and nurses and doctors are also ageing. In 1989-2005 the population of Saxony-Anhalt fell by 16%, and by 2050 is likely to drop a further 36% - a loss of 900,000 inhabitants. The population will be cut in half, with impacts on all planning decisions. The number of people over 65 will increase by 38%. Compared to neighbouring regions, there will be an increase in heart disease, strokes and cancers such as colon cancer.

With a declining and ageing population, the goal is healthcare stability in rural areas, coupled with transformation to meet the needs of older patients. There are currently 1,500 GPs with their own surgeries, 1,700 specialists with their own surgeries, and 3,300 doctors working in hospitals. By 2025 the *Land* will lose 1,000 doctors, with a replacement rate of 50%. He claimed that the women who now make up 70% of graduate doctors will not want to work 80-90 hours a week in rural practices. There will have to be more cooperation between doctors in the future.

Policy-makers need to think about how to keep existing surgeries open when doctors retire, through collaboration between hospital doctors and GP practices. The project is developing surgery network centres (SNCs), recruiting hospital doctors who are prepared to work half a day or a few hours a week in general practice, and bringing in intersectoral elements.

Modern technologies are necessary to create a common technical basis for coordination, including electronic patient files and harmonised software and hardware, as well as calendar planning for staff in main and affiliated surgeries. In an affiliated surgery, a doctor is available for between one and five days a week, and is backed up by specialised nursing staff and administrative support. Mr Groh concluded that the aim of the project is to guarantee the adequate availability of healthcare structures: care has to follow the needs of the ageing population. Flexibility is one of the advantages of SNCs, which can be restructured as change occurs. "We have to be flexible in the future, or our regions will die," he insisted.

### Questions and discussion

Questioned whether doctors mind sharing electronic patient files with other professionals, **Mr Groh** said these records are already in use: doctors must know what treatment has already been given, and there are big advantages in sharing data. Older doctors are also so desperate to find successors that they are more open-minded. The records are not given to patients. **Mr Reiners** reported that negotiations on an electronic health card have been going on in Germany since 2004. By 2010, insurance scheme members should have such a card, with basic data.

Asked why more women are qualifying as doctors, **Mr Groh** said girls get better results at school and therefore access to university. In the course of a discussion on the "feminisation" of the medical profession, **Prof Maynard** said research shows women doctors have an activity rate 10-15% lower than men. This may be because women listen more, and could bring better outcomes, but there is no evidence on this. It still means more doctors are needed to maintain activity rates.

## Peer Country contributions

### *Slovenia*

**Robert Medved** from the Health Care Directorate of the Ministry of Health said Slovenia may be considered as a single region due to its small population. The country is expecting a fall in population because of fewer young people and women in a fertility period and because of low fertility rate. Like other developed countries, the population is ageing: recent figures show 14% of inhabitants aged 14 or under, 70% aged between 15 and 64, and 16% aged 65 and over. This will bring consequences for healthcare services for elderly people.

More than 40 years ago, health care policy-makers in Slovenia realised that elderly people had specific health problems. An Institute of Gerontology and Geriatrics was set up in 1966, but ceased work in 1989, bringing an end to its educational and research activities.

In 2006, the government adopted a *Strategy of Care for the elderly till 2010 – Solidarity, living together and quality ageing of the population*, including the re-establishment of the Institute of Gerontology and Geriatrics within an interdisciplinary framework. In 2007 the Ministry of Health signed a letter of intent for cooperation with the Anton Trstenjak Institute of Gerontology and Intergenerational Relations, implemented in 2008 with the adoption of a work programme.

The regular tasks cover the provision of knowledge and the management of health gerontology. Two special projects focus on establishing a Slovenian network of ageing friendly cities, and the development of local intergenerational centres.

The majority of healthcare needs among elderly people are expected to fall into the primary sector, which has to be adapted to cope. With a permanent shortage of doctors in Slovenia and especially in rural areas, the professional profile of practitioners will need to be redefined to provide integrated care. In Slovenia there are practically no gerontology specialists, so the Ministry plans to introduce specialised training. It estimates a need for one gerontologist per 100 hospital beds.

**Question:** asked whether specialised training for nurses is also planned. Mr Medved said the main problem is doctors. Nurses are already more specialised.

### *Greece*

**Dimitris Florinis** from Greece's permanent representation to the EU said Greece has a population of 11 million, with 75% living in urban areas. There are also 300 inhabited islands. In 2007, 18.6% of the population was aged 65+, the highest proportion in the EU. By 2050 the figure will be almost 35%. The total population will decline by 3%.

In the 1950s and 1960s a mass movement towards cities took place. The ageing population left in rural areas is a challenge for health providers. In the 1980s, primary healthcare centres were set up in rural areas, and today there are 230 of them, as well as 370 Open Care Centres for the Elderly (KAPI) in both rural and urban areas. In the 1990s the KAPI started to cooperate with a network of 100 municipalities to provide help at home. Today there is a shift towards more

targeted provision for isolated people needing special support.

With an ongoing shortage of medical staff in rural areas, Greece has adopted incentives/strategies including salary bonuses and mandatory service for junior doctors. The latter policy is controversial since research suggests it contributes to downgrading of health standards. Nursing care could cover 65% of rural health needs, so replacement of junior doctors by nurses would be effective and less costly. However there are problems: nursing education is clinically orientated, so nurses might not be able to perform all the tasks required. Secondly, for cultural reasons, most Greeks prefer to consult a doctor rather than a nurse. The introduction of telemedicine is a priority, but at present there is no comprehensive system, and no uniform patient medical records.

**Questions:** asked if these measures are adequate, Mr Florinis said the government is considering legislation offering incentives for all health professionals to work in rural areas. They would need to be more than just salary-based. It was pointed out that exchange of patients' records between different services would be illegal in some countries due to data protection laws. Mr Florinis said ethical problems will have to be dealt with as a unified system evolves.

**Deborah Sturdy** from the Department of Health in England commented that, as a nurse who had chosen to specialise in geriatric care, she was depressed by the tone of the debate and the negativity regarding elderly people. "We need to talk up why it's good to work with older people, or it will become a self-fulfilling prophesy," she warned.

### *United Kingdom*

Deborah Sturdy said in 2001 the government adopted a 10-year plan for older people, followed by a series of further policy proposals including a five-year national dementia strategy in 2009. Work is now underway on ill-health prevention policy. The aim is to keep older people out of hospital and in their own homes for as long as possible, preventing them going into hospital where other options exist and getting them out after treatment. The department sets directions, a regional tier of management monitors spending, and primary care trusts in communities decide what care should be provided locally.

Specialist nurses ('community matrons') do not reduce costs because they uncover problems that were not known about before through direct contact with the community. Health services and local authorities are getting better at working together to provide social care. People with complex health needs also require social support, so the sharing of budgets and resources is beneficial.

In the UK, team working is widely accepted. There has been much evaluation of telemedicine. Some technologies, allowing dementia sufferers to stay independent longer, for example, have their place, but telemedicine can never be a substitute for care. More should be done to boost public confidence in nurses, at the same time enabling nurses to develop their abilities. The law allows nurses to prescribe, if they are on a register, and more and more are wanting to do it. Some procedures are supervised by doctors, but nurses are accountable to their own professional body.

**Prof Maynard** added that there are 20,000 nurse-prescribers in the UK, and training does not

take very long. They are found to adhere to protocols more than doctors – especially male ones. As to whether nurses substitute for or complement doctors, he argued that investment in nurses does not necessarily reduce the number of doctors, or save money.

### *Portugal*

**Sérgio Gomes** from the Directorate-General of Health said Portugal is currently undertaking reforms. The country has a population of 10 million, 17% of them aged 65+. It has 35,000 doctors and 55,000 nurses. Generally, healthcare is good, but access differs across the country. On the positive side Portugal has a network of 350 health centres and 2000 health units. Doctors are well trained. On the other hand, replacement rates are low, primary care is under-resourced and the salary system offers no incentives. Due to the unequal distribution of doctors and nurses, 10% of the population does not have a family doctor.

Reforms are focused on community services, flexibility, teamwork, autonomy and accountability, and development of human resources. 'Health 24' is a new scheme developed in the last two years, with contact centres offering clinical and non-clinical services, with nurses in attendance. The centres refer patients to the appropriate care provider so as to avoid bottlenecks, for example, in emergency departments. The aim is to establish a closer relationship with citizens. Results have yet to be evaluated, but look promising. Step by step, the country is undertaking a complete reform of primary care and hospital services over the next two years.

**José Pardal** from the Portuguese Primary Health Care Mission explained that reforms are taking place in eight major areas: autonomy of health centres, including financial autonomy; family health units with multiprofessional, self-organising teams; restructuring of public health services; community health intervention with mobile units for home care, palliative care and family support; local health units to improve communication between health centres and hospitals; development of human resources and health information systems; and ongoing professional training for health practitioners. The objective is high quality care for all citizens.

### *Romania*

**Alexandra Constantinescu**, coordinator of the Social Inclusion Unit of the Ministry of Health, said Romania has a population of 21 million, and has enjoyed steady GDP growth of around 4.5% over the last five years. Since 1990, the population has been declining by an average of 0.2% a year. The forecast is for a continuing fall of 0.3% in 2007-2013, reaching 18.6 million by 2030. The proportion of 65-and-over is increasing, and stood at 14.9% in 2007. The rural poverty rate rose from 29.6% to 29.9% in 2007: around 70% of those at risk of poverty live in rural areas, with the greatest poverty found in the north-east of Romania. The urbanisation rate of 54.9% is the lowest in the EU. In Europe, only Albania and the former Yugoslav republics have lower proportions of urban population.

Primary healthcare is the weakest link, with a rise in chronic diseases among the elderly increasing the demand for doctors' services. Access to healthcare is especially poor in rural areas. In 2005, there were 19 care homes for elderly people in the country.

Severe regional inequalities make the number of patients per doctor is six times bigger in rural areas than in cities. This means that the northern part of Romania in the rural areas is the most uncovered medical part (3,000 patients per doctor) and there are up to around 30,000 patients per community nurse in the north. There were 98 communes with no doctor at all (3,5% of the population). Most dependent elderly people are cared for by families.

The Ministry of Health's national strategic plan until 2010 aims to attract medical personnel to underprivileged areas through incentives, including a pay settlement equivalent to two basic salaries, and help with accommodation and equipment. A fully qualified doctor earns less than any other doctor in the EU as well as a nurse. A large number of them are currently leaving to work in other EU countries, or the US. This is a problem for the population that remains in Romania.

### *France*

**Arnaud Vanneste** from the Ministry of Health and Sport said France measured it was facing a demographic crisis five years ago. The imminent retirement of doctors of the baby boom generation will cut the number of doctors per 100,000 people from 322 to 276.

The liberal statute of physicians enshrines doctors' freedom to set up where they wish. Only 39% of French doctors work in group surgeries, compared with 97% in Sweden. To deal with the unequal distribution of primary care doctors around the country, the government chose incentives rather than compulsion (grants, income supplements, fiscal advantages). However, only 1,000 doctors took advantage of these measures, 800 of them already settled in areas classified as underprovided. The incoming generation of doctors is more interested in family life and conditions than money. Action was more successful among nurses, who are barred from settlement in overprovided zones.

As a result of the lack of success among doctors, the government is currently considering coercive measures: the Health Solidarity Contract requires doctors in overprovided areas to provide extra services elsewhere, or pay a financial penalty. Medical students often set up in the area where they graduated. From next year, students will be proposed grants in exchange for committing to working in an underprovided area for the same length of time.

Five years ago, France started to set up pluridisciplinary care centres bringing together doctors, auxiliaries and specialists. Local authorities provide the facilities, and they are supported by state funds. So far there are only 158 of them, but the hope is to attract more doctors, since the younger generation is interested in working alongside other professionals such as nurses and physiotherapists.

The government would like doctors to be more active in prevention strategies, and to give more power to nurses, but so far take-up is poor. The physicians' statute dates back to 1927, which obviously needs to be modernised, is the major key of the demographic issue.

### *Finland*

**Simo Kokko** from the Finnish National Institute for Health and Welfare said the country is in the middle of complex reforms of health centres and the municipalities that run them. The aim is to reduce the number of centres from 230 to about 120 by 2013, in line with a minimum primary healthcare catchment population of 20,000. Nurses' tasks are not a priority issue, largely because there is no problem. However there is a shortage of doctors and dentists. Nurses have taken on some of the load, not substituting for doctors but providing additional services. Finland has a long tradition of employing public health nurses in local communities. Starting from TB care and child health, their duties have expanded over the years with nurses taking on specialist tasks in dealing with, for example, diabetes, asthma, arthritis, and psychiatric problems. Home care nursing has developed as an area of expertise in itself.

As the shortage of doctors became more acute in the 1990s, rural centres started to rely more and more on nurses' advice. From 2005, health centres were required by law to answer phone inquiries. Many of them outsourced answering to nurses, but this became so expensive as the demand for services increased that they brought it back in-house. In Lapland there have been some experiments with video consulting but generally, despite Finland's reputation as a pioneer in communication technologies, there has been more rhetoric than action on telemedicine.

Elder care is becoming a big problem because the population will age rapidly from 2020. How can needs be met in a society that has always relied on public services? The state is trying to push the obligation back onto families, but older people themselves are becoming much more demanding.

**Hanna Nyfors** from the Finnish Ministry of Social Affairs and Health added that the government is introducing a crucial legislative proposal on nurse prescribing.

### *Ireland*

**Jimmy Duggan** from the Department of Health and Children said the country introduced nurse prescribing not to resolve problems in rural areas but due to nurses' demands for further professional development and a recognition by Government that this would be a good way to proceed. They must have special training, and only prescribe in their own area of expertise. There is a lot of enthusiasm, and the practice is growing.

Ireland is trying to transform existing facilities, with the same or less resources. Over the last 10 years people got used to growing resources, but this is no longer the case. The country has an ageing population and an ageing population of GPs. The key challenge is switching from hospital-based to primary care services. In Ireland, GPs are the gatekeepers of hospital access, and government policy is for 90-95% of health needs to be met by primary care.

## Day 2

### Approaches for ESF funding of health-related objectives in Brandenburg

**Katrin Müller** from the managing authority for the European Social Fund in the Brandenburg MASGF said ESF funding for health projects is still quite new – it's a topic of the future. How can health-related issues be integrated, especially into labour market initiatives?

Brandenburg's ESF allocation for the 2007-2013 funding period is about €620 million. To secure financing, under current rules, projects must be linked to the labour market. All Member States submit Operational Programmes (OP) setting funding priorities. In Germany, each *Land* has its own OP. Brandenburg has set three priorities:

1. Adaptability, competitiveness of workers and enterprises, especially focusing on SMEs, including human resources, training, and management skills.
2. Development of human resources outside companies: programmes in schools, universities, career centres, support for networks.
3. Social inclusion, improving employability, focusing on long-term unemployed.

Brandenburg also has an extra priority for: transnational cooperation, exchange of experience on labour issues (3% of funding) – taking a holistic perspective, focusing on improving working conditions and quality of work.

Health-related issues could be addressed under the first priority e.g. promotion of healthy conditions for workers, programmes to support older workers etc. It could also cover the development of transnational exchange on health-related issues in the context of labour market, looking at how other Member States are using ESF funding.

In Brandenburg it is important to develop human resources because the state needs qualified employees. Health issues linked to labour market could also be integrated into priority 2 (e.g. looking at school curricula, or vocational training), and priority 3 (health of the long-term unemployed).

### Lessons for healthcare from the Budapest conference on combating poverty and social exclusion in rural areas

**Mr Schulte** reported on the conference, held in Hungary in June 2009, organised by DG Employment together with DG Agriculture and DG Regional Policy (REGIO). The aim was to improve coordination of social exclusion, agriculture and regional development policy at EU and Member State level.

The basis was a very thorough study commissioned by DG Employment and carried out by the *Fondazione Brodolini* (<http://www.fondazionebrodolini.it/Public/Brodolini/Home/home.aspx>), including best practice examples. Poverty is defined as having an income below 60% of national average. But in concrete terms it varies widely across Europe (being poor in Denmark is different

from being poor in Bulgaria). Poverty in rural areas is more remote and therefore not so obvious. Furthermore, the rural poor are more satisfied with their living conditions than urban poor.

EU funding for rural anti-poverty programmes comes from three main sources: the ESF, the Cohesion Fund, and the Common Agricultural Policy (CAP). DG SANCO offers funding through its action programme on health, limited to €50 million per year. Farmers are the only group in the EU with a guaranteed minimum income. CAP funding 2003-2006 went largely to price guarantees for agricultural products. Since 2006, 14% is earmarked for rural development. One of the four programme axes is quality of life in rural areas, covering health.

The *Brodolini* study presents 19 successful projects, with a total budget of €236 million. Only one concerns health: setting up cross-border public health centres in Greece, Albania and the Former Yugoslav Republic of Macedonia (FYROM). It was agreed that European dialogue on rural poverty needs to be enhanced through the OMC.

**Anna Kanakaki** from the managing authority of the Health and Welfare OP in Greece added that there are plans to expand this transborder health support. The Greek experience could be very useful to Germany, for example if it wished to extend the AGnES project to Poland.

### Council of European Municipalities and regions (CEMR)

**Hannele Häkkinen** said the CEMR is the European umbrella organisation of national associations of towns, municipalities and regions, with over 50 members in 38 countries. There are 95,000 regions in the EU, and they are very different. Some have declining and some have increasing populations, but all have ageing populations and ageing workforces. The demand for health and elder care services is increasing.

The health workforce needs to be expanded, and to attract more young people, through better working conditions and working time that can be reconciled with family life. Social dialogue is important. In Norway, young health sector workers visit schools to boost interest in their professions.

Remote regions in particular face a shortage of doctors, and adopt a variety of strategies to deal with this. Finland has had a system of public health nursing for over 60 years, and specialist nurses now hold their own consultations. Scotland uses telecare services to improve patient safety at home. In Lapland, where there are big distances between communities, a bus takes doctors and nurses to remote villages. On the Franco-Spanish frontier, a new cross-border hospital makes care more accessible for the whole region.

Prevention services are especially important for elderly people, giving them the information they need in order to stay healthy. Cooperation is required at all levels of administration, and between providers and stakeholders. "We are all growing older, it's our future."

### Discussion

Questions centred on how best to obtain funds for projects, for example for mental healthcare for

the long-term unemployed. Participants were urged to develop project proposals in cooperation with DG SANCO and national health ministries. **Mr De Raeve** argued that there is no shortage of ideas, but the application process is so complex it puts people off. **Ms Müller** said the managing authority could offer help, but the European Commission and all Member States should examine whether their procedures are too complicated. **Jorge Antunes** from DG SANCO said the European Commission is not to blame since Member States are responsible for managing funds. Care is required when spending taxpayers' money, but the Commission could do more to improve communication and exchange of good practice.

### Developing healthcare provision and infrastructure in regions with declining and ageing populations – the role of EU structural funds

**Roland Bladh** confirmed that structural funding involves three DGs: Employment, REGIO and SANCO. DG SANCO has been pushing for health to be a priority of the structural funds. He drew attention to a useful paper by Annegret Litz on *Financing Healthcare Projects and EU Structural Funds*.

Under EU Cohesion Policy (2007-2013), the convergence regions (GDP below 75% of EU average) are the primary areas for support, in order to raise their level of wealth and production. 82% of the €347.4 billion budget is for convergence regions. The three funding sources are the European Regional Development Fund (ERDF), the European Social Fund (ESF) and the Cohesion Fund (for convergence regions only). Almost 60% of the budget is allocated via the ERDF, 20% via each of the others.

Health projects can be funded from the ERDF or from the ESF under convergence or territorial cooperation objectives. It is possible to obtain money for investment in health-related projects, but not for running costs. The ERDF has considerable sums available for health infrastructure to support regional development. In 2007-2013, €5.1 billion of structural funds have been earmarked for health infrastructure (1.5% of the cohesion budget), €5 bn for e-services and €1 bn for active ageing. Hungary and the Baltic States have planned the largest proportion of investment on health. Health related actions are now possible within the ESF priorities, as long as projects are linked to the labour market objectives, such as health and safety at work. However, in the current funding period the decisions on how to actually use the money available has been devolved more to Member States.

The Commission lays down the framework of rules but shares management with Member States. The Commission does of course not set out to make access to funds complicated, but it is under scrutiny from the European Parliament and the Court of Auditors to ensure that various rules are adhered to.

Member States submit National Strategic Reference Frameworks and regional and thematic Operational Programmes, and take charge of implementation. The Commission approved 117 ESF OPs for the 2007-2013 period. Mr Bladh listed Member States' health priorities, and gave the example of the **Saude** project in Portugal, co-funded by the EU since 1986, covering the building of health centres, nurse training, and health promotion. He gave many more examples of the sort of health projects the ESF can support.

## Discussion

**Anna Kanakaki** welcomed the information and said she had been looking for such a presentation for three years. The Greek health OP received €0.5 billion from both the ESF and ERDF, dedicated largely to mental health. In the 1990s the country decided to close its asylums and help mentally ill people to return to society. Money has been used to set up community support, launch anti-stigma campaigns, and train mental health professionals, through 35 mental health training centres. Twelve financially viable social cooperatives throughout Greece employ people rejected by the mainstream labour market. Through the programme, the ERDF contributed €200 million for medical equipment and urban health centres, and more than 5,000 new hospital beds.

After two years of negotiations, the programme has secured €400 million from the ESF and €800 million from the ERDF in 2007-2013. Money for health infrastructure is delivered through regional OPs. Greece gets the health sector involved in ESF projects through strong communication, a 'quality project pipeline' and constant support throughout the programme. Communication with stakeholders takes place through networks, a website and a monitoring committee that meets twice a year. At EU level, DG REGIO and Employment run specialised networks for communication officers and working groups on horizontal topics like discrimination, but there is no EU-wide network on health. This would be a good opportunity for DG SANCO to set one up.

**Savvatou Tsolakidou** from the ESF unit responsible for monitoring corresponding national policies drew attention to the thematic sheet on ESF health funding, available at [http://ec.europa.eu/employment\\_social/esf/docs/health\\_en.pdf](http://ec.europa.eu/employment_social/esf/docs/health_en.pdf)

## Presentation of a German study for the Peer Review: Financing Healthcare Projects and EU Structural Funds

**Björn Kümmel** from the General European Health Policy Planning office of the German Federal Ministry of Health asked why structural funds should be used for investing in health, when under the EU treaties, health is a competence of the Member States. Nonetheless, in 2007, all Member States agreed basic shared principles of access to good quality care, solidarity and equity, which form part of the EU's social model.

Yet major health inequalities still exist. 2005 figures show male life expectancy is 12 years shorter in Estonia and Latvia than Sweden, lung cancer kills twice as many people in Hungary as in Finland, and heart disease kills almost 10 times more women in Slovakia than in France. Across the EU there is a difference of 18 years in healthy life expectancy for women at birth. Belgium has almost twice as many doctors per 100,000 people as Poland.

Health and consumer protection programmes take up just 0.1% of the EU budget. In 2000-2006, health was not a priority area for the structural funds. But from 2007 the new Cohesion policy signalled a major shift, in recognising that a healthy population is important to economic and social development.

The EU's health funding provision for 2007-2013 is inadequate, argued Mr Kümmel. It is not possible to increase it, but there is some room for Member States to re-allocate spending between policy areas. The next funding period will be 2014-2020, and it will be more difficult to

argue for an increased health budget if the current allocation is not spent.

## Discussion

**Ms Kanakaki** suggested that health-related projects could also be funded under other headings, like transport or education. Ideally, health should be integrated into all policy areas. **Ms Botzenhardt** pointed out that good health enhances productivity and economic development and is therefore linked to the goals of the Lisbon Strategy. **Mr Antunes** insisted there is no contradiction in the EU funding health projects, even though organisation of health systems is Member States exclusive competence. He pointed out that the European Commission is committed to redressing inequalities between countries and these also included regional health inequalities.

## The findings: key lessons for policy responses

**Prof Maynard** put forward a series of conclusions:

1. A gradualist approach is necessary since all reforms are also experiments on patients and should be carefully evaluated. A lot of change is taking place, but there are no agreed measures of success, so we miss the opportunity to learn from one another. RCTs are the gold standard for evaluation but are often too expensive. Before, during, and after assessment is robust enough. Peer countries would learn more if they concentrated on good quality evaluation.
2. Existing reforms remain largely structural, and we are not asking patients if they get better outcomes.
3. There should be further steps to reduce the dominance of hospitals in overall healthcare provision, and redress the funding balance between primary and hospital care. One solution would be to award the entire health budget to GPs and allow them to ration access to hospital services. However the UK abolished its 'GP fundholders' scheme in 1999, amid doubt over its success.
4. Nursing is a female occupation; doctors used to be largely men, but more and more are now women. Research shows women doctors spend more time with patients than men, so this will mean nurses' and doctors' activity rates becoming closer. There is scope for substitution of doctors by nurses, but so far this has expanded service provision rather than cutting costs i.e. they tend to be complements rather than substitutes. Nurses can do a lot of what doctors do, but can they replace them given current political constraints?
5. Productivity and management need to improve. Prof Maynard noted that nurses may spend too much time chatting in the nursing stations rather than caring for patients.
6. Pay for performance can encourage doctors to improve, but do we need 'pay for performance for patients', bribing them to change lifestyles? Is it better to reform healthcare supply, or use resources to influence how patients use it?

He concluded that it is difficult to take the experience of one country and adopt it in another. Instruments exist to tackle the problems of sparsely populated areas, but the political will to use them may be lacking.

### Concluding discussion

**Mr Antunes** said the challenges of an ageing population across Europe require creative solutions, coupled with changes in behaviour. He wondered how far Member States have started strategic thinking about the future, using targets and indicators. **Mr Vanneste** reported that a French study on the relative merits of hospital and home care failed to reach a conclusive verdict. **Ms Constantinescu** pointed out that in Romania, doctors study for 10 years and nurses for three. She could not imagine nurses filling doctors' roles. In Romania, tax income from alcohol and tobacco goes into health funding.

### Closing remarks

**Mr Bladh** said the aim of the Peer Review was to provide useful feedback for the German hosts, the participants, and the Commission, and to table ideas for future reviews. From the point of view of the Commission, he was rather disappointed – it was not the best Peer Review he had attended, although some good things could hopefully come out of it.

He was expecting the meeting to throw light on specific solutions for healthcare in the regions concerned, but he felt it had not made much progress in this direction. He noted the general discussion on doctor/nurse substitution. Regarding the structural funds, he underlined the opportunities in all Member States for health-related projects. As already pointed out, it would be a good idea to spend the already allocated funds for health in the period 2007-2013 so that they are not withdrawn in the next funding round, when he hoped to see a more explicit health strand.

He noted two proposals for future Peer Reviews:

1. Bringing together people responsible for dealing with health in the OPs at national level together with NGOs in order to develop projects which are fit for practice (Taking EFN proposal into account);
2. Prevention policies.

**Prof Maynard** had called for better evaluation. The Commission is currently inviting proposals for projects on *transnational actions in social experimentation*, which could offer opportunities for developing evaluation methods. About 10 projects will be selected, with funding of €350,000 each: <http://ec.europa.eu/social/main.jsp?catId=630&langId=en>

**Mr Schulte** felt it was a useful Peer Review which allowed the issue to be tackled within the OMC. Countries like the UK, France, Ireland and Greece have experience Germany can learn from. Germany's self-governing health system has both advantages and disadvantages, one of these being the slowness of reform. AGnES is part of a political process, acting as an icebreaker, and he noted that the Peer Review supported the German government's point of view. The debate on substitution also has repercussions for nurses' pay and conditions.

He welcomed the fruitful discussion on the structural funds. It remains a problem that Member States health systems are all different, not harmonised. There needs to be greater awareness of the challenges at EU level and in Germany, and everyone can learn from success stories. One option for boosting resources would be taxes on health-related products, just as in Germany the Environment Ministry receives €400 million a year from pollution charges, for climate change projects. He also welcomed the cooperation between the federal and state governments in organising the Peer Review.

**Mr Reiners** highlighted three issues:

1. Health policy should be seen as part of the infrastructure of labour market policy, not as charity. Many politicians do not take health policy seriously, but in fact it is big business. In Germany it represents more than 10% of GDP and provides 4.5 million jobs. In Brandenburg, hospitals are one of the biggest employers, but in rural areas there is a lack of stakeholders to carry out policy.
2. We have to improve the status of nurses, in order to guarantee good healthcare in rural regions.
3. There is no lack of money, but rather a lack of skills in healthcare management. More and more money - €3 billion a year - goes to paying doctors, without any improvements in service.