

# 16th European Health Forum --- GASTEIN

2nd to 4th October 2013



## Resilient and Innovative Health Systems for Europe

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Conference Report

2013



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# The Gastein Health Outcomes 2013

## Resilient and Innovative Health Systems for Europe

The 16th edition of the European Health Forum Gastein (EHFG) held under the main title of “Resilient and Innovative Health Systems for Europe” in the Gastein Valley from 2nd to 4th October 2013, explored the relationship between austerity policies and necessary innovations in health care systems in order to keep them resilient. The EHFG 2013 looked for answers to the following three questions:

- What are the key strategies to make health systems resilient?
- What are the most important innovations to promote health system performance and resilience?
- How can decision-makers best introduce and implement these innovations?

The 2013 conference featured opinion cards to involve participants in defining answers to the above questions. Additionally, three Young Gastein scholars collected the main outcomes of the different sessions and together with senior experts Martin McKee and Josep Figueras determined and summarised them as the “Gastein Health Outcomes” and presented them in the closing plenary.

### Resilient health systems - strategies

Key strategies to make health systems resilient are policies, prevention and governance. There seemed to be a general consensus that consistent and sustainable policies were needed to make health systems more resilient. Furthermore, a need for a renewed commitment to health in all policies was called for. Another prominent outcome was a call for a good balance between regulations and patient involvement with the aim of putting patients at the centre of care and using patient centred outcomes as the basis for evaluating health care performance.

Regarding prevention, the objective is a sustainable model of prevention not only inside the health sector but cross-sectorally to promote sustainable change.

Governance as a key dimension in creating resilient health systems was a recurring theme. Economic governance calls for health system reforms that ensure cost effectiveness and sustainability and assess performance for the best use of public resources, while keeping them transparent and ensuring accessibility and solidarity.

A need for “tailormade” governance structures was expressed in a session where conceptual dimensions of governance, such as transparency and participation, were stressed as the foundation for the decision-making of health policy makers.

As the Greek Minister of Health, Adonis Georgiades said during the EHFG “This is not a crisis, this is the new reality”.

### Resilient health systems - innovations

Concerning the most important innovations needed for resilient health systems, three pillars of innovation were identified: governance, technological and social innovations.

Regarding the first pillar of governance, a need to remove barriers between sectors was expressed whereby the crisis could also be seen as a window of opportunity to translate Health in All Policies into practice. This could include measures implemented jointly with other sectors that have a decisive impact on health like education, environment or employment. In addition, we should enhance the use of evidence for decision-making in policy and not forget about the potential benefits of task shifts and skill mixes. This seems to be important especially when strengthening primary care services.

Innovations in information technology ideally supply real time and more accessible data in order for policymakers to be able to implement strategies earlier.

A need to discuss and assess the impact of these new technologies was requested and innovative approaches were discussed in several sessions during the EHFG 2013, for example during a parallel forum session on mHealth and a workshop on big data.

Furthermore, Health Technology Assessment should not only be performed once for new technologies but be repeated over time - especially in times of financial constraint. Social innovations should work towards breaking down the barriers mentioned above, such as barriers between health professionals in order to rethink working routines in the health sector. We should also look into innovations that give us more empowerment and support patients during times of crisis. Innovations related to behaviour changes are the most challenging though crucial ones to implement, as we also need resilient people in order to introduce resilient innovation.

Patients, care, technology, assessment and involvement were the terms mentioned most frequently by the EHFG 2013 participants in response to the question of the most important innovations.

## Resilient health systems - decision-makers

What advice should we give to policy makers regarding the implementation of these innovations? It appears vital that the three pillars do not work independently from each other. For technological innovation to support sustainable and resilient healthcare systems for Europe, governance reforms and social innovations are needed.

What was noted as being essential was the basic willingness to embrace change and the continuous demonstration of improvements. Keywords which were mentioned prominently in this context: education, support, evidence, reform, leadership and change.

We need leadership to implement the 'old and new' measures to redefine the way we look at health including the patient, the health professional, and the population as a whole.

And we need an agenda to communicate the value of the reform sustained by information and good evidence, so that we can aim for different approaches to change.

## Main outcomes of the European Health Forum Gastein 2013

- Resilient and innovative health systems require sustainable and patient-centred policies, a renewed commitment to Health in all Policies and tailor-made governance structures which follow the principles of transparency and accountability.
- Innovations needed to foster and promote resilient health systems have to be evidence based. They can be technological, social or organisational innovations and require innovative governance approaches.
- Innovative leadership and communication strategies are needed to display the values of health systems for a society. Health system reforms have to take the economic and financial policies into account.

# Resilient and Innovative Health Systems for Europe

## Opening plenary

By Paul Giepmans, Indre Laurinciukaite, Martina Naschberger and Elena Nicod

**Helmut Brand**, President of the International Forum Gastein, opened the Forum with a warm welcome to all participants and introduced the main theme of the 16th edition of the European Health Forum Gastein, entitled “Resilient and Innovative Health Systems for Europe”.

Brand presented the three key questions to be addressed during the course of the conference:

- What are the key strategies to make health systems resilient?
- What are the most important innovations to promote health system performance and resilience?
- How can decision-makers best introduce and implement these innovations?

Brand invited all participants to contribute to this debate by filling in an opinion card with their answers to these questions.

Brand introduced the moderator of the high-level debate, Josep Figueras, Director of the European Observatory on Health Systems and Policies, as well as the panel participants: Regional Director of WHO Europe Zsuzsanna Jakab, Director-General of DG SANCO, European Commission Paola Testori Coggi, the Presidency Trio representatives from Ireland, Lithuania and Greece and keynote speaker Uwe E. Reinhardt, James Madison Professor of Political Economy at Princeton University.

**Zsuzsanna Jakab** highlighted that making health systems more resilient was one of the core pillars of the WHO, and presented WHO activities aimed at enhancing health system resilience. Furthermore, Jakab emphasised that all people must have access to high quality, people-centred care including preventive services and financial protection. Jakab highlighted the importance of investing in health promotion, diseases prevention and innovations.

**Paola Testori Coggi** pointed out that health systems must become more resilient to ensure their financial protection against the negative impact of budget-driven reforms. She also emphasised that operationally, they need to remain resilient in order to maintain and improve accessibility and effectiveness of health care. According to Testori Coggi, the main factors which make health systems resilient are efficient funding, solidarity and transparency principles, as well as health workforce planning.



Helmut Brand,  
President, International Forum Gastein

## EU-Trio Presidency debate

The EU-Trio Presidency debate was represented by the Deputy Secretary General of the Irish Health Ministry, Fergal Lynch, Health Minister Vytenis Andriukaitis from Lithuania, and Health Minister Adonis Georgiades from Greece. The session highlighted the common priorities on sustainability and health system performance, their resilience, and the focus on public health.

Health is inter-sectoral and we must work together

The main challenges Member States (MS) are facing include the ageing population and the increasing numbers of chronic diseases that need to be addressed differently on one hand, and financial pressures and sustainability on the other. Cooperation and exchange of experiences amongst MS around best practices and implementation of reforms, together with debates around these topics at different meetings such as the European Health Forum Gastein, can only contribute to generating a better understanding of how to improve the efficiency and sustainability of our health systems.

The Lithuanian Minister of Health [Vytenis Andriukaitis](#) emphasised that health was a value which should be reflected in all policies and understood from a social, political, cultural, and economic perspective. The healthier the population, the higher the productivity and life expectancy are. Given the importance of health for other sectors, all European Commissioners should consider themselves Health Commissioners. The Minister highlighted an example of success in inter-sectoral collaboration at national level. Cooperation between the Ministries of Health, Transport and External Affairs in Lithuania led to decreasing mortality rates from external causes. He further highlighted the four topics prioritised during the Lithuanian Presidency based on initiatives from the Irish Presidency, which are:

- drafting and adapting the Council conclusions on modern and sustainable health systems,
- reaching an agreement with the European Parliament on the Tobacco Product Directive,

- following up the adoption by the Council of the Directive on the conduct of clinical trials for medicinal products for human use, and
- advancing the revision of the Directive on medical devices and in-vitro diagnostic devices.

It's time to change and change is good

[Adonis Georgiades](#), Greek Minister of Health, continued the debate around health system reform by sharing the Greek experience. He thanked all the friends of Greece for their solidarity and support, and particularly the WHO, the Troika and MS that provided technical assistance, which have all contributed to the timely and successful implementation of some of the reforms. He compared health system reform to solving a riddle, where funds are less, needs are more, the population is ageing, technology costs more, and budgets are limited. This “new reality” should not be seen as a crisis – as crises come and go – but as something that is here to stay. The sooner we realise this, the sooner we can solve the riddle. He also highlighted the challenges in persuading society of the need to change, and that this change is for the benefit of all and without it, society as a whole will lose.

Some of the successful reforms implemented in Greece are around hospital and pharmaceutical policy contributing to €5 billion in savings. One such measure was the implementation of e-prescribing. Although it was initially negatively received by physicians, its implementation took less than a year and is now used by 98% of physicians. This system now enables the Health Ministry to monitor use and increase transparency around pharmaceutical prescribing.

Another main issue in Greece is the very high unemployment rate (27%), where hundreds of thousands of people have lost access to primary care. As hospital care (accident & emergency services) is free to use for all, the burden on hospital services has increased. Therefore the government has implemented a health voucher programme to provide access to primary care services for the unemployed. Since its start this September, more than 25,000 vouchers have been distributed, showing the success of this measure.

Minister Georgiades concluded that one of his

priorities during the Presidency will be to share experiences learnt around the Greek health system reform with other MS, and to work together towards finding ways to solve the main challenges being faced today.

Communicate the value of reform and quality of care for all

Deputy Secretary General of the Department of Health of Ireland, [Fergal Lynch](#) began by showing his appreciation for the positive engagement seen by all three Presidencies around the enormous challenges faced on health systems given the economic difficulties. He underlined that the Irish experience provides a good basis for the discussions about resilience and health systems, given the successful reduction in health expenditures seen, and highlighted four areas where this could be done.

There is a need to focus on efficiency by constantly re-questioning how public money is being spent, and a need to reduce the cost of services to protect the level of services being provided without unnecessarily slicing budgets. An example of such a measure is the negotiation of work practices with unions that resulted in an increase of the number of hours being worked. The willingness to accept reform, including financial reform and structural reform, by increasing the primary care system, is an important aspect.

Finally, priority has been given to the on-going framework on health and well-being, with a particular focus on childhood obesity and a tobacco-free environment.

His key messages included the importance of a European and common approach in addressing problems, and the sharing of evidence and best practices amongst MS. A shift should be seen in the debate that health expenditures are not a financial burden on MSs' budgets, but perceiving health expenditures as an investment in a healthy and productive population. In conclusion, Lynch underlined the need to be ambitious about reforms, keeping all stakeholders on board, communicating in clear and simple messages, and never losing sight of the need to keep services safe and of high quality.



Zsuzsanna Jakab, Regional Director,  
World Health Organization Regional Office for Europe

Call for a paradigm shift and political commitment

WHO/Europe Regional Director [Zsuzsanna Jakab](#) emphasised the need to obtain a clear political commitment to addressing the social determinants of health, and adopt an inter-sectoral approach to respond to health challenges. She also highlighted the need to explain in clear and understandable language the added-value of investing in health given the associated societal gains, in order to convince policy makers. She concluded by emphasising the need for a paradigm shift in the health system to address the current challenges of NCDs, accounting for 77% of deaths, by improving the primary care system and integrating public health in a more flexible and people-centred model, with the cooperation of health professionals.

Promoting health both as an economic asset and a social asset

[Paola Testori Coggi](#) emphasised the role of the EU Semester as a means for economic surveillance. Although it is not popular, it has been set up by the MS based on the Fiscal Compact Treaty to promote macro-economic reform. The Commission advocates for health as an investment and prerequisite for economic growth, and highlights the need for reform.

## Bailing out healthcare through innovation: what can we learn from each other?

Keynote lecture

Health economist [Uwe E. Reinhardt](#) from Princeton University enlightened the audience on what we can learn from each other in terms of new innovations. He highlighted the differences, but even more so the similarities, between Europe and the United States and shed some light from a health economist's point of view.

In the future, a greater shift should be seen towards the production of health, for which health care is only one of many inputs.

According to him, innovations are needed in order to overcome cumbersome administration, outdated organisational forms and expensive acute care, targeting all these elements that are resource intensive, but to a large extent inefficient. The health system bail-out can be achieved through the simplification of administration processes, more efficient "industrial" processes, and better health

management by individuals.

Hence, both evidence-based clinical practice, and evidence-based administrative practice are needed. Further, he suggested the implementation of an integrated delivery of care using the Kaiser model, the enforcement of greater transparency around cost and quality, and he proposed a payment reform - from fee-for-service to payment-per-case or capitation. Finally, he highlighted the urgent need for innovations encouraging individuals to better manage their own health, including teaching young people how to do this more effectively and efficiently. In order to satisfy any critiques, he underpinned his statements with Einstein's value theory on health care and illustrated them with a doctored obese picture of Michelangelo's statue David after having toured the United States upon its return to Italy.



Uwe E. Reinhardt, Princeton University, USA; Paola Testori Coggi, DG SANCO, European Commission; Adonis Georgiades, Minister of Health, Greece; Vytenis Andriukaitis, Minister of Health, Lithuania; Fergal Lynch, Deputy Secretary General, Department of Health, Ireland (from left)  
Josep Figueras, European Observatory on Health Systems and Policies; Maggie Davies, HAPI; Helmut Brand, International Forum Gastein; Paul Giepmans, EHMA (top, from left)

# Resilient and Innovative Health Systems for Europe

## Closing plenary

By Marieke Kroezen, Gabriele Pastorino and Iva Rincic

The closing plenary of the EHFG was opened by the presentation of a short conference film documentary that looked at the role of innovation and resilience in times of economic crisis. The film-maker visually conceptualised ideas on how to change what we do as a health community and how to learn from each other. The film showed a wide range of statements from political representatives, researchers, policy advisors and civil society representatives, stressing the importance of exchanging best practices and common work; of designing health systems around patients; of enhancing the key role of women, and stressing how the crisis had an impact also on gender inequality. The film also emphasised the importance and centredness of innovation in addressing some of the existing gaps, the key role of inter-sectoral governance and the importance of having a long-term vision and working for sustainable and long-term change.

The film was followed by a presentation of the Gastein Health Outcomes: three representatives of the Young Forum Gastein initiative presented three key strategies as the ones most mentioned during the Forum as approaches to make health systems resilient: prevention, policies and governance. The Young Gasteiners discussed the topic of innovation trying to provide a definition and to find some fresh examples in their own countries. They finally presented three main pillars for innovation, based on the innovation wall and opinion cards:

- Governance, e.g. enhanced evidence for decision making in policy; task shifting between healthcare professionals
- Technology, e.g. E-health and use of real time and reliable data

- People, e.g. patient empowerment and breaking the barriers between health professionals; re-engineering health and how people use and perceive care

To implement these pillars for innovation it was stressed that it was important that they worked in synergy. Real leadership is needed to implement the 'old and new' measures to redefine the way we look at health, including: the patient, the health population and the health system as a whole. We also need an agenda to communicate the value of the reform sustained.

The plenary continued with keynote speeches by Tonio Borg, the EU Commissioner for Health, Alois Stöger, the Austrian Minister of Health, and Daniel Bahr, the German Minister of Health. The overarching themes of their interventions were that health was a value in itself while at the same time it payed off to invest in health, for example in economic terms.



Participants of the EHFG 2013.

## Keynote speeches

Tonio Borg,  
EU Commissioner for Health

**Tonio Borg** started his keynote speech by saying that he was impressed by the Gastein Forum. He stated that one of the first things that came to mind when reflecting on the last year was the Tobacco Directive, a revised version of which was introduced in December 2012. Another important achievement of last year was the new regulation concerning the Clinical Trials Directive.

Finally, Commissioner Borg mentioned the important changes in the Cross Border Healthcare Directive that would come into force on 25 October 2013 and will allow citizens to use health services across borders and being reimbursed under strict conditions. The changes seek to clarify and simplify the rules and procedures that relate to patients accessing cross border healthcare, and to ensure that the care that patients receive abroad will be reimbursed in their own country.

According to Commissioner Borg, health is a value in itself. It is the primary objective and economic gains resulting from health gain, are only an additional benefit.



Tonio Borg,  
EU Commissioner for Health

Commissioner Borg stated that he has two principle points of concern:

- Fighting discrimination in healthcare in all its forms, as an important element to improve society. For example by working to ensure that inequality in infant mortality and life expectancy in the EU will decrease and men's health improves across Europe.
- Investing in health. Not necessarily spending more, but spending better. There is no 'one size fits all' solution in the EU. Every EU country must reform its own healthcare system in the most feasible way.

The Commissioner concluded stating that it was important to shift the current perception of health: health is not a cost, but an investment.

Alois Stöger,  
Minister for Health, Austria

**Alois Stöger** started his speech focusing on the importance of intersectoral governance and stating that his role as Minister of Health was to be able to explain to other ministers that they were also responsible for health and should consider health in their policies.

He also stressed the importance of solidarity: "Only through solidarity in health systems can we be strong". He emphasised that even though the regional health fund in Austria is secured, it is the duty of the Ministry of Health to take responsibility to modernise the system. In Austria, for example, they have tried to streamline the system by improving cooperation between different providers and making them work together on a common process that focuses on the patient and on the best possible therapies.



Alois Stöger,  
Minister of Health, Austria

Minister Stöger said that Commissioner Borg was correct in mentioning that health is a value in itself, but health is also a parameter that is important in economic terms. Investing in health pays off. In Austria there has been a political agreement to increase resources for the health system and this resulted in better unemployment figures and better labour market figures.

According to Minister Stöger, in order to improve health systems' quality and effectiveness more investments are needed but it is also important to broaden the type of services provided. Small interventions such as preventive care, with a particular focus on children's nutrition and mental health, can make the difference.

Stöger concluded by saying that people have to believe that health systems based on solidarity are the best and most sustainable ones and also that the European Health Forum Gastein is a great platform for discussing these issues.

Daniel Bahr,  
Minister of Health, Germany

[Daniel Bahr](#), the German Minister of Health, opened his speech reflecting on the sustainability of our health systems.

He pointed out that there is an ongoing mismatch between patients who want the best quality of care but who are not willing to pay too much money for it. The question is how we can afford a healthcare system in light of an ageing population? Regardless of the sort of healthcare system, you need economic welfare. Hence, healthcare expenditures should be understood as an investment. European companies need to understand how important it is to invest in the health of their employees. According to Minister Bahr we also need to make people willing to pay more for their own health.

Minister Bahr also asked the question: what is innovation? Not everything that is new is better. He stated that in Germany only if a drug is demonstrably better is it allowed to be more expensive than existing drugs. According to Bahr, this policy should be introduced in more areas concerning healthcare. We need process innovation, for example: how can the chronically ill do more to improve their own health?



Daniel Bahr,  
Minister of Health, Germany

## High level debate

Among the core topics (innovation strategies for making health systems resilient, innovations for promoting health-system performance and resilience, the role of decision makers in implementing health system innovations) this session also raised interest in unduly neglected issues of healthcare: ethics, confidence and trust.

The everyday practices of the European healthcare system are burdened by cultural differences and contrasts; still, the diversity of European traditions regarding health related values needs not to be seen as an obstacle, but as a new chance. Europe needs to foster tolerance, understanding and exchange in every sense, in the field of innovation and new methods as much as in the field of culture.

The high level debate was moderated by **Thomas Zeltner**, while Tonio Borg, Alois Stöger, Daniel Bahr, **Karin Kadenbach**, Member of the European Parliament (S&D, Austria), **Antonyia Parvanova**, Member of the European Parliament (ALDE, Bulgaria) and International Forum Gastein President **Helmut Brand** participated in the debate, offering a wide range of perspectives and priorities regarding health related issues and concepts.

Common priorities can be summarised in the following way: overcoming barriers together, improving health literacy in Europe and creating new job opportunities.

These are necessary advancements in modern Europe today.



Alois Stöger, Minister of Health, Austria; Karin Kadenbach, MEP (S&D, Austria); Helmut Brand, International Forum Gastein; Antonyia Parvanova, MEP (ALDE, Bulgaria); Daniel Bahr, Minister of Health, Germany and Thomas Zeltner (from left)

The Twitter Round-Up comments, facilitated by [Monika Kosinska](#), Secretary General of European Public Health Alliance (EPHA) and [Leonardo Palumbo](#) a Young Forum Gastein scholar, introduced new topics and dynamics into the session, including questions such as:

- How does the long term crisis and unemployment reflect on public health?
- Who is responsible for decreasing investments in health?
- What structural changes need to be made to improve vulnerable populations' access to health care?

Such complex questions never have easy answers: many countries in Europe today are fighting an economic crisis, cost cuttings are everyday practice, and there is no doubt, 1% inflation kills a lot of people. Bearing in mind that EU recommendations are only recommendations, how much money different countries invest in health is their own responsibility. Still, the consequences of such cost savings are never nationally isolated – according to Commissioner Borg, subsidiarity is important - yes, but reforms are needed!

No matter with what specific problem of health care we are dealing, building resilient systems is always related to responsible stakeholders, including national governments.

Health in all policies might be seen as a difficult goal to be achieved, but it is crucial for health improvement in Europe. Fundamentals already exist (health and life expectancy and Maastricht criteria), but the future commitment can start here, at the European Health Forum Gastein.

The EHFG offers an intellectual revolution on health policy and hopefully can foster further steps in producing platforms to support other countries and regions. What is crucial in achieving this goal, is the unique opportunity of interactions between decision makers, researchers and representatives of civil society, having together basically different perceptions (patients, health-care providers, health professionals etc.). Such different views can serve as capital to produce something qualitatively new. Innovation is not always a new product, but can be a new process, or just a fresh insight, often far from mainstream centres.

The EHFG offers a remarkable framework for taking such health innovation approaches a step forward.

The EHFG 2013 movie.

## Opening plenary

### Panellists and speakers:

Helmut Brand, President, International Forum Gastein  
Zsuzsanna Jakab, Regional Director, WHO Regional Office for Europe

Paola Testori Coggi, Director-General, DG Health and Consumers, European Commission

Vytenis Andriukaitis, Minister of Health, Lithuania

Adonis Georgiades, Minister of Health, Greece

Fergal Lynch, Deputy Secretary General, Ministry of Health, Ireland

Uwe E. Reinhardt, James Madison Professor of Political Economy, Professor of Economics and Public Affairs, Woodrow Wilson School of Public and International Affairs, Princeton University, USA

### Twitter round-up:

Maggie Davies, Executive Director, HAPI and Paul Giepmans, Young Forum Gastein Scholar

### Moderation:

Josep Figueras, Director, European Observatory on Health Systems and Policies

## Closing plenary

### Panellists and speakers:

Tonio Borg, EU Commissioner for Health, European Commission

Alois Stöger, Minister of Health, Austria

Daniel Bahr, Minister of Health, Germany

Karin Kadenbach, Member of the European Parliament (S&D, Austria)

Antonyia Parvanova, Member of the European Parliament (ALDE, Bulgaria)

Helmut Brand, President, International Forum Gastein

### Twitter round-up:

Monika Kosinska, Secretary General, EPHA

Leonardo Palumbo, Young Forum Gastein Scholar

### Video reflection:

Tamsin Rose, Independent EU Health Advocate and the following Young Forum Gastein Scholars:

Kirstine Korsager, Tania Lourenco, André Peralta Santos

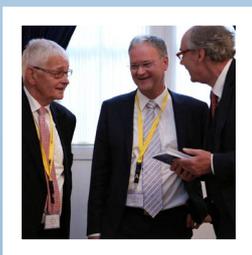
### Moderation:

Thomas Zeltner, former Secretary of Health of Switzerland and Director-General of the Swiss National Health Authority, Special Envoy on WHO's Engagement with Non-State Actors

**SAVE THE DATE**

**17th European Health Forum  
GASTEIN**

**1 - 3 October 2014  
Gastein Valley**



# Mental health

## The motor for a healthy economy

By Adrienn Ecseki and Lucyna Gromulska

Mental health will be the motor for a healthy economy in the 21st century. Forum 1 looked at present and future economic, social and public health challenges that health systems in Europe have to face. Innovative and cost-effective solutions will have to be implemented in order to decrease the growing costs of poor mental health. Only the evidence-based (epidemiological and financial data) approach is the most probable to successfully convince decision-makers to prioritise mental health in reshaping health systems management and to focus on mental health promotion as the most effective tool we can utilise.

### Innovative mental health delivery models in times of austerity and financial crisis

**Giediminas Černiauskas**, Vice Minister of Health from Lithuania, presented a report on increased alcohol-related health problems in his country and measures undertaken to minimise their consequences. Decreased alcohol consumption was observed as a consequence of toughening the policy, a reduction in alcohol advertisement, an increase in taxes related to alcohol and restrictions on outlets selling alcohol. Minister Černiauskas emphasised the economic and social advantages of the transition from institutional to community-based mental healthcare that Lithuania has been undergoing.

**David McDaid**, Research Fellow in Health policy and Health Economics at LSE Health and the European Observatory on Health Systems and Policies, spoke on the economic losses associated with poor mental health and suggested cost-effective and

evidence-based measures to address these. McDaid noticed that the most prevalent mental disorders such as depression and anxiety disorders cause major economic problems for society: decreased entrepreneurship and productivity, premature mortality and increased risk of suicides (depression reduces life expectancy by 10 years). Measures to reduce these negative consequences are much simpler and more cost-effective for the national economy than those necessary to treat psychotic disorders requiring hospitalisation. There is growing evidence on the net return on investment through the early detection of mental health problems and mental health promotion.

**Mark Pearson**, Head of the Health Division at the Organisation for Economic Co-operation and Development (OECD), presented economic evidence on the effectiveness of prevention interventions. People with severe mental health problems are two times more likely to be poor and 2-8 times more likely to be unemployed. Of those who are employed they are significantly less productive and lower paid, indirectly contributing to the economic loss of their employers. Interventions in the workplace should focus on risk assessment, improving line management and ensuring flexible working time.

Social and humanitarian reasons for mental health interventions are not sufficient from the perspective of decision makers facing economic crisis. Benefits – illustrated by clear economic evidence - must exceed the costs of investing in such programmes. Pearson emphasised the fact that there is cost-effective treatment of mild to moderate mental health problems but that health systems fail to use it efficiently.

**Margaret Walker** from the European Liver Patients Association spoke about the direct linkage between physical and mental health using liver illness as an example. Better mental health leads to better physical and general health and healthy people who are more capable of taking care of their health.

**Michael Hübel** from DG Health and Consumers, European Commission, presented European initiatives focused on mental health, e.g. “European Pact for Mental Health and Well-being”. Issues related to mental health and well-being cover the whole spectrum of human life, which makes it difficult to communicate with people outside the medical field or decision makers. Hübel observed that mental health suffers in times of recession but in times of economic growth it may not necessarily improve, for it is multi-conditioned. This all makes mental health an area particularly difficult to handle, define and address adequately.

The main outcomes and policy recommendations derived from the debate:

- Mental health problems account for a significant health and economic burden. The costs of poor mental health - mostly indirect - are very high. The rate of disability claims due to mental illnesses is increasing.
- A strong argument must be provided to policy makers that benefits from actions (investments) in the mental health area will exceed the costs.
- There is growing evidence of a net return on investment in good mental health and health promotion.
- Interventions in mental health are more cost-effective outside the health care system e.g. in work places or in schools, than within healthcare.

- Engaging all community members at all levels, not only professionals and authorities, is key to effective mental health interventions (example of intervention from Australia “Are you OK?”: My well-being directly and indirectly depends on the well-being of people around me).
- Early detection and prevention of the most prevalent mild and moderate mental disorders such as affective or anxiety disorders is significantly more cost-effective for national economies than treatment of psychotic disorders requiring hospitalisation.

## Mental health in the workplace: Europe’s greatest challenge in the 21st century?

**George Christodoulou**, President elect, World Federation for Mental Health, discussed how important social networks, like family and those made in the workplace are as a source of support and protection for those who suffer from depression or some mental illness. He predicted that depression will be one of the leading disease problems in the next decades. The main problem is that depression can be hidden behind drug use, alcoholism and association with other diseases. He emphasised the importance of different mental health promotion programmes in the workplace.



George Christodoulou,  
World Federation for Mental Health

These programmes can help detect and treat depressed people in the early stages of their illness. Appropriate management and consistent prophylaxis can be rewarding in terms of both human suffering and investment. Due to the economic crisis the number of unemployed people, who may be susceptible to a variety of mental health problems such as depression, suicide and alcoholism, is increasing.

**Zinta Podniece**, DG Employment, Social Affairs and Inclusion, presented the importance of mental health programmes in the workplace. The topic is very current. 79% of managers are concerned about stress at work but less than 30% of organisations have procedures for dealing with psychosocial risks. Almost half of senior managers believe that none of their employees will suffer from a mental health problem, but the truth is that up to 1 in 6 will. The costs associated with mental health disorders in Europe are very high, approximately €240 billion per year. The main aims of mental health programmes in the workplace are the prevention of psychosocial risks, promotion of mental health, ensuring the health and safety of workers with mental health problems and help employees return to work. There are several projects supported by the European Union which are relevant to mental health at work.

**Olaf Tscharnetzki**, Medical Director, Unilever, emphasised that the nature of work has undergone drastic changes over the last century and therefore work-related stress is a growing problem all

over the world. Stress at work is a relatively new phenomenon arising from modern lifestyles that affect not only the health and well-being of employees, but also the productivity of companies. Symptoms of work-related stress may include for example depression, anxiety, a drop in work performance, feelings of being overwhelmed, fatigue and an increase in sick days or absenteeism. Tscharnetzki emphasised that companies and employers should recognise work-related stress as a significant health problem. A company can and should take steps to ensure that employees do not suffer unnecessary stress. It is very important for example to ensure a safe working environment, or to organise access to a counsellor or human resources manager, for example. He emphasised that good stress management in the workplace is therefore critical and crucial to the overall health of employees.

**Peter Anderson**, Professor at the University of Oxford and London School of Hygiene and Tropical Medicine, presented on Europe's favourite drug: alcohol. Due to the economic crisis and the higher unemployment rate, the number of alcohol related deaths has increased over the last decades, despite overall alcohol consumption in Europe remaining relatively stable in recent years. There are many social and economic burdens resulting from the effects of alcohol on individuals, families, workplaces, and society. Alcohol consumption and dependence have sizable impacts on many people other than the drinker.



John Bowis, former Member of the European Parliament; Zinta Podniece, DG EMPL, European Commission; Don Shenker, Alcohol Health Network; George Christodoulou, World Federation for Mental Health; Olaf Tscharnetzki, Unilever (from left)

The alcohol-attributed social costs can be estimated at €155.8 billion a year. Anderson highlighted that the main problem was that people who suffer from alcoholism are less likely to be employed. Finally, he emphasised the importance of different actions that can reduce the harm done by heavy drinking including social welfare policies, minimum prices per gram of alcohol, structural reforms at the workplace, and advice and treatment for heavy drinkers.

**Don Shenker**, Director and Founder of Alcohol Health Network, introduced his organisation. It is a new social enterprise that aims to reduce alcohol related harm in the workplace. The aim of this network is to improve health and productivity in the workplace through an evidence-based model of alcoholism reduction, to encourage screening and brief advice, to provide online resources for staff and managers and to signpost those who wish to engage with local services (EAP, alcohol services). The main network partners are academics and Public Health Professionals. He emphasised the importance of alcohol screening using AUDIT tools that are also recommended by WHO and NICE.

The main outcomes and policy recommendations derived from the debate:

- Mental illness and substance abuse are much more common and costly to employers than most realise. A psychologically healthy work environment is very important to support employee engagement, worker health and well-being, recruitment and retention, productivity, effective risk management and corporate social responsibility.
- The treatment of mental illnesses, including substance use disorders, are crucial and these require early and accurate diagnosis, well-informed choice of medications with active management of dosing and side effects, and/or skilled psychotherapy.
- Workplaces should take care of people with mental health issues (depression, alcoholism). Employers should detect employees with alcohol problems and help them.

- 'It's good for businesses' - companies and employers have come to recognise the importance of the relationship between sustaining business and a healthy workforce by changing the culture of their companies and shifting focus to the mental health of their employees.
- Early detection by offering mental health screening at workplaces and GPs is a key mental health intervention.
- 'Go back to work': it's much better for depressed people to be in the workplace and not at home alone.
- The social environment, like the workplace and family, is the most important factor in helping mentally ill people. The social network and family are crucial.
- Increasing cigarette, drug or alcohol prices could be an effective policy tool for reducing smoking, alcohol and drug consumption among individuals.

## Conclusion

Poor mental health translates directly into economic losses that may be minimised by health promotion and early prevention, within but mostly outside health systems: in work, school and local community environments.

## Session 1

### Panellists and speakers:

Gediminas Černiauskas, Vice Minister of Health, Lithuania  
David McDaid, Scientific expert, Eurohealth  
Mark Pearson, Head of the Health Division, OECD  
Margaret Walker, European Liver Patients Association  
Michael Hübel, Head of Unit, DG SANCO, European Commission

### Chair:

Robert Madelin, Director-General, DG CONNECT, European Commission

### Moderation:

Patricia Kelly, Journalist

## Session 2

### Panellists and speakers:

Zinta Podniece, DG EMPL, European Commission  
George Christodoulou, World Federation for Mental Health  
Don Shenker, Alcohol Health Network, UK  
Peter Anderson, Maastricht University, The Netherlands  
Olaf Tscharnetzki, Unilever

### Chair:

John Bowis, former Member of the European Parliament

### Moderation:

Patricia Kelly, Journalist  
Peter O'Donnell, European Voice

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Forum 1 was organised by Lundbeck A/S.



# Investing in health

## From health to wealth

By Anna Sagan and Tiina Sats

The increasing demand for health and healthcare services combined with austerity measures puts health systems under severe pressure and calls for an efficient allocation of the limited available resources. In this context, both the use of performance assessment tools as well as the exchange of lessons learned at national level can provide useful guidance to countries across Europe. The EU can act as facilitator by encouraging the convergence of standards and practices as well as the sharing of good practices.

One key argument in the case for “investing in health” is to emphasise the nature of health as a “profitable” investment, rather than a cost. When looking for such areas of smart investment in health, prevention appears as one key domain that offers a high cost-effectiveness potential. Yet, for various reasons discussed during this forum, it remains an underfunded area.

While looking into the mutually reinforcing link between health and wealth, this second forum highlighted the importance of not restricting the debate to economic issues, but rather to also consider health as a value in and of itself.

### Investing in health – the case for better public spending

Round 1

In the first session [Paola Testori Coggi](#), Director General of DG Health and Consumers, introduced the key messages of the Commission Staff Working Document ‘Investing in health’ adopted in February 2013: health has a value in itself and investment in health contributes to economic growth (e.g. by reducing work absenteeism due to ill health or disability) and social cohesion (healthcare

coverage can help reducing poverty and fighting social exclusion). However, investing in sustainable health systems is very challenging, given factors such as the ageing population and rapid development of health technologies, and has been further complicated by the austerity measures introduced in response to the financial crisis. In this context it is even more important to use the resources wisely, emphasised [Testori Coggi](#). Since the relationship between health spending and population health is not always linear, priority should be given to measures that most improve population health. Reducing unnecessary use of specialist and hospital care, improving primary care and better health promotion and prevention are examples of such ‘smart investments’. Measures should be pursued at both national and EU levels. Examples of pan-European actions led by the European Commission include work on the effective use of European Structural and Investment Funds and the European Semester, which is an annual cycle of macro-economic, budgetary and structural policy coordination aimed at monitoring the progress with the Europe 2020 strategy and ensuring active involvement of EU countries.

Examples of national level actions presented by [Miklós Szócska](#), Minister of State for Health at the Ministry of Human Resources of Hungary, and [Raed Arafat](#), Secretary of State for Health at the Romanian Ministry of Health, offered many valuable lessons for other countries.

The contrasting examples from the two countries demonstrated the importance of long-term thinking in pursuing austerity reforms. Hungary is the textbook example of wise health care reforms. The country, which suffered from migration of young doctors abroad, raised physicians’ salaries several times to stop this trend and sought savings elsewhere, for example by cutting pharmaceutical



Paola Testori Coggi, DG SANCO, European Commission; Raed Arafat, Ministry of Health, Romania and Miklós Szócska, Ministry of Human Resources, Hungary (from left)

subsidies, reorganising the hospital sector and introducing a public health tax to improve health outcomes and generate additional revenues. Romania, on the other hand, had to face the unintended consequences of reforms that were pushed forward too quickly and without thinking about their long-term effects.

## Resolving the efficiency and quality dilemma

### Round 2

For example, big cuts in the salaries of health care personnel led to huge departures of young physicians, and some of the hospitals that were closed, in an attempt to shift inpatients to outpatient settings, had to be reopened as the primary care sector was not prepared to absorb the additional volumes.

Measuring and monitoring the effectiveness of health investments dates back to the work of Florence Nightingale in 19th century England - reminded [Olivia Wigzell](#), Deputy Director-General at the Ministry of Health and Social Affairs of Sweden, in her presentation on health systems performance assessment (HSPA). The goals of HSPA are: to drive performance improvement, learn “what works”, support future policy decisions, evaluate policy

deployment, identify areas where there is room for improvement and promote benchmarking and accountability. However, Wigzell stressed that the key goal of HSPA is the attainment of safe and equal health-care of high quality for the patient and a sustainable and effective health system. With many countries within the EU having different on-going HSPA activities, varying levels of experience (with some countries, such as England, having a longer HSPA tradition and others only recently starting), and a large variation in processes, number of indicators, domains covered, regularity in reporting, etc., Wigzell sees much scope for improving the use of HSPA in the Member States and a great value in sharing experiences among the countries. The EU, on the other hand, could have more visibility in this area and assume a greater role in coordinating HSPA activities among the Member States.

More coordination is also needed in the area of health technology assessment (HTA). [Rosanna Tarricone](#), Director of CeRGAS, spoke about HTA as a tool aimed at informing policy-decisions to efficiently allocate scarce resources. She pointed out that although harmonisation in the area of HTA is not entirely feasible in practice today, e.g. there is no consensus on which utility measures to use in the calculation of Quality Adjusted Life Years (QALYs), it is still desirable in principle: different utility measures bring different results and different results lead to different policy recommendations. Tarricone has therefore called for a clear convergence around the key issues, such as clinical evidence, utility

measures, type of costs, type of technologies (e.g. medical devices vs. drugs), organisational and ethical aspects, and the involvement of stakeholders (patients, industry, etc.).

**Tapani Piha** from DG Health and Consumers, European Commission, explained how the EU can help in promoting the use of HTA and HSPA among the Member States. In the area of HTA, Directive 2011/24/EU on the application of patients' rights in cross-border care to be transposed by the Member States by 25 October 2013, sets up a permanent, voluntary HTA network of Member States (EUnetHTA) with the aim of improving cooperation between national authorities and bodies, providing information on the effectiveness of health technologies, enabling exchange of information and avoiding duplication of assessments. The Expert Panel on effective ways of investing in health, which started work in July 2013 to facilitate access to informal and independent multisectoral expert advice, has HSPA as one of its three areas of work.

Finally, **Nicola Bedlington**, Executive Director of the European Patients' Forum, emphasised the need for greater patient involvement in finding solutions to achieving sustainable health care systems, at both individual level (by giving them a greater say in managing their own care) and as a group, through, for example, participation in EUnetHTA and in the implementation of the cross-border care directive.

## Prevention – a way to avoid the financing and ageing dilemma?

Round 3

The second session focused on prevention and other investment priorities. Evidence on health promotion points towards a set of interventions that have significant public health impact, are highly cost-effective, inexpensive and feasible to implement.

These so-called prevention “best-buys”, as pointed out by **Mark Pearson**, Head of Health Division at the OECD, have been identified in many areas, including tobacco and alcohol consumption, diet, physical activity and infections. Although for most interventions, the costs are higher than the resulting



reduction of health expenditure (though there are exceptions, e.g. fiscal measures to tackle obesity), the associated production gains may be substantial. In spite of this evidence, spending on prevention is very small (on average, in 2010, prevention accounted for less than 3% of total health spending among EU member states) and budgets for preventive activities are traditionally the first to be cut in times of austerity. The recent commitment to sustain funding for prevention (by both WHO-Euro in 2009 and OECD in 2010) has not changed this pattern: spending on prevention fell in each year between 2009 and 2011, while spending in other areas, such as inpatient care, recorded positive (albeit much lower) growth rates.

What explains this paradox? First, many preventive interventions, e.g. interventions aimed at children and worksite interventions, take several decades to become cost-effective. Implementing such far-sighted measures is not attractive to politicians who need to show results before elections. Second, beneficiaries of preventive measures are not always aware about these interventions and their benefits (they may just notice a change in their environment, e.g. restaurant and bars becoming smoke-free). And third, in some cases, overselling prevention by promising savings, as the example of Japan demonstrates, may not be a good idea – if savings fail to materialise on time, it may be much harder to secure such investments in the future.

## From health to wealth – priorities for investment by 2020

Round 4

At the EU level, action on risk factors, health determinants and healthy ageing is taken through measures such as legislation and strategies, explained **John F. Ryan** of DG Health and Consumers, European Commission.



Antonyia Parvanova, MEP (ALDE, Bulgaria); Paola Testori Coggi, DG SANCO, European Commission and Władysław Piskorz, DG REGIO, European Commission (from left)

These measures increasingly try to involve not only Ministries of Health but actors such as NGOs and the industry and retail sectors, and employ innovative solutions, such as PPPs. The European Innovative Partnership on Active and Healthy Ageing introduced by [Sibilia Quilici](#), Senior Manager at Sanofi Pasteur MSD, which is an EU 2020 Initiative, is one such example. However, as exemplified by the Europe 2020 strategy, more efforts should be made to bring health to the forefront of EU policies: health did not make it to the Eleven Thematic Objectives of the strategy and DG Health and Consumers had to work very hard to ensure that health was included in the strategy's sub-objectives.

The EU's health policy, explained Bulgarian Member of the European Parliament [Antonyia Parvanova](#), ALDE Group, is not as well set-up and predictable as policies in other areas, such as agriculture (which commands more than a third of EU funds). In addition, health is the focus of intense lobbying and MEPs may find it hard to discern what is desirable by the public – as also emphasised by [Monika Kosinska](#), Secretary General of the European Public Health Alliance.

Currently, the works of the European Parliament in a total of 14 health-related areas, including clinical trials and medical devices, have been blocked or delayed and lobbying is likely to have played a role.

As the case of the confidential Philip Morris report (leaked in September 2013) demonstrates, lobbyists employ huge amounts of time and money to achieve their goals – the tobacco giant waged a formidable lobbying operation in order to undermine efforts to make cigarettes less attractive to children and women, and force packs to carry larger health warnings.

In order to support investment in prevention, we have to develop a culture of prevention at all levels, said [Paul Smit](#) of Agathellon. People should be educated about the benefits of preventive measures and take more responsibility over their own health. They should support policy makers in their efforts to implement far-sighted solutions and not penalise them for choosing such solutions in the elections. The academic environment should work to strengthen the evidence-base to support both individuals - in making healthy choices - and politicians - in shaping health policies. Countries should learn from each other and there should be more cooperation between various stakeholders, at both national and EU levels. Ultimately, both national and EU politicians should be re-elected if they spend more on prevention, not less.

## Session 1

### Round 1

Investing in health – the case for better public spending

Introduction and moderation:

Josep Figueras, Director, European Observatory on Health Systems and Policies

Panellists and speakers:

Raed Arafat, Secretary of State for Health, Ministry of Health, Romania

Miklós Szócska, Minister of State for Health, Ministry of Human Resources, Hungary

Paola Testori Coggi, Director General, DG Health and Consumers, European Commission

### Round 2

Resolving the efficiency and quality dilemma

Introduction and moderation:

Sylvain Giraud, Head of Unit, DG Health and Consumers, European Commission

Panellists and speakers:

Pedro Pita Barros, Professor of Economics, Centre for Economic Policy Research, UK

Olivia Wigzell, Deputy Director General, Ministry of Health and Social Affairs, Sweden

Rosanna Tarricone, Project Director, HTA Project at CERGAS, Bocconi University, Italy

Tapani Piha, Head of Unit, DG Health and Consumers, European Commission

Nicola Bedlington, Executive Director, European Patients' Forum

## Session 2

### Round 3

Prevention – a way to avoid the financing and ageing dilemma?

Introduction and moderation:

Clive Needle, Director, EuroHealthNet

Panellists and speakers:

Mark Pearson, Head of the Health Division, OECD

John F Ryan, Director of Unit, DG Health and Consumers, European Commission

Sibilia Quilici, Senior Manager, Health Policy, Sanofi Pasteur MSD

### Round 4

From health to wealth – priorities for investment by 2020

Round-table discussion with:

Antonyia Parvanova, Member of the European Parliament (ALDE, Bulgaria)

Władysław Piskorz, Head of Unit, DG Regional and Urban Policy (DG REGIO), European Commission

Paul Hendrik Smit, Advisor, Agathellon

Monika Kosinska, Secretary General, European Public Health Alliance (EPHA)

Pascal Garel, Chief Executive, European Hospital and Healthcare Federation (HOPE)

Moderation:

Paola Testori Coggi, Director General, DG Health and Consumers, European Commission

Forum 2 was organised by DG Health and Consumers of the European Commission.



# Free-Trade Zone EU-US

## Implications for health systems

By Christoph Aluttis and Olivier Wouters

### Background

Every day, goods and services worth approximately €2 billion are traded between Member States of the European Union (EU) and the United States (US), which represents the largest trade flow in the world. The Transatlantic Trade and Investment Partnership (TTIP) is presently being negotiated between the EU and the US to remove trade barriers across a wide range of economic sectors and to harmonise differences in technical regulations, standards, and approval procedures. Proponents of the TTIP argue that it would stimulate cost savings, generate additional jobs, and provide a global reference framework for trade rules, regulations, and safety standards. The European Commission estimates that it would lead to gains of \$160 billion and \$128 billion for the EU and US, respectively, as well as 400,000 new jobs in the EU. Critics, however, claim that the trade negotiations are not transparent and could instead erode standards of consumer, environmental, and health protection.

### Panel discussion

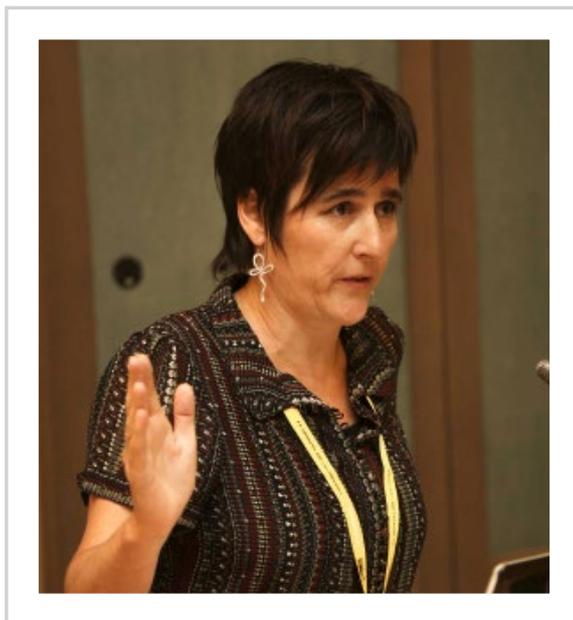
Parallel Forum 3 of the European Health Forum Gastein 2013 focused on the merits and demerits of an EU-US free-trade zone (FTA) for health systems in Europe from the perspectives of various stakeholders, including academia, business and industry, civil society, and political and administrative organisations.

**Angela Brand**, professor at the Maastricht University, opened the session and discussed the historical context of the proposed bilateral FTA. The TTIP is a contentious issue and has polarised the

academic and policy communities. Notably, some claim that the TTIP merely aims to satisfy vested commercial interests, rather than legitimate national concerns. Others believe that the TTIP is the only solution for the EU to remain an important actor in the global economy.

For example, Javier Solana has stated that the EU is too small to compete on its own and should seek strength in unity and in good relations with the US. Brand argued that the development of the largest free-trade zone in the world would provide an opportunity to overcome global health challenges, generate cross-fertilisation of ideas, improve data collection and sharing, and harmonise regulatory processes.

**Bernard Merkel**, Policy Analyst at DG Health and Consumers of the European Commission, acknowledged that there is a clear economic impetus for the proposed free-trade zone. Health, however, is only indirectly considered through the key contributors to the health economy. For instance, issues affecting the pharmaceutical industry are being discussed, including mutual recognition of good manufacturing practices, enhanced exchange of information between regulatory agencies (i.e. European Medicines Agency [EMA] and US Food and Drug Administration [FDA]), greater clarity and transparency on pricing and cost containment measures, and convergence of randomised controlled trial (RCT) requirements. There is also a push to align the regulatory systems for medical devices in both the US and EU. The projected economic growth and increase in wealth has the potential to curtail some of the austerity effects in the EU and to ultimately improve health and well-being. Most of the economic gains from the TTIP agreement would result from reducing conflicting and redundant requirements in EU and US regulations.



Els Torreele,  
Open Society Foundations, USA

**Jody Ranck**, Co-Director of Digital Health Catalyst Working Group at TM Forum, explained that an EU-US FTA can stimulate the harmonisation of practices and regulation for data collection. There is an ongoing debate on how to share data more effectively in the age of eHealth and Big Data. Efficiency gains in data analytics and collection can generate better health evidence, produce substantial cost savings, and improve patient health outcomes.

**Pierre Anhoury**, managing director at Accenture, presented the pharmaceutical industry's perspective on the potential TTIP advantages and disadvantages. He explained that the convergence of regulatory practices can lead to simultaneous patient access to medicines in the EU and US, as well as limiting duplicate testing by pharmaceutical manufacturers (e.g. for marketing approval applications, etc.). These changes would enable manufacturers to submit identical value dossiers to different regulatory agencies, enhance the efficiency of drug development, and lower drug prices. Therefore, the TTIP may be a useful tool to overcome regulatory inertia and could provide the necessary political momentum to generate pharmaceutical policy reform.

**Els Torreele**, project director for the Access to Essential Medicines Initiative, argued that the TTIP

was a threat to access to lifesaving drugs. The TTIP would commoditise medicines further and reduce the affordability of medicines, even in high-income countries where medicines are unaffordable for some socioeconomic groups. While the free market paradigm is appropriate for many industries, the pharmaceutical sector is characterised by salient market failures, including patent monopolies, stringent regulatory environments, and limited price competition (e.g. third-party payment system). The TTIP will likely strengthen intellectual property rights and thus limit access to generic medicines. Additionally, a stronger patent system does not necessarily incentivise socially beneficial innovation. For example, there is currently a lack of novel antibiotic treatments and a high number of me-too drugs with limited added therapeutic value on the market.

**Detlev Ganten**, President of the World Health Summit, discussed the interconnectedness of trade and health. Transatlantic cooperation may facilitate infectious disease control, as the cross-border movement of people requires a concerted effort to mitigate disease transmission and to define risk mitigation strategies in case of an emergency. Although the economic benefits of an EU-US FTA could be immense, it may also restrict local governments from maintaining regulatory environments that promote health. Therefore, the TTIP negotiations should involve all relevant health stakeholders to ensure that health interests are adequately represented in the agreement.

**Gordon McVie**, president of the European Institute of Oncology, presented the views of patient organisations. Although more stringent patent regulation may limit access to medicines, the FTA could also foster multidisciplinary research and collaboration between EU and US stakeholders. This is especially important for EU patient organisations, who are often less effective than the US organisations at generating health system changes. In the US, there is committed government funding, a single public health strategy, central coordination through the National Institutes of Health, tax incentives for charities, among other factors, that increase the political visibility of patient organisations. Transatlantic cooperation may thus help patient organisations in the EU achieve their institutional goals and objectives.

**Falk Ehmann**, a researcher at the EMA, discussed the on-going regulatory harmonisation between the EMA and the US FDA. This harmonisation began prior to the initiation of the transatlantic dialogue. There is a long history of ad hoc collaboration between the FDA and the EMA, and there are today about 80 formal interactions per month between the two agencies (e.g. exchange listings of current EMA and FDA marketing authorisation applications). The TTIP could strengthen these efforts, provide the regulatory framework to protect non-public information, and facilitate cooperation. Additional collaboration is also needed to harmonise regulatory requirements for biosimilars, good manufacturing practices (GMPs), and RCTs.

**Petru Luhan**, a Member of the European Parliament, urged EU Member States to first resolve health issues within the EU that would not necessarily be fixed through an alignment with the US (e.g. inequitable access to medicines across EU countries). The societal values of the EU Member States and the US may be incompatible, which could hinder cooperation to address contentious health issues. Luhan criticised the secrecy and lack of transparency surrounding the negotiations that are preventing open and inclusive dialogue about the merits and demerits of such an agreement.



Petru Luhan, MEP (EPP, Romania)

## Conclusions and policy implications

The forum concluded that the effects of an EU-US FTA on the EU health system remain unclear and that a health impact assessment of the TTIP should be conducted. While TTIP proponents are convinced that the agreement will improve health and well-being in the EU, critics fear that the FTA is inherently a business arrangement that aims to protect commercial trade interests.

There are several potential gains for EU health systems from the TTIP. First, the discussion provides the political pressure and opportunity to improve EU health systems. It allows policymakers to consolidate EU health policy and to engage in US discussions with an aligned EU health position. Second, the economic gains from the TTIP could alleviate some of the financial pressures on health systems in the EU. Finally, it can reduce the regulatory burden for health stakeholders by limiting redundant requirements, fostering collaborative efforts, and consolidating existing rules and procedures.

The free-trade negotiations will have important implications on health systems if implemented, although it will be difficult to reconcile conflicting stakeholder views and standards. For example, there is a concern in the US that the FDA would compromise drug safety, quality, and efficacy standards if it is forced to adopt EMA methodologies. Meanwhile, stakeholders in the EU do not want to abandon their more stringent evidence requirements and adherence to the “precautionary approach” when evaluating the possible effects of goods on consumer, public, and environmental safety.

Overall, the TTIP negotiations can provide the political impetus to implement health system changes that will benefit patients. The EU needs to negotiate proactively to protect high health standards and to ensure that the TTIP is a win-win situation for both the EU and US. A fruitful TTIP outcome will require comprehensive stakeholder involvement and transparent discussions to thoroughly evaluate the effects on the health sector.

## Session 1

### Introduction:

Angela Brand, Institute for Public Health Genomics, Maastricht University, The Netherlands

### Panellists and speakers:

Bernard Merkel, Minister Counselor, Delegation to the United States of America, European Union

Els Torrelee, Director, Access to Essential Medicines Initiative, Open Society Foundations, USA

Jody Ranck, Director of Digital Health, TeleManagement Forum, USA

Pierre Anhoury, Senior Executive, Accenture, France

### Chair:

Stephane Berghmans, VP Academic & Research Relations EU, Elsevier Global Academic Relations, The Netherlands

Kristine Steinhausen, European Science Foundation, France

## Session 2

### Panellists and speakers:

Detlev Ganten, President, World Health Summit

George McVie, Secretary, European Alliance for Personalised Medicine

Falk Ehmann, Scientific Support and Projects, European Medicines Agency (EMA), UK

Petru Luhan, Member of the European Parliament (EPP, Romania)

### Chair:

Elke Anklam, Director, Institute for Reference Materials and Measurements, Joint Research Centre, European Commission

Stephane Berghmans, VP Academic & Research Relations EU, Elsevier Global Academic Relations, The Netherlands

Forum 3 was organised by European Alliance for Personalised Medicine (EAPM), IPHG at Maastricht University and Max Planck Institute for Molecular Genetics (MPIMG). Supported by the European Science Foundation.



European Alliance for Personalised Medicine



Maastricht University



MPIMG



# Building resilient healthcare systems

By Louise Boyle, Daniel Cauchi, Brigitta Gyebnar and Valerie Hughes

## Strengthening health systems resilience: An introduction

Round 1

„Resilience is the intrinsic ability of a system to adapt and respond to unexpected internal and external pressures and shocks. Resilience rests on strong governance including accountability, transparency, participation and integrity and policy capacity.”

**Josep Figueras**, Director, European Observatory on Health Systems and Policies, introduced a session that saw top policymakers sharing their views on how resilient our current healthcare systems are, and how to ensure that health systems of the future are able to recover quickly from financial difficulties, through a discussion of recent country experiences and examples from the WHO, European Commission and civil society organisations.

**Scott Greer**, Professor, School of Public Health, University of Michigan, USA presented a governance oriented framework. Greer’s team have identified five dimensions of good governance, distilled from the literature:

- **Transparency:** makes decisions and their grounds clear
- **Participation:** affected parties should be engaged in decisionmaking
- **Accountability:** clear reporting to principals with sanctions, how we know people are doing their jobs
- **Integrity:** clear jobs, hiring, tenure
- **Policy capacity:** Skills for policy analysis at the centre.

Greer stated that a resilient system is a system that has these five properties of good governance. All of these properties are collective goods, but one can also see why there are private incentives to undermine all of them. This is why everyone involved in the welfare of the health system should think about good governance: it doesn’t happen automatically and its easier to undermine it than it is to create and improve it. These five dimensions set the tone for the rest of the session, with the speakers that followed referring back to them and citing their own examples.

**Miklós Szócska**, Minister of State for Health, Ministry of Human Resources, Hungary, presented recent key interventions in Hungarian health policy. He detailed a raft of actions that had been taken during the last 3.5 years, stating that the speed and magnitude of change had been exceptional. Policy innovations indeed seem to have been introduced exceptionally quickly with the help of an overwhelming parliamentary majority, for example public health regulations such as a smoking ban took just five weeks to pass. Coca Cola was banned from school canteens and new catering regulations resulted in salt being banned from restaurant tables. A public health tax on salt, sugar and energy drinks as well as transfats bans in food were introduced and incentivised companies to reformulate their products, with prior regulations on designer drugs making them easier to ban. Szócska described how the fundamental principles of the national health service were altered, with hospitals brought into state hands, thus enabling government to have central capacity planning and patient pathway management, and central procurement



Matthias Wismar, European Observatory on Health Systems and Policies; Isabel de la Mata, DG SANCO, European Commission; Monika Kosinska, EPHA; Miklós Szócska, Ministry of Human Resources, Hungary; Scott Greer, University of Michigan, USA (from left)

processes leading to massive savings. An eHealth national strategy was developed and with regards to pharmaceutical policy, one third less was spent on the subsidy of pharmaceuticals and prices still decreased for citizens. Human resource interventions included raising salaries using funds from the public health tax, and lots of emphasis put on citizen and patient opinion. Big data was seen as key and used to inform evidence based policy, such as a social network analysis of cancer care patient pathways in Hungary used to create eight care regions on which a WHO national care map is based.

Szócska's final couple of points were given from a highly personal perspective. Firstly, in terms of policy capacity, his opinion was that the fundamental conditions of feasibility and sustainability needed to be outlined before getting into power. His advice was to plan manoeuvres in advance, because once in power, it was extremely difficult to find time to plan and strategise any more: he and his political team had benefited from such a period of extensive planning before coming to power. Finally he stated that personal and ethical integrity was vital, and that all too often people became victims of their desire for power or money. Practical skills and luck were also important, especially to manage the paradox between evidence-based health policy/adaptive work and the demands of political actors and their quest for public popularity.

A panel discussion followed with [Monika Kosinska](#), Secretary General, European Public Health Alliance, and [Isabel de la Mata](#), Principal Adviser, DG Health and Consumers, European Commission.

Using the example of civil society in Hungary, Kosinska provided an example of a counter-point regarding transparency. She said that by and large civil society in Hungary was quite weak, and we should be aware that if there isn't the capacity in the system to manage the outcomes of transparency, then we have to be careful that we do not do harm. She also suggested an additional point under the governance heading, concerning the capacity of civil society. She exemplified that in 2008 civil society organisations such as suicide helplines were providing early intelligence about increasing numbers of calls, raising a red flag about a social issue that was becoming increasingly urgent. However, the political rhetoric for the first half of 2008 from governments was a refusal to acknowledge that anything was amiss and that society was reaching a point of change. There was no mechanism to address the serious concerns of civil society. In terms of transparency and accountability she gave a current example from Greece that also emphasised this point, where evidence from civil society conflicts with reporting at an official level about how things are „on the ground”. The importance of building civil society into accountability mechanisms, particularly in a time of rising popularity of social media, is a key issue that needs addressing. Kosinska also criticised policy makers for presuming that civil society was uniform, when it is actually a manifestation of the social, cultural and economic context of a particular community, region or country. She maintained that if we do not invest in civil society one element of our democracy will fail, and described evidence that shows there is a multiplier effect and added value when investment is made in networks and civil society.

Isabel de la Mata from the European Commission outlined some successful case studies of good governance and said that the European Commission was committed to work to improve health systems through the economic governance of the European Union and the European Semester. Within the area of economic governance, she briefly described a number of different mechanisms for health system reform under some of the five dimensions of governance, including cost effectiveness of medicines and how to ensure equity by applying risk pooling methods under the heading of transparency. We have examples of countries following recommendations of EC or in their own capacity. She stated that times of economic crisis provided an incentive for Member States to learn from each other, share good practice and apply different measures.

## Resilience through health system reform?

Round 2

**Peter C. Smith** from the Imperial College Business School and Centre for Health Policy gave a very interesting insight into efficiency gains in health systems. In his view there were three reasons why efficiency was important:

- because we need reliable health systems,
- equity, particularly inter-generational equity
- and solidarity and security.

Smith explained that there was significant potential for structural reform. He stated that the OECD estimates that given its spending the USA should achieve an extra four life years for each citizen than it currently does – indicating huge inefficiencies. Smith asserted that there is the potential to improve efficiency at every level through good quality information, incentives and institutional capacity to make reforms work, closely associated with governance. He identified four levels (system, organisation, practitioner, citizen) where these efficiencies can be made, and gave some examples, highlighting the importance of the quality of the Board and Non-Executive Directors of institutions at an organisational level, and the development of professional capacity in the form of leadership and

training at a practitioner level.

The biggest efficiency gains in Smith's opinion resulted from the reconfiguration of services – for example the integration of hospital and community services (picked up on by Dessislava Dimitrova later on); information; funding mechanisms, such as how we pay our providers; health related behaviours (with the corollary that at a narrow level keeping people alive for longer is a cost to the health system) and competition. Finally he asserted that none of these can work properly without good governance, and systems do not work well without challenge, which in his opinion is the fundamental issue of governance, and this can be realised through voting, through markets and patient ability to choose; through professional organisations demanding good quality health services and through governments with top down command. His final question to the audience: We should be thinking (about our systems of governance): are they delivering the challenge we need to ensure that our health system becomes more efficient, more effective, better and more resilient?

A panel discussion followed with Hans Kluge, WHO Regional Office for Europe, Dessislava Dimitrova, former deputy Minister of Health, Bulgaria, and Harry Cayton, Chief Executive of the Professional Standards Authority, UK.

**Hans Kluge** gave three concrete examples of WHO work on governance for resilience. The first was a high level meeting in April 2013, hosted by the Norwegian Directorate for Health, looking at the Impact of the crisis on health and health systems for 53 Member States. He described how ten policy lessons and recommendations resulted from this work, which were formally adopted at the recent WHO Europe Regional Committee Meeting in Turkey. One finding was that systems which were more resilient to the shocks of the crisis were those which were performing well before the crisis, because they were efficient, had better management capacity and had better evidence and data systems to inform policy decisions made at the difficult time. The second example was a forthcoming high level meeting in Tallinn in mid-October, which would examine health system performance assessment as a tool for health system governance in the 21st century to improve transparency and accountability.



Hans Kluge, WHO Regional Office for Europe; Dessislava Dimitrova, former member of the Ministry of Health, Bulgaria and Harry Clayton, Professional Standards Authority, UK (from left)

The meeting would commemorate the 50th anniversary of the Tallin Charter and give an update on what has happened in the framework of Health 2020. Finally Kluge cited the example of Greece, and detailed the transparent governance structure of the work being undertaken to support health reforms there with the Greek Ministry of Health in the lead, supported by a health reform steering committee.

**Dessislava Dimitrova** made the interesting point that one cannot have a structure of governance applied to the entire health system: instead the five principles need to be applied to different aspects of the health system, as they each need different governance structures. Multiple resilience strategies are also required. She shared her experience of a failed health reform related to the closure of excess hospitals in Bulgaria, stating that the failure arose from a lack of champions to take on the responsibility and role of making the plan, lack of participation, no agreement between MPs even though there was a parliamentary majority; no plan or cost estimates of how much the reform would cost and the implications for the population. Nobody wanted the hospital in their region to be closed, precipitating a philosophical debate that continues to this present day four years (and 40 more hospitals!) later.

Dimitrova also described a more successful reform: the integration of disabled children from hospital institutions back into their families, where

all components of governance were in place. A collaborative government strategy drawn up by a high level working group with sign-up from all relevant ministries resulted in an action plan taken forward by expert working groups. With clear costing of the process till 2020, Bulgaria secured €100 million from the European Commission. This was a new process without a pre-determined governance structure, but a successful structure was developed following principles of participation, integrity and accountability. Dimitrova suggested that there are some reforms which can be taken without a bottom up collaborative approach, but said that these tended to be administrative reforms related to the internal capacity of a Ministry, for example. She illustrated this through the example of Bulgaria streamlining the number of regional offices of the Ministry of Health, resulting in a 17% reduction in staff numbers, and central procurement of medical device equipment with a corresponding 27% reduction in prices.

**Harry Cayton** of the Professional Standards Authority made a powerful statement that really resonated with the audience: We ARE the system... we cannot talk about systemic failures in a way that absolves responsibility from the people who make up the system. We cannot have a resilient health system without resilient people. He referred to the example of the Mid-Staffordshire NHS Foundation Trust in the UK, where there were found to be widespread staffing failures from the Management

Board to the doctors and nurses and external oversight bodies: the only people with the courage and tenacity to expose what was happening were the patients and their families. Cayton described interesting work undertaken by the PSA to look at the major influences on health professional behaviour when they are in a working environment. Literature reviews indicate at least 40 different influencers on behaviour. Regulation comes in at 38 (least important!) and the group leadership is the most important aspect. Cayton advocated the need to build in to the training and identity of health professionals a “return to responsibility”, saying accountability (which he translated as “telling people what you did”) was too abstract. Responsibility is clearer, meaning that health professionals should own the consequences of their actions. He ended by saying that there was much in the model of resilient governance that could be applied to resilient organisations and resilient people.

## Resilience through new models and technologies

### Round 3

The second session built on the discussion from the first session on the meaning of resilience, how it can be applied to health systems and how crisis can be turned into opportunity – both in terms of using it as an opportunity to come back stronger and

to innovate by focusing on the issue of resilience through public health reform including ensuring sufficient and appropriate capacity, implementation of new models of health care delivery, integrating health into all sectors through the implementation of Health in All Policies, and the use of new technologies.

**Bernhard Bührle**n, MetaForum: Innovation for More Health, emphasised the need for innovation to be at the centre of health care and presented a number of challenges at global, policy and structural levels, and potential solutions to these challenges. He stated that in order to create resilient health systems, there is a need to involve all stakeholders, including those outside the health sector, which reflect the idea of health in all policies, for governance that is a balance of these different interests in a democratic manner.

**Beatrice Falise-Mirat**, Orange Healthcare, spoke of the need for innovative practices such as interactive tools to increase patient interaction within health systems and gave examples of these (e.g. a Spanish pilot project that used SMS messaging for on-going communication between coronary patients and doctors which was proven to increase activity while decreasing costs). However, she noted that none of these have been implemented fully and that there is a need for change management to successfully integrate technology fully into health systems.



Beatrice Falise-Mirat, Orange Healthcare; Jose Carvalho des Neves, Central Administration of the National Health System, Portugal and Boris Azaïs, MSD (from left)

[Boris Azaïs](#), Director of Public Policy, MSD, highlighted the significant challenges that health systems will face in the coming decade through aging populations, the need to contain costs and the impact of new technology. He said that future health systems needed to focus on the drive for efficiency through patient pathways, measurable outcomes, teamwork and responsiveness rather than cutting care.

On the issue of whether innovation is a solution or if it adds pressure to already strained health budgets, [Jose Carvalho des Neves](#), Central Administration of the National Health System, Portugal, noted that while innovation in health products and health research can be a source of increasing costs, organisational innovation can add value to health systems while reducing costs. Health systems need to implement cost-containment measures through price negotiation with providers, reductions in pharmaceutical costs and better use of generics and cutting salaries and overtime. Since 2009, a number of Portuguese hospitals have adopted the Kaizen approach to improving efficiency. This has led to increased productivity, a reduction in waiting times for operations and a reduction in costs.

## Resilience through public health reform?

Round 4

[Matthias Wismar](#) from the European Observatory on Health Systems and Policies spoke of work undertaken by the Observatory to assess the determinants of health and the use of health impact assessment and the drive for Health in All Policies (HiAP). To successfully implement HiAP, it is important that systems have a clear understanding of what is meant by 'health' and put strategies in place to support the governance and resilience of HiAP. It is also important to counter the strategies of vested interests which may oppose the implementation of HiAP. Finally, as policy making is a non-linear process, it is important for governments to seize windows of opportunity to implement HiAP.

Following on from this, [Vesna Kerstin Petric](#), Ministry of Health, Slovenia, spoke about the preconditions for introducing Health in All Policies, which includes a working public health system as a key tool for the resilience of the overall health system. In practice, this involves building capacity, partnership, planning and an understanding of the values of the health system. Slovenia has used the on-going economic crisis as an opportunity to reform its public health system.

The World Health Organization's support for Health in All Policies is evident in Health 2020. [Gauden Galea](#), WHO, stated that governance for health was one of the pillars of the strategy, which gives it a clear mandate. Health should be at the centre of each policy across sectors, with arguments and evidence bases that are tailored to each sector. He also suggested that health may need to develop its own evidence paradigm as traditional, medico-centric evidence models may not produce a robust base for HiAP.

Commenting on the panel discussion, [Josep Figueras](#) suggested that the focus of schools of public health should be widened beyond the training of doctors to include other public health professionals as a way of building capacity.

## Conclusion

Innovation for resilience may not marry with cost containment – traditional research methods may not provide the evidentiary proof required to justify innovative practices and policy makers and health professionals should look to the impact of policies and interventions. This is of particular relevance in the area of public health. Further, there is a need to build capacity to place health in all policies and to advocate for it as a core benefit, that is, that health goes beyond the health care system and is a central benefit to each country.

## Session 1

### Round 1

#### Strengthening health systems resilience: An Introduction

##### Panellists and speakers:

Josep Figueras, European Observatory on Health Systems and Policies

Scott Greer, University of Michigan

Miklós Szócska, Minister of State for Health of the Ministry of Human Resources, Hungary

Isabel de la Mata, Principal Adviser, DG Health and Consumers, European Commission

Monika Kosinska, Secretary General, European Public Health Alliance

### Round 2

#### Resilience through health system reform?

##### Panellists and speakers:

Peter C. Smith, Imperial College, UK

Hans Kluge, WHO Regional Office for Europe

Dessislava Dimitrova, former Deputy Minister of Health, Bulgaria

Harry Cayton, Professional Standards Authority, UK

##### Facilitators and chairs:

Boris Azaïs, Director Public Policy, MSD

Helmut Brand, President, International Forum Gastein

## Session 2

### Round 3

#### Resilience through new models and technologies

##### Panellists and speakers:

Bernhard Bührlen, MetaForum Innovation for more health

Beatrice Falise-Mirat, Director of Government Relations and Regulatory Affairs, Orange Healthcare

Boris Azaïs, Director Public Policy, MSD

Helmut Brand, President, International Forum Gastein

Jose Carvalho des Neves, President, Central Administration of the National Health System, Portugal

### Round 4

#### Resilience through public health reform?

##### Panellists and speakers:

Matthias Wismar, European Observatory on Health Systems and Policies

Gauden Galea, WHO Regional Office for Europe

Vesna-Kerstin Petric, Ministry of Health, Slovenia

##### Facilitators:

Willy Palm, European Observatory on Health Systems and Policies

Matthias Wismar, European Observatory on Health Systems and Policies

Forum 4 was organised by International Forum Gastein and supported by an unrestricted educational grant from MSD.



# mHealth for innovation

## Health at your fingertips

By Ellie Brooks and Kristina Köhler

### Overview

The two sessions on mHealth introduced the recent developments and challenges in the area of mobile health (or mHealth). Presentations outlined the potential of mHealth for patient engagement, tackling of health issues in less-developed parts of the world, truly patient-centred care and improved treatment outcomes. Speakers demonstrated the application of mHealth to psychiatry, diabetes, disease control and general well-being. In the first session, [Robert Madelin](#), Director General of DG CONNECT, stated that there was almost nothing the data revolution could not do; it is about having data in our pockets to change our access to knowledge and information and to change the nature of the community within which we live and work. Successful implementation of mHealth, he said, is reaching a situation where we ‘carry our doctors around in our pockets’.

A consensus which emerged from the discussions was that mHealth apps are inevitable, as a result of technological advances but also because patient empowerment and self-care are important parts of the way out of the current economic crisis and towards sustainable healthcare systems. The sessions pointed to a new paradigm of solidarity, where ‘helping myself is helping my health system’, encouraging individual responsibility and collective efforts to promote sustainable health systems.

### Stakeholders’ perspectives

Over the two sessions, the views of a range of stakeholders were presented and discussed – their perspectives are summarised below.

From the point of view of health authorities and healthcare funding bodies, the priority is to ensure that mHealth apps improve the health of the population and help to generate health gains with reduced resources. As such, they need to generate added value and be able to demonstrate this concretely.

The WHO expressed its support for mHealth and the opportunity it presents for addressing non-communicable diseases in parts of the world with less developed health systems but relatively high mobile phone coverage. The WHO has developed an impact assessment for mHealth and has begun a project to integrate mHealth into the health system in Costa Rica.

The European Commission supports the use of mHealth to empower patients and increase individual responsibility taking. It also sees the potential for Europe to be one of the biggest markets for mHealth in the world, if this potential is acknowledged and the regulation is designed effectively.

The concerns around mHealth centre mainly on the uncertainty of the current regulatory framework for mHealth apps. The proposal for a new medical devices regulation is being discussed in the legislative procedure and, since much of mHealth regulation has yet to be mapped, the uncertainty makes it difficult for developers to anticipate and ensure compliance with medical device, as well as data protection, regulation.

From the patient perspective, the key factor is transparency of evaluations.

Patients need to be able to access a trusted source of information to help them decide which apps are trustworthy, efficient and best for them. There are currently 97,000 health, wellness and fitness apps on the market, but it remains difficult for consumers to distinguish between them or recognise those which are unsuitable.

## Discussion and key debates

The current medical devices framework was discussed in relation to the complexity of its implications for app designers. The session identified the potential burden that regulation can put on young innovators and stakeholders recognised the need to ensure that a clear and integrated legal framework is adopted quickly and uniformly.

Some issues were raised on the 'doctor in my pocket' notion, specifically that doctors cannot be available 24 hours a day, seven days a week and mHealth should not be sold as a way of making such a situation the status quo. Also, it was noted that some patients do not want to be accessible to or have access to their doctors around the clock. A balance between convenience and intrusion into private life needs to be struck, to ensure true added-value. It was also noted that the concept of having 'my doctor in my pocket' is an amalgamation of many elements of mHealth and broader eHealth developments, including digital and health literacy, access to information and the implementation of electronic health records which can be used and managed by the patient. Patient empowerment should be balanced with remote access to a doctor who might be alerted in response to important life signals transmitted via telemonitoring.

Research shows that most apps are used for three to four months and then the adherence rate drops off, much like in pharmaceutical treatment plans. Participants discussed the reasons behind this trend and pointed out that in some cases this is because lifestyle apps, such as those delivering fitness programmes, are predominantly used by



Jesper Thestrup, In-Jet, Denmark and Robert Madelin, DG CONNECT, European Commission

those not in medical need of a regimen – for people who are not sick, the apps are an optional extra and therefore demand and adherence is more elastic. Also, many apps have a shelf-life, in that once the patient has lost weight, or stopped smoking, he or she is likely to stop using the app. As such, this not necessarily a trend that needs addressing or which represents a negative factor.

Finally, interoperability, a known problem across the eHealth sector, was identified as a barrier to full implementation of mHealth. Participants discussed the open mHealth project, which has developed an open source structure with open APIs to allow for integration and interoperability and agreed that projects like this should be supported. The development of mHealth, they agreed, must be tied to the broader expansion of eHealth and systems such as electronic health records.

## Main findings and policy recommendations

Both sessions concluded that mHealth is one of the most promising technologies for supporting resilient healthcare systems and for the empowerment of citizens in terms of health. A large number of apps are already available on the market and we are likely to see even more in the future. Continued development in network and smart phone



Jeanine Vos, GSMA; Terje Peetso, DG CONNECT, European Commission; Tapani Piha, DG SANCO, European Commission; Robert Sinclair, Regional Secretariat Department of Health Care, Sweden; David Sainati, Medappcare, France; Sameer Pujary, World Health Organization and Peter Ohnemus, dacadoo ag, Switzerland (from left)

technologies will further drive the deployment of such apps, as is witnessed in the developing world.

The sessions also concluded that there is a clear need for a suitable regulatory framework. However, this must be implemented in a way that does not interfere with or discourage innovation. For the moment, the lack of legal clarity is the barrier, but this should not be replaced with the burden of over-regulation.

Two main suggestions were made:

- Firstly, that regulation is designed around two different categories of mHealth app – one set of regulation for clinical apps, and one set for fitness and well-being apps.
- Secondly, that regulation is divided according to its aims, with one set of clinical and technical regulation, and one set of consumer regulation.

The idea of combining these two approaches was also discussed in particular, as the distinction between fitness and well-being apps and medical apps for clinical purposes may be sometimes difficult.

It was also noted that regulation is not the only aspect of the mHealth debate. Boosting the uptake of mHealth in European healthcare systems will require something more than just regulation, such as involvement of users (both patients and healthcare professionals) in the development of mHealth technologies and promotion of the benefits of mHealth amongst healthcare providers and funders.

On the evaluation of apps and accessibility to this information for patients, the Forum concluded that evaluating applications according to user preferences is important but evaluation must also consider other aspects. For example, technical aspects such as data protection, credibility considerations such as medical testing, sources of funding and information bias should all be taken into account.

The discussions of the Forum were productive, insightful and wide-ranging. Participants heard the positions of the full range of stakeholders and shared their views and experiences in the use of mHealth both in clinical practice and in the broader context. Consensus was reached that mHealth is an important factor in the future of healthcare systems but that clear regulation is needed. The first step to this is the European Commission's upcoming Green Paper on mHealth.

## Session 1

### Panellists and speakers:

Peter Beck, Joanneum Research, Austria  
 Sandra Kooij, Psycho-medical Programmes Expertise  
 Centre Adult ADHD, The Netherlands  
 Alexandra Wyke, Founder and CEO, Patientview, UK  
 John O'Donoghue, UCC's Health Information Systems  
 Research Centre, University College Cork, Ireland

### Chair:

Robert Madelin, DG CONNECT, European Commission

### Moderation:

Jesper Thestrup, In-Jet, Denmark

## Session 2

### Panellists and speakers:

Jeanine Vos, Executive Director, mHealth, GSMA  
 Peter Ohnemus, Vice-Chairman, Founder and CEO,  
 dacadoo ag, Switzerland  
 David Sainati, Medappcare, France  
 Tapani Piha, Head of Unit, DG Health and Consumers,  
 European Commission  
 Robert Sinclair, Regional Secretariat Department of Health  
 Care, Sweden  
 Sameer Pujari, World Health Organization

### Chair:

Terje Peetso, DG CONNECT, European Commission

Forum 5 was organised by DG CONNECT of the European Commission.



# Non-communicable diseases

## From research to action

By Hannah Brinsden and Andrius Kavaliunas

### Overview

Non-communicable diseases are one of the current 'hot topics' in health policy discussions today, with the WHO setting a target to "reduce NCDs by 25% by 2025" and the publication of a global NCD action plan at the World Health Assembly 2013. Attention is now turning to actions and solutions to address the global burden and as such the topic of the NCD forum at EHFG 2013 was "from research to action", exploring what can, should and has been done to meet these targets and reduce disease.

### NCD research and critical factors for building resilience

The first session in the NCD forum explored the critical factors to success in NCD prevention and treatment. A strong theme of accountability was evident throughout the forum, in particular the importance of being able to hold governments and corporations to account for their actions which impact on population health. The value of preventing NCDs was also raised, in particular in relation to resilience and discussions focused on corporate power and interference in policy making.

#### Accountability

The first speaker, [Johan P. Mackenbach](#), spoke about the development of a series of best practice indicators for health policies across Europe. These indicators enable policies to be benchmarked, rated and compared within and between countries and regions. Benchmarks have been developed across key areas of health policy including tobacco,

alcohol, food & nutrition, fertility & pregnancy, child health, infectious diseases, hypertension and cancer screening. When comparing country policies it is possible to highlight where the successes and failures lie. National income was found to be a strong determinant of policy status, however it was not the most critical factor – in fact a country's willingness to "give it a go" is more critical, and this is related to cultural and social values. For instance, where quality of life was an important part of culture, there was more emphasis placed on prevention.

#### Europe: a benchmark for others?

To highlight the value of benchmarking actions and providing indicators of "good practice", [Shu-Ti Chiou](#), Director General of the Health Promotion Administration (HPA) at the Taiwanese Ministry of Health and Welfare spoke about the health policy in Taiwan in comparison to European countries.

Chiou explained how the HPA compared the health policy performance of Taiwan with that of 43 European countries using the set of indicators discussed by Mackenbach in the previous presentation: the first time this set of indicators was used outside Europe. Taiwan's summary score of health policy performance ranked 17 in 44 countries, lower than most Western European countries but higher than 27 other countries. Among these 27 indicators, Taiwan performed better than the average of 43 European countries on 19 indicators, including on tobacco control, per capita alcohol consumption, teenage pregnancy, child safety and male average systolic blood pressure. Interestingly, Taiwan is an outlier on overall health policy performance and certain areas such as performance on tobacco control and teenage pregnancy rate, but not on all areas.



Martin McKee, London School of Hygiene and Tropical Medicine, UK; Shu-Ti Chiou, Health Promotion Administration, Ministry of Welfare, Taiwan R.O.C.; Johan P. Mackenbach, Maastricht University, The Netherlands; Tsung-Mei Cheng, Princeton University, USA; Bayard Roberts, London School of Economics, UK and Young Forum Gastein scholars: Hannah Brinsden, Stephanie Kumpunen, Alessandra Ferrario and Charlotte Kühlbrandt (from left)

Chiou suggested that unlike other countries where the responsibility for control of NCDs is either not clearly defined or located in the same agency as control of communicable diseases (with the latter often more visible and attention-catching) Taiwan has a separate agency (the HPA) affiliated to the Ministry of Health and Welfare which is purely responsible for the prevention and control of NCDs and maternal and child health (MCH). The areas with higher performance in this analysis just happened to be the areas governed by this agency, and it is possible that such a “protected” organisational design has contributed to some extent to these results, in addition to strong advocacy, clear action pathways, political buy in and hard work, coupled with Taiwan’s drive to be number one!

[Tsung-Mei Cheng](#) then presented an insight into the USA health system and ‘Obamacare’, highlighting the cost of healthcare as a key problem in relation to NCD and general health and wellbeing. However, the Affordable Care Act/ Obamacare will increase access to medical care which will help with earlier diagnosis and treatment/management of NCDs which may help reduce the country’s burden of disease.

## Resilience

Resilience was a key theme of this year’s European Health Forum Gastein and this is an important consideration in relation to the growing NCD epidemic. [Bayard Roberts](#) described resilience as an individual’s capability, which can change over time, to adapt and bounce back in the face of significant adversity or risk. Preventative activities in this context, rather than reactive actions, are important for resilience and Mr Roberts called for a broader approach to tackling NCDs which is more integrated in its approach to supporting health and well-being, rather than simply looking at risk factors.

## The future faces of public health

In this year’s parallel forum session on NCDs, four “faces of the public health policy of the future” from the Young Forum Gastein initiative were given the opportunity to showcase some of their work addressing issues related to NCDs. [Hannah Brinsden](#) and [Stephanie Kumpunen](#) both raised the important issue of corporate power and their influence on policy and health, in the context of “big food” and “big tobacco” respectively. Brinsden presented a case for addressing food environments so as to reduce and prevent NCDs, highlighting how it is an obesogenic environment that drives our choices. She went on to present a new initiative – INFORMAS – focused around holding governments and companies to account for their actions and resulting food environments which

impact on population health. Kumpunen focused on the interference of “big tobacco” in policy, a particularly relevant topic given the EU vote that was to be held a few days later. She took a case study of the UK’s considerations of plain packaging, resulting in a government U-turn on the issue, and presented some of the tactics used by the tobacco industry such as direct lobbying of MPs, funding of think tanks, research to undermine evidence, media activity, targeting supportive MPs and policy elites and funding anti-plain packaging campaigns to ensure legislation that would impact sales was not passed.

**Charlotte Kühlbrandt** then presented a toolkit developed by LSHTM to measure health systems response to chronic disease from the perspective of patients. The idea behind the toolkit is to introduce greater accountability into health system policies and to make the policy process within health systems more transparent.

Finally **Alessandra Ferrario** presented some research on access to medicines for diabetes, highlighting some of the critical factors that influence availability beyond access and affordability, to include the rationale for selection and use, sustainable financing and reliable health and supply systems.



Pamela Rendi-Wagner,  
Ministry of Health, Austria

## Policy developments and innovations in the fight against NCDs

The second session was focused on the policy response to NCDs from different actors at different levels, giving observations by both national and international policymakers and NGO perspectives for NCD prevention.

From policy to action – WHO perspective

**Pamela Rendi-Wagner** from the Austrian Ministry of Health gave an insightful presentation on NCDs from a WHO perspective and that, according to the session’s moderator **Martin McKee**, was one of the most comprehensive and clear overviews he had heard on what the WHO was doing on this issue. Rendi-Wagner reviewed the Omnibus resolution, Global Action Plan, Global Monitoring Framework from the global perspective and Health 2020, European Strategy and Action Plan for Prevention and Control of NCDs 2012-2016, and the recent Vienna Declaration on Nutrition and NCDs from a European perspective. She also highlighted Austrian national health targets and the main pillars in the process of implementation.

Addressing chronic diseases – EU perspective

**Michael Hübel** from the European Commission’s Directorate General SANCO, presented the impact of NCDs on EU healthy life years at birth, DALYs projections and the economic burden before turning on EU work towards these challenges. Hübel emphasised the significance of the risk factors while introducing an EU Strategy on alcohol, a proposal for the revised Tobacco Products Directive, an EU Strategy on health inequalities, EU reflection process on chronic diseases and health care systems and illustrating with example initiatives: “Ex-smokers are unstoppable” Campaign, European Innovation partnership on Active and Healthy Ageing, Joint Action on chronic diseases.

## Driving prevention – NGO perspective

**Wendy Yared** from the Association of European Cancer Leagues focussed her presentation on cancer, as it the second most common cause of death in the Union. She presented the European Partnership for Action Against Cancer and the European Code Against Cancer, that joins different partners and stakeholders in the Member States. She also gave successful examples on youth outreach strategies with communication competitions (poster and video competitions, flashmobs) during European Weeks against Cancer. In her closing remarks Yared wanted to remind us that “at least one-third of all cancer cases are preventable. Prevention offers the most cost-effective long-term strategy for the control of cancer.”

## Lessons from abroad

**Shu-Ti Chiou** from the Taiwanese Ministry of Health and Welfare, and **Sea-Wain Yau** from the John Tung Foundation, Taiwan, shared their steps forward in waging the unfinished war against tobacco by advocating for measures including strict bans on advertising, tax increases, smoke-free public spaces, mass media campaigns, etc. They suggested three ways to regain freedom: push: price, open: cessation support, pull: your family and your life!

## Policy recommendations/ implications of discussions

- Research shows that the diverging health trends in Europe are a testimony to both the successes and failures of public health policy in Europe over the past decades. Countries where citizens have high levels of self-expression and a history of governments with a more egalitarian political ideology have been most successful in public health measures, while success is reduced in ethnically divided societies less willing to invest in public goods.
- The success of certain public health measures against NCDs in Taiwan shows that organisational design and robust public health leadership, coupled with strong advocacy, clear action pathways and political buy in, are facilitators of public health success.
- The research showcased across Forum 6 presentations showed that on NCDs, we know what we have to do, and have a range of information and tools at our fingertips to assist us. What is more often missing is the political will to change the status quo. Accountability is vital and beneficial for monitoring, supporting and initiating change.
- As citizens we have the responsibility to keep applying pressure on our political leaders to encourage them to tackle NCDs and hold them to account for their actions.



Wendy Yared, Association of European Cancer Leagues; Shu-Ti Chiou, Health Promotion Administration, Ministry of Welfare, Taiwan R.O.C.; Martin McKee, London School of Hygiene and Tropical Medicine, UK; Pamela Rendi-Wagner, Ministry of Health, Austria; Michael Hübel, DG SANCO, European Commission and Sea-Wain Yau, John Tung Foundation, Taiwan R.O.C. (from left)

- Resilience is important because as a concept it has an upstream focus on prevention and takes a holistic, integrated, cross-sectoral approach to health and wellbeing, trying to understand the interface between individuals, their environment, health systems and how they combine to result in improving health.
- Much policy interest on economic crises has so far concentrated on investment in banks, and infrastructure, and less on investment in human capital and supporting human resilience, which is fundamental. If we are to reframe this debate we need much better evidence around the cost effectiveness of interventions that can support health resilience. Interventions in health, education, protection, welfare etc can all be developed and integrated to improve health resilience and wellbeing.
- The importance of consultations with public and stakeholders and intersectoral working on NCDs, cannot be emphasised enough. Better win-win actions and integration across policies is also key.
- We need to ensure more efficient use of EU funding and policies in the context of the prevention and management of chronic disease.
- We need more effective health promotion, with innovative preventive actions based on social media, based on stronger insights into behavioural science and economics and utilising new technologies and social media.
- We should be wary of corporate power, persist with work and take the long view. Tobacco companies are versatile and will change policies and approaches and develop various creative strategies to target new markets (e.g. tobacco companies in Taiwan are concentrating on increasing the number of smokers amongst women and young people, and have moved away from the focus on men). The tobacco war is about winning over the next generation.
- Cancer is the second most common cause of death in the EU (responsible for 29% of male deaths and 23% of female deaths) – figures that are expected to rise due to the ageing European population. The most frequently occurring forms of cancer in the EU are colorectal, breast, prostate and lung cancers. Despite these stark figures, at least one-third of all cancer cases are preventable. Prevention is key for resilience and ensuring the ability to adapt: we can't rely on reactivity only. Prevention offers the most cost-effective long-term strategy for the control of cancer.
- Promotion, Prevention, Protection, Participation!

## Session 1

### Panellists and speakers:

Johan Mackenbach, Chair of the Department of Public Health, Erasmus MC, The Netherlands  
 Shu-Ti Chiou, Director General, Health Promotion Administration, Ministry of Health and Welfare, Taiwan, R.O.C  
 Tsung-Mei Cheng, Health Policy Research Analyst, Princeton University, USA  
 Bayard Roberts, Senior Lecturer in Health Systems and Policy, London School of Hygiene and Tropical Medicine, UK

### Young Forum Gastein NCD Research Showcase:

Hannah Brinsden, Policy/Advocacy Researcher, International Association for the Study of Obesity, UK  
 Alessandra Ferrario, Research Officer, London School of Economics and Political Science, UK  
 Stephanie Kumpunen, Research Officer, London School of Economics and Political Science, UK  
 Charlotte Kühlbrandt, Research Assistant, LSHTM, UK

### Moderation:

Martin McKee, Professor of Public Health, London School of Hygiene and Tropical Medicine, UK

## Session 2

### Panellists and speakers:

Shu-Ti Chiou, Director-General, Health Promotion Administration, Taiwan, R.O.C  
 Pamela Rendi-Wagner, Chief Medical Officer, Ministry of Health, Austria  
 Michael Hübel, Head of Unit, DG Health and Consumers, European Commission  
 Sea-Wain Yau, CEO, John Tung Foundation, Taiwan, R.O.C  
 Wendy Yared, Director, Association of European Cancer Leagues

### Moderation:

Martin McKee, Professor of Public Health, London School of Hygiene and Tropical Medicine, UK

Forum 6 was organised by Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C.



**SAVE THE DATE**  
**17th European Health Forum**  
**GASTEIN**  
**1 - 3 October 2014**  
**Gastein Valley**



# Anti-discrimination in health

## Improving access and combating discrimination in healthcare with a focus on vulnerable groups

By Megan Challis

This session aimed to identify issues in relation to discrimination in access to healthcare in the EU, to discuss possible actions to improve access, to identify barriers and challenges and highlight best practice.

### Summary of opening speeches

EU Commissioner for Health [Tonio Borg](#) opened the session, highlighting that examples of discrimination still exist across groups and despite recent progress we must recognise that discrimination is still rampant. In terms of health inequalities, he argued that Europe was not so ‘united’, and that there was plenty remaining for the EU to do to tackle this.

[Morten Kjaerum](#), Director of the Fundamental Rights Agency, reported on studies carried out by the Agency. He highlighted the reduced access to quality healthcare amongst migrant groups, the variable entitlements across Member States of irregular migrants to healthcare, and other access

problems such as language barriers and disabled access to medical facilities.

[Michael Cashman](#), MEP (S&D, UK) gave an overview of what the EU is doing to tackle discrimination in healthcare. He noted that whilst a Member State has competence, pressure to act can be increased at a European level. He highlighted the importance of the Roma strategy but questioned the existence of the necessary political will to implement it, and argued that mutually reinforcing stigmas can affect access in the most acute ways - for example the instances of late testing and delayed treatment for LGBT people with HIV. Overall, he argued that the EU could play a greater role in increasing data and information sharing between Member States, and that the role of European solidarity was vital in a fiscal climate where the weakest in society were often bearing the brunt of austerity measures.

[Aurel Ciobanu-Dordea](#), Director at the European Commission Directorate General for Justice, reported on what the EC was doing on these issues, focusing on three major pillars - legal protection, mainstreaming, and concrete steps



Morten Kjaerum, Fundamental Rights Agency; Aurel Ciobanu-Dordea, DG Justice, European Commission; EU Commissioner for Health Tonio Borg and Michael Cashman MEP (S&D, UK) (from left)

on specific issues. On legal protection he argued that protection against discrimination on the grounds of religion or sexual orientation should be extended to the provision of goods or services (this currently only exists in the field of employment). On mainstreaming, he gave a number of examples of EC action including the conditionality of anti-discrimination on structural funds, to ensure that no EU money is going into projects which do not respect human rights. Examples of concrete steps on specific issues covered the Roma strategy and the development of indicators to measure the status of rights for disabled people including access to healthcare.

## Key issues emerging from the panel discussion

### Solidarity and inclusion

- The most common theme running through the discussion was the importance of prioritising solidarity, particularly in a climate of economic uncertainty and fiscal pressures that can impact disproportionately on the most vulnerable groups in society.
- It was argued that human rights should have no borders, and that social rights were not given a high enough priority in the EU.
- There was a call to healthcare professionals to act against discrimination and to be champions of people's rights to healthcare.
- A role for the EU was suggested to be taking action against Member States where discrimination in general, and in healthcare in particular, was not being adequately tackled.
- The case for solidarity was argued to be economic as well as social - an ageing Europe needs migrants.

### Migration and stigma about migrants

- Migration was argued to be a trend that is increasing and clearly here to stay, but is accompanied by increasing anti-migrant sentiment across Europe.
- It was suggested that evidence points to migrants being on the whole healthier than the average population and under-utilising healthcare services; however there is a trend towards cutting services available to migrant groups.
- A variety of examples of direct discrimination in healthcare settings were given, and the issue of mutually reinforcing stigmas creating particular barriers - e.g. for gay migrants.

### Wider societal discrimination

- A number of panel members focused on the role of wider societal discrimination affecting access to healthcare and health outcomes - in addition to direct discrimination happening in healthcare.
- For example, social constructs of gender affecting women's health as much as biological differences. There is a need to put the recognition of health differences between men and women into practice - differences in symptoms and reactions to therapies points towards gender sensitive drug development and trials.
- Discrimination on any grounds (race, ethnicity etc) can lead to extreme stress and associated mental health problems.
- As a result, it was suggested that tackling direct discrimination in healthcare is a first step - and an important one - but that wider action on discrimination and stigma in all of society and culture was perhaps even more critical.

## EC Session

### Panellists and speakers:

Tonio Borg, EU Commissioner for Health, European Commission

Morten Kjaerum, Director, Fundamental Rights Agency

Michael Cashman, Member of the European Parliament (S&D, UK)

Aurel Ciobanu-Dordea, Director, DG Justice, European Commission

Gay Mitchell, Member of the European Parliament (EPP, Ireland)

Alexandru Athanasiu, European Committee of Social Rights, Council of Europe

Frank Vanbiervliet, European Advocacy Officer, Médecins du Monde (Doctors of the World)

Monika Kosinska, Secretary General, European Public Health Alliance (EPHA)

Roumyana Petrova-Benedict, International Organisation for Migration

Cecile Gréboval, Secretary General, European Women's Lobby

Sophie Aujean, International Lesbian, Gay, Bisexual, Trans and Intersex Association

Luis Mendao, European AIDS Treatment Group (EATG), Representative of the European Disability Forum

### Moderation:

Jonathan Cohen, Open Society Foundations

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The EC Session was organised by DG Health and Consumers of the European Commission.



# Tackling non-communicable diseases in Russia and the CIS countries

## Harnessing innovations to improve access and quality of NCD treatment

By James Selley

Non-communicable diseases (NCD) represent the main cause of mortality globally; in Russia and the Commonwealth of Independent States (CIS) this burden has been acutely felt since 1990 with transitional economic factors and a recession leading to a massive rise in mortality. In this workshop the consequences of NCD in the region were highlighted both in terms of health and economic consequences; a healthier population drives economic growth. Globally the loss of income due to the four major NCD (cancer, cardiovascular disease, diabetes, chronic respiratory diseases) runs into trillions of dollars.

Speakers at this workshop took the opportunity to outline how the ‘story’ of NCD in the region is slowly being reversed, with positive changes demonstrated over the last decade. Key challenges remain however, including utilisation of resources and funding in attempts to further manage and reduce the impact of NCD.

One of the challenges highlighted was the decrease in government spending on healthcare and how Russia compares in terms of GDP spending compared to the rest of Europe. In 2010, Russia’s public expenditure on health as a percentage of GDP was 3.8%, 1.7 times lower than the average of other OECD countries at 6.5%. It was highlighted that controversially, federal spending on healthcare looked set to decrease (by as much as 34%) as budgets are transferred to a regional level.

The other significant challenge facing the Russian Federation and perhaps more pertinently, the CIS, is the ‘resource’ gap. Significant gaps in approved clinical recommendations and economical

standards of treatment exist alongside gaps in the quality of statistical data. This topic proved to be one of the more debated topics throughout the workshop. Is the greater issue an actual lack of information to enable risk monitoring and accurate diagnosis or is there a data surplus that is not being analysed appropriately?

A general consensus appeared to be that it was a combination of both arguments. It was acknowledged that Russia and the CIS are ‘lagging with the transfer of the world’s technologies’ which impacts on all health factors. However, better use of current resources (including equipment, facilities and data) should be encouraged as part of a ‘resilient’ approach to healthcare.

In line with the theme of the conference, ‘innovative and resilient’ strategies were advocated as key to overcoming these issues. Chief among these strategies was a shift towards preventative NCD goals. Sharing NCD strategies for prevention and control across the CIS were strongly endorsed.

There were notable success stories from Uzbekistan, Kyrgyzstan, Tajikistan and Armenia that could be replicated across the wider CIS. Innovative use of resources such as tele-health and eHealth can be strategic solutions to many health problems in Russia and the CIS, enabling early diagnosis, pharmaceutical management and screening.

Private sector engagement was proposed as a potential means to bridging the funding gap. The economic argument was cited as a strong motivating factor for the private sector to contribute to health care funding and initiatives.



Speakers and panellists of the workshop session on NCDs in Russia and the CIS countries.

The World Health Organization's Global NCD Action Plan 2013-2020 and European Health 2020 programmes were both cited as blueprints for Russia and the CIS to follow. Continued management of NCD requires the continuing evolution of the health systems of the Russian Federation and CIS. Although there are noticeable gaps in resources it is essential that efforts are made to further standardise health systems and implement new programmes. It is a fundamental right that people receive the best medical care.

There was heavy emphasis on equity and governance of healthcare systems, comments that were echoed throughout the sessions at the EHFG. Access to healthcare, a focus on the social determinants of health and equity of interventions were but a few of the points raised in this workshop that consistently emerged as themes throughout the EHFG 2013.

### Workshop 1

#### Panellists and speakers:

Dimitry Borisov, ERL, Russian Federation  
 Representative of Federal Ministry of Health, Russian Federation  
 El Alexeeva, Federal State Budgetary Institution, Scientific Centre of Children's Health, Russian Academy of Medical Science, Russian Federation  
 R Khabriev, Institute of Public Healthcare, Russian Federation  
 Representative of the Ministry of Health, Kazakhstan  
 V Yanin, Minister of Public Health, Krasnoyarsk Region, Russian Federation  
 Representatives of the Federal and Regional Healthcare Authorities from Russian Federation and CIS countries  
 WHO representatives  
 Healthcare administrators  
 Representatives of Patients' Advocacy  
 Groups and NGO leaders

#### Moderation:

Oleg Chestnov, Assistant Director-General, NCD and Mental Health, WHO

Workshop 1 was organised by Non-commercial Partnership Equal Right to Life and supported by Roche-Moscow and R-Pharm.



NON-COMMERCIAL PARTNERSHIP  
**EQUAL RIGHT TO LIFE**

# Patient-centred care

## Exploring barriers and solutions to patient-centred care in diabetes

By Sandra Stiefel

Patients living with chronic diseases are often confronted with several societal challenges due to the lack of existing patient-centred care. Cooperation between member states will be essential in order to find a resolution on chronic care, however many barriers of implementation are still very much present. This patient-centred care workshop specifically shifted its focus onto patients living with diabetes, a very common and ever growing global chronic disease. 55 million people in Europe are diagnosed with diabetes, 21.2 million people are not diagnosed yet and 1 in every 10 deaths is due to diabetes. Less than half of all diabetes patients achieve control of their diabetes, for there simply is a lack of a real model of chronic care. Austria, for example, is the European country with the highest uncontrolled hospital admissions for diabetes, which is four times the rate of Italy. These variations between countries show great potential for mutual learning.

### The DAWN 2™ Study

Diabetes Attitudes Wishes and Needs

The results of the Dawn 2 study were presented by one of the panel speakers [Søren Eik Skovlund](#), Global Director Patient Research and Engagement, Novo Nordisk, Denmark. The study analysed and identified barriers preventing the implementation of more patient-centered care among people living with diabetes. Dawn 2 included 5426 adults, 3982 healthcare professionals and 13 countries. The main goal of Dawn 2 was to enable all people with diabetes to live a full, healthy, and productive life and be actively engaged in preserving their own health.

Another important long-term goal of this study included the necessity to raise awareness of unmet needs of the family members of people with diabetes, which actually has never been analysed previously. Dawn 2 also dealt with the emotional impact of diabetes on a person, prevalence of discrimination experienced by people with diabetes and prevalence of people who have participated in a diabetes education programme. Most results showed a lot of room for improvement, such as a need for education programmes for people living with diabetes and more importantly for family members of patients, for diabetes is a family matter.

This notion was supported by [Marco Comaschi](#), diabetologist and panel expert from Italy, who believes that communication and listening to patients is key. He emphasised that patients need to be educated before they can take responsibility and family members need to be educated as well. There seems to be a barrier between educational/psychological supports versus clinical support, for family members need to have more understanding of the chronic disease. Many family members are even incorrectly informed what type 2 diabetes is, explained panel speaker [Jens Kröger](#) from the Centre for Diabetes Care, Hamburg-East, Germany. [Annemarie Bevers](#), Board Member, International Diabetes Federation Europe, panel expert and patient living with diabetes from the Netherlands also highlighted the need to have psychological counselling as part of a diabetic person's treatment



Søren Skovlund, Novo Nordisk; Marco Comaschi; Jens Kröger, Centre for Diabetes Care, Hamburg-East, Germany; Annemarie Bevers, International Diabetes Federation Europe and Nick Fahy (from left)

Living with the disease, not against it

The second part of the session focused on overcoming these barriers whilst finding solutions to patient-centred care.

Several national policies that emerged recently are related to the survey results from the Dawn 2 study. This has included:

- patient involvement in diabetes health policy processes;
- public efforts to advance person, family, and community-centred chronic illness and diabetes care;
- use of “patient reported outcomes” to improve diabetes care and education;
- national initiatives for access to education (an elaborate programme in the UK for reimbursement for education);
- formal standards and policies on quality of self-management education and support for people with diabetes and
- formal standards and policies for psychological support.

However, there is still a vast amount of potential to ameliorate patient-centred care especially at the EU level. Telemedicine was mentioned as a method to further be developed in order to monitor health status at home to avoid worsening of the situation and relapse.

“Living with the disease, not against it,” was a wonderful phrase expressed by Marco Comaschi, which illustrates once again the importance of overcoming all the mentioned hurdles that patients living with a chronic disease have to face every day. Action is ongoing, but there is a lot more work to do!

## Workshop 2

Panellists and speakers:

Annemarie Bevers, Board Member, International Diabetes Federation Europe, The Netherlands

Jens Kröger, Diabetologist, Centre for Diabetes Care, Hamburg-East, Germany

Marco Comaschi, Professor, ICLAS Rapallo, Italy

Søren Eik Skovlund, Global Director Patient Research and Engagement, Novo Nordisk, Denmark

Moderation:

Nick Fahy, Independent Consultant and Researcher, UK

Workshop 2 was organised and sponsored by Novo Nordisk.



## Resilient Gx policy

### Will generic use policy stand up to resiliency?

By Christof Kern

Generics (Gx) and their manufacturers are of vital importance for meeting public health objectives given that the majority of patients worldwide are treated with off-patent drugs (originators, branded generics, INN generics). Achieving financial savings for the healthcare system by simultaneously ensuring equal or improved health outcomes (increased effectiveness) as well as reducing co-payments for patients (increased accessibility) present major objectives for generic policies. However, decisions of health policy makers are increasingly based on price after patent loss. In the light of concerns regarding total healthcare costs and outcomes which are not currently addressed in generic policies, the findings of a recent systematic literature review revealed scarce scientific evidence on the impact of generic substitution. In addition, the assumption cannot always be supported that generic substitution generates financial savings for the healthcare system.

By using a structured group discussion approach, the workshop “Resilient Gx Policies” invited the audience to actively participate in order to expand and stimulate discussion beyond the current decision-making paradigm in the off-patent space for strengthening healthcare systems.



Nikos Maniadakis,  
National School of Public Health, Greece

Predominantly, the following questions were placed at the heart of the discussion and were subjected to a holistic analysis:

- Should evidence-based decision-making persist in the off-patent space and HTA take the lead?
- Are there particular constraints and value issues which have to be considered?
- What are alternative models for value-based decision-making and core drivers of value?
- What are funding scenarios of healthcare, with emphasis on pharmaceuticals that could strengthen resilience and sustainability of healthcare systems?
- Does more regulation lead to lower drug expenditure and greater efficiency or is there a value in the freedom of choice regarding the prescription, listing and purchasing of patented and unpatented drugs?

With regard to the main theme of the 16th EHFG “Resilient and Innovative Health Systems for Europe”, it was presented that generic penetration is often cited as a key indicator for healthcare efficiency. The findings of a recent study emphasised that diverse definitions for generics as well as different conditions for their market authorisation exist. Furthermore, heterogeneity in the cost-effectiveness of generic policies and the total lack of clear guidelines in some countries were identified. The necessity to improve standards and evidence in order to establish resilient, appropriate and affordable generic policies in the future, especially with regard to the bioequivalence or therapeutic equivalence and potential limitations of current conventions on the interchangeability of generics, for instance, constituted an integral part of the discussion.

Given the workshop's theme "Resilient Gx policy" which aimed to elaborate how generic use policy can best stand up to resiliency, the discussion was additionally enriched by a presentation on a study which sheds light on different kinds of policies applied to regulate the domains of pharmaceutical markets and was aimed to answer the question of whether more regulation leads to lower drug expenditure and greater efficiency. As the findings of the study indicate that heavily regulated policies may not lead to efficiency gains but may often generate detrimental effects, the importance of having a balanced view of regulation and market competition which allows for some freedom of choice with regard to the prescription of patented and unpatented drugs was suggested and put up for discussion.

Redefining the decision-making process with regard to generic policies by moving from a "lowest-price-priority" perspective towards an integrated and holistic "value-based priority" approach (cost per health outcome) built a critical starting point which encouraged further discussions on how value dimensions can be considered and rewarded in healthcare decision-making.

In this context, a study was presented which inter alia analysed the impact of switching to and among generics on health care costs and outcomes. The findings suggest that expected benefits (efficiency gains) may be compromised by suboptimal implementation and conceptualisation of generic drug policies. As a result, it was expressed that generic policies should not only be geared towards price reduction but be aimed at maintaining and improving desired health outcomes, i.e. achieving equal or improved health gain at lower costs, persistence and adherence to generics as well as equal therapeutic equivalence and quality for instance. It was discussed that decision-making in regards to unpatented medicines has to consider multiple criteria (value dimensions) which from an

industry perspective include supply reliability, proof of quality or bioequivalence, outcomes evidence, clinical improvement investments, outcomes improvement programmes or other investments. The increasing occurrence of drug shortages might negatively impact access to medicines and their quality due to aggressive price pressures leading to unsustainable profit levels. It was therefore discussed and recommended to foster an integrated multi-stakeholder approach, to provide incentives for those willing to invest in stable drug supply and to regard the permanent access to safe, effective and consistently used medicines as important endpoints and value dimensions which have to be considered in the decision-making process.

### Workshop 3

#### Panellists and speakers:

Nikos Maniadakis, Professor, National School of Public Health, Greece

Zoltan Kalo, Professor, Eötvös Loránd University (ELTE), Hungary

Jie Shen, Abbott Products Operations AG, Switzerland

Helen Chung, Head of Health Policy Research, Swiss Re Services Ltd., UK

#### Moderation:

Diana Brixner, Professor, Pharmacotherapy Outcomes Research, University of Utah, USA

Anke-Peggy Holtorf, Health Outcomes Strategies GmbH, Switzerland

Workshop 3 was sponsored by Abbott Products Operations AG, Switzerland and co-organised by Health Outcomes Strategies GmbH.



# Knowledge translation

## Research knowledge translation for policy development: barriers and facilitators

By Swantje Schmidt

The workshop focused on the theoretical and practical aspects of knowledge translation, providing examples of how research findings from health research projects conducted under the EU's 7th Framework Programme have been translated into policy.

The session was moderated by [Barbara Kerstiëns](#), Head of the Sector Public Health, DG Research and Innovation, who highlighted that research can provide a pathway to innovation and improve public health. Translating public health research evidence into policy is also an important contribution to making health care systems more resilient.

### Knowledge translation: Concepts and strategies

The workshop started with a presentation by [Tanja Kuchenmüller](#) from the World Health Organization, who set out different theoretical underpinnings of knowledge translation.

A trend from opinion based to evidence based policy making has been observed. Explanations for this phenomenon are the increase in expenditure associated with population ageing, more vigilance of taxpayers over the use of financial resources and the general insight that research evidence should play a key role in health policy development. However, evidence is one of many factors that influence the policy-making process besides the political context, available resources and pressure groups. The assessment of research-policy links is complex because two distinct communities, namely research and policy, with different time lines, different agendas and value systems, must engage

in efforts of knowledge translation. Therefore, knowledge translation is impeded, which, in the field of health care, may result in the provision of interventions that are not cost-effective or unnecessary care.

The uptake of research evidence can be increased through knowledge translation, which entails effective communication processes and exchange between the research and policy community to overcome existing barriers. Various concepts of knowledge translation have been proposed, each focusing on different aspects such as the underlying processes or the actors involved.

To close the gap between health systems research and policy, EVIPNet Europe – a regional arm of the global Evidence-Informed Policy Network (EVIPNet) – was launched in October 2012 by the WHO Regional Office for Europe. With a vision of a Europe in which high-quality, context-sensitive evidence routinely informs health decision-making, EVIPNet Europe promotes partnerships between researchers, policy-makers and the civil society at country level, and supports governments in developing and implementing evidence-informed



Tanja Kuchenmüller, WHO Regional Office for Europe; Barbara Kerstiöns, DG RTD; George Nikolaidis, Centre for the Study and Prevention of Child Abuse, Greece and Winfried Meißner, Jena University, Germany (from left)

## Examples from research projects funded under the EU's 7th Framework Programme

**George Nikolaidis**, from the Department of Mental Health and Social Welfare, Centre for the Study and Prevention of Child Abuse in Greece, explained how knowledge translation has taken place in the context of a research project on Child Abuse and Neglect (CAN) that was implemented in nine countries of the Balkan Peninsula (BECAN: <http://www.becan.eu/>).

The research revealed that child maltreatment represents the tip of an iceberg because only a small part is visible to authorities, providing for the first time quantitative estimates for this discrepancy. Hence there is a need to bring the issue to the attention of authorities and civil society to devise effective strategies. The research involved a large network of organisations to overcome institutional resistance to this sensitive topic and disseminate findings. There was intense press and media engagement. Policy briefs were distributed in participating countries. These measures helped bringing research findings to the attention of civil society and policy makers. Ultimately, discussions of the outcomes took place in national and EU parliaments, NGOs and international organisations.

The Greek government has launched projects for developing two important tools: a National Child Abuse and Neglect (CAN) registry and a CAN diagnostic National Protocol for identifying CAN cases and verifying CAN reports and allegations. A similar project was launched at the pan-European level within the DAPHNE program in the context of identifying a minimum dataset for CAN cases

The second set of examples for effective knowledge translation came from research projects on alcohol and addictions (AMPHORA: <http://www.amphoraproject.net> ALICE RAP: <http://www.alicerap.eu>) that was presented by **Peter Andersen**, Institute of Health and Society at Newcastle University, UK.

From this research, six relevant lessons for effective knowledge translation emerged:

- First, policy processes are complex and contextual matters, requiring transdisciplinary research to grasp, take into account, link and develop knowledge.
- Second, research remains underused, so it should be tailored to a particular policy question.
- Third, projects need to be structured in a way that they can influence policy-making by actively communicating with outsiders and monitoring influences on policy.
- Fourth, communication with policy makers throughout the research project must be established to understand barriers and facilitators of knowledge translation.
- Fifth, findings should be communicated through all channels (e.g. websites, NGOs, policy briefs).
- Sixth, the media should be briefed before research findings are officially released.

**Winfried Meißner**, from the University of Jena in Germany, explained knowledge translation for a project on pain medicine focusing on bridging the gap between evidence from RCTs and real-world data. In pain medicine, evidence from RCTs is often

not transferable to the clinical setting.

The PAIN OUT project involved setting up a registry for the patients' status, informing health professionals about pain outcomes and process data (e.g. medical history, demographics) in hospital. The goal of the registry for health professionals at the bedside was to identify deficits and best practices, change clinical practice if necessary, monitor success of interventions and allocate resources for pain management. To achieve this, immediate feedback and benchmarking at the hospital level were introduced. Knowledge was translated to the wider scientific and policy community through publications, presentations and normative regulations and guidelines.

The conclusion was that first hand health outcomes collected locally are more convincing and should be combined with data from RCTs in the field of pain medicine.

The final debate evolved around different aspects of effective knowledge translation. Digital media constitutes a potential channel for communication yet its usefulness depends on the target audience. For example, the internet is still not used by some groups of the population. Regarding processes, the mutual influence of researchers and policy makers was highlighted. Research evidence helps to inform policy about the state of evidence. At the same time policy makers can define what research is needed to tackle a particular policy problem. Practice-based evidence and value-based practice are important types of evidence, which both need to be taken into consideration when shaping policy. Systematic reviews are a key instrument for synthesizing information from a body of literature in a neutral way. The process of communication between researchers and policy makers can be facilitated by knowledge brokers, who package information in a format that it can be used in different cultural contexts.

The importance of networks was furthermore highlighted as well as the importance of transdisciplinary research. Thus, all of these aspects call for a structured approach to knowledge translation that involves iterative discussions with different stakeholders.

## Workshop 4

Panellists and speakers:

George Nikolaidis, Department of Mental Health & Social Welfare, Centre for the Study & Prevention of Child Abuse, Athens, Greece

Wilfred Meissner, Department of Anaesthesiology and Intensive Care, Friedrich-Schiller University Hospital, Jena, Germany

Peter Anderson, Substance Use, Policy and Practice, Institute of Health and Society, Newcastle University, UK; Alcohol and Health, Faculty of Health, Medicine and Life Sciences, Maastricht University, The Netherlands

Tanja Kuchenmüller, Evidence and Intelligence for Policy-Making, Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe

Moderation:

Barbara Kerstiëns, Head of sector Public Health, DG Research and Innovation, European Commission

Workshop 4 was organised by DG Research and Innovation of the European Commission.



# Health economics

## Stress test for health economics

By Laura Schang

Most European health systems face similar challenges: health expenditures are rising whereas available funding remains at the same level or is even decreasing. Health economists are asked to provide their advice on how to ensure health systems remain resilient and innovative. But is health economics able to prepare or facilitate political processes and decision-making? Or is its strength limited to retrospective analysis?

In this workshop, chaired by [Thomas Czypionka](#), Institute for Advanced Studies, Austria, three renowned experts in the field of health policy offered their perspectives on the use of health economics in policy.

[Richard B. Saltman](#), Professor of Health Policy and Management, Rollins School of Public Health, Emory University, USA, argued that health economics can help think about fiscal aspects of good health policy by providing useful quantitative evidence about possible fiscal outcomes of alternative options. He asserted, however, that health economics is not an adequate basis for making health policy. Saltman identified as a key problem the reliance of economics on maths and the lack of tools in the economist's toolbox to deal with cultural and political contexts. These factors explained why real-world policies were formulated and implemented in ways very different from a sole basis on maths.

Unlike clinical medicine, health policy is characterised by a non-linear decision process and there is no right answer: making health policy is a matter of developing alternatives and sorting through them, based on norms and values (judgement), culture, political context, ideological preferences; and it is mainly pursued through legislation (that means coalitions, compromise and

incrementalism) and implementation (using regulation, administration and management), as Saltman pointed out.

Saltman cited examples where economists had run afoul of the policy process. For instance, the economists' idea of introducing a basic package of services had so far not been realised, for example in Israel, where an attempt by the health insurer Clalit ended in 100% of the previous benefits package. Citing Luther Gulick, who as advisor to the incoming U.S. President Hoover maintained that economists should be on tap, not on top, Saltman argued that the role of economists in health policy was as advisors, not as decision makers. Taking austerity as a case study, he questioned the suitability of economic tools to answer essentially value-based problems about rationing and how societies should make judgements about who wins and loses in times of economic downturn.



Richard B. Saltman,  
Emory University, USA

**Peter C. Smith**, Professor of Health Policy, Imperial College London, UK, objected that economics was fundamentally about trade-offs, i.e. deciding who gains and loses. Further, in reality economists are very rarely decision makers themselves, but are instead advisors to legitimate decision makers. Smith argued that health economics provided a natural language for health policy. By addressing questions such as why some people are healthy while others are not, how much societies should spend on health, how to organise and compensate providers, and how to finance and distribute health services, health economics addressed key policy concerns. It offered a theoretical framework to, for instance, examine benefits and opportunity costs of a policy, i.e. what decision makers need to give up when choosing a course of action, to clarify the measurement of benefits and costs, and to conceptualise inefficiency as a waste of resources that could have helped patients.

With reference to Williams' 1987 "plumbing diagram" that represents and relates key areas of health economic study, Smith illustrated the multi-faceted applications of health economics to policy. He pointed to various instances where health economics had successfully influenced policy. Selected examples were:

- the comparative measurement of hospital performance in the context of EuroDRG;
- better targeting of preventive efforts such as the Quality and Outcomes Framework to interventions that really were effective in improving health outcomes;
- assessments of health technology by bodies such as NICE which, based on delegated authority, work within carefully prescribed rules and strong applications of micro-economic theory;
- the design of provider payment and pay-for-performance mechanisms such as in North West England, which begin to show conditions for successfully fostering quality improvement and
- fair funding of competing claims through resource allocation mechanisms.

Nevertheless, health economics continued to have some blind spots, as Smith conceded: in contrast to work into micro-economic evaluations of health technology, for instance, less advanced areas of health economic study were health system evaluations, planning, budgeting, and monitoring mechanisms essential for good governance, and studies of human resources and labour supply. Smith concluded that while objectives of health economic studies should be better informed by health policy, economics offered a theoretical framework, buttressed with increasingly strong empirical support. Although policy makers might still misuse health economic evidence, he emphasised scientific rigour as the best safeguard and noted that there was always room for other disciplines.

**Clemens-Martin Auer**, Director General, Federal Ministry of Health, Austria, was one of the main architects of the recent Austrian health care reform and thus one of the potential users of health economics. He illustrated the complexity of reforms using the example of Austria. In a time of budgetary crisis, he and his team were asked to organise a health reform process, given the complex institutional context of nine federal states, several self-governed sickness funds and strong professional interest groups. As Auer pointed out, the reform process involved various interlinked decisions and negotiations: first, the negotiation of an inter-state treaty; second, the introduction of a federal law; third, the agreement on a five-year programme involving the definition, measurement and monitoring of detailed goals and targets and specifications of responsibilities for implementation with the sickness funds.



Clemens-Martin Auer, Ministry of Health, Austria

In the case of Austria, Auer noted that health economics provided practical help in policy development. To come up with a realistic picture fitting fiscal realities, a health economic tool was used in order to estimate the impact of alternative scenarios on public spending. This approach was used in order to reach a top-down agreement on a sustainability path for public health care spending in high-level meetings between the Minister of Health and the Minister of Finance. This process was informed by health economic evidence and resulted in a decision to limit nominal growth of public expenditure on health to general GDP growth. However, Auer concluded that while health economic tools proved to be helpful in policy development, for policy implementation a bottom-up dialogue on how to reach that goal would be equally essential.

## Workshop 5

### Panellists and speakers:

Peter C. Smith, Imperial College London, UK

Richard B. Saltman, Health Policy and Management, Rollins School of Public Health, Emory University, USA

Clemens-Martin Auer, Federal Ministry of Health, Austria

### Chair:

Thomas Czypionka, Institute for Advanced Studies, Austria

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Workshop 5 was organised by the Federal Ministry of Health, Austria.



# Transatlantic lessons

## What can the US and Europe learn from each other?

By María Grau and Louise Boyle

The US and European countries differ fundamentally in terms of how health care is organised. Traditionally, European criticism focuses on the significant gaps in coverage in the US with large parts of the population uninsured or underinsured. On the other hand, in the US the European model is often pictured as rigid and overregulated.

The speakers in this workshop, which also saw the launch of the first US HiT (Health Systems in Transition) were Andrew J Barnes, Uwe E Reinhardt, Ewout van Ginneken, Bernard Merkel, Maria Horfmacher and Richard B Saltman.

To kick off the workshop, [Andrew J. Barnes](#) gave a comprehensive presentation entitled “The US Health System after the Affordable Care Act (ACA): Achievements and Challenges in Accessibility, Expenditures and Quality”. His presentation outlined historical challenges facing the US health system and how the system itself and access, cost and quality is likely to change under the ACA (also known as Obamacare), and future challenges that remain to be tackled. Classically, the four historical challenges in the US health system have been:

- The high fragmentation that leads to the existence of many different health systems based on the ownership of providers (government, private but non-profit, private and commercial), the payer (social or private insurance) and the developer of health care or finally, no health insurance.
- The poor access to the system that means that 48 million people in the US (15% of the entire population) lack health insurance. In addition, a high percentage of these people are vulnerable citizens.
- Several studies have shown that access to healthcare in the US mainly depends on where you live and on your income.
- The high variability in the quality of healthcare is shown by the high mortality amenable to healthcare.
- The highest health expenditure per capita in the world, yet a life expectancy below that of most of Western Europe (with most Western European countries spending only 50% of what the US spends annually on health). For what the US spends annually on healthcare, the OECD estimates that American citizens should actually have 4 extra years of life expectancy than is currently the case.

Barnes then outlined what the ACA will achieve for the US health system. The Act aims to improve three characteristics: cost, quality and access, by acting above public and private insurance, employers, consumers and providers. It will essentially expand three existing coverage systems: employer based insurance; Medicaid (public insurance for the poor), and the underdeveloped market for individual private insurance. The majority of provisions will be implemented in 2014 and by 2020 it is estimated that under the ACA an extra 30 million Americans will gain insurance who would otherwise be uninsured.

Nevertheless challenges remain: in access (30 million will remain uninsured); in outcomes; in expenditure and politically, with public opinion remaining more negative than positive, considerable lack of knowledge about the reforms and the possibility that the ACA will be revoked if the Republicans win in 2016.



Uwe E. Reinhard, Princeton University, USA; Ewout van Ginneken, Berlin University of Technology, Germany; Maria Hofmarcher, European Centre for Social Welfare Policy and Research, Austria; Bernard Merkel, DG SANCO, European Commission; Richard B. Saltman, Emory University, USA and Andrew J. Barnes, Virginia Commonwealth University School of Medicine, USA (from left)

**Maria M. Hofmarcher**, author of the latest Austrian HiT (Health Systems in Transition), gave a brief outline of the Austrian health system as a comparative case study of a European health care system, outlining some of the HiT's main findings. In Austria, everybody has access to a provider at every level of the health system hierarchy, from primary care to the highest specialised hospital, and this probably goes some way towards explaining the high reported patient satisfaction with the system. However this doesn't necessarily translate into high performing outcomes. When one looks at outcome data and healthy life years, Austria scores less well. One such reason is the current weakness of preventive medicine, attracting only 2% of total health spending. The degree of fragmentation is also great, which can have both positive effects, enabling decentralised planning and governance adjusted to local conditions, but it can also lead to inadequate financing and planning, especially when these two areas are not linked closely enough. There are also challenges in access to and the utilisation of healthcare, and social inequalities in the use of some medical services.

Presentations from both Barnes and later Richard B. Saltman emphasised that it was almost impossible to undertake comparative health system analysis between the US and European health systems. The adoption of the ACA in March 2010 may seem to indicate that the US health system is converging towards more of a European model, however in reality it might be more accurate to compare the USA to the EU as a whole, with variations across

the American states mirroring variations in health systems between the different EU countries.

**Bernard Merkel** observed that from his perspective the US health system operated like a business. It has the culture of a business, with the values and mechanisms and issues of a business (or businesses), however one in which suppliers have captured the entire market. For example in the US one is constantly bombarded by advertisements for the best surgeons, clinics and pharmaceutical products. His personal conclusion from a brief stint living and working in the US was that it was an intransparent system with very high costs, a view probably reminiscent of most Europeans.

**Richard B. Saltman** gave the final presentation and put up some counter-arguments to the points made by Merkel, particularly his criticism of the high salaries received by US medical professionals. He suggested this discrepancy was largely down to the difference in funding of medical education. In the US physicians can reach residency owing \$500,000, which were needed to finance their way through college and then medical school. The cost of this education is not publicly funded, like it is in much of Europe, and therefore higher remuneration is necessary in order to help relieve this debt.

Saltman explained that the US HiT describes the structure of the US health system with the ACA being a piece of new reform in this framework. He was keen to suggest that despite the differences, there might nevertheless be a number of areas

where European health systems might look at US examples from the HIT and think about how the US system could provide some perspectives and suggestions for knowledge transfer into European health systems. He suggested that we can think about health systems in three different ways, and joked that in terms of trying to change health systems across these levels the scope runs from hard to extremely difficult:

- The mechanical level (e.g., tools and mechanisms). This level gives multiple possibilities to transfer knowledge because it is mainly based on tools and mechanisms.
- The policy level (e.g., strategies, programmes and initiatives). The possibilities decrease at this level due to the historical differences between both territories, although with the right effort it is still possible.
- The values level (e.g., social norms and beliefs). Changes at the social level are the most difficult level to achieve as they are rooted in historical and cultural experience. In fact, one of the most important threats to the ACA is negative US public opinion.

Saltman suggested that the mechanical level holds the greatest potential for knowledge transfer. This would definitely be more difficult at the policy level, although there is some knowledge transference taking place i.e. Kaiser Permanente running courses attended by Europeans every week on how to do integrated care. He suggested that at the values level there is little consonance, and referred back to a map of the US shown by Andrew Barnes earlier that highlighted the US states that were going to join the Medicaid programme versus the states that refused to join. It almost exactly replicates the states that voted for Obama and those who voted against him. So in the US we can see a different prioritisation of values, with equity being more important in those states on the coasts, and the independence of the individual, the notion of self reliance, being more important in those states in the middle. This is both where the internal conflict originates and where you can see the lack of transference into a European environment. These three levels and their interactions make navigating health systems especially complex. In the plenary discussion, Nick Fahy questioned whether the lesson to be learned from this three tier

diagram is that Europe should not be looking to the US for answers at all, but rather within EU health systems.

The final conclusion was that at the macro level it would be challenging, but there are lots of small things we can learn.

## Workshop 6

### Panellists and speakers:

Andrew J. Barnes, Assistant Professor, Virginia Commonwealth University School of Medicine, USA  
 Uwe E. Reinhardt, Professor of Economics and Public Affairs, Princeton University, USA  
 Maria M. Hofmarcher, European Centre for Social Welfare Policy and Research, Austria  
 Ewout van Ginneken, WHO Collaborating Centre for Health Systems Research and Management, Berlin University of Technology, Germany  
 Bernard Merkel, Policy Analyst, DG Health and Consumers, European Commission  
 Richard B. Saltman, Professor of Health Policy and Management, Emory University, USA

### Facilitators:

Josep Figueras, Director, European Observatory on Health Systems and Policies  
 Willy Palm, Dissemination Development Officer, European Observatory on Health Systems and Policies

Workshop 6 was organised by European Observatory on Health Systems and Policies.

European  
**Observatory**   
 on Health Systems and Policies  
 a partnership hosted by WHO

# The State of Oncology 2013

By Martina Naschberger

After a warm welcome by [Yvette Venable](#), Head of International Public Policy for F. Hoffmann-La Roche, Switzerland, the podium was handed to [Peter Boyle](#), President of the International Prevention Research Institute Lyon, France, an outstanding expert in the field of oncology.

Boyle presented his recently published report on “The State of Oncology” developed by the International Prevention Research Institute. Looking at the numbers of the global cancer burden, they have doubled over the last 25 years and are estimated to double again before 2030. As a consequence the pressure on health services worldwide is already massive and set to grow continually. Simultaneously, it is of course also important to mention that there has been a remarkable improvement in oncology in many aspects, from understanding the causes, both lifestyle and biological, and in the development of more effective treatments in the recent decades.

Despite the progress, unfortunately not everyone can profit and not every patient has access to these modern advances. One of the main messages Boyle conveyed was that “It is bad to have cancer and worse to have cancer if you are poor. The gap between rich and poor, highly and little educated and the North-South divide is substantial and continuing to grow.” In fact, the contrast in diagnosis, treatment and its outcome between the high-resource and the low-resource countries is dramatic. That said, the pattern of cancer globally in the foreseeable future will depend heavily on what happens in China, India and Africa, where half of the world’s population currently live. Growing and ageing populations and lifestyle habits conducive to increased cancer risks have become a major issue worldwide, but with a particular severity in these parts of the world.

In Africa the situation is particularly dire with as few as 277 radiotherapy machines, and a need for at least 700 more. In India there are currently 0.98 oncologists available per one million inhabitants. In contrast, in high-resource countries successful steps are being taken in the direction of personalised medicine, which is absolutely non-existent in low-resource countries. Hence, this phenomenon increases the gap between these countries even further, resulting in a great and growing disparity.

## Four pillars of oncology

Prevent all cancers that can be prevented

Next, Boyle presented the four pillar model of how to deal with cancer. The first pillar being “Prevent all cancers that can be prevented”. Avoiding tobacco smoking, reducing alcohol consumption, avoiding excessive exposure to natural or artificial sunlight, taking all possible precautions with regard to carcinogenic chemicals and adopting a healthier lifestyle including increasing physical activities and reducing overweight and obesity all contribute to cancer prevention and can to a large extent be influenced by each individual. In low-resource regions the majority of cancers (liver, Kaposi’s Sarcoma, cervical cancer) are caused by chronic infections and could be avoided by the development and delivery of effective vaccines.



Treat all cancers that can be treated

Secondly, the goal must be to “Treat all cancers that can be treated”. The knowledge about the right treatment mostly exists and successes have substantially improved over the last years. Sadly, not every patient has access to even the most basic package of cancer treatment, even though it should be their basic right.

Cure all cancers that can be cured

Thirdly, oncologists pursue the aim to “Cure all cancers that can be cured”, and in high-resource countries they do so successfully, since there are many cancer patients who are now living longer and are able to maintain a good quality of life. Cure, of course implying that a treated patient has a life expectancy similar to the population of the same age.

Provide palliative care whenever palliation is needed

Last, but not least, the fourth pillar is to “Provide palliative care whenever palliation is needed”. Palliation is needed not only for pain control in the final moments of life, but should be available at every part of the cancer pathway: at the time of surgery, radiotherapy and during chemotherapy. In Africa the situation is especially bad and there are very few actually trained in this type of care. Paracetamol is not effective in severe cancer pain control, but often all that is available.

Thus, all the evidence for a need for radical solutions and new models was laid out in the report, proving that the status quo is not an appropriate response to the current situation. New and innovative models are needed to cope with and improve this situation. According to Boyle and many others, there is a pressing need for a major Public-Private-Partnership to make the necessary progress with the briefest delay. The pharmaceutical industry together with governments and non-governmental organisations need to cooperate for the underlying cause of improving cancer care worldwide. Most importantly, fundamental to every approach taken has to be the right of every patient with cancer to



Peter Boyle,  
International Prevention Research Institute Lyon, France

have the most appropriate treatment and care for his or her disease.

Therefore, the audience was called to action and in an interactive speed-networking session fruitful discussions were stimulated, facilitated by [Kajsa Wilhelmsson](#), Director, Health Policy and Market Access at A&R Edelman. After having asked delegates to answer 10 questions, some answers were picked and discussed in the plenary. One of them for instance directly asked for a model for selling cancer drugs cheaper in low-resource countries than in high-resource ones. This is something that has recently been discussed by the CEOs of major pharmaceutical companies, which actually resulted in a reasonable strategy on how to prevent the spread of them via the black market. This and some other issues were also discussed during this session.

Finally, one of the main take home messages from the session was Boyle’s call to action for everyone to ask themselves ‘what can I do?’ to prioritise and address the growing cancer burden that we collectively face.

As a future outlook, there clearly needs to be cooperation amongst all stakeholders and a policy framework which meets the satisfaction of all four pillars to ensure every cancer patient’s right to obtain the appropriate treatment.

For further details please consult the official report on “The State of Oncology” 2013 by Peter Boyle, Richard Sullivan, Christoph Zielinski, Otis W. Brawley et al.



EHFG 2013 participants during the interactive part of the workshop - speed-networking.

## Workshop 7

### Speaker:

Peter Boyle, International Prevention Research Institute  
Lyon, France

### Facilitators:

Yvette Venable, Head of International Public Policy, Roche  
Kajsa Wilhelmsson, Director, Health Policy and Market  
Access, Edelman

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Workshop 7 was organised by  
F. Hoffmann-La Roche Ltd.



# A health literate Europe

## Shaping a health literate Europe – a recipe for sustainable healthcare

By Indre Laurinciukaite

Discussion moderator journalist [Peter O'Donnell](#) from the European Voice welcomed all participants and introduced the workshop on “A health literate Europe” which was organised by Maastricht University and MSD in collaboration with the European Patients' Forum and the Standing Committee of European Doctors. O'Donnell also introduced a wide-ranging panel of discussants.

The interactive panel discussion covered the following questions:

- the first consensus paper on “Shaping a health literate Europe”;
- the importance of making health literacy a priority in the EU;
- the solid facts on health literacy from a new WHO publication;
- the cost-benefits of investing in health literacy in the context of a resilient Europe;
- the European Union's approach to health literacy within their health strategy and
- the national perspective on the role citizens and patients play in healthcare.



Antonyia Parvanova, MEP (ALDE, Bulgaria) and Karin Kadenbach, MEP (S&D, Austria) (from left)

### Limited health literacy is a challenge

Health literacy refers to the capacity to make sound health decisions in the context of everyday life – at home, in the community, at the workplace, in the healthcare system, in the market place, and in the political arena. [Katrín Fjeldsted](#), President of the Standing Committee of European Doctors, pointed out that health literacy has existed for ages, but now it is more accessible. Recent research undertaken as part of the European Health Literacy Study has shown that limited health literacy is a challenge in several countries in Europe – across 8 European countries, nearly every second has limited health literacy. This shows limited health literacy related to healthcare, disease prevention or health promotion is a problem not only for particular vulnerable groups, but also for the general population and society at large. Furthermore, notwithstanding the efforts of the European Commission, European Parliament and WHO Regional Office for Europe, policy action to improve health literacy in Europe remains fragmented. What is more, [Karin Kadenbach](#), MEP (S&D, Austria) highlighted that we spend a lot of money on measures which do not effectively reach people (for example screening).

Support better understanding of health literacy among policymakers and key stakeholders

[Kristine Sørensen](#) from Maastricht University and [Alexander Roediger](#) from MSD introduced a consensus paper on “Shaping a health literate Europe”, which was developed as a result of a joint collaborative effort from the representatives of The Standing Committee of European Doctors (CPME), the European Patients' Forum (EPF), Maastricht University (UM) and Merck-Sharp & Dohme (MSD).

According to Sørensen, the consensus paper aims to support a better understanding of health literacy among policymakers and key stakeholders and highlight its value for individuals, healthcare systems and society. Kadenbach added that the consensus paper clearly defines health literacy and its benefits for patients and citizens, the health care system and society as a whole and contributes to the identification of what could be done to improve health literacy.

### Why is health literacy important?

Health literacy is an important concept, which fosters health and puts citizens and patients at the centre of health and healthcare.

Including health literacy in EU policy as an overarching objective contributes to the overall objectives of the EU health strategy, which is to strengthen citizens' role with regard to their health, to improve health outcomes and to reduce the growing burden on healthcare systems.

Roediger pointed out that on the one hand health literacy improves health outcomes while on the other it contributes to make healthcare more efficient and enable more effective use of health resources. People with higher health literacy make better choices about their health, are more adherent to treatment, report less chronic illness, feel healthier, and live longer.

**Kaisa Immonen-Charalambous**, Senior Policy Adviser, European Patients' Forum, added that health literacy is crucial to empower patients and give them the possibility to better manage chronic conditions. She also highlighted its importance in enabling patients / consumers to make healthy choices.

Furthermore, Lithuanian Vice Minister of Health **Gediminas Černiauskas** emphasised that citizens are quite rational and can actually be seen to be pursuing a "health in all policies approach". He quoted a statistic from a Lithuanian study that health considerations can guide consumer decision-making on the purchase of non-medical goods (i.e. food, clothes, housing) by up to 50%. Tapping

into this thinking potentially yields much greater outcomes than all the public health interventions instituted by governments.

What could be done to improve health literacy?

Sørensen highlighted that it is very important to develop an overarching European level strategy on health literacy that reflects the critical role of health literacy in health promotion, prevention, patient-centred cure and care, as well as its impact on quality of life, productivity and the economy. What is more, it is important to set concrete targets on health literacy levels, develop a monitoring mechanism to assess literacy levels and partnership work (actions on health literacy should include stakeholders from all relevant sectors).

**Sylvain Giraud**, Head of Unit, DG Health and Consumers, European Commission pointed out the importance of investing in education.

**Shu-Ti Chiou**, Director-General, Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C., suggested to try to define key issues and key knowledge, find out the channels to disseminate this knowledge and ensure the transfer of essential information into education systems. She also highlighted the importance of supporting research work on how to improve health literacy. Giraud emphasised the importance of looking for cross-cutting themes, for example nutrition labelling.



Shu-Ti Chiou, Ministry of Health and Welfare, Taiwan R.O.C. and Sylvain Giraud, DG SANCO, European Commission (from left)

Later in the discussion, Kadenbach emphasised the importance of how best to communicate, for example using brochures, pictures, pictograms and plain language. According to Parvanova citizens and patients must be involved in the decision making process.

**Josef Probst**, Director General, Main Association of Austrian Social Security Institutions, added that if you want to get the people to make healthy choices, you need to make transparent policy. What is more, Immonen-Charalambous pointed out that different health literacy interventions are needed in different countries and for the different vulnerable groups. At the end of the discussion, Parvanova mentioned that the issue of health literacy was a recurring theme across a lot of sessions of this year's European Health Forum Gastein - for example during the Investing in Health session (Forum 2) it was remarked upon that noone would benefit from the most sophisticated healthcare systems or public health initiatives if there is a very low level of health literacy.

## Conclusions

Fjeldsted emphasised the importance of investing in education, while Immonen-Charalambous remarked that health literacy was absolutely crucial through the entire spectrum from health promotion and healthy lifestyles, to prevention and patient-centred disease management. If we want citizens to become co-producers of health, we need to empower them to do that. Kadenbach added that even if we have health literate Europeans, it does not reduce the responsibility of policymakers and politicians to deliver the health services that are really necessary in order to ensure that health literate people will have the best access and the best treatment possible. Giraud and Parvanova highlighted the importance of the subsidiarity principle in decision making on these issues.

In conclusion, it is essential to improve health literacy, support a better understanding of health literacy among policymakers and key stakeholders and make it a priority across EU policy.

## Workshop 8

### Panellists and speakers:

Sylvain Giraud, DG Health and Consumers, European Commission

Kaisa Immonen-Charalambous, Senior Policy Adviser, European Patients' Forum (EPF)

Katrín Fjeldsted, President, Standing Committee of European Doctors (CPME)

Kristine Sørensen, Maastricht University

Antonyia Parvanova, Member of the European Parliament (ALDE, Bulgaria)

Karin Kadenbach, Member of the European Parliament (S&D, Austria)

Shu-Ti Chiou, Director-General, Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C.

Gediminas Černiauskas, Vice Minister of Health, Lithuania

Josef Probst, Director General, Main Association of Austrian Social Security Institutions, Austria

Alexander Roediger, MSD

### Moderator:

Peter O'Donnell, Journalist, European Voice

Workshop 8 was organised by Maastricht University and MSD in collaboration with the European Patients' Forum and the Standing Committee of European Doctors.



# EU Health Programme 2014-2020

## Information Workshop

By Louise Boyle

This highly informative and practical workshop covered information on the new EU Health Programme, the 3rd multi-annual programme of EU Action in the Field of Health (2014-2020). Topics covered included the state of play in terms of programme negotiations, how the programme looks in terms of objectives and actions, and details of project implementation and project management including the role of the Executive Agency for Health and Consumers (one of the six Executive Agencies of the European Commission, which was established in 2005 as the Public Health Executive Agency, and changed its name in 2008 as its remit broadened). Presentations were delivered by [Michael Hübel](#), Head of Programme Management and Chronic Diseases, DG Health and Consumers, European Commission, and [Ingrid Keller](#), Health Programme Coordinator, Executive Agency for Health and Consumers (EAHC).

### Health Programme 2014-2020

The new health programme should enter into force on 1st January 2014, and is the successor to the 2nd Community Action in the Field of Health – “Together for Health” – 2008-2013, which is currently running until the end of the year. [Michael Hübel](#) clarified that the new health programme should not be seen as a health strategy but as a funding instrument which supports the implementation of health policy work. So it is important to look at EC policy priorities alongside the programme.

The EC have tried to build this programme slightly differently from previous programmes. The programme focuses on urgent emerging policy priorities, without neglecting those looked at previously: demographic change, crisis, health

inequalities, increased awareness of the chronic disease burden, health threats and pandemics and health technologies. The scope has now changed too, as DG SANCO is now in charge of pharmaceutical policy and policy on medical devices, for example. One of the downsides is that more has to be done with roughly the same budget as before. €446 million have been allocated for seven years (it was previously five) for 28 countries across the whole range of health policy priorities.

The European Commission has made efforts to streamline a few general principles across the Multi-Annual Financial Framework in terms of support to broader objectives of EU policies i.e. links to Europe 2020, and links to policy. The Health Programme follows policy (the EU Health Strategy “Together for Health”), building upon previous programmes, and implementation of legislation on medicinal products, medical devices and policy. The programme aims to add value to what Member States are already doing, and underpins policy on areas like health promotion, health systems sustainability, innovation and health and serious cross border health threats.

There are four main objectives which are now more focused and tangible:

- Promote health, prevent disease and foster supportive environments for healthy lifestyles;
- Protect citizens from serious cross-border health threats:
- Contribute to innovative, efficient and sustainable health systems;
- Facilitate access to better and safer healthcare for European Union citizens.



Michael Hübel, DG SANCO, European Commission

Hübel explained how DG SANCO is taking a more systematic approach to monitoring and evaluation, with the development of progress indicators to monitor the objectives and their impact and annual work plans based on long-term policy planning. He also explained that the EC hopes to simplify the administrative and financial processes of applying for health programme funding, including a move towards online applications, and will continue to provide help and support to applicants, and ensure better dissemination and communication of results.

In terms of the current state of play, a programme decision will be taken before the end of 2013, then a workplan will be adopted and a call for proposals issued in 2014. From 2015 onwards a call for proposals will be published in the autumn/winter for the year to come but this is unavoidable in year one.

## Implementing the Health Programme – the Executive Agency for Health and Consumers

Ingrid Keller introduced the Executive Agency for Health and Consumers (EAHC). EAHC implements three programmes: the EU Health Programme, the Consumer Programme and the Better Training for Safer Food initiative. The Agency is based in Luxembourg with a staff of 50 people managing nearly 500 public health actions including projects, operating grants, conferences, joint actions, international agreements and service contracts under the Health Programme 2008-2013.

Keller described activities undertaken by EAHC to implement the Health Programme. The Agency manages calls for proposals and tenders; provides information about the actions co-funded e.g. via a public database; disseminates the results achieved by the actions co-funded, including new know-how and best practices; feeds back the project results into DG SANCO policymaking processes and organises dissemination and information exchange meetings. In terms of work responsibilities, DG SANCO looks at policy priorities and the annual workplan, then once this is in place EAHC hosts information days, and produces guidelines, forms and literature for applicants.

Information days used to take place mainly in Luxembourg, but have now moved to national locations, and are organised by a network of national focal points usually in a Ministry of Health or a Public Health institute. These focal points visit the EAHC three times a year to receive training and privileged information which they can then disseminate in the national language at country level.

EAHC also have responsibility for evaluation, using external evaluation for projects and joint actions and internal evaluation for tenders; monitoring the implementation of projects (carried out externally) and auditing how money was spent and was it correctly spent, with finances recovered if there are legitimate concerns even 3-5 years after project completion.

Keller emphasised the support available to ensure that final deliverables of a high quality and public money has been well spent. For example, the provision of assistance to weaker or delayed projects in the form of project coaching is offered to help projects come back on track.

The EAHC publish documents for applicants on the EAHC website to support them in the application process once a call is announced. There are a range of beneficiaries of these instruments, including NGOs, international organisations, public authorities and public sector bodies (research and health institutions, universities and higher education establishments).

## Instruments in use under EU Health Programme 2008-2013

### Call for Proposals

Instrument	Description
Project	Classical example of several organisations across Europe coming together to work on a project. Financing of €1,5 million would be a fairly large project.
Joint Action	The main actors are competent authorities or ministries or those mandated by ministries. They are usually larger in scale than projects so co-funding is normally higher than for projects too, i.e. €5 million.
Conferences	Pan European, organisations receive grants to contribute to the cost of funding a conference.
Operating Grant	Instrument to co-fund specialised networks without a legal personality or European umbrella NGOs to operate on a day to day basis (as opposed to funding a specific project this NGO might be undertaking), i.e. paying rent, staff, website, printing costs.
Direct Grant	Paid to international organisations which have a monopoly in a certain area, WHO, OECD, IOM (grant on migration).

### Call for Tenders

Instrument	Description
Service contract	Open call is issued – anyone can participate who fulfils the requirement.
Framework contract	One or several companies over several years in a specific field (i.e. health reporting) receive these contracts. When a specific product is required, the companies then compete against each other to win the contract to compile the report.
Specific contract under a framework contract	Winner of contract above.
Experts for evaluations	Expressions of interest are required. The EC is always looking for Public Health experts for a range of diverse subjects i.e. for evaluation of proposals; for coaches for projects; reviews at interim report stage.

## Difference between public procurement and a grant

	Procurement	Grant
Purpose	Procurement is done to acquire a product or service via a call for tender.	To encourage actions indicated in the Work Programme, which fall primarily within the scope of the beneficiary's activities (creativity on the part of the organisation is ok).
Procedure	Call for tender	Call for proposals
Legal Outcome	Service contract	Grant agreement
EU Financial Contribution	EU pays 100% of the contract price.	EU pays a contribution (ie. 60% or 80%) towards the overall funding : the rest of the funds the beneficiary needs to raise.
Ownership	Since the service or product has been purchased and paid for by the EU, in general it belongs to the EU in its entirety (i.e. reports – the EU will determine when, if and how it is published).	The ownership as a rule is vested in the beneficiary of the grant.  Public deliverables should generally be available to the EC.
Profit	The operator's remuneration should include an element of profit.	The grant must not have the purpose or the effect of producing a profit for the beneficiary.



## Evaluation Process

Keller emphasised that significant time is spent on the proposal evaluation process in order to be transparent and fair.

The evaluation stages are as follows:

- Step 1  
Screening check: to check compliance with inclusion/exclusion criteria.
- Step 2  
Financial and organisation analysis: does the organisation conform to the selection criteria? Is it financially viable? Does it have a sound operational capacity?
- Step 3  
Evaluation by external experts to check compliance with quality criteria.
- Step 4  
Consensus meeting: Consensus evaluation report produced.
- Step 5  
Evaluation committee: ensures compliance and prevents duplication. Funding decided based on co-funding and indicative available budget.
- Step 6  
Programme committee meets to endorse findings of the evaluation committee.
- Step 7  
Adaptations to proposals made and grant agreement issued.



Ingrid Keller,  
EAHC, European Commission

## EAHC Dissemination Activities

While responsibility for policy development lies with DG SANCO, EAHC does lots of policy dissemination via websites, publications and information meetings. Keller outlined the dissemination activities undertaken by the EAHC. Cluster meetings with one journalist per Member State normally take place on an annual basis to showcase projects, i.e. all projects on rare diseases, or vaccine promotion, or substances of human origin. In terms of information available via the website (being revamped for 2014: <http://ec.europa.eu/eahc/>), searches by keyword, country, year or organisation yield results on projects funded. The website is periodically updated with deliverables.

National focal points described earlier hold national information days in-country for applicants wishing to find out more about how to obtain EC funding. Recent information days took place in Italy, Norway, Greece, Slovakia and Ireland.

Keller encouraged interested colleagues to sign up to the EC database of public health professionals who provide a range of project assistance. Themed brochures (i.e. on transplantation and transfusion) are launched at cluster meetings, and a brochure compiled with involvement of national focal points outlining pan European projects that really made a tangible difference is available. Brochures on joint actions; project management of public health in Europe; how to write project proposals; and information on the essentials for evaluation or dissemination plans are also available.

Finally, Keller echoed Hübel's earlier comments that the whole process of applying for funding would hopefully become more streamlined in the future, with a move to an online portal for the application and management of grant agreements and all communication concerned with these elements.

## Workshop 9

Panellists and speakers:

Michael Hübel, Head of Unit, DG Health and Consumers,  
European Commission

Ingrid Keller, Executive Agency for Health and Consumers,  
European Commission

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Workshop 9 was organised by  
the DG Health and Consumers  
of the European Commission.



## Men's health

### A step into no man's land: Improving men's use of primary care services in Europe

By Iva Rincic and Louise Boyle

The aim of this workshop was to foster discussion on men's under-use of different aspects of primary care services and the potential improvements that could be made in increasing men's access to health by changing policy, healthcare settings, service delivery, and most challenging – views around men's own perceptions of their role in society.

#### Improving men's use of primary care services in Europe

One of the important healthcare issues in Europe today is the lack of use of different primary care services (prevention and screening services, early diagnosis, treatment) among the male population. Such poor use of primary care services has long-term consequences: it affects their health status and life expectancy, burdens their families, communities, employers, national health status, and impacts on national economy costs. Long-term strategies aimed at improving men's use of primary care services are crucial and needed.

As an introduction to this workshop, a roundtable event "Men's health and primary care: improving access and outcomes", was held in Brussels on 11 June 2013, organised by the European Men's Health Forum (EMHF), to provide the main recommendations on the questions in this field.

The chair of the roundtable meeting was [Ian Banks](#), President of the European Men's Health Forum, also the moderator of this workshop in Gastein, who emphasised in his introductory comments the need

to integrate all aspects of public life to achieve the common aim.

Related to the topics of the workshop, [Peter Baker](#) from the Men's Health Forum offered his perspective of the main reasons for the current situation: men's role in society and the practical barriers associated with accessing healthcare (booking system, working hours, inconvenient locations etc). Crossing these barriers is a step in improving health care delivery and can be achieved by improving health literacy among men and introducing care for their health into their main everyday activities.

[John Bowis](#), Hon President, Health First Europe and EMHF Board Member, mentioned men's „do not do health“ principle, rooted in men's mind due to role models, education, and training; and asserted that this needs to be questioned in the era of telemedicine.

From a practical perspective, [Jacques de Haller](#), Vice President, Standing Committee of European Doctors (CPME), supported new technologies (not Skype however!) in helping men recognise and gain a feeling of autonomy regarding their health, i.e. making appointments, monitoring their status, etc. Improving men's health literacy is not (only) about raising their awareness, but also empowerment.

How to eliminate stigma and embarrassment was a central question in the presentation by [Nicola Bedlington](#), Executive Director, European Patients' Forum (EPF). Although this may be seen unlikely to happen, it is not impossible – the parenting experience, for example, could be a trigger for taking care of their own health, both for men and women.



Monika Kosinska, EPHA; Maximin Liebl, Pharmaceutical Group of the EU; Nicola Bedlington, EPF; Jacques de Haller, CPME and John Bowis, Health First Europe and EMHF (from left)

The potential of pharmacies to improving men's health in terms of their increased scope to take on primary care services (with advantages including more flexible working hours, no need for appointments, more easily reachable locations) were pointed out by [Maximin Liebl](#), President of the Pharmaceutical Group of the European Union. Their increased use could also eliminate the problem of illegal sales on the internet.

The last speaker in this workshop was [Monika Kosinska](#), Secretary General, European Public Health Alliance (EPHA), who was asked to talk about the public health side of men's health and the perceived barriers. She asserted that knowing what we should be doing to improve men's health is the first step, then creating the conditions to allow men to take control of their health is the second. Using a personal example, Kosinska described how Polish society is matriarchal by default, because of so many men dying so young.

She emphasised that we need to give men the space to prioritise their health, we need to question what sort of health professionals we need to create „safe spaces“ for men to access primary care, and moreover we need to think about the wider social framework: how do we create a society where it is ok to be vulnerable, which can be a very difficult feeling for men to admit as society conditions them to believe that such traits, perhaps considered to be more feminine, should not be part of their identity.

The role of women as advocates for men is important here, as well as considering how we can use public health measures (for example tobacco and alcohol regulations and also take into account wider policies such as urban planning) to create an environment that is more protective of men.

## Conclusion

Men's health in Europe needs to be improved, especially their uptake of primary care services. This can be achieved by new adjusted models in healthcare delivery (also through workplaces), cooperation of all stakeholders, education (of both patients and providers), improving health literacy, and finally through changing men's traditional social role and related gender prejudices.

## Key messages

Quoted from the Workshop Report by the European Men's Health Forum

- Primary care services are currently used ineffectively by men, leading to late diagnosis of serious conditions and the use of counterfeit drugs purchased online.
- Engaging with health care is perceived by many men to be incompatible with masculine norms and men, particularly those in full-time work, face many practical barriers such as restricted opening hours.
- The practical issues must be addressed, including through the use of digital technologies for making appointments.
- Pharmacies have a potentially significant role as a first point of contact with the health system.
- Training for health professionals on men's health issues is important.
- There is a need for better outreach services.
- Men's health literacy, including symptom awareness, should be improved.
- Ways of encouraging men to seek help from health services could be explored.
- Key transition points in men's lives, such as becoming a father, present opportunities for engagement.

You can find the whole report here:

## Workshop 10

Panellists and speakers:

Nicola Bedlington, Executive Director, European Patients' Forum (EPF)

Monika Kosinska, Secretary General, European Public Health Alliance (EPHA)

John Bowis, Hon President, Health First Europe and EMHF Board Member

Jacques de Haller, Vice President, Standing Committee of European Doctors

Maximin Liebl, President, Pharmaceutical Group of the European Union

Peter Baker, Consultant, European Men's Health Forum (EMHF)

Moderator:

Ian Banks, President, European Men's Health Forum

Workshop 10 was organised by European Men's Health Forum (EMHF) and sponsored by European Federation of Pharmaceutical Industries and Associations (EFPIA), Pfizer, Amgen and PGT Healthcare.



## Big Data

### How can we harness Big Data to improve Research and Development and translation of new therapies?

By Jochen Mikolajczak and Erjona Shaqiri

Over the past decades we have been collecting a lot of data that allows us to analyse various aspects of our health systems, for example their effectiveness, costs and the quality of the care that is delivered. Data for such purposes has ‘traditionally’ been gathered on the basis of medical data of patients (collected in the process of the delivery of care) or on the basis of research data (collected to answer a specific research question). Recent technology, such as the internet, smart phones, apps, and more advanced computers in general have given birth to a new phenomenon of which, at this moment in time, we can barely begin to imagine the impact or usefulness for health issues. It is called Big Data, and refers to data sets with sizes beyond the ability of commonly used software tools to capture, curate, manage, and process the data. According to some, big data are the future answer to all our problems, since we will be able to find relations between things that we were previously unable to think of ourselves (we need advanced computers to do that for us), and thus come up with new solutions that were previously unfathomable.

This workshop saw international experts from research, policy and industry convening to discuss new ways of harnessing Big Data, including how to improve the understanding of benefit risk, how to provide tools for more accurate health technology assessment and how to reduce the dreaded efficacy gap. A round table format promoted free-flowing interactive discussion amongst participants.

The workshop was moderated by [Duane Schulthess](#), Managing Director, Vital Transformation, who opened the session with the question “What is the role and the importance of the phenomenon of Big Data in Public Health and healthcare systems?”

The co-chair [Angela Brand](#), Professor of Social Medicine and Public Health Genomics, Maastricht University, talked about how big data had the power to provide “individualised evidence” on all aspects of health, which will help us move away from a one size fits all approach to a truly personalised medicine.

[Leonas Kaletinas](#), Member of the Board of Directors of the Lithuanian Health Forum, highlighted the use of basic data for being cost-effective, avoiding waste and increasing the value and efficiency for patients, professionals and payers. According to Kaletinas, health systems are in a revolution and there is a need for better management of them. Rational use of big data plays a big role in making the healthcare system more resilient and sustainable.

[Terje Peetso](#) from the Health and Well Being Unit, DG CONNECT, European Commission highlighted that we are not using existing data to their maximum potential, but instead we are looking to collect more and more data.



Interactive round-table session on Big Data.

She suggested that we should work with the data that we already have and to maximise the benefits from this before collecting more, and furthermore we have to prioritise quality over quantity.

**John Crawford**, Healthcare Industry Leader Europe, IBM, discussed the interoperability of medical data systems across Europe. He cited a number of examples including the epSOS project (one of the shortlisted projects for the 2013 European Health Award) as one example of excellence, in the way it transmits medical data from one country to another and simultaneously translates it from one language to another.

Does the ability to apply new IT possibilities to analyse an enormous amount of large datasets from different locations come without risk? No it does not, and this was strongly pointed at by **Amelia Andersdotter** MEP (Greens-EFA, Sweden). One of the technologies that enables Big Data, the internet, is an environment that is not secure in itself. She strongly argued that people should not be using the internet as a means to share personal – sometimes medical – information, or to enable Big Data in general. We have no idea who has access to the information that is shared and it can easily be abused, she said, speaking from personal experience. Andersdotter suggested that the European Commission needs to do more work on the issues of data ownership, trust and security, and as a first step the focus for Big Data should be on opening up less personalised data that nevertheless has value for public health.

**Barbara Kerstiäns**, Head of Sector, Public Health, DG Research, European Commission, raised other challenges concerning Big Data: the need to devise the tools to successfully analyse and manage it. The European Commission is funding research into these aspects and Kerstiäns called for international collaboration to tackle the challenges and reap the joint benefits.

**Ernst Hafen**, Institute of Molecular Systems Biology, ETH Zurich, spoke about issues of providing a safe and secure place to store data, and put forward the suggestion of „The People’s Health Databank” – a secure storage space where people’s data would only be transmitted onwards following their consent, with companies who wanted to use the

data charged for it and then the money invested into the running of the Databank, so that it functioned along the lines of a cooperative. People would be empowered by this arrangement, and trust and transparency would be guaranteed.

In conclusion, there is a need for looking at best practices for applying big data tools to healthcare and considering how to bring more coordination to the field, and a need for a strong framework for data sharing and access. The potential benefits of sharing information and allowing big data to be further explored as a new way of conducting research in the area of health are huge. As stated during the workshop, EU-wide collaboration to ensure maximum security and privacy protection, and the development of adequate policies that anticipate the latter, are urgently needed in the coming years. That and an active role for citizens themselves in deciding how and in what form other parties can access their data. In the context of health, that would be an innovation that contributes to really putting people in the centre of future health care models.

## Workshop 11

### Panellists and speakers:

Amelia Andersdotter, Member of the European Parliament  
Terje Peetso, Unit H1 - Health and Well Being, DG Connect,  
European Commission

Leonas Kaletinas, Member of the Board of Directors,  
Lithuanian Health Forum

Barbara Kerstiens, Head of Sector Public Health,  
DG Research, European Commission

Angela Brand, Institute for Public Health Genomics,  
Maastricht University

Bonnie Wolff-Boenisch, Head of Research Affairs, Science  
Europe

Ernst Hafen, Institute of Molecular Systems Biology, ETH  
Zurich, Switzerland

John Crawford, Healthcare Industry Leader Europe, IBM

Adam Heathfield, Director Science Policy Europe, Pfizer

### Moderator:

Duane Schulthess, Managing Director, Vital Transformation

Workshop 11 was organised by  
the European Alliance for Personalised Medicine.  
Supported by the Lithuanian Health Forum,  
EFPIA, IBM and Pfizer.



European Alliance for  
Personalised Medicine



efpia

European Federation of Pharmaceutical  
Industries and Associations



Supported by the Lithuanian Presidency of the  
Council of the European Union 2013.



Lithuanian Presidency  
of the Council of the  
European Union 2013

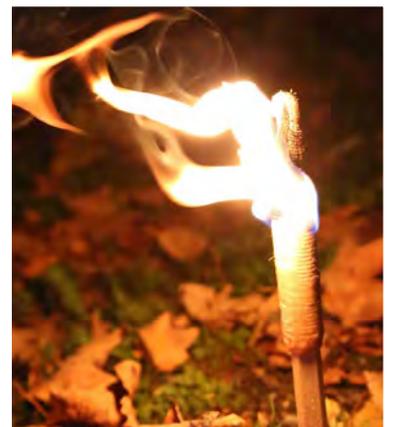
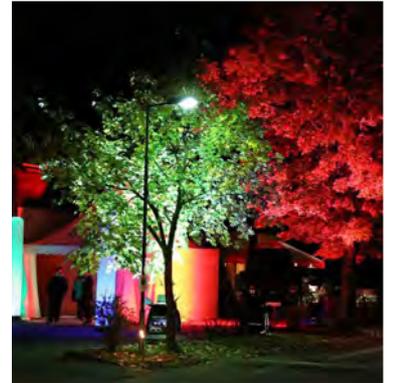


# SAVE THE DATE

17th European Health Forum  
GASTEIN

1 - 3 October 2014

Gastein Valley



# Healthcare-Associated Infections

## Time to take responsibility

By Erjona Shaqiri and Louise Boyle

This workshop was moderated by [Marc Sprenger](#), Director of the European Center for Disease Control. Sprenger opened the session with a case report and highlighted that behind each case there is always a patient. In any given day 1 in 18 patients acquire Healthcare Associated Infections (HAI) which equates to just over 3 million patients a year (in the EU, Iceland and Norway). He emphasised that we could prevent a substantial number of these.

The objective of this workshop was to engage key stakeholders, the state, the hospitals, the patients and the healthcare inspectorates as well as the audience in a discussion about how Europe can provide the highest standards of hygiene and infection control in its innovative health care systems.

The first presenter was [John F. Ryan](#), DG Health and Consumers, European Commission. Ryan emphasised that it was time to take responsibility and enact legislation to help the work on combating HAI to go forward. He presented a review of European legislation regarding surveillance of HAI and antimicrobial resistance. Council recommendations on patient safety recommend that member states adopt and implement a Strategy for combating HAI, establish intersectoral mechanisms or equivalent systems for implementation of the strategy and continuously report to the Commission on the progress made.

According to the report of implementation of this strategy, 26/28 countries have implemented a combination of actions on HAI. Most of the strategies for the prevention and control of HAI are linked to strategies for the prudent use of antimicrobial agents in human medicine and/or patient safety strategies.

The next step is preparation of a multi-annual Public Health Programme which prioritises healthcare-associated infections in the context of antimicrobial resistance.

[Dominique Monnet](#), Senior Expert and Head of Programme, Antimicrobial Resistance and Healthcare Associated Infections at the European Centre for Disease Prevention and Control, introduced some data from the ECDC “Point Prevalence Survey” (PPS) 2011- 2012.

This study involved 28 Member States plus Croatia (not a MS at that time), Iceland and Norway. It was an attempt by ECDC to measure something other than outcomes, and required significant efforts to undertake the work. A protocol was produced and training of trainers undertaken, with around 2,800 healthcare workers involved in the study. Final analyses were undertaken of 947 hospitals and a total of 231,459 patients. This kind of study enabled the linking of data on Antimicrobial resistance (AMR) vs antimicrobial use, and AMR vs infection control indicators.

Large variations between countries and hospitals were found, with the overall finding that on any given day 1 in 18 patients (6%) have at least 1 HAI. In terms of microorganisms discovered, there is still a lot of MRSA around, and increased resistance to broad spectrum antibiotics and last line antibiotics. Retrospective validation studies have been offered by ECDC, but so far these have only been taken up by four countries.

Next steps are linking of data between surveillance systems (AMR, Anti-microbial consumption and HAI). More training opportunities are needed to enable health professionals across MS to undertake further surveys and also to liaise with patients and



Panel discussion during the lunch workshop session.

Jan Wijngaarden, Ministry of Health, Welfare and Sport, The Netherlands; Laurène Souchet, European Patients' Forum; John F. Ryan, DG SANCO, European Commission; Marc Sprenger, ECDC; Dominique Monnet, ECDC and Elisabeth Presterl, Medical University of Vienna, Austria (behind, from left)

providers on HAI and address their problems and concerns. A 2nd ECDC point prevalence survey in European acute care hospitals is planned for 2016-2017.

**Elisabeth Prestel**, Professor, Clinical Institute of Hospital Hygiene at the Medical University of Vienna and Head of Infection Control and Hospital Hygiene at University Hospital Vienna, presented her experience in undertaking the ECDC "Point Prevalence Survey" in Austria.

The commitment of the managers of hospitals was obtained, then knowledge about how to undertake PPS was spread throughout health professionals in the hospital, and data collectors were trained and warmly welcomed on wards. An effective and trust-generating process resulted in good tests and definitions, with good data as the result, and the eager anticipation of results by those involved. Through this study, Prestel emphasised that we have to spread knowledge and confidence on AMR and HAI.

**Laurèn Souchet**, Policy Officer, European Patients' Forum (EPF), gave a presentation on patients' role in patient safety, and presented the results of an EPF survey on patient involvement in safety.

The survey showed that 42% of respondents were unaware of the Council Recommendations on patient safety outlined by Ryan earlier, despite the fact that many of the respondents had some role in

developing patient safety information or participating in consultations. 65% of respondents recommended involving patients and citizens more in promoting patient safety in their country. Overall the survey revealed the untapped potential of patients who are willing to contribute to prevention risk and drive change towards a culture of patient safety, and be seen as a partner in the safety chain.

**Jan Van Wijngaarden**, Chief Inspector of Public Health and Mental Health Care, The Netherlands, presented a case study concerning a pneumonia outbreak caused by a multiresistant bacteria (*Klebsiella*) in a new hospital in the Netherlands and its consequences.

Lessons learned were that early detection of outbreaks and strict adherence to infection control guidelines are of paramount importance for patient safety.

A second lesson was that hospital management are responsible for adequate infection control policies and clearly assigning responsibilities in these kind of situations, and finally the follow-up investigation following the outbreak highlighted that auditing is essential to discipline health care workers regarding infection control.

## Discussion outcomes

The following is a brief overview of some of the issues discussed during the question and answer session:

- The global burden of HCAI remains unknown because of the difficulty to gather reliable data. HCAI surveillance is complex and requires the use of standardised criteria, availability of diagnostic facilities and expertise to conduct it and interpret the results.
- Everyone needs to be involved in patient safety: from hospital managers and staff, to patients and politicians.
- It's all very well having protocols, but medical staff need to be aware of these and be able to put them into action automatically (without in some cases patients telling them to do it!)
- Patients and families need to feel that if they raise a complaint it will be addressed, and that hospital staff need to be able to report concerns without risk of action against them. Perhaps new technologies can be used to help with this or some kind of independent body established?
- There should be a dedicated policy for healthcare providers to learn from each other concerning patient safety.
- Unannounced auditing of infection control measures and then making the results of this audit public could help: more transparency of data is necessary.
- In some countries incentives for hospitals to improve infection rates may be too few: for example payers (i.e. German or Austrian sickness funds) will pay the hospital whether the patient is hospitalised for 4 days or 40 days.

## Lunch Workshop 1

Panellists and speakers:

John F. Ryan, DG Health and Consumers, European Commission

Elisabeth Presterl, Professor, Clinical Institute of Hospital Hygiene, Medical University of Vienna, Austria

Jan Wijngaarden, Chief Inspector of Public Health, The Health Care Inspectorate, Ministry of Health, Welfare and Sport, The Netherlands

Laurène Souchet, European Patients' Forum

Dominique Monnet, Senior Expert & Head of Programme, Antimicrobial Resistance and Healthcare-Associated Infections, European Centre for Disease Prevention and Control (ECDC)

Moderation:

Marc Sprenger, Director, European Centre for Disease Prevention and Control (ECDC)

Lunch Workshop 1 was organised by European Centre for Disease Prevention and Control (ECDC).



# Self-care perceptions

## Epposi Self-Care Perception Barometer: Today's perception can lead to tomorrow's reality

By Megan Challis

### Overview

This session reported the preliminary findings of Epposi's qualitative study on perceptions of self-care. The researchers presented the methodology and initial findings of the Epposi Self-Care Barometer, which identifies consumer perception of self care in ten selected EU countries. The study investigates what consumers understand by the concept of self-care, its importance, benefits and what they see as the barriers to uptake. It explores individuals' confidence to take responsibility for their health or to undertake self-care, and their view of the role of health professionals. The researchers intend the work to raise awareness of the potential value of self-care in reducing pressure on healthcare systems and to help stakeholders to make policy decisions that take public views on self-care into account, including supporting individuals to undertake self-care where appropriate through the provision of necessary products and services.

#### Overview of study

The key messages from the study are that an increase in self-care can potentially reduce the pressure on healthcare systems whilst bringing concurrent benefits to individuals in terms of health outcomes, well-being and quality of life. It found that many consumers already practice self-care and most are already willing to take greater responsibility for their own health. However, only 20% of the study's participants felt very confident in managing their own health, suggesting the need for increased health literacy as a prerequisite for self-care. Participants also pointed to healthcare professionals

as pivotal in the prevention and management of their health and as the primary source of information, suggesting that rather than replacing the role of healthcare professionals, self-care is an additional tool for health management and a shift in the relationship between patient and healthcare professional.

### Views on the findings

#### Politics and administration

Those representing politics and administration in the discussion focused on the practical policy options emerging from the research. It was felt that the key point emerging was the willingness and motivation of the participants to undertake self-care, but their outstanding need for the right skills and knowledge to do so. Discussants argued there was an opportunity to move away from healthcare professionals being the only gatekeepers of health information, with patient organisations and the expertise of lived experience being a potential avenue to explore in order to ensure the provision of high quality health information.

#### Industry

Industry representatives were also interested in the future provision of quality information, and suggested a need to examine the regulation of this function. Positive about the potential of self-care, they focused on the benefits to healthcare systems as a whole as well as individuals. It was felt that to focus on the practical steps needed to further the uptake of self-care, the inform-incentivise-enable

model was helpful - individuals need to be informed and health literacy needs to increase, they need to be incentivised or activated to self-care, and finally need to have access to the facilities, products or services to support them to self-care.

## Civil society

Civil society organisations, including patient and consumer representatives, were concerned about any potential shift in the balance of responsibility towards patients, in particular if they lacked the skills and knowledge to take responsibility for their health. This would risk widening health inequalities. It was felt that policy-makers can have in mind the 'ideal' consumer - well informed, empowered - and that the realities of health literacy levels and behavioural insights need to be taken into account. There was a role for wider society, government and industry to make healthy choices easier choices for individuals, for example via marketing policies. Interesting points were also made about widening the definition of self-care - for example, setting up or taking part in patient organisations or support groups might be considered to be a form of self-care. Another angle explored was the important question of what happens when self-care goes wrong - when individuals make decisions which medical evidence suggests are not optimal for the management of their conditions? There were questions in this vein about whether self care was in fact of more benefit to government or to industry than to patients.

## Practitioners

Representatives of practitioners in the room argued that an important shift in the role of healthcare professionals would be to learn how to teach people to self-manage/self-care, and to be prepared to relinquish control as a corollary to this. One argument put forward was that patients depend on medics because of medics - that their confidence to ask the advice of other private individuals or to seek healthcare information from a variety of sources had been gradually eroded. Overall positive about the possibilities of self-care, they focused on the need for self care to be a partnership between patients, healthcare professionals and others, and that the primary driver for self-care was that it was what patients wanted, and any benefits to the sustainability or resilience of healthcare systems was a welcome by-product.

## Concluding thoughts

Discussion participants were asked to conclude with their policy recommendations to realise a widening of uptake of self-care. Overall, the key points were that this would require culture change in the medical profession, from government and from industry. It was clear that increasing health literacy levels was a prerequisite, but with the recognition that there was not a direct causal relationship between literacy and healthy choices. There was consensus for a balance between the potential of self-care and the ongoing role of healthcare professional-patient relationships.



Vincent Clay, Pfizer; Audrey Birt, Health and Social Care Alliance; Paul de Raeve, European Federation of Nurses Associations (EFN) and Ilaria Passarani, European Consumers' Organisation (BEUC) (from left)

## Lunch Workshop 2

Leaders of an open fishbowl discussion:

Audrey Birt, Health and Social Care Alliance

Andrea Pavlickova, Project Manager, Epossi

Paul de Raeve, European Federation of Nurses Associations (EFN)

Ilaria Passarani, European Consumers' Organisation (BEUC)

Vincent Clay, Pfizer

Moderation:

Jacqueline Bowman-Busato, Epossi

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Lunch Workshop 2 was organised by European Platform for Patient Organisations, Science and Industry (Epossi).



# Schizophrenia and social inclusion

## Perspectives, needs and solutions

By Marieke Kroezen

Schizophrenia is a word that spells stigma. Stigma from the world around patients as well as within patients themselves.

**John Bowis**, Health Policy Advisor and former MEP and MP, put it very clearly in his opening remarks on this important session. In order to reduce the stigma, some countries are changing the name of the mental disorder, for example Japan and the Netherlands. However, it is highly questionable whether this will solve the problem. Schizophrenia should be de-demonized. And up to now, Europe has failed to address mental health problems in Europe.

Therefore, in this workshop, under the inspiring leadership of **Nick Fahy**, the viewpoints of patients and their carers on social inclusion formed the main focus.

Bowis drew a clear picture of how schizophrenia is being perceived these days. In the UK, where 250,000 people are diagnosed with schizophrenia, the general population in a national survey indicated that they were afraid of schizophrenia patients. Fears mostly grew from the assumption that schizophrenia patients are violent. Moreover, people reported that they would not let a woman who was ever hospitalised for schizophrenia babysit their child. Another commonly held assumption was that schizophrenia patients can never fully recover from their disease and are not able to live independently. While Bowis was able to refute these assumptions with some powerful facts, for example showing that most schizophrenia patients never commit a violent act, it shows how widespread wrong assumptions about schizophrenia are and hence the stigma surrounding the disease.

Ask yourself the question; would you tell your friends or colleagues if you were diagnosed with schizophrenia?

And if so, would they support you or slowly retreat from you and keep their children away from you?

People with schizophrenia need to be socially included. And this is possible. As an example, the movie 'A beautiful mind' was mentioned. This movie shows that schizophrenia can be cured or managed, with the help of social inclusion.

Hoffmann-La Roche, who sponsored this session on schizophrenia and social inclusion, try to understand and address the social inclusion of people affected by schizophrenia. One of the activities they have undertaken is the "Schizophrenia and Social Inclusion Study".

This study is open to people living with schizophrenia and their caregivers from all around the world. In the workshop, participants contributed to this study by answering some of the questions that were asked in the real study by live voting. Afterwards, workshop participants' answers were compared with those of real patients and their caregivers, and a discussion about the implications took place.



Voting during an interactive workshop session.

For schizophrenia patients, not having a job was one of the most important issues that prevented them from being as much part of the community as they would like. Workshop participants also recognized the importance of having a job in their voting. Moreover, getting rehabilitation with help from the government/state organisations was very important for survey participants to help them be socially included.

Overall, four main themes emerged that were discussed by the expert panel, including John Bowis, [Kevin Jones](#), Secretary General, EUFAMI and [Esko Hänninen](#), Health and Social Policy Adviser, and the workshop participants.

## Education

One of the most important issues that emerged was education. For patients, the ability to have an education is extremely important. This issue was considered more important by patients than their caregivers. Both patients and caregivers experienced a lack of support from governments and/or state organisations in obtaining/finishing an education.

## Employment

The second main theme that came up was employment. A lack of job and/or finances was considered the most important barrier to social inclusion by patients. Their caregivers agreed with this. One of the key issues that came up, was that

governments should help patients with finding a job. Just over half of the respondents stated that they received no help from the government in finding a job.

## Housing

The third issue that was mentioned concerned housing. Schizophrenia negatively affects patients' ability to choose their own place of living. Moreover, a close correlation was felt to exist between discrimination and housing. Strikingly, caregivers deemed the housing issue more important than patients. In the discussion, it was mentioned that one possible explanation for this finding is that schizophrenia patients are usually in their late teens or early twenties and used to living at home, while caregivers would expect them to move out by that time and therefore consider this more of a burden, especially as caregivers are growing older themselves and also deal with taking care of their parents, etc.

## Discrimination

The fourth and final main issue that came up was discrimination. Schizophrenia is viewed as a barrier for social inclusion by two thirds of patients and the same number of patients deemed participation in society very important. Moreover, forty per cent of patients believe that discrimination can be reduced in/by medical care and this should be an important issue for government policy as well. Governments must do more to overcome discrimination.



Kevin Jones, EUFAMI; Esko Hänninen, Health and Social Policy Advisor and John Bowis, former MEP (from left)

Esko Hänninen summed up the findings of the global survey by stating that it gives a signal to governments worldwide to further develop care for schizophrenia patients.

All panel experts agreed that housing is a big problem for schizophrenia patients. It was concluded that more attention should be paid to the voice of the patient in choosing his/her own preferred form of housing. Hänninen suggested to maximise the number of patients in institutionalised housing (units) to six persons, resembling the home situation as much as possible. Moreover, it was agreed that it would cost less for governments to support caregivers in taking care of patients in their own home setting than by institutionalising them.

A final issue that was discussed concerned more responsible reporting by media. Kevin Jones acknowledged the problem of negative stereotyping of schizophrenia patients in media reports, reinforcing stigma. We should keep on correcting media in this regard. Finally, it was mentioned that celebrities suffering or having suffered from mental illnesses and openly talking about it, are powerful forces in changing stereotypes and reducing the stigma surrounding mental illnesses, including schizophrenia.

## Lunch Workshop 3

### Panellists and speakers:

Kevin Jones, Secretary General, EUFAMI

Esko Hänninen, Health and Social Policy Advisor

John Bowis, Health Policy Advisor; former MEP

### Moderation:

Nick Fahy, Senior Advisor Health, A&R Edelman

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Lunch Workshop 3 was organised by  
F. Hoffmann-La Roche Ltd.



# Navigating health systems

## Lessons from navigating health systems through economic crisis: short term responses and long term vision

By Gabriele Pastorino

The objective of this session was to review the latest evidence on the impact of the economic crisis on population health and on health systems in the WHO European Region, particularly in terms of:

- Maintaining and reinforcing equity, solidarity and universal coverage;
- Providing policy responses to growing fiscal pressure, with a focus on hard-hit countries and measures to improve efficiency;
- Improving health system preparedness and resilience.

The workshop was opened by [Hans Kluge](#), Director of the Division of Health Systems and Public Health, WHO Regional Office for Europe.

Kluge explained the work done on the financial crisis by WHO EURO in collaboration with the European Observatory on Health Systems and Policies and presented the resolutions of the WHO High-Level Meeting on “Health systems in times of global economic crisis: an update on the situation in the WHO European Region” hosted in April 2013 by the Government of Norway.

The 10 policy lessons and recommendations included in the Oslo Resolution are the following:

- Be consistent with long term health systems goals;
- Factor health impacts fiscal policies;
- Safety nets can mitigate many negative effects;
- Target efficiency over patient charges;
- Protect funding for cost-effective public health services;

- Avoid prolonged and excessive cuts in health budgets;
- High performing health systems may be more resilient;
- Structural reforms require time to deliver savings;
- Information and monitoring are needed to ensure access;
- Resilient health systems result from good governance;

WHO EURO’s follow-up work in this area and next steps include:

- Facilitating dialogue between health and finance by strengthening the collaboration with the OECD and engaging in the discussion with other partners such as the International Monetary Fund.
- Strengthening policy responses driven by up-to-date evidence. This will be achieved using the research generated in this area by the European Observatory and by the organisation of in-country policy dialogues to support policy development.
- Improving systems to monitor the health impact of financial and economic crisis, by developing indicators in line with Health 2020 and by supporting WHO EURO Member States to collect the data needed in a more timely way.

The session continued with [Tamás Evetovits](#), Head of Office a.i., WHO Barcelona Office for Health Systems Strengthening, who presented on health financing policies in times of economic crisis. Evetovits stressed that preparedness for a crisis and

resilience depends on good governance, that policy responses are as important as the health finance system in place and that there is a need for a more productive dialogue between finance and health ministries.

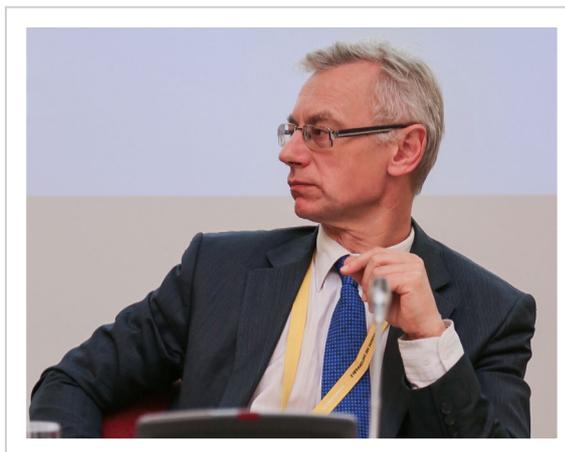
A key message for the health financing policy is that improving efficiency is far better than cutting back on services or imposing fees that affect the most vulnerable population groups. Balancing the State budget should not be just an accounting exercise, and the health sector has to try to influence fiscal policy by stressing that these policies should be based on choices in public policy priorities to minimise adverse effects on health, equity and financial protection.

Health spending over the last years did not carve out an unfair amount of resources. It is carving out a slightly higher share of public spending but very little compared to the general public spending increase. European countries are actually spending less on health than in the past. Since the crisis started in some countries health expenditure was disproportionately cut. For instance this was the case in the Baltic countries.

Evetovits concluded his presentation by talking about preparedness and resilience for the crisis saying that crisis responses depend a great deal on policies and institutional arrangements introduced prior to the crisis; that prioritising and addressing major inefficiencies as an answer to the crisis is important but also that during the years of economic expansion it is important to invest in an appropriate



Tamás Evetovits, WHO Barcelona Office for Health Systems Strengthening



Gediminas Černiauskas, Vice Minister of Health Lithuania

way so as not to make waste of opportunities; that short-term solutions are important to keep the system running, but that it is important to proceed with care when looking for savings since they are not necessarily equal to efficiency.

The discussion went on with an intervention from [Gediminas Černiauskas](#), Vice Minister of Health of Lithuania, who explained the experience of his country in dealing with a serious financial crisis in 2009. The crisis in Lithuania was characterised by a strong economic shock and the Ministry had to take strong measures: stabilisers helped but expenditure had to be significantly cut.

Similarly in Greece, as explained by [Giulia Del Brenna](#), from the EU Task Force for Greece, the crisis resulted in quick and important decisions being made in order to tackle big problems in efficiency. The crisis was used as an opportunity to implement change.

The Task Force came up with a number of measures to modernise the Greek health system such as the introduction of diagnostic innovative groups, hospital management, new regulation on generics, changes in the primary healthcare sector, etc. A steering committee was set up in order to address the main challenges and to make changes compatible with the goals of the Memorandum of Understanding. The Greek authorities are at the beginning of a process to bring on board experts to work on the priorities identified by the Steering Committee.

The discussion continued with an intervention from **Clive Needle**, Director of EuroHealthNet, who pointed out that solidarity within social and health systems is a key principle.

He referred to the WHO model to stress the benefit of action and the cost of inaction in times of a financial crisis and mentioned the importance of the social determinants of health.

In particular he said how important was to invest in employment and quoted Sir Michael Marmott: the number of young people unemployed and not in training is a major public health threat. He concluded his intervention calling for stronger collaboration between international agencies, in particular the OECD and WHO, with the European Commission to resolve the problems.

The session was concluded by Josep Figueras, Director of the European Observatory on Health Systems and Policies, who stressed the central role of governance in making health systems resilient: the responses to the crises pass through stronger governance and leadership.

## Lunch Workshop 4

### Panellists and speakers:

Hans Kluge, WHO Regional Office for Europe  
 Tamás Evetovits, Acting Head, WHO Barcelona Office  
 Josep Figueras, Director, European Observatory on Health Systems and Policies  
 Clive Needle, Director, EuroHealthNet  
 Giulia Del Brenna, EU Task Force for Greece, ECFIN  
 Gediminas Černiauskas, Vice Minister of Health, Lithuania

### Moderation:

Hans Kluge, WHO Regional Office for Europe

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Lunch Workshop 4 was organised by World Health Organization, Regional Office for Europe.



## Outcome variation

### Moving towards safer and more efficient health services – evidence from the ECHO project on systematic variations in healthcare delivery

By Laura Schang

Does access to effective diagnostic or surgical procedures depend on where a person lives? Does a patient admitted to one hospital receive less or more care than a comparable patient admitted to another hospital? These are key questions that ECHO, the European Collaboration for Healthcare Optimization, aims to answer. In this workshop, participants learned about the approaches and preliminary findings of ECHO, and discussed challenges and promises in using this data to improve health services management and policy.

#### The ECHO project

**Enrique Bernal Delgado**, Senior Health Services Researcher, Health Services Research and Health Policy Unit at the Institute for Health Sciences in Aragon, Spain, introduced ECHO, an international project on healthcare performance that has set about the task of bringing together, and making comparable, patient-level data from hospital discharges in Austria, Denmark, England, Spain, Slovenia and Portugal.

ECHO expands the usual approach to healthcare performance comparison, which tends to show averages, by adding the variation framework. ECHO aims to examine variations, both within and between countries, in utilisation, equitable access to effective care, quality and efficiency in terms of opportunity costs, and provider-level efficiency.

Two perspectives are taken: the geographical perspective examines population exposure to

effective care (e.g. hip fracture), care of uncertain benefit/harm balance in “non-average” patients (e.g. knee replacement) and care of lower value and opportunity costs (e.g. spinal fusion, tonsillectomy).

The hospital perspective examines in-hospital case fatality rates for a condition (e.g. admissions with principal diagnosis of ischaemic stroke), in-hospital case fatality rates after a procedure (e.g. hip replacement) and patient safety event rates (e.g. postoperative sepsis).

What does the preliminary analysis reveal?

- Utilisation of effective procedures: At population level, the burden of ischaemic disease barely explains variation in revascularisation; this might signal over- or underuse.
- Equity: Revascularisation is performed differently across income quintiles, not always coherent with need. Differences beyond need might represent inequities in access.
- Quality of care: Case-fatality rates vary dramatically across high-volume hospitals, irrespective of the differences in patient case-mix. Hospitals flagged as poor (or good) performers are likely to behave consistently over time.
- Efficiency (value): Variation in low-value procedures is huge, within and across countries. Areas with high numbers of low-value procedures are facing high opportunity costs regardless of differences in patient case-mix. On the other hand, hospitals are managing differently those resources devoted to treat similar patients.

## Using the data

**Jeni Bremner**, Director of the European Health Management Association, emphasised that ECHO data is not a tool to diagnose good or bad performance, but a tool to screen for potential problems that might require intervention. She discussed how ECHO can help decision makers: in supporting learning from places and providers that appear to be doing the same for less resources (e.g. in terms of lower lengths of stay), or that seem to secure better outcomes for their resources spent.

While ECHO data does not explain why variations exist, performance comparisons can help to challenge potentially poor practice within a country and to look deeper when performance appears to look relatively good within a country, but other countries seem to do better. Even if there was no definitive evidence, there was surely enough reason to look further into the data and to start a discussion about policy instruments, how to reduce (unwarranted) variation, and shape the policy agenda for the next years, argued Bremner.

So far, the data has been used in a series of in-country meetings, using local dissemination groups, that sought to validate and discuss the usability of the data. A careful methodology was developed to enable people to understand and use the data. Country reactions were positive: there was much curiosity about who is doing well, and why particular countries were doing better. Countries doing well were often willing to share good practice. For example, the experience from Denmark suggested that a strong ten-year policy focus on cardiovascular care combined with leadership and managerial support helped to rearrange chains of care and secure good primary care, which were seen as key contributors to good outcomes in hospitals.

## Challenges

Although information on variations has been available for decades, not until recently has it started to be taken up by policy-makers in Europe and the United States. Like most analyses that use routinely available data, the data may not be perfect – but if countries are to improve the quality of their



Enrique Bernal-Delgado, Aragon Health Sciences Institute; Mark Pearson, OECD and Jeni Bremner, European Health Management Association (from left)

reporting and coding systems, then comparative analyses of healthcare variation may help to put this issue on the policy agenda. Furthermore, although ECHO is a screening, not a diagnostic tool, it does provide some certainty: that variations are not likely to be due to chance, differences in patient case mix, or differences in data systems, as Enrique Bernal Delgado emphasised.

Screening performance might, even unintentionally, be harmful, as some participants argued. Health system comparisons might be misused as a political weapon to, for instance, close down hospitals that are seemingly performing worse relative to hospitals in other regions or countries. The more important it is thus to help decision makers understand the data and enable them to look deeper to see why their practice differs from others.

## Outlook

Participants stressed the importance of looking not only at the backend (hospital care) but also at the frontend (primary care) where patients enter the health system. This includes a stronger focus on chains of care, and an understanding of variations in primary care quality and how that might affect outcomes in hospital care.

ECHO includes the most recently available data for the years 2007 to 2009, and many countries were keen to have more timely and regularly up-dated data, as policy makers and providers might argue

that their performance has improved meanwhile. As Bernal Delgado stressed, so far ECHO has been a pilot study. Subject to funding, the databases could in principle be updated annually to help overcome problems of timelag and promote access to more recent data.

In conclusion, information from the ECHO project can be a tool for asking questions: it can help policy-makers and managers to benchmark their performance against other hospitals, healthcare geographic areas and countries, where lower spending might buy the same or better outcomes. In times of austerity, comparative data may thus help in making health systems more resilient by asking whether money spent secures equal access to effective and efficient services.

## Breakfast Workshop 1

Panellists and speakers:

Enrique Bernal-Delgado, Head of the Health Services Research Unit, Aragon Health Sciences Institute (IACS)

Jeni Bremner, Director, European Health Management Association (EHMA)

Mark Pearson, Head of the Health Division, OECD

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Breakfast Workshop 1 was organised by European Collaboration for Health Optimization (ECHO) project.

The session was co-financed by the European Commission in the framework of the 7th Framework Programme (Grant Agreement FP7-health-2009-242189).



# Patient involvement

By Fedor Gassner and Louise Boyle

## Introduction

**Tamsin Rose**, Independent EU Health Activist, chaired this breakfast session, and at the outset framed the context and areas for discussion. Society has increasingly high expectations of patients in terms of their role in managing their own conditions and well-being and involvement in improving healthcare, while they are simultaneously suffering from the constraints the system is currently facing in terms of cuts and austerity (i.e. rationing, longer waiting times and higher co-payments).

Everyone agrees that there is a need for a paradigm shift in health systems – so that they can become more patient centric and patient focused, putting patients at the heart of the policy-making process. But what does this mean in reality? To facilitate a paradigm shift, a change is needed both in patients themselves as well as from other actors in the health system. This workshop sought to explore further some of these issues.

## Investing in health

**Sylvain Giraud**, from the European Commission Directorate General SANCO, presented the European Commission Staff Working Document “Investing in Health. This document is a blueprint for EU 2020 and an extension of the 2008 EU health policy. It outlines the dual aims of achieving efficiency gains and high quality and accessible care for all, and how these can be complementary. The first section of this document deals with investing in sustainable health systems and addresses the issue of what policymakers can do when faced with the problem of fiscal consolidation.

It aims to show why health is part of the solution, and outlines a set of recommendations, methods and policy tools to try and prevent compromises being made in health budgets in the wrong places.

The document also explores investing in health as human capital – how health is a fundamental value and also a condition to facilitate economic prosperity and therefore a sound economic investment. In simple terms, poor health leads to absenteeism and low productivity, better health leads to longer working life. This section of the document focuses on prevention and promotion measures, healthy lifestyle choices and health literacy. The final section of the document discusses the importance of investing to reduce health inequalities, and how health is a fundamental driver for social cohesion. Universal access to healthcare can reduce poverty and help fight social inclusion. This needs to be tackled through a health in all policies approach, to see how we can use other policies to tackle the complex reasons for inequalities across the different determinants of health i.e. housing, living and working conditions.

Giraud also discussed a 2012 Eurobarometer survey commissioned by the EC on patient empowerment, which revealed participants had a general lack of clarity about what patient empowerment actually is. Therefore the EC has undertaken a mapping exercise to look at the different patient empowerment initiatives in EU Member States with a view to seeing what best practice could be shared.

Helping patient organisations build capacity

**Nicola Bedlington**, welcomed the EC's Investing in Health document and picked up on some of Giraud's points.

Regarding human capital, she stated that patients should be part of the solution towards developing the quality health systems of the future, and she welcomed strongly the aspects of the document dealing with health inequalities, emphasising that it cannot be stressed enough how much of an issue access and equity is.

Bedlington agreed that there can be a lack of clarity about what patient empowerment is and welcomed the mapping work, in which EPF are partners. She also described work underway to "inject" patient empowerment in EC joint actions, and highlighted further work being undertaken by EPF with their members at national level to engage in capacity building i.e. the basics of running an effective organisation, including good governance, sound funding, having a clear strategic plan and clear engagement with "political animals". Importantly, the latter includes using the leverage of the political gains made in Brussels and translating these into a national context so that patient organisations can use this capital at a national level to engage with politicians, policymakers and the health community to drive better, more patient centred health systems. Bedlington's final comment was that the EC has set the scene well, and now it is the responsibility of all of us to take this work forward.

The relationship between the economy and mental health

**Rebecca Muller**, from the Global Alliance of Mental Illness Advocacy Networks (GAMIAN-Europe) commented that one of the impacts of the economic crisis has been an increase in burnout and depression, as well as people needing longer absences from work.

She praised the EC's "Investing in health" initiative, although lamented the lack of a specific mention of mental health. She stated that fighting stigma is important – people do not understand mental illness, therefore it is something that remains more hidden and stigmatised than other diseases, and less talked about. Muller said she would welcome more understanding and information campaigns for managers and workplaces, in addition to campaigns for the general public to highlight the importance of maintaining a healthy work life balance.

GAMIAN-Europe stresses that everybody is a potential patient, especially under times of austerity and economic stress, and empowerment - putting the patient at the centre of the process - meant also seeing the positive side of being a patient.

The changing relationship between patients and doctors

**Katrín Fjeldsted**, from The Standing Committee of European Doctors (CPME) described how she foresees that the doctor - patient relationship will



Marion Olsson, EHMA; Katrín Fjeldsted, CPME; Karin Kadenbach MEP (S&D Austria); Tamsin Rose, Independent EU Health Activist and Nicola Bedlington, European Patients' Forum (from left)

instead become a patient - doctor relationship, with the dialogue between patient and doctor becoming more like personalised health management.

Fjeldsted's experience as a General Practitioner in politics is that a good foundation is needed for health services to be effective and efficient, and that patient empowerment and good health literacy is also crucial. Health is integrated in society, and doctors and patients are allies in changing policy. A reinforcement of the patient-doctor relationship is needed to strengthen the effect on policy at EU level.

Transparent funding for patient organisations

**Marianne Olsson**, from the European Health Management Association (EHMA) described how EHMA has observed a paradigm shift in healthcare delivery, where knowledge of patients is essential for innovation. The "old paternalism" approach has vanished and true partnerships are needed. But she highlighted a missing link at the micro level, where she thought a greater focus on the link between policy making and practice was needed.

Echoing some of Bedlington's earlier observations, Olsson agreed that transparent funding for patient organisations is essential, so patients can be effectively involved in policy development. It is important to listen to patients, but the system does not really support partnerships. One example would be a hospital meeting, where a patient is invited to tell his/her story of their experience as a patient at that institution.

Her final observation: "Patients seem to be better represented in Brussels than in the clinical setting, and this is truly something that needs to be changed."

The voice of the people

**Karin Kadenbach**, MEP (S&D, Austria), discussed that health is mainly a Member State competence issue, but the European Parliament is the second biggest chamber in the world so is therefore the "peoples' voice". The Parliament has the ability to set frameworks, therefore it is vital that Parliamentarians learn from patient expertise and

listen and respond to their arguments.

In terms of a multi-stakeholder approach, Kadenbach commented that it is not always clear for policy makers what the competing goals of different organisations are, for example, in a case where there is competition between patient organisations, who is the voice of the patients in such a situation? She appealed to patient organisations to join forces and work together for the common good of patients.

Patient platforms for dialogue and involvement

**Milena Richter**, Senior Director, European Affairs, Sanofi, contributed an industry perspective. She observed that patients are the best judges of what works and does not work, and their needs should be at the centre of health policy. Therefore a multi-stakeholder approach involving public and private actors provides a forum where industry and others can engage with patients is called for. Industry would like to see more such platforms for patient dialogue and involvement created within an institutionalised framework.

Richter saw three key areas for patient engagement being discussed in such fora:

- patient management of disease, including compliance and adherence, prevention and disease management;
- equitable access to treatment: how to build a stronger single market for health, and
- patient engagement in medical innovation – how to bring deeper patient insights into the research and development process, which also leads to an increase in patient expertise.

## Audience and Panel Debate

A number of issues were touched on in the ensuing debate. Audience members commented that there is a huge satisfaction patient involvement, but that this somehow needs to be legally embedded.

Patients are needed to challenge, Olsson suggested, through disruptive innovation. In addition more on-line mechanisms could be useful, e.g. in the UK where "patient + opinions" can be posted online.

Kadenbach commented that it was a big problem that the current system has little room for empowered patients, while Muller reported national differences in the extent of support and involvement of patients.

All agreed better funding mechanisms for patient involvement were necessary. Kadenbach and Richter both pointed out that structural funding needs to be transparent and a good framework is needed.

Giraud commented that DG SANCO recognised and were acting on this need to support civil society. At an EU level, Bedlington suggested developing financial instruments and tools, research programmes, a cross border healthcare framework, and developing legislation. Finally Bedlington reminded everyone that it was important to start by clarifying patient needs, not only in terms of participation, but ultimately in how to really create patient centred health systems, involving multiple stakeholders.

## Breakfast Workshop 2

### Panellists and speakers:

Sylvain Giraud, DG Health and Consumers, European Commission

Nicola Bedlington, Executive Director, European Patients' Forum (EPF)

Rebecca Muller, GAMIAN-Europe

Katrin Fjeldsted, The Standing Committee of European Doctors (CPME)

Marion Olsson, European Health Management Association (EHMA)

Karin Kadenbach, Member of the European Parliament (S&D Austria)

Milena Richter, Senior Director, European Affairs, Sanofi

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Breakfast Workshop 2 was organised by European Patients' Forum in cooperation with Sanofi.



# European Health Award 2013

## Background

The European Health Award was established in 2007 to mark the tenth anniversary of the European Health Forum Gastein.

Promoting trans-border cooperation in health policy with the goal of meeting significant European health challenges was the main driving factor in creating the Award. The health challenges Europe faces touch both public health and health care services, and obstacles to overcome include inequalities and disparities in health status, access to services and the provision of treatment.

The purpose of the European Health Award is to highlight and reward multi-country initiatives that clearly contribute to meeting some of these challenges.



Günther Leiner, International Forum Gastein; Ingo Raimon, FOPI; Ornella Corazza, ReDNet Project and Clemens-Martin Auer, Ministry of Health, Austria (from left)

The European Health Award is kindly sponsored by the Austrian Federal Ministry of Health and the Forum of the Research-based Pharmaceutical Industry (FOPI)

## Winning project 2013

The 2013 European Health Award was presented to the [ReDNet Project](#), at the 16th European Health Forum Gastein.

**ReDNet project: new and rapid forms of identification and dissemination of evidence-based information on novel psychoactive substances (NPS) among vulnerable individuals**

The Recreational Drugs European Network (ReDNet) is a multicentred project, funded by the European Commission (Grant agreement no: 20091216), based in eight EU countries, aimed at identifying new psychoactive substances sold online and improving the information stream to vulnerable individuals, especially young people and professionals working with them, via a range of innovative technological tools.

The recent emergence of novel psychoactive substances (NPS), or 'new drugs', combined with the ability of the internet to disseminate information quickly, have raised a number of concerns in the fields of drug policy, substance use research, and public health across the EU and internationally. Despite increasing amount of attention being given to this area, these new emerging products, often unregulated and sold online as 'legal' and 'safer' alternatives to traditional illicit drugs, are rarely mentioned in scientific literature, and there is limited information available on their nature and potential risks. Such a phenomenon has posed unprecedented challenges to global public health and there is therefore an urgent need to develop new approaches to identify their emergence, to inform and to develop cutting-edge preventative measures.

Participating countries: UK, Germany, Italy, Hungary, Poland, Spain, Belgium and Norway.

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## Organiser

International Forum Gastein

## Co-organiser

Federal Ministry of Health, Austria

## Supported by and in collaboration with

Communities of Bad Hofgastein and Bad Gastein

European Commission, DG Health and Consumers

European Commission, DG CONNECT

European Commission, DG Research and Innovation

Land Salzburg

## Supporting organisations

European Alliance for Personalised Medicine (EAPM)

European Science Foundation (ESF)

F. Hoffmann-La Roche Ltd.

Forum der forschenden pharmazeutischen Industrie (en. Forum of the Research-based Pharmaceutical Industry) (FOPI)

Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C.

Lundbeck A/S

Maastricht University

Max Planck Institute for Molecular Genetics (MPIMG)

MSD

Österreichische Ärztekammer (en. Austrian Medical Chamber) (ÖÄK)

Paracelsus Medical University

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European Alliance for  
Personalised Medicine



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ÖSTERREICHISCHE  
ÄRZTEKAMMER



# SAVE THE DATE

## 17th European Health Forum GASTEIN

1 - 3 October 2014  
Gastein Valley

