

# European Health Forum Gastein

Creating a better future for health in Europe

## 17th European Health Forum Gastein

1-3 October 2014, Bad Hofgastein, Austria

# ELECTING HEALTH - THE EUROPE WE WANT!

CONFERENCE REPORT 2014

Supported by



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European Health Forum Gastein 2014

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# 17TH EUROPEAN HEALTH FORUM GASTEIN

## ELECTING HEALTH - THE EUROPE WE WANT!

### THE EHFG 2014 IN A NUTSHELL

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1-3 October 2014, Bad Hofgastein, Austria

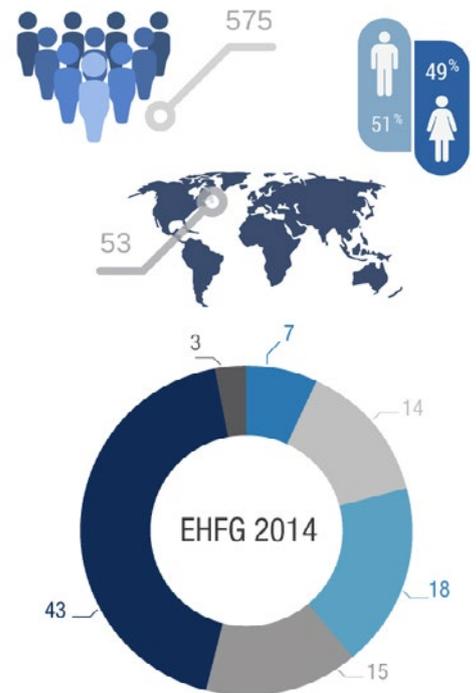
The political context in Europe is changing, for health and for healthcare funding, and the time is right for the healthcare community to influence the direction of travel.

- ◆ Among the priorities in seeking to influence the future of healthcare is a renewed attachment to health for all, health in all policies and a better coordination between social and health policy.
- ◆ Collaboration among a wide range of stakeholders and the identification of powerful common themes are essential if the opportunities for constructive change are to be realised by a new health strategy.
- ◆ Chief among the objectives is a shift from short-term to long-term thinking about health - embracing the real potential of prevention as part of a holistic approach.
- ◆ The European semester puts a new onus on the public health community to effectively argue for investment in health and highlight how health makes a measurable contribution to growth.
- ◆ Better balance must be found between competing objectives, such as supporting innovation while keeping health spending under control and offering real choice within healthcare systems.
- ◆ The EU Commissioner-designate for Health and Food Safety, Vytenis Andriukaitis, expressed his strong commitment to the prevention, promotion and protection of people's health.
- ◆ The future of health and healthcare requires new workforce approaches and the development of the right sort of leadership for a new age.
- ◆ Health system performance must be raised, which requires the optimum use of new tools for delivery and outcomes measurement.
- ◆ The person - and the patient - must be given priority in policies related to health.
- ◆ Europe does not exist in a vacuum: health issues are by definition international, and Europe has a duty to extend solidarity to the wider world population, in strategy and in delivery.

# THE EHFG 2014: BACKGROUND

Across three days in early October, the European Health Forum Gastein 2014 hosted animated discussions between the 600 health professionals that took part. The Forum's review of the underlying issues - demographic, social, scientific, economic, ethical, environmental - was based squarely on the four pillars that support health policy: the EHFG drew on the worlds of research and practice, on the community of patients and civil society, on governmental organisations, and on the healthcare industries - and all of them were encouraged to challenge the status quo.

The discussions extended across some of the immediate pressures in the wider world. The EHFG 2014 hosted an International Forum Gastein sponsored NGO workshop on undocumented migrants, provided expert front-line insights into the Ebola crisis (a last-minute addition to the programme), and focused on collaboration as a force for advancing the common interest. And input from the next generation was assured by the engagement of the Young Gasteiners, enthusiasts drawn from professions and studies linked to health, who contributed with recurrent provocation in the content.



Participants structure of the EHFG 2014:  
575 participants from 53 countries worldwide;  
51% male - 49 % female

## VIDEO AND PHOTO MATERIALS

We are pleased to share with you the recordings of this year's conference.

To access webcasts of selected sessions please follow this link:

<http://www.streamdis.eu/EHFG2014/>,  
register and use this passcode:  
EHFG172014.

Further we invite you to watch the EHFG 2014 Movie and view the photographs from this year's event, which will give you a feeling of the Gastein experience.





**SAVE THE DATE**

**18th EHFG**  
30 Sept - 2 Oct 2015

Bad Hofgastein,  
Austria

# THE GASTEIN HEALTH OUTCOMES 2014

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The EHFG 2014 deliberately grasped the opportunity offered by the changing political context - with a new European Parliament, a new European Commission a new urgency in the WHO European Region, at a time of international discussions on new global health goals.

A combination of thought leaders and practitioners analysed how it might be possible to forge the health policy that citizens deserve in this new political space. Newly-elected MEPs, WHO and EU officials, and the European Commissioner-designate for Health not only came, and spoke, but stayed to listen, and to engage in discussions of "the Europe we want".

The priority tasks that the President of the European Commission has assigned to the new Health Commissioner include rapid responses to crises associated with food safety and pandemics, and a prompt evaluation of the decision-making process for genetically modified organisms - signalling to citizens a readiness to tackle issues that affect them directly and provoke their anxiety. A further priority is to help maximise the efficiency and performance of healthcare systems, by building up expertise for assessing performance and the outcomes from public health spending, and making the findings available. The link that

the Commission is now explicitly making with the activities of the European semester, the mechanism for coordinating Member States' economic and budgetary policies, demonstrates the decisive role of the health system as a factor for the economy and for stability and growth.

## A defining moment

The awareness that health policy is at a turning point, for Europe and for the wider world, was a constant stimulus throughout this year's EHFG.

Whether discussing the prospects for personalised medicine or the scope for integrating technology into healthcare, or reflecting on the inequalities of opportunity or the surging costs of social provision, participants confronted the gaps between aspirations and reality, between potential and achievement. But the evidence served only to reinforce the common determination to seek

better health for all. The Forum focused on formulating remedies, improvements, and solutions, and on seeking synergies among distinct interpretations, rival ambitions or conflicting pressures.

## Radical approaches

The search for solutions ran through virtually every aspect of health and healthcare, from the impact of the environment or the importance of good nutrition through to spotlights on specific diseases, workshops on workforce planning, and reviews of regulatory systems. And the discussions were marked by a readiness to suggest radical approaches and to entertain courageous options for breaking out of routine pathways. The leitmotif of the EHFG 2014 was that business as usual is no longer an option, and that consideration must be given to dramatic changes of course and to the involvement of a wider range of stakeholders.

How, for instance, it was repeatedly asked, is it possible to persuade policy-makers to move away from their habitual short-term fixes to meet immediate political imperatives and electoral timetables, and to take instead a longer-term view that is based on evidence - and even on conviction. Without such a shift, it was argued, prevention will



not receive the attention it merits, since population-based measures deliver tangible benefits only in a longer time-frame. In addition, health systems must also shift their current focus from expensive and ineffective late-stage disease response towards more results-based and cost-effective prevention measures and early intervention strategies. A clear change in trends is needed, since health promotion and disease prevention are key factors for the long-term sustainability of health systems.



If traditional thought-processes are not modified, the infrastructure required for effective healthcare systems will not be created - most conspicuously leaving poorer countries, in Europe as well as in the developing world, vulnerable to epidemics and condemned to little more than crisis responses, it was argued.

The Forum sessions raised questions of solidarity, of core values, and of tackling “unacceptable inequalities” - and in so doing, debates extended into the hinterland of health policy, across issues of social provision, development policy, and poverty eradication.

## Investing in health

Against the sombre background of austerity, the Forum reflected on how to convince senior policy-makers that health is a political priority and a political choice, and how to influence them to see health budgets as an investment rather than a cost. Although that battle may already be won among much of the health policy-community, the harsh reality is that finance ministers and prime ministers are yet to be won over. A number of sessions examined aspects of financing - of health, of healthcare, and of political economics. The current widespread preoccupation with competitiveness and growth cannot be at the cost of society's health, it was fiercely maintained in the course of discussions about securing health with good growth, and about the interdependence of social and economic models. Proposed remedies ranged from the simplest - such as reducing societal costs of specific conditions like hearing loss or sight impairment - to the most adventurous, with calls for budgetary targets to be set for prevention.

The new foothold that the EU has gained in national policies on healthcare was highlighted in discussions of the European semester - the EU's recently-acquired and still-evolving guide to public-spending priorities in the Member States. This extension of EU fiscal powers into the health domain is now generating instructions to Member States over their health and social spending as part of the struggle to ensure sustainable public finances. The consequence is to confer influence as a health policy-maker on the EU, going far beyond its limited authority for health under the EU treaty. This, the EHFG concluded, puts a new onus on the public health community to argue its case more effectively, and at

the highest levels of government, to prevent economic interests taking precedence over health. The Commission's specific recommendations for health system reform are frequently derived from European advisory gatherings or committees that formulate lists of desirable policies. Such meetings offer a real opportunity to bring public health expertise and values into the detailed mechanisms of fiscal governance and policy - especially by making a serious evidence-based case for investment in health.

## People at the centre

Another of the concepts that won unconditional support at Gastein was an attachment to bringing the patient effectively into the centre of healthcare provision.

The multiple implications of a person-centred approach were addressed, and old assumptions about top-down healthcare were rigorously questioned. The new emphasis on giving priority and power to patients in healthcare scenarios was warmly welcomed by seasoned health campaigners. This strategy has to be linked with strengthened approaches to health-in-all-policies and good governance, with particular emphasis on taking the implications for health into account in all areas of policy - and particularly in economic and budgetary affairs.

One of the drivers for greater attention to the patient - personalised medicine - was examined not only in terms of its scientific and medical potential, but also in the light of the changing relationship between the patient and the health professional. The new paradigms of shared decision-making that personalised medicine implies are consistent

with the holistic approach of treating the person rather than just the disease. At the same time, there was intense discussion of how to ensure that the opportunities are matched with adequate capacity-building among patients - and adequate safeguards against possible discrimination and the risks to privacy.

Real empowerment was deemed necessary for patients and citizens to play a fuller role right across the range of health maintenance, prevention and care. The role - and resource limitations - of patient associations as well as healthcare authorities came under scrutiny. There were ample illustrations of the need for better provision - and even definition - of health information, promotion of health literacy, and delivery of health education. Stress was placed on creating communications that commanded trust, and on constructively responding to the uneven distribution of lexical and digital skills in distinct population groups. The rights of patients - and the need to respect them - were also repeatedly evoked in discussions of data access, of the revolution created by information technology, and in the context of the widening options for cross-border healthcare.

### Tools for boosting health system performance

The full benefit of investments in health and closer attention to patients can be realised only if the performance of countries' health systems is also improved - and the EHFG 2014 homed in on how that could be done. Part of the discussion related to the tools and mechanisms which will increasingly be needed for reconfiguring services to improve delivery, for measuring outcomes,



and for educating citizens to be more health-conscious.

In that context, the part that ICT can play received close attention, as a channel that can both deliver care and also investigate the level of care that patients actually receive - insights considered fundamental for improving performance. The EHFG 2014 considered ICT-based opportunities and assets for health conditions such as the management of chronic disease to treatment for depression. Discussion ranged over the advantages of eHealth, telemedicine, integrated health management and other ways that technology can cut costs, improve the "patients' journey", or prevent unnecessary duplication of clinical examinations.

There was hopeful talk of a new generation of health data, and of new scope for linkage between medical records, biological data, and administrative information.

But the hurdles facing technology also received attention - the still-insufficient interoperability and incomplete standardisation, the persistent legal uncertainty, the unresolved issues of privacy for citizens, and of acceptance among healthcare professionals. There was insistence on the dangers of merely trying to bolt new technology onto systems that were themselves in need of reform, and on the dilemma of whether to realise new services piecemeal, or to delay action until

comprehensive solutions emerge. Strong arguments were presented that it is better to realise individual eHealth services step-by-step than to delay implementation because of its complexity. And reservations were clearly expressed: there were strong sentiments that it should be for technology to adapt to patients rather than patients having to adapt, and there were unanswered questions about how far the benefits of some technologies are measurably apparent. eHealth opportunities could contribute to the quality and efficiency of healthcare, but widespread usage still faces hurdles. A rapid deployment of available solutions and increased standardisation at the European level is required.

The Forum also covered more controversial aspects of health systems. Against the background of the need to constrain healthcare budget increases, discussions reviewed how innovation could be funded without disrupting public spending - and inevitably assessed the role of pricing and reimbursement systems in the supply of medicines and medical devices. While there was strong support for keeping costs down through the wider use of generic medicines, joint procurement, and external reference pricing, the argument was made by representatives of the research-based industry - and by some economists present - that a radically updated approach was needed in decisions about maintaining innovation in therapy, both on the economics

and in terms of more flexible regulatory frameworks. Health technology assessment is starting to offer some more considered input to decision-making, but is not yet a panacea. And the recognition was widely shared - even if differences remain over what the solutions might be - of evident market failures in the current approaches, as demonstrated by gulfs in some therapeutic categories, such as vaccines or antibiotics, and notably in relation to Ebola.

### Guiding modified performance

But the discussion of performance went deeper than evaluating the tools, and touched on the very design of healthcare systems - how far they plan for an ageing population, how they tackle health-related behaviour in the general population, how they coordinate efficient continuity of care across sectors. The EHFG 2014 explored how primary-care services can play the role of health broker rather than gate-keeper in balancing patient choice against effectiveness. Primary healthcare was described as a key to optimising healthcare systems, rather than as standing in the way of patients' freedom of choice: well planned and properly implemented primary care could lead to more efficient supply structures and continuity in patient care. The potential of strong primary healthcare with a pilot function will help to optimise health promotion, prevention, and the care of chronically ill patients, it was argued.

The Forum reflected on the balance that has to be found in a changing world between top-down regulation, that can, for instance, counter undue outside influence - as in intensive industry lobbying that might be inimical to health interests -

and a cooperative approach in which policy-makers are enablers encouraging desirable behaviour among partners. And to really improve the performance of health systems, countries need to get both "macro" and "micro" factors right: from sharper competition among healthcare providers to better organisation of hospitals, and from wider use of generic drugs to creating more health-awareness among citizens. Analysing the numerous factors is becoming increasingly feasible as the next "data revolution" appears in the shape of data linkage. This could help in assessing whether horizontal health-maintenance goals offer more sustainability than vertical disease-specific goals, or to what extent national systems favour expensive late-stage disease response over prevention or early intervention.

Unsurprisingly, these discussions elicited views on how health systems are managed, and how they can be guided. Under the theme of leadership, it was argued that good leaders are needed at all levels of organisations, across all sectors, and throughout every level of society. Being a



leader is a skill, and the meeting looked at the characteristics required of a new generation of public health leaders, so that they not only have public health knowledge, but the skills to communicate and lead the fight to support, promote and improve health. They will also have to be able to adapt to a rapidly changing environment of uncertainty and ambiguity, and capable of planning for resilience in the face of climate change, demographics, increased prevalence of chronic diseases, rising costs, and variations in resources.

Leadership was also urged in meeting the pressing challenges of workforce planning in the face of rising demand, the emergence of new professions for new patterns of care and new specialisations, and the delicate and closely-linked issues of workforce brain-drains in both developed and developing countries.

Countries cannot develop effective workforce policies solely at the national level, particularly in tackling all the social and economic implications of decisions in this field, it was contended. Europe's growing demand for care as its population ages is coinciding with the increasing age of the health workforce. East-west and south-north migration has helped to ease the problem for some western and northern European countries, but patterns of health professional mobility are changing and are often unpredictable. Governments of outward migration countries need to implement strategies to keep their health service personnel at home. These countries may not always be able to compete with destination countries in terms of offering the same levels of pay, but they can look at improving the overall package they would offer to workers and so improve retention (offering

better career prospects, better education for children, political stability). Bilateral agreements between outward migration and destination countries are another policy option recommended to tackle the issues raised by health professional mobility.

## EU role in guidance

Alongside the influence the EU is now exerting on healthcare funding through the European semester, the Forum sessions examined other areas in which the EU may be able to contribute to improving health delivery by Member States. Health remains predominantly a national competence, but that boundary is becoming blurred, not least by the development of cross-border healthcare and social security coordination, and by the increasing impact of global events and decision-making. So the opportunities are there for the EU to play an increasing role in facilitating coordination and, where it is of benefit, collaboration.

Dialogue at EU level between the purchasers of care and the healthcare providers can help to identify common challenges, and to evaluate possible mechanisms to improve outcomes or obtain better value for money. The EU can also play a major role in developing and pooling the data that is needed in order to make robust comparisons and to ensure health services make best use of resources.

In research and innovation too, the potential of the EU was acknowledged, since the scale and complexity of scientific advances - and the regulatory demands they create - are increasingly beyond the capacity of individual countries. There was wide support for stepping up European approaches that

could bring benefits in synergies, in the avoidance of duplication, or in the design of regulatory systems that support innovation or that can overcome the current handicaps that result from fragmentation or the lack of a common vision.

## An interconnected world

The theme of collaboration resonated throughout the EHFG's reflections on solidarity and health in the broader context of an interconnected world.

The discussions on the Ebola crisis highlighted the lack of effective collaborative strategies, and displayed, it was argued, the systemic failure of the global healthcare model. There was sharp criticism of what was seen as inadequate international development assistance and the striking absence of joint work to provide an immediate response. The crisis was also depicted as an expression of long-standing and growing inequalities in access to healthcare services. The EU should from now on be more energetic in raising the underlying global governance issues that have been so long neglected, and in focusing on the promotion of sustainable health system structures rather than relying on short-term crisis responses.

The lack of available vaccines or treatments was also evoked as a demonstration of the deep market failure of research models.

Discussions of health in an interconnected world also ranged across the impending decisions on new global development strategies, and on how to ensure that international cooperation in global health is embedded in foreign policy, and that attention is devoted to the particular difficulties faced by migrant populations.

The post-2015 development goals currently under discussion within the international community should, it was argued, embrace universality and equity at their core. They should go beyond specific disease targets and adopt horizontal approaches tied closely into poverty eradication and tackling inequalities. That, it was maintained, would permit the emergence of functional health systems that address problems holistically rather than vertically. Similarly, Europe should be contributing to setting standards in global health through emphasising solidarity in its discussions of trade or development.

And as an example closer to home, the precarious situation of undocumented third-country nationals and the barriers to medical care they face - even in Europe - were highlighted as contrary to the principles and



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objectives of public health, medical ethics and social cohesion.

## Working together

The dominant theme of the EHFG 2014 was collaboration. The consensus was that only by working more closely together, across a wide spectrum of stakeholders, with new partnerships, and by learning together, would it be possible to construct a health system that Europeans could be proud of. But it was recognised that there was nothing automatic about achieving such a degree of collaboration. Existing healthcare structures are often a barrier for reforms, diverse and divergent interests would have to find reconciliations, and the necessary changes in governance and accountability will require breaking down much of that silo mentality - at national and local level, within health sectors, and among institutions and stakeholders. The shift towards a more comprehensive care continuum will not be easy.

Nonetheless, delegates exhibited a confident determination to overcome the obstacles, and ambitions were high, with repeated suggestions that Europe should aim for a "health union" to equal its commitment to energy union or currency union. The MEPs who came to Gastein expressly invited input from Forum participants to feed into the European Parliament's incipient reflections on health policy. And European Commissioner-designate for Health and Food Safety Vytenis Andriukaitis, while under no illusions about the political will

needed to break down silos, spoke of a new spirit ushering in a new era of promotion, prevention, and protection, so that health is genuinely reflected in all policies.

He too urged the widest collaboration, and promised he would seek input from all stakeholders for a round table that could make a start within weeks on a new agenda.

At a time of widespread public scepticism about the benefits of Europe, better delivery by the health sector could offer a demonstration - in an area of such intimate concern to all Europeans - of the concrete advantages of a strong Europe. But better delivery still has to be achieved. So it is not just a question of electing a Europe of health. As ever in European integration, the best results emerge only from assiduous engagement in the process of making better EU policies. If the health community wants to secure the ambitions it outlined at the EHFG 2014, it will now have to work for them. That is the only way to get "the Europe we want".



# ELECTING HEALTH - THE EUROPE WE WANT!

## OPENING PLENARY

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Written by Laurene Souchet and Wietze Sijtsma

In his opening words, **Helmut Brand**, President of the International Forum Gastein, referred to the election of the European Parliament earlier this year, the current developments regarding the formation of the new Juncker Commission and the growing anti-EU sentiments across the Union. 25% of the new European Parliament is EU-sceptic but Brand is convinced that all the recent discussions also helped to bring the EU back to the table as Eurobarometer shows that 42% of voters believe that their vote counts. He then referred to the mission letter that Jean Claude Juncker sent to the Commissioner-designate for health Vytenis Andriukaitis, pointing out three EU priorities concerning health for the coming years:

- ◆ Ensuring that the Commission is always ready to play its part in supporting the EU's capacity to deal with crisis situations in food safety or pandemics.
- ◆ Reviewing the existing decision-making process applied to genetically modified organisms (GMOs), in line with the Political Guidelines.
- ◆ Developing expertise on performance assessments of health systems, drawing lessons from recent experience, and from EU-funded research projects to build up country-specific and cross-country knowledge which can inform policies at national and European level.

Helmut Brand commenced by introducing the four questions that would shape the subsequent panel discussion:

1. What are the possible developments of the European social model and its core values?
2. After the first 20 years of an EU health mandate what should be the EU's role in health and health systems in the next 20 years?
3. In preparation for the next legislative period and the implementation of its Europe 2020 Growth Strategy, how will the current policy frameworks and instruments have to be used or reviewed in order for the EU to fulfil its role in promoting, protecting and restoring the health of its citizens?
4. As European citizens demand more value for money in healthcare, what can the EU contribute to improving the performance and efficiency of Member States' health systems?

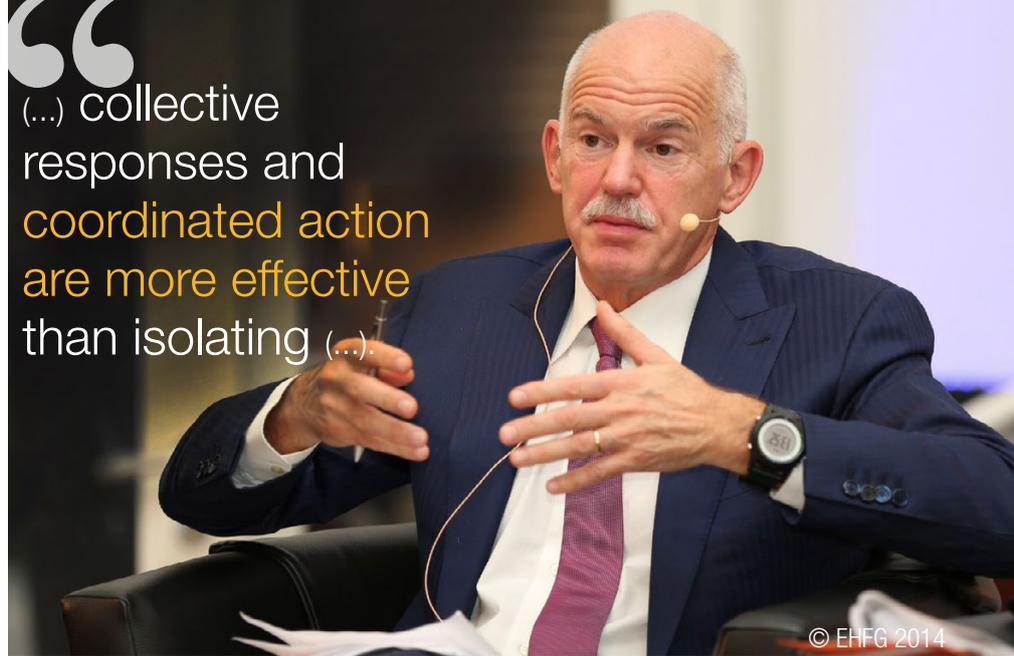
### Keynote speech by George Papandreou

**George Papandreou**, former Greek Prime Minister and President of International Socialists, took the audience back to a side event on the Ebola pandemic at the UN General Assembly earlier this year where

Gambia called on other Member States not to isolate them. This call reminded Papandreou of the reaction of the EU Member States towards Greece in 2008 when the financial crisis hit them. He distinguished two international responses towards his country: 1) this is a Greek problem and 2) Greece *is* the problem!

He emphasised that such an approach missed its goal in 2008 (further increased market pressure) and will also miss its goal now, in the global fight against Ebola and other future pandemics. The financial crisis showed the world the interdependence of nations and taught us that collective responses and coordinated action is more effective than isolating countries. Papandreou stated the importance of this for the current Ebola crisis and that we should not focus on the symptoms but on fighting the cause. With such a collective approach at an early stage irreversible losses and perhaps even a lost generation could have been prevented.

According to the former Greek Prime Minister a strong EU is essential for effective global (health) governance. He stressed that the EU needs to be a global force at the forefront of global trends while laying down the rules. A worrying observation of current trends in the EU is that while everything is crossing borders, politics increasingly stays



George Papandreou

is a word that counts. It is a key concept that has been missing in the debates about the EU in the past years and she wants to bring it back on the table. She also explained her experience as an early supporter of a tobacco ban.

**Martin Seychell**, Deputy Director General for Health and Consumers, European Commission, explained that health is the third major concern of citizens in Eurobarometer surveys. He stressed that we need a paradigm change, as health is perceived as an item of expenditure when actually it is a driver for growth. Regarding the instruments that should be used, he insisted on sharing of information, as every Member State and every region has strong points and weak points. In health, legislative competence is limited, and we have to ensure legislation contributes to the efficiency of health systems. Financial instruments are another key tool, including Horizon 2020. He highlighted the importance of working with stakeholders, giving the example of the platform on diet, physical activity and health. In his view, one key area where Europe has contributed and needs to continue its good work is in the coordination and planning of responses to health threats. Infectious

diseases are not a thing of the past, and finding replacements to some antibiotics could become a life or death question. Seychell called for the necessity to show what citizens get for the money they spend and concluded with the need to identify the potential of health to contribute to growth with eHealth as one example for generating growth and benefiting patients.

**Agis Tsouros**, Director of the Division of Policy and Governance for Health and Well-being, WHO Europe, reminded the audience that health is a political choice. We have good knowledge about the determinants of health, on how to create health, and we are also aware of the consequences of not paying attention to health. Among the key issues at stake in the future, he mentioned universal coverage, and ensuring that we apply the principle of health in all policies. The health of the population could become an indicator that a nation is doing well. Many issues that touch the health system are beyond public health, e.g. youth unemployment, demographic change, migration. When talking about patient-centred healthcare systems, we should remember patients in the EU are multi-ethnic and from different cultural backgrounds. Tsouros views the

at the local level: we need to prevent citizens from becoming alienated from governments and EU politics. At the moment people experience that the EU has lost power and populations move backwards to “narrower families”, like in the UK and Spain.

Papandreou called for more democracy, more citizen empowerment, more education and for deepening our trust in our citizens. He further expressed his hope that governments start to think more out of the box, promote transparency and participation and reinvent the social model with each other: return to our core values!

In the discussion that followed his speech the key question raised was what we can learn from Greece if we consider the social system in the EU as bankrupt. Papandreou confirmed his optimism about the EU but that there is a need to rethink the current model, reorganise it and make it more efficient. The EU needs to realise that if it wishes more cross-border mobility, it is competing with other social models with lower standards and it should thus promote higher standards instead of what happens now: emulating their standards.

## Panel discussion

The moderator **Josep Figueras**, Director of the European Observatory of Health Systems and Policies, gave the floor to the newly elected Austrian Minister of Health, **Sabine Oberhauser**, asking her how the EU could support her in her work as Minister of Health of one the Member States. Oberhauser explained that to her the most important role of the EU is to give a podium to talk to each other and to look across borders. Austria is implementing reforms and she would like to learn from the best. She hopes that the EU is and remains a place where solidarity

“ (...) collective responses and coordinated action are more effective than isolating (...)”

tackling of health inequalities as an essential area where we can all cooperate. He also noted that the financial crisis taught us that nobody is immune to being deprived of social support and entering into a vicious cycle towards disease.

WHO has adopted the strategic framework Health 2020 to suggest priorities and solutions that work. The key issues we need to work together on are addressing health inequalities, universal health coverage and governance for health. We need commitment and the capacity to implement these issues. To this end, Tsouros explained, engaging civil society is essential. He also referred to the Tallinn Charter which contains a strong commitment to act in order to strengthen health systems.

**John Bowis** provided his insight as a former Member of the European Parliament for the UK, and as the father of the Directive on patients' rights in cross-border healthcare. He explained that every generation of new MEPs is told that "the EU doesn't do health". Yet in the treaty health has always been a fundamental principle, though there is no adequate clause for action. He constantly struggled to put health on the agenda, working on mental health, where the European Pact for Mental Health and Well-being can be considered a key milestone. As regards patient mobility, he said that his preference would have been that individuals do not have to pay upfront to go to another EU country to find the care they cannot receive at home. He pointed out some legal uncertainties in the final compromise and said future legal cases are likely to happen. To tackle diseases, he added, we need to look beyond health. WHO and DG Health and Consumers need to enter into discussions with finance ministers. Another example,

“  
Health trends  
are changing  
and we need  
to do more -  
put health  
at the centre.”

Alojz Peterle

of this is air quality, which strongly affects health but is sometimes beyond the remit of health departments. In conclusion, Bowis explained that we need to focus less on cures or treatments and more on outcomes. "We need to listen more to patients," he stated.

**Alojz Peterle**, Member of the European Parliament (EPP, Slovenia), explained that we need more directives like the cross-border healthcare legislation, for example on pesticides or food safety. He strongly endorsed the cross-sectoral approach supported by previous speakers and stated that "A Health Union is more needed than an Energy Union."

Health trends are worrying, for example cancer is moving faster than the solutions put in place. Peterle, as part of the MAC group (MEPs against Cancer), explained that he was currently working on a cross sectoral health intergroup. He also reminded the audience that the highly successful Erasmus programme had no legal basis either in the treaties. He concluded that things are moving forward for health, and believes that we are now at a turning point. "We are all EU citizens. Let's work together!" he concluded. Figueras asked the panellists why health

is not more important for the EU, and how to prove the added value, e.g. whether we need new health indicators?

Papandreou took the example of his own country, famous for its healthy diet, and highlighted the opportunity to make it a wellness centre of Europe.

Oberhauser explained that we need to invest in prevention, even though it is not popular among politicians as the effects are seen much later than the date of the next election. She commented that we also need to stop discussing health in all policies, and finally start acting upon it.

Seychell explained that there are many instances where Europe has proven its added value. Cooperation on rare diseases is one flagship example of where Member States have joined forces on an issue they could not solve alone. This has resulted in establishing the Orphanet network. Another example is that the most downloaded document from the DG Health and Consumers website is a guideline on colorectal cancer. The European Partnership against Cancer is another key achievement. The Tobacco Products Directive is another success, and it allows countries to voluntarily implement stronger standards like plain packaging, which some Member States are considering. Seychell

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Helmut Brand and George Papandreou

concluded with a call for country specific health system performance assessment and customised advice.

Brand summarised the debate by explaining that while speakers analysed the situation very well, the health community still needs to improve on concrete examples. He noted that the key messages of this plenary were:

- ◆ Strong social models make a strong economy;
- ◆ There is low trust in decision-makers, we need to re-focus on European citizens;
- ◆ Investing in prevention and in long-term planning is key.

Brand closed the Opening Plenary by calling for a new strategy for health encompassing these elements.

Detailed session information and materials



## OPENING PLENARY

1 October 2014

**George Papandreou**, former Prime Minister, Greece; President, International Socialist

**Sabine Oberhauser**, Minister of Health, Austria

**Agis Tsouros**, Director of the Division Policy and Governance for Health and Well-being, WHO Regional Office for Europe

**Martin Seychell**, Deputy Director-General, DG Health and Consumers, European Commission

**Alojz Peterle**, Member of the European Parliament (EPP, Slovenia)

**John Bowis**, former Member of the European Parliament (UK)

**Helmut Brand**, President of the International Forum Gastein

Moderated by **Josep Figueras**, Director, European Observatory on Health Systems and Policies

Twitter round-up

**Maggie Davies**, Executive Director, HAPI

**Paul Giepmans**, Young Forum Gastein Network

Organised by International Forum Gastein in cooperation with European Observatory on Health Systems and Policies



# ELECTING HEALTH - THE EUROPE WE WANT!

## CLOSING PLENARY

Written by Alexandra Ziemann and Dimitra Panteli

**Armin Fidler**, Lead Advisor, Policy & Strategy, World Bank, kicked off the 2014 Closing Plenary by commending the resilience of EHFG delegates, who excelled both in sessions and on the dance floor, and creating the link to the four questions that had been posed during the Opening Plenary. He furthermore commemorated the date (October 3rd) and commented on the relationship between the anniversary of the Berlin Wall falling and the conference topic, The Europe We Want.

**Helmut Brand**, President of the International Forum Gastein, provided a recap of the main insights of the EHFG 2014, potential building blocks of a new European health strategy or “EU Health Policy 2.0”.



The four pillars of the European Health Forum Gastein

These insights encompassed:

- ◆ the crucial link between social and health policy with solidarity as the guiding principle;
- ◆ the need for more system preparedness and a ramped-up global effort against epidemics such as Ebola;
- ◆ a renewed focus on prevention and its funding;
- ◆ a smart approach to workforce development with increased attention to investment and the impact of demographic change (“don’t work hard, work smart!”);
- ◆ new (fun) ways to promote healthy behaviours regarding alcohol and food consumption;
- ◆ encouraging citizen participation along the lines of public health initiatives, such as water quality;
- ◆ the further development and deployment of eHealth as well as mHealth as many promising examples were showcased during the EHFG 2014;
- ◆ the continued strive towards value for money in the context of health system performance;
- ◆ the intensified implementation of the Cross-border patients’ rights Directive across Member States.

**Tamsin Rose**, Director, Progress Works, took to the podium to present this year’s EHFG video, which interprets the conference topic, “electing health” as making choices across the health and healthcare spectrum. The video was greeted by enthusiastic applause and served as a bridge and introduction to the policy panel that followed.

Moderator Fidler pointed out that **Vytenis Andriukaitis**, Commissioner-designate for Health and Food Safety, would be sharing his vision and comments with the delegates in his private capacity as he had not yet been formally appointed to office.

The Commissioner-designate informed the plenum that he had many inspired discussions at the conference already in 2013 and was happy to be back. He then provided a short overview of his vision for EU health policy during the next term.

From his viewpoint, the moment was opportune for reviewing what has been achieved and determining what still needs to happen to achieve “The Europe We Want.” He envisions a European Union of Health where cooperation extends across borders and policies and health for all becomes a reality, not least supported by introducing a health protection component in all policies.



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Vytenis Andriukaitis and Armin Fidler

Andriukaitis stipulated that the most important points to keep in focus and work towards included:

- ◆ social problems and combating exclusion;
- ◆ health safety (e.g. regarding food);
- ◆ improving working and living conditions across the EU;
- ◆ eliminating barriers dividing Europe and reducing inequalities.

He also wanted to translate EU Treaties into better health, and recognised that spending on health is not limited to health expenditures but also investing in human capital and productivity.

He outlined the important help the EU can provide in boosting performance, efficiency and sustainability of national health systems, and the crucial nature of data and indicators if performance is to be improved in a sensible, durable manner. He discussed investing in health professionals (“How do we get the right professionals in the right places?”), the promotion of eHealth, and expanding the joint procurement agreement for vaccines. He stressed that a general motto across these focal areas were the three Ps of “Prevention-Promotion-Protection.” With these three components in mind, his aim is to breach the health divide in Europe and

transform EU laws passed in recent years into improvements that will affect the daily lives of European citizens, shaping together a Europe for Health.

Before inviting the four panellists representing the four EHFG pillars, namely civil society, science, research and academia, business and industry and government and administration to give their introductory statements, Fidler pointed out that the Commissioner-designate had been a champion of health in other sectors already as the Lithuanian Minister of Health.

**Nicola Bedlington**, Executive Director, European Patients’ Forum (EPF), said that EPF welcomed many of the points mentioned in the Commissioner’s vision and called for patient-centred, high quality, equitable health for all. She underlined that patients should be viewed as part of the solution, contributing to sustainable health and inclusive healthcare and pointed out that genuine access and participation are intrinsic to the social model.

From the science and research viewpoint, **Bonnie Wolff-Boenisch**, Head of Research Affairs, Science Europe, pointed out the importance of research both for identifying

social solutions and for stimulating the economy. It is paramount that the assets we have in Europe in terms of research are maintained, but research should be more goal-oriented and based on cross-sectoral collaboration. Most importantly, academia needs to have a long-term plan and look beyond 2020 and the political agenda, in other words have a vision for the next 20 years.

**Boris Azaïs**, Director, Europe and Canada, MSD, followed up by stressing the need for broad platforms that enable exchange and collaboration and the EHFG being a testament of how the debate can be moved forward. Different stakeholders need to come together as no single one has all the solutions. Collaboration is key. For example, while the government is in the driver’s seat regarding pharmaceutical innovation, there can be no real innovation without investment in science and without a functional healthcare system. At the same time, there is a need for a change in the nature of partnering across the value chain, introducing much more dialogue early on.

**Karin Kadenbach**, MEP, Austria initiated her contribution by stating that the European Parliament relies on people such as the EHFG participants for input and contributions. While patients are undoubtedly of paramount importance, we need to start earlier on with citizens by investing in prevention and people empowerment, thus fostering understanding and a greater tendency to make healthy choices. Furthermore, she called for action to eventually achieve Health-in-all-Policies. She spoke out with a request to President-elect Jean-Claude Juncker to reconsider the planned shift of responsibilities on pharmaceuticals and medical devices from

DG Health and Consumers to DG Enterprise (Note: In the ensuing weeks the shift was cancelled.).

Peter O' Donnell, Associate Editor, European Voice, picked up the new Commission's portfolios issue and wondered whether a loss of momentum could be identified. In relation to that, Fidler reminded the plenum of President-elect Juncker's adage that "the whole is greater than the sum of its parts" and asked Commissioner-designate Andriukaitis for his own interpretation. In response, Andriukaitis noted that in all 10 commandments of the new Commission he could see possibilities for health, be it in relation to the workforce (as the health sector is a major employer), education or digital innovation. He confirmed his strong believe in inter-sectoral collaboration towards a health economy with reduced risk factors that would improve European recovery. In his mind, Commissioners are the bodyguards of the Treaties, and sincere cooperation is key in terms of moving forward. He saw the EHFG as a unique opportunity in this sense, as participants can both bring questions from their countries and take messages home.

In a final round among the panellists, Bedlington stressed the importance of health literacy, which brings together prevention and patient-centred management of chronic conditions. To realise it, we need robust, high-quality, understandable information. Wolff-Boenisch followed in a similar direction, saying that scientists need to learn how to explain their work to other stakeholders if they wish to contribute not only to health, but also to system and data literacy.



Jochen Mikolajczak and Tamsin Rose

Boris Azaïs agreed with the Commissioner-Designate on the importance of health economy and supplemented that the real cost is disease itself and that is not comparable to the money spent on healthcare. Siloing of budgets is an issue for industry as new technologies can be disruptive to overall budgets. On this front, discussions are ongoing with HTA agencies. As an industry representative he remained optimistic, as he mentioned that society and governance signalled "We want innovation". Kadenbach reiterated that health is instrumental to building trust in Europe and all decisions should have people in their focus, not financial markets or banks. On the benefit of a United Europe, she commented that health should be on top of the agenda as it is a value in itself and is not just a driver for growth. Only with a healthy environment, workforce and food can there be a strong, united Europe.

As a parting comment, O' Donnell provided food for thought by wondering why all Commissioners are connected to a team except Competition and Health. Referring to President-elect Jean-Claude Juncker's vision of a European Union that is bigger on big things and smaller on small things, he put forward his worry that health could become the "neglected child" that is overlooked as a "small thing" within the new Commission's priorities.

The insights from Twitter endorsed honest cross-sectoral collaboration but warned about cementing people in their silos. This was an ideal cue for Commissioner-designate Andriukaitis who wrapped up the panel by reminding the plenum (and Twitter!) that he is there to listen, he is open-minded, and has the platform to interact together on the way to act together!

In his closing words Brand called for the "new" three-P-model of **Prevention-Promotion-Protection (PPP)** to become the health motto for the European Commission for the next five years.



## CLOSING PLENARY

3 October 2014

**Vytenis Andriukaitis**, Commissioner-designate for Health and Food Safety

**Nicola Bedington**, Executive Director, European Patients' Forum

**Boris Azaïs**, Director, Europe and Canada, MSD

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

**Peter O'Donnell**, Associate Editor, European Voice

**Helmut Brand**, President of the International Forum Gastein

Moderated by **Armin Fidler**, Lead Advisor, Policy and Strategy, World Bank

Video presentation

**Tamsin Rose**, Progress Work, Belgium

Twitter round-up

**Tamsin Rose**, Progress Work, Belgium

**Jochen Mikolajczak**, Young Forum Gastein Network

Organised by International Forum Gastein



European Health Forum Gastein 2014



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EHA Sponsors 2014: Ingo Raimon (FOPI), Peter Brosch (Austrian Ministry of Health); EHA Winning Project 2014: Marie Roseline Belizaire, Massimo Fabiani; EHFG Honorary President Günther Leiner

### European Health Award

The European Health Award (EHA) highlights and rewards an initiative involving collaborative working in at least two European countries, which contributes in a clear and significant way to meeting some of the challenges facing Europe such as disparities in health status, access to services and the provision of treatment within Europe.

#### European Health Award Sponsors 2014

- ◆ Austrian Federal Ministry of Health
- ◆ Austrian Research-based Industry Association (FOPI)



Forum der forschenden pharmazeutischen Industrie in Österreich

FOPI

### EHA 2014 Winner: EpiSouth Plus Project

The EpiSouth Plus Project is aimed at increasing health security in the Mediterranean Area and Balkans by enhancing preparedness to threats, which can affect health security, and to bio-security risks at national/regional levels in the framework of International Health Regulation implementation. Building upon the Network of 27 EU and non-EU Countries established by the previous project EpiSouth (2006-2010), the whole initiative has lasted more than seven years (2006-2014). The project has strengthened countries' capacity to cope with health threats through concerted and coordinated capacity building activities, including the establishment of a Mediterranean Regional Laboratories network; promotion of common procedures in interoperable Generic Preparedness and Risk management among the countries involved in the Network; enhancement of Mediterranean Early Warning Systems (EWS) allowing alerts and Epidemic Intelligence (EI) information sharing among EpiSouth countries and developing interoperability with other Early Warning Systems, including the European EWRS; production of guidelines and a strategic document based on assessments and surveys aimed at facilitating IHR implementation.



# PUBLIC HEALTH LEADERSHIP TO REDUCE INEQUALITIES AND IMPROVE HEALTH

## FORUM 1

Written by Hannah Brinsden, Ute Linnenkamp, Peter Ravn Riis and Amalia Vinogradova

Leadership is a complex and constantly evolving topic and the importance of understanding and harnessing effective leadership as part of achieving public health goals is critical.

Forum 1, organised by the Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C, focused on leadership in public health. Specifically it explored the kind of leaders that are required to champion public health issues and the values and skills that those leaders require, an issue that is becoming ever more important in the context of rapidly changing environments throughout the EU.

The sessions covered theoretical issues, such as defining public health leadership and the educational requirements, and focused on the practical application of leadership, drawing on a number of different perspectives including patient, government and civil society.

### Investigating leadership excellence to improve health and reduce inequalities

#### The theory and practice of public health leadership to tackle inequalities

The forum looked at the theory of public health leadership is and the role that it plays in tackling inequalities, a key global challenge in public health today. The opening words from **Ma Ying-jeou**, President, Taiwan, R.O.C., set the tone for the forum, defining public health leadership as being about taking action to do the right thing so as to improve the health of citizens.

The first speaker, **Katarzyna Czabanowska**, Associate Professor at the Maastricht University, explored the requirements for educating a new generation of public health leaders who are fit to face the challenges of public health in Europe. Presenting findings from a study “Public health in the 21st century: working differently means leading and learning differently,” Czabanowska identified a number of key leadership competencies required in 21<sup>st</sup> century public health, including collaboration, inter-professional action, interdisciplinary work, and a global and digital consideration. This

Public Health Leadership Competency Framework  
Source: Czabanowska K, et al. In search for a public health leadership competency framework to support leadership curriculum—a consensus study. Eur J Public Health. doi:10.1093/eurpub/ckt158



requires young upcoming leaders in public health today to take on the challenge of horizontal leadership, rather than working top-down or within disciplinary silos.

Harry Burns, Professor of Global Health, University of Strathclyde, then presented a need for public health leadership to challenge conventional thinking, maintaining that major advances in healthcare status are achieved through small incremental changes. He focused on the challenge of health inequalities and the flaws of traditional models of thinking in health - that a cause is followed by a disease and the aim of public health is to protect the population from that cause. This, he argued, oversimplified the health problems we are faced with today, where tackling the social determinants of health (especially providing a secure, early start in life) are key. Burns highlighted a quote by Edgar Schein, Professor Emeritus, MIT Sloan School:

"You can't impose anything on anyone and expect them to be committed to it." and he urged public health leaders to focus on co-creating well-being and wellness to empower people with a positive outlook, a sense of control over their life, a purpose and meaning in life, confidence in their ability to cope with problems and, last but not least, a sense of community as family and peers. Echoed in other EHFG 2014 sessions, he also argued for a better balance in Europe between corporate responsibility and the need to grow economies.

#### Leadership from a patient perspective

Building on the need to move away from top-down leadership, Sara Riggare, Doctoral Student at the Karolinska Institutet, presented her own experience of patient leadership, having been diagnosed with

Parkinsons at a young age. She described two main forms of leadership that can come from the patient - either by increasing self-care which enables patients to take a greater leadership role in their own health and treatment, or through patients playing an active role in organisations at local, national and international levels, advocating for patient rights so as to initiate "bottom-up" changes.

#### Leadership from an NGO perspective

Civil society, particularly NGOs, also play an important role in leadership, bridging the gap between citizens and governments. Jin-Chuan Sheu, President and Hsiao-Ching Nien, CEO of the Liver Disease Prevention and Treatment Research Foundation in Taiwan, described the work of the Foundation and how it had successfully

managed to address the major challenge of hepatocellular carcinoma, a disease that mainly results from chronic hepatitis B and C in Taiwan. Their work involved a process of education, screening and research focused around building a cooperative relationship between different sectors so as to stimulate action.

#### From local to international health leadership, and prospects for the future

##### Effective local-level leadership in Taiwan and Europe

A local initiative from Taichung City to support healthy ageing was presented by Jason Hu, Mayor of Taichung City, via pre-recorded video. Under the slogan "Getting Grey is Great in Taichung City!",

# DON'T FORGET TO BE COMMITTED NOW!

YEAH, SURE!  
I WILL DO!



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"YOU CAN'T IMPOSE A SET OF RULES & EXPECT PEOPLE TO BE COMMITTED!"

he described how the local government was able to promote a series of political initiatives, such as subsidies on buses and housing, learning centres, an annual Senior Day and support for local networks, using strong local support and leadership.

**Shpend Ahmeti**, Mayor of Pristina, Republic of Kosovo, then presented a series of examples to show how local government leadership and advocacy can be important to overcome local problems efficiently. One of Ahmeti's main points was that national government efforts often experience delays in tackling local level problems, for example within education, infrastructure and healthcare. Therefore, a bottom-up perspective is necessary, with local action by local politicians in order to tackle local problems.

#### **Effective national-level leadership in Taiwan**

**Shu-Ti Chiou**, Director-General of Health Promotion Administration, Ministry of Health and Welfare in Taiwan, introduced a 5-step model of how national leadership can lead to change in healthcare. The central idea of the model is that leadership involves influencing

the whole government and the whole of society in order to achieve equitable and sustainable gains. Importantly it was noted that good public health leaders will not only lead the direction but will also have followers who support, engage and initiate change. Taking Taiwan's Age-Friendly-City initiative as an example, Chiou showed how the model had been used to create and implement new policies on healthcare. Among the tools were the creation of positive competition between cities, collaboration with academic experts and NGOs and an extensive focus on the evaluation of performance and the selection of best practices.

#### **International leadership within the EU**

Using the example of cancer as a key health challenge for the European Union, **Alojz Peterle**, Member of the European Parliament (EEP, Slovenia), presented the need for strong leadership at the European, national and family level. He described how it is not always new research or new funding that is needed, sometimes political will is the most important requirement. Giving the example of Members Against Cancer (MAC), he highlighted the importance of having a cross-party and cross-sectoral

group that can have a strong influence on parliamentary decisions, working with NGOs to ensure that the issue of cancer remains high on the political agenda at all times.

For **Ilona Kickbusch**, Director of the Global Health Programme, Graduate Institute of International and Development Studies, Switzerland, health is a political choice at all levels of governance and it is therefore crucial that our advocacy and leadership efforts are political.

Kickbusch highlighted two key areas of leadership within her presentation. The first was the role of leaders in increasing health literacy, ensuring that parliamentarians, as well as the citizens who elect them, understand and value health policies and decisions, particularly where resources should be invested. The second issue she raised focused on the need to not always look inwardly at what the EU needs to do for itself, but also to look at what the EU is doing for global health, and also across sectors outside health.

She drew on Tonio Borg's farewell speech, where he stated that "regarding health matters in the EU, the European Union is not a union. Why not? We have health issues not only between Member States but also within Member States." As a final remark, Kickbusch underlined that leadership is contagious, in a positive sense, and you learn different things from leaders at different levels.

This year's conference focus was "the Europe we want." This forum was particularly relevant to this topic as what we need for Europe is strong, effective, knowledgeable leadership.

Demanding what we want, whether linked to services, care, eHealth, prevention or

“Health is a political choice at all levels of governance.”



policies, requires such leadership, whether it be a national government taking the lead, an NGO demanding action, the EU uniting on an issue or patients having a voice. Not only that, we need multiple levels of leadership, which can help to address multiple problems, in a way that helps people throughout the Union.

### Policy recommendations

Drawing on the range of presentations, a number of key points on public health leadership can be made.

- ◆ Inter-sectoral, cross cutting public health leadership requires **training in leadership at multiple levels of education**, in all levels of society and across all disciplines.
- ◆ Public health leaders **need to challenge conventional** thinking in health and consider not just the health implications, but the wider issue of wellness, compassion, patient empowerment and ownership, and how this can be used/utilised to improve health.
- ◆ **Effective leadership** does not necessarily require money - but it does require informed **leaders with ideas for people to follow and above all passion** so that people are inspired to achieve health.
- ◆ Health is a political choice at all levels of governance. The EU therefore needs to better **engage citizens** in the issues and decisions made on health, and **invest in health literacy** for all.
- ◆ **Downstream, bottom up and local level commitment and involvement** is vitally important for health policies and programmes to succeed.

Detailed session information and materials



#### FORUM 1

1 October 2014

**Katarzyna Czabanowska**, Associate Professor, Maastricht University, the Netherlands

**Harry Burns**, Professor of Global Health, University of Strathclyde, UK

**Sara Riggare**, Doctoral Student, Karolinska Institute, Sweden

**Jin-Chuan Sheu**, President, Liver Disease Prevention & Treatment Research Foundation, Taiwan, R.O.C.

**Hsiao-Ching Nien**, CEO, Liver Disease Prevention & Treatment Research Foundation, Taiwan, R.O.C.

Moderated by **Harry Rutter**, London School of Hygiene and Tropical Medicine, UK

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

Detailed session information and materials



#### FORUM 1

2 October 2014

**Jason Hu**, Mayor of Taichung City, Taiwan, R.O.C

**Shpend Ahmeti**, Mayor of Pristina, Republic of Kosovo

**Shu-Ti Chiou**, Director General, Health Promotion Administration, Taiwan R.O.C.

**Alojz Peterle**, Member of the European Parliament (EPP, Slovenia)

**Ilona Kickbusch**, Director, Global Health Programme, Graduate Institute of International and Development Studies, Switzerland

Moderated by **Harry Rutter**, London School of Hygiene and Tropical Medicine, UK



# BUILDING EU HEALTH POLICY FOR THE FUTURE

## HEALTH ♦ GOVERNANCE ♦ GLOBAL

### FORUM 2, SESSION I

Written by Gabriele Pastorino and Elisabeth Kasilingam

The forum was introduced by **Martin Seychell**, Deputy Director-General, DG Health and Consumers, European Commission, who stressed the importance of global health governance from the European Union's perspective and pointed out the role played by the EU on global health and the actions it should be taking and leading as key issues.

**Ilona Kickbusch**, Director, Global Health Programme, Graduate Institute of International and Development Studies, Switzerland, gave an overarching presentation on global health domain governance that set the scene for the overall forum.

Global governance implies a system of rules, processes and institutions, which function and operate at the global level and provide the frame within which actors interact and take decisions. In order to structure cross-border collective actions, there is a need for institutions, rules, instruments and processes and a whole range of actors. It is therefore important to define what is needed, what has to be maintained and protected and what should be reformed.

Kickbusch stressed, by quoting Robert Cooper, that while in the past it was enough

for a nation to look after itself, today that is no longer sufficient. Good global health begins at home, and this means in Brussels for the EU. The positions taken at Member State (MS) level are essential. There are however a number of challenges in governing global health that include:

- ♦ The increasingly political nature of the global health agenda;
- ♦ The power of global industries - the health industry but also food, tobacco, alcohol industries;
- ♦ The clash of norms and ideologies;
- ♦ The rise of sovereignty and nationalism;
- ♦ The use of health as a political tool.



The governance and diplomacy interface.

© Ilona Kickbusch, 2014.

During the rest of the session the topic was approached from three different angles.

#### **Global health governance: The EU working “with and at” WHO**

The panel assessed the role played by the EU in the WHO governing bodies at a time when the WHO is undergoing a reform process. It also considered the cooperation processes put in place by the EC and the WHO.

**Louise van Schaik**, Senior Research Fellow, Clingendael Institute, set the scene for the debate with a presentation highlighting the key EU foreign policy characteristics. These include the dilemmas of EU representation in Multilateral Organisations and its collaboration with WHO both in terms of content and formal structures.

The presentation stressed that while the EU is a standard setter and policy innovator in many areas, its unity becomes problematic when it is represented in multilateral organisations such as the WHO. Thus leading to the question, whether the EU a common voice? The EU has shared competence with the MS, therefore more unity between Member States will automatically lead to



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Ilona Kickbusch, Louise van Schaik, Lourdes Chamorro and Leen Meulenbergs

increased negotiating power.

There is an increasing need for the EU to be involved in international health policy. This creates more pressure on the EU Member States to coordinate better and to operate through a common and single voice.

The presentation was followed by a debate that took on the perspectives of **Lourdes Chamorro**, European External Action Service (Delegation in Geneva), and **Leen Meulenbergs**, Executive Manager, Strategic Partnerships, WHO Regional Office for Europe, both actively engaged in making this coordination mechanism between the EU and WHO possible.

Chamorro stressed the fact that the EU has a strong and genuine commitment to the UN system, and thus to WHO. Health policy debates which might divide MS in the EU context (Brussels) do not create division when the EU talks at global level. This proves that unity and EU common values are stronger when discussed with the rest of the world. Also, there is a political will that has been formally stated by the European Council confirming that the EU should have a role in global health and recognising WHO's role and valuing the UN system. The key challenge for the future will be to ensure that the EU becomes increasingly able to speak with one voice.

Meulenbergs stressed that the last five years have brought a major change in the EU-

WHO relationship, strategically supported by Zsuzanna Jakab, WHO Regional Director for Europe. Since 2010 declarations on specific collaboration with the Commission in key areas have been signed. This included health security, health information, research and innovation and collaboration in countries with a focus on health systems strengthening. What matters is not only what is stated in the formal decision bodies but also the day-to-day collaboration. In the last five years a big change in the proceedings of the World Health Assembly and Regional Committee were observed, with more common EU statements being made by EU Member States leading to other EU Members States aligning. Speaking with one voice is therefore already happening increasingly.

Kickbusch stressed in her closing remarks that strengthened collaboration between different entities (EU/WHO, but also EU Council, European Parliament) was a major step towards better policies. One of the main challenges faced by the EU to become more powerful in the different health fora is to be able to talk with one voice.

### **Global governance for health, EU trade and health policies**

The second panel looked at how other global policy areas have direct and indirect effects on global health. International trade and regulatory cooperation was taken as an

illustration of that process in the particular context of the negotiation of the Transatlantic Trade and Investment Partnership (TTIP).

**Meri Koivusalo**, National Institute for Health and Welfare, Finland set the scene providing a presentation on the key issues for health policies related to trade.

She provided an overview of the challenges that European health policy faces when trade agreement negotiations take place. This involves not only the issue of the national policy space for health being under question but also the negotiation practices based on previous agreements, the lack of transparency and the fast pace of some of these negotiations, and, last but not least, the scope for action for the health community. Health and trade issues range from health services to health protection, health promotion and issues related to access, affordability and safety of new medicines and medical devices. Challenges with respect to TTIP are not only about maintaining existing standards, but also how and on what basis health and health-related products are regulated. It was discussed in particular how trade negotiations affect the precautionary principle and how to achieve a higher level of health protection in future. The presentation was followed by a panel debate that included **Ratso Signe** from DG TRADE, European Commission and **Emma Woodford**, Interim Secretary General, European Public Health Alliance. Signe introduced the TTIP and reminded us

that health safety is a very important priority for the EU and that DG TRADE holds dialogues with stakeholders in the development of this key agreement. She underlined that trade agreements should take into account health issues and involve different stakeholders in the discussion. She also remarked that the dialogue in the implementation of the TTIP is unprecedented. There are different mechanisms of involvement currently in place such as stakeholders groups and dialogues explicitly organised to discuss areas of concern. Regarding the security for medical devices Signe reminded the audience that EU is committed not to lower the level of protection, as a non-negotiable value. Trade policy interacts with health policy and the right balance should be found to integrate them.

Woodford stressed that in the absence of a proper impact assessment made by DG TRADE it is hard to say what the impact of the TTIP on the health sector would be. She mentioned a number of areas of concern for the health community such as: how to ensure health protection in a free trade world; how to guarantee employment standards in the healthcare sector and how to respond to threats from tobacco companies challenging governments that aim to legislate in favour of public health in the future. Woodford also mentioned that the international dispute settlement raised 190.000 responses to the public consultation, signposting real concerns related to this agreement. She concluded by making a call to the health community to bring greater awareness of the consequences of these negotiations and their potentially negative impact.

### Governance for global health: EU and national strategies for global health

The third panel looked at the mechanisms and policies designed by health authorities, both at EU and Member State levels, to achieve coherence between internal and external policies through global health strategies. The 2010 Commission Communication on global health and some of the national strategies were assessed and discussed and common goals and values highlighted.



**Mathias Bonk**, Researcher, Ruprecht-Karls University Heidelberg, set the scene for the third panel by providing an overview of the new global health governance trends and some examples of national global health strategies developed by Member States.

A debate that involved **Kevin McCarthy**, DG Development and Cooperation – EuropeAid, European Commission, and **Björn Kümmel**, Ministry of Health, Germany, followed.

McCarthy stressed that the role of the EU has changed over the years and has improved enormously in the recent past. In terms of global health, the recent crisis in West Africa has brought health security to the top of the EU agenda and there is now pressure to use indicators to show how and where EU funding is being used.

Kümmel shared the experience of the German government of developing and adopting a white paper on global health. The lack of German profile in global health was criticised a few years back. The Global Health Strategy was used by Germany as an opportunity to enhance coordination among ministries. The process started with an evaluation, involved civil society consultations, was embraced at government level and had the support of the Chancellor. One of the current issues Germany is facing is the need to develop research capacity building on these themes. Among the EU Member States only the United Kingdom has started to strengthen its research capacity building and Kümmel suggested action at European level, with the Commission launching a call on global health research to boost the debate.

**Christoph Aluttis**, PhD Candidate, Maastricht University, and a representatives of the Young Forum Gastein initiative, made some final remarks highlighting the key outcomes of the panel discussion, and Kickbush closed the forum by stating that the EHF offers a great opportunity to continue the discussion on global health strategies with the key health community stakeholders and other stakeholders such as DG Trade.

# BUILDING EU HEALTH POLICY FOR THE FUTURE

## STAKEHOLDER INVOLVEMENT ♦ SCIENTIFIC COMMITTEES

### FORUM 2, SESSION II

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Written by Anna Gallinat and Sabrina Montante

#### **Stakeholder involvement: Not enough, just right or too much of a good thing?**

While there is broad agreement that health is a matter of relevance across policies and that its promotion requires the commitment of multiple actors, there is room for discussion as to what concerns the right balance in the relationship between public health authorities and stakeholders. The question at the outset of this panel was: how much and what type of involvement should stakeholders have in the development of public policy in the field of health?

**Artur Furtado**, Health Determinants Unit, Directorate General for Health and Consumers and **Peter O'Donnell**, Associate Editor, European Voice, opened the first part of this second forum and set the scene.

They asked the two panellists to take opposite points of view and Furtado highlighted that both the panellists and the audience were invited "to go beyond political correctness" to have a truly lively debate.

**Hanne Melin**, Policy Strategy Counsel EMEA, eBay, took the stage and explained in a passionate talk how she envisioned

what she called "smarter intervention". This "sophistication of regulation" depends on partnerships between policy-makers and all "agents" involved. These "agents" can be individuals or crowds, experts or non-experts, and they can be of a public or private nature.

In an age of non-linearity, hyper-connectedness and technology that underpins everything, including health, Melin called for policy-making to deal with the uncertainties of our society and of our time. From her point of view, traditional top-down regulation is not sufficient anymore. She appealed to policy-makers to be leaders that enable (by helping new ideas to emerge) and make sense (interpreting rather than creating them). She suggested the complex matter of policy-making and regulation should be performance-based and always underpinned by data. Melin also mentioned the importance of dialogue and of a common language shared by all actors. She concluded by saying that rather than arguing for less regulation, she would prefer to call for a better structure and method in regulation, i.e. for smarter intervention.

**David Stuckler**, Professor of Political

Economy and Sociology, University of Oxford, took quite an opposite stand. Though less futuristic, Stuckler's talk was equally passionate when he described the well-researched tactics of lobbyists. Tobacco, alcohol, soft drink and processed food industries use similar tactics to defend deregulation and free access to markets and to box in public health initiatives. These tactics can range from "buying science" and co-opting health professionals to influencing voters, lobbying politicians or "simply" playing hardball (i.e. threatening to cut funding, etc.). According to Stuckler, regulation for food and alcohol is about 50 years behind that of tobacco. Another issue raised by Stuckler was that of the impact-assessment procedures that help prepare EU public health regulations. While they are meant to take into account multiple voices in a balanced way, in practice industries vastly overpower the health sector.

This session offered a genuine exchange of different opinions.

As intended, the panellists did not a priori force themselves into a non-existent consensus on whether there should be more



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or less stakeholder involvement in public health. Since the relationship between industry and public health professionals can sometimes be frustrating, Melin started from a more a difficult stand. Nevertheless, calling for smarter regulation (rather than for less regulation as so often is done by industry) resonated well with the audience. On the other hand, Stuckler's fierce case, based on the existing evidence on the (mis)use of industry power, left the listener wondering how carefully one must tread the road of less (or smarter) regulation.

### Scientific advice: Between innovation and health protection

When preparing its policy and proposals relating to consumer safety, public health and the environment, the Commission relies on independent Scientific Committees to provide sound scientific advice and to draw attention to new and emerging problems. Their opinions are vital for policy-makers to ensure the highest level of health and environmental protection that European citizens expect from the EU institutions. The aim of this final session was to exchange experiences of the working of the EU Scientific Committees, as well as of

the principles governing their functioning. Moving from specific opinions, the workshop addressed the question of how best to ensure the appropriate involvement of stakeholders and citizens.

Participants from the European Commission, the scientific communities and healthcare professionals, from European patient organisations and from industry shared their own experience and perspective on how to effectively contribute to EU policy-making.

#### Overview of the European Commission Scientific Committees

Donata Meroni, Deputy Head Unit, Health Information Unit, DG Health and Consumers, European Commission, presented the Scientific Committees that have supported the Commission in preparing its policy and proposals relating to consumer safety, public health and the environment since 2009. There are three Scientific Committees:

- ◆ Scientific Committee on Consumer Safety (SCCS),
- ◆ Scientific Committee on Health and Environmental Risks (SCHER) and
- ◆ Scientific Committee on Emerging and Newly Identified Health Risks (SCENIHR).

Following an open call for expressions of interest, the Commission appointed the members of these Committees on the basis of their expertise in one or more fields of competence. Members are well-established scientists with more than ten years of professional experience and multi-disciplinary accomplishments. Criteria for the selection are competence, independence, geographical coverage and gender balance. In addition to the members, external experts may be invited into working groups when external expertise is needed on a specific subject.

The objective of the Scientific Committees is to support the risk management decisions across a variety of policies. Meroni highlighted the important separation between risk assessment and risk management. What the members of the Scientific Committees do is to provide independent scientific advice describing the level of risk. Risk managers can then use this advice to make decisions, taking into consideration other relevant aspects. The separation between risk assessment and risk management is at the core of EU policy-making.

Meroni also highlighted the importance of communication in working with the support of the Scientific Committees as they can easily be exposed to criticism with regards to transparency. Furthermore, lack of proper communication can cause either underestimation or overestimation of the risks. For these reasons, information needs to be available online and shared publicly. The Scientific Committees are supported by a secretariat, which is located in DG Health and Consumers. The Inter-Committee Coordination Group, composed of the chairs and vice-chairs of the three Committees,

helps coordinate the Committees. Meroni's presentation launched a debate on the risks and opportunities of working with Scientific Committees and the role of NGOs, healthcare professional organisations and industry in the development of public policy in the field of health.

**Breda Flood**, European Federation of Allergy and Airways Diseases Patients Associations (EFA), opened the round table discussion by stressing the importance of involving NGOs in order to raise public health concerns that might not have been considered and to give the citizens and patients a proper voice.

She presented the position of the European Federation of Allergy and Airway Diseases Patients Association on fragrance allergens in an open consultation by the EU Commission. EFA's position refers to the new Opinion on fragrance allergens and cosmetic products prepared by the Scientific Committee on Consumer Safety, which only includes contact allergens, Flood pointed out. Yet, it has been recognised that perfumes also expose the eyes and naso-respiratory tract to allergens and that 2-4% percent of the adult population is affected by respiratory or eye symptoms. Approximately 1-3% of European citizens and 16% of eczema patients are affected by allergies caused by cosmetics containing fragrances. Flood pointed to the need to put consumers in the position to choose by ensuring a comprehensive approach towards citizen safety.

On the other hand, **Matthias Vey** from the International Fragrance Association (IFRA), responding to the same Opinion developed by SCCS, firmly believes that the recent Opinion demonstrated the need for a multi-stakeholder approach and proposed a cooperative approach and a formal

process to review and revise protocols, methodologies and the definition of criteria. IFRA also suggested using technologies to help consumers obtain detailed, accurate and beneficial information to evaluate a product.

**Eduardo Rodriguez-Farré** introduced the Scientific Committee on Emerging and Newly Identified Health Risks (SCENIHR), which recently issued an opinion on "The safety of dental amalgam and alternative dental restoration materials for patients and users."

**Edith Bon** from World Alliance for Mercury Free Dentistry (WAMFD), a coalition of NGOs dedicated to ending dental mercury pollution, pointed out that although SCENIHR has now given more attention to the rising threat of dental mercury pollution, concerns remain as to how much it is adequately addressing the health concerns scientists have. WAMFD works with NGOs, dentists, and dental patients on six continents and throughout the EU Member States.

**Sara Roda** from the Council of European Dentists shared the dentists' perspective.

The conclusions were based on the two main questions of: what we expect from the Scientific Committee and how we can improve?

Meroni stressed once again the importance of keeping separate the two phases of risk assessment and risk management. However, the two questions raised important challenges that still need to be further addressed.

Firstly the capacity of the Scientific Committees: What can really be done in such a short time? Secondly, the importance of the involvement of all stakeholders (including civil society organisations and

especially patient organisations) in the public health debate. Thirdly a formal process for a multi-stakeholder approach that will ensure independence, and fourthly more data, but most of all, better coordination across sectors.



## FORUM 2

1 October 2014

**Martin Seychell**, Deputy Director-General, DG Health and Consumers, European Commission

**Louise van Schaik**, Senior Research Fellow, Clingendael Institute

**Lourdes Chamorro**, Health and Social Affairs, European External Action Service (EEAS)

**Leen Meulenbergs**, Executive Manager, Strategic Partnerships, WHO Regional Office for Europe

**Meri Koivusalo**, National Institute for Health and Welfare, Finland

**Ratso Signe**, DG TRADE, European Commission

**Emma Woodford**, Interim Secretary General, European Public Health Alliance

**Mathias Bonk**, Researcher, Ruprecht-Karls-Universität Heidelberg, Germany

**Kevin McCarthy**, DG Development and Cooperation - EuropeAid, European Commission

**Björn Kümmel**, Ministry of Health, Germany

**Christoph Aluttis**, PhD Candidate, Maastricht University, the Netherlands

**Iлона Kickbusch**, Director, Global Health Programme, Graduate Institute of International and Development Studies, Switzerland

Organised by DG Health and Consumers, European Commission

This Forum is part of the 17th EHFG conference which has received funding from the European Union, in the framework of the Health Programme (2008-2013).



## FORUM 2

2 October 2014

**Hanne Melin**, Policy Strategy Counsel EMEA, eBay

**David Stuckler**, Professor of Political Economy and Sociology, Oxford University, UK

**Eleanor Brooks**, Lancaster University; Research Associate, European Public Health Alliance

Moderated by **Peter O'Donnell**, Associate Editor, European Voice

**Donata Meroni**, Deputy Head Unit, Health Information Unit, European Commission

**Edith Bon**, World Alliance for Mercury Free Dentistry

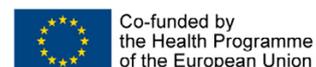
**Breda Flood**, European Federation of Allergy and Airways Diseases Patients Associations (EFA)

**Sara Roda**, Council of European Dentists (CED)

**Eduardo Rodríguez-Farré**, Scientific Committee on Emerging and Newly Identified Health Risks (SCENIHR)

**Matthias Vey**, International Fragrance Association (IFRA)

Moderated by **Thomas Platzek**, Chair of the Scientific Committee on Consumer Safety (SCCS)



# BALANCING CARE COORDINATION AND PATIENT CHOICE

## SOLVING THE CONUNDRUM

### FORUM 3

Written by Magda Filonowicz and Lies Lammens

The session was opened by **Sabine Oberhauser**, Austrian Minister of Health, who briefly introduced the subject of the ongoing health reform in her country. **Clemens Martin Auer**, Director General of the Austrian Federal Ministry of Health, stated further that balancing care coordination and patient choice in the context of the reform implies facing cultural fears. The current system is characterised by broad patient choice. In order to strengthen care coordination it will be necessary to get more health professionals to work in primary healthcare (especially in rural areas) as well as to encourage the population to choose their primary healthcare team as the first point of contact for any health related question. Gatekeeping and financial incentives alone will not fulfil the goals of the reform. Other conceivable options for the reform would be:

- ◆ Fostering continuity of care for vulnerable groups (chronically ill, youth, elderly);
- ◆ Intensified health promotion and prevention in primary health;
- ◆ Single entrance points for comprehensive healthcare;
- ◆ Extended opening hours in primary care facilities;

- ◆ Enforce multi-professional and cooperative teamwork;
- ◆ Encourage flexible working conditions;
- ◆ Contract design and payment schemes;
- ◆ Integration through information and communications technology;
- ◆ Measuring outcome quality;
- ◆ Improve quality and education and training of health practitioners.

The panellists asked the EHFG delegates to share their expertise and opinions in this forum, where voting would take place to determine the answers to a number of different statements and questions.

#### Panel 1: Voting results and panel and audience comments

The participants were firstly asked to identify which sectors they represented (%):



#### What are the three most important types of choice?

- ◆ Choice of treatment i.e. being involved in shared clinical decision making (19%);
- ◆ choice of GP/practice (17.1%); and
- ◆ choice of provider type: private/public/voluntary/other (14.3%)

were the top three choices of participants.

The expressed preference for shared clinical decision making is about trust and giving information, not exactly about choice. Choice is not that much of a problem or the solution; the competent specialists should tell us who is allowed to be treated and in which way. Different levels of real services need to exist, not an abstract gatekeeper. The gatekeeper needs to provide the services. The competences of the gate-keepers are crucial for providing services necessary to retain patients at the primary level of health.



### Why choice of provider? Choose your top three reasons.

- ◆ It improves responsiveness and quality (23.4%);
- ◆ it empowers the patients (18.9%);
- ◆ it results in competition and value for money (16%).

The panel disagreed with the top three choices of the public. They thought that access to service was a value in itself, regardless of whether we use it or not.

Patients do not want to be bothered by the insurance company, but wish to have a GP that they trust to guide them through the levels of care. There is no evidence that access to choice itself improves the quality of services. The rules of using the system mean more than the access to choice. For instance, if the patient chooses to seek treatment unnecessarily in France, he will need to cover a certain part of the expenses.

### Choice of primary care provider enhances the access to and improves the quality of care because it...

- ◆ ...gives strong incentives for responsiveness (e.g. opening hours, weekends) and quality improvements to providers (31.3%);
- ◆ ...I disagree with the statement that choice enhances access and quality (37.5%);
- ◆ ...all of the above (26.6%).

Comments from the panel: Choice is neither the solution nor the problem. Accessibility is not a question of choice but of the level of supply. On the opposite side, if you have choice you might trigger the supply. If you make a choice for a new provider every day, you will introduce fragmentation. In most gate-keeping systems you have clear regulations concerning the access



to change of providers. In France you can however change your GP as often as you wish, however only 7-8% of the population do so.

### Choice of healthcare provider...

...creates inequities, because choice is exercised mostly by the educated, active and young population who is better informed about the options available (36.5%).

If choice is interpreted as an aspect of a primary healthcare system, which is not particularly strong, then one could counter with evidence that strong primary care allows access for more vulnerable groups.

### The choice of specialists and hospitals without gate-keeping...

- ◆ ...decreases efficiency because it leads to wasteful use of unneeded services (66.7%);
- ◆ ...increases efficiency because competition brings costs down (11.5%);
- ◆ ...neither of the above (15.4%);
- ◆ ...I don't know (6.4%).

The primary care function is about collaboration, and you need to be able to make a choice about the person with whom you would like to collaborate regarding your health. It is therefore important to define the roles and tasks of the specialists. The general trend in healthcare is towards more specialisation, increased of bureaucracy and

unnecessary hospital admissions for those with multiple diagnoses. Services need to be less profession-centred and more patient-centred.

### Panel 2: Voting results and discussion

Choice encompasses both instrumental and normative values.

The focus of the presentation is on primary health providers and whether patients actually register with providers or not. Direct access to specialists is possible for patients in Austria, Belgium and Switzerland. In countries like France there are incentives for patients to obtain a referral from primary healthcare providers. The evidence of the influence of gate-keeping on patterns of choice remains inconclusive. Europe's strong primary healthcare systems are linked to better population health but also to higher health spending. At the same time there is a slower increase in healthcare spending in these countries to be noted. In England a study was conducted, which showed that the effect of gate-keeping on a lower survival rate of 1st-year cancer patients was significant. The rising burden of chronic disease is a global risk and it requires a different approach to service delivery. Very few countries rate high on both primary healthcare and coordinated

care. Coordination occurs at different levels (system, organisational or individual), which raises the question, "How to choose and what to choose from?" Will a patient decide for the nice but average doctor or the gloomy but competent one? In order to find a trusted doctor patients are willing to trade off their time and spend it on longer journeys to their doctor of choice. However, the most common reason to change the provider is proximity and dissatisfaction with care received. The option of being able to choose a primary care doctor is a common preference among patients in different health systems though making that choice requires appropriate information.

#### Which kind of referral system regarding the consultation of a specialist is better?

- ◆ Partial gate-keeping: access to a selection of specialists and referral for the others (61.1%);
- ◆ incentivised referral: direct access to most specialists however in the presence of financial incentives such as a reduced co-payment with referral (22.2%);
- ◆ full gate-keeping (11.1%).

It is perceived to be difficult to introduce a pure gate-keeping or self-referral system. The challenge is to find a good balance. Primary care, specialised care and social care are about to be delivered by five regional providers in Finland.

#### Evidence shows that reforms to increase choice have often limited impact on consumers switching providers. Why?

##### Choose your top two reasons.

- ◆ Insufficient information about provider availability and quality (28.8%);
- ◆ patients with ill health are often vulnerable and not able to form rational views on choice (16.1%).

The socioeconomic aspect was not presented as an optional explanation in the survey. This might be a more important factor than the poor health of patients. Patients are generally not involved in designing policy and choice options. For patients it is therefore difficult to judge the professional service quality and may base their choices on the aesthetic aspects of the facility, for example. Transparency of quality data is necessary to drive up the general quality of health provided regardless of what impact it has on patients' choices. In patient organisations the term "care coordinator" is used instead of "gate-keeper". Freedom is important but needs to be sustained by informed guidance/coordination.



#### What do you think are the sources of information used by patients to help them choose? Select the top two.

- ◆ Friends/family (41.7%);
- ◆ GP (24.3%).

Friends and family top the list which is explained by the underlying trust people place in the views of these groups.

#### Can we combine a strong health promotion and prevention function with freedom of provider choice in primary healthcare?

- ◆ No. Effective health promotion and prevention require a full population-based approach and the involvement of the PHC providers in addressing socio-economic determinants of health in the community (42.4%);
- ◆ Yes (30.3%);
- ◆ Yes, but only for a defined set of individually based preventive services (15.2%).

Patient choice has to do with health determinants and how informed patients are. Nurses should be more connected to social services and be prepared to take the role of a navigator through the services. The focus is on minimising the inequalities in primary healthcare.

#### Final conclusions

Availability, accessibility and quality of primary healthcare are the main issues in the Austrian context. Choice is not the most important aspect. The core issue which was highlighted in this session is to assure coordinated community health and patient-centred care.



### FORUM 3

1 October 2014

**Clemens Martin Auer**, Director General,  
Federal Ministry of Health, Austria

**Peter Groenewegen**, Director, NIVEL, the  
Netherlands

**Dominique Polton**, Economist, CNAMTS,  
France

**Ellen Nolte**, former Director, Health and  
Healthcare, RAND Europe, Cambridge,  
UK

**José M Martin-Moreno**, Professor,  
University of Valencia, Spain

**Suzanna Palkonen**, European Patients'  
Forum

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

Chaired by **Josep Figueras**, Director,  
European Observatory on Health Systems  
and Policies

Organised by Austrian Federal Ministry of  
Health and Main Association of Austrian  
Social Security Institutions in cooperation  
with the European Observatory on Health  
Systems and Policies



# PERSONALISED MEDICINE 2020 AND BEYOND

## PREPARING EUROPE FOR LEADING THE GLOBAL WAY

### FORUM 4

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Written by Verónica Alonso and Sonia García-Pérez

Personalised Medicine (PM) is an approach to medicine, which uses molecular analysis as well as other personal information to customise healthcare. PM is one of the most innovative areas in health research and its implementation is a key challenge for Europe and beyond.

In this session various aspects of this complex issue were discussed and recommendations for a timely, socially acceptable, effective and efficient implementation of Personalised Medicine were presented.

**Angela Brand**, Professor of Social Medicine and Public Health Genomics at Maastricht University, introduced the PerMed project: "Personalised Medicine 2020 and beyond - Preparing Europe for leading the global way," an EU-funded Coordination and Support Action (CSA) that started in September 2013. PerMed was initiated to step up coordination efforts between key European stakeholders, to allow synergies and avoid duplication or competition, and to provide recommendations to foster the implementation of personalised medicine in transnational research and health systems.

It is considered a unique consortium due to the variety of partners involved, i.e. federal ministries, funding agencies, research centres, societies and industry.

**Erica Hackenitz**, from the Netherlands Organisation for Health Research and Development (ZonMw), presented a preliminary PerMed shortlist of recommendations in six main areas:

- ◆ basic research;
- ◆ translational/clinical research;
- ◆ information and communication technology;
- ◆ legal aspects;
- ◆ health systems and
- ◆ patients.

The following speakers elaborated upon regulatory aspects, ethical and legal issues, citizens' perspectives and needs, both hospital and general practitioners' viewpoints, and two examples for the development of PM: rare diseases and nutrition.

**Falk Ehmman** of the European Medicines Agency (EMA), focused on the need to

#### The PerMed consortium

CSA PerMed is a consortium - created by decision-makers in Europe, including more than ten ministries and funding bodies - which aims to prepare Europe to be a global leader in the implementation of PM. It differs from other consortia and working groups due to the partners involved and its aim to carry out focussed discussions on concrete research actions, rather than prolonging on-going broad discussions and recommendations (see [www.permed2020.eu](http://www.permed2020.eu)).

Moreover, transparency, openness, collaboration and the avoidance of duplication lie at the core of the CSA PerMed approach. The consortium's unique features create the potential to develop a strategic research and innovation agenda for Europe (SRIA) and be the starting point for a European Innovation Partnership (EIP) in PM acting across the entire research and innovation chain, bringing together key actors at European, national and regional level.



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Ferenc Hajnal, Antonio Andreu Periz, Christoph Klein, Kaisa Immonen-Charalambous and Andre Boorsma

distinguish the grade of individualisation. Targeted therapies and multi-stratification of patients have been increasing strategies in the last years. He also explained some of the regulatory aspects of PM: the innovative regulatory approach of “adaptive licensing” enables fast product development and marketing authorisation, making therapies available in a timely manner.

The development of PM involves legal and ethical considerations that were assessed by **Effy Vayena** of the University of Zurich.

The main challenges are connected with sensible information (genetic, incidental findings, etc.) and promoting people’s participation. Personalised Medicine has to deal with the issue of “privacy” which is not something that begins and ends at an individual level, but which is part of the whole society. How to respect choices, how to enable participation and how to protect and respect privacy are the main problems identified. PM needs innovative ethical thinking which should go beyond informed consent. Society should move to novel governance models with bottom-up participation, long-term involvement, and person-centred approaches.

**Kaisa Immonen-Charalambous,**

European Patients’ Forum, represented the patient voice, citizens’ perspectives and needs. Personalised Medicine is a topic of much relevance and promise for

patients: better health outcomes, quality of life and cost-effective use of resources. However, besides promises and hopes, PM is also surrounded by many questions. Patients are concerned about timely access without discrimination and about the protection of personal data. In addition, innovative treatments tend to be costly which also questions equitable access to new therapies. The main aspects related to the presented PerMed recommendations were the education of health professionals, promotion of models for individual ownership of private information, development of different communication strategies for a heterogeneous audience, and involvement of all stakeholders (companies, academia, regulators, etc.) to increase patient participation.

The institutional perspective was presented by **Antonio Andreu Periz** from the Instituto de Salud Carlos III, who stated that there is a long way to go for PM to be implemented in national health systems. The implementation of Personalised Medicine needs to develop proof of concepts, identify mechanisms, bring basic science to clinical practice and demonstrate efficient allocation of resources.

Other key elements for the implementation of PM are EU platforms, among others BBMRI, EATRIS, ELIXIR and ECRIN, and national programmes, as those promoted by

the Instituto de Salud Carlos III. The future of PM will also be influenced and shaped by public-private partnerships as well as international collaborations.

Representing the General Practitioner’ (GP) perspective, **Ferenc Hajnal** from the European Union of General Practitioner’s (UEMO) stressed that Personalised Medicine should be based on reliable scientific evidence.

PM really upgrades evidence based medicine and GPs can help in that contribution. GPs as the first points of contact with citizens in health systems are in the unique position to be able to prevent over-screening and over-medication resulting in the improved well-being of European citizens. Therefore GPs need to be guided by the principle to deliver only scientifically acceptable, personally necessary, ethically justified medical care. This medical care has to be adjusted to the needs and values of the patients to achieve maximum quality with a minimum quantity of interventions.

Best practice examples on rare diseases and nutrition were presented by **Christoph Klein** from the University of Munich and **Andre Boorsma** from the Netherlands Organisation for Applied Scientific Research.

Patients with rare diseases need personalised attention, innovation and, sometimes, personalised approaches to therapy. Requests for policy-makers in this field are: to re-think medicine and re-define its structural environment, provide protected time for creativity and innovation, create better “option spaces” for interdisciplinary and global investigations aiming to understand diseases and to develop novel and better therapies.

Boorsma, on the other hand, illustrated an example in the area of nutrition that focused

on the possibility of monitoring health by oneself to improve everyone's own health. This "quantified self" approach could be connected to PM activities especially in terms of prevention strategies.

During the final discussion, discrimination on the part of insurance or employment emerged as the most important concern. For the future it is important to assess a risk-benefit balance and share data at a wider level, but ensure as well data protection policies at a broader level. The value of PM increases with the aggregation of data but to control the use of this data is extremely important.

Another key point was related to citizen's empowerment for making appropriate decisions. Patient organisations are keen to move towards patient registries containing sensitive individual data, which they consider a "common good." Scientists specialising in rare diseases are also pushing for patient registers because they wish to know how many and where patients with a certain rare disease are and have access to the data of other patients with a similar rare disease, to compare and learn from commonalities and differences, e.g. in the development of the disease and treatment responses.

Today PM is becoming part of reality and this session concluded that we should identify the benefits and face the challenges that remain to further implement PM.



#### FORUM 4

2 October 2014

**Angela Brand**, Professor, University Maastricht, the Netherlands

**Erika Hackenitz**, the Netherlands Organisation for Health Research and Development (ZonMw)

**Falk Ehmann**, European Medicines Agency (EMA), UK

**Effy Vayena**, University of Zurich, Switzerland

**Kaisa Immonen-Charalambous**, European Patients' Forum (EPF)

**Antonio L Andreu Periz**, Instituto de Salud Carlos III, Spain

**Ferenc Hajnal**, European Union of General Practitioners (UMEO), Hungary

**Christoph Klein**, University Munich, Germany

**Andre Boorsma**, the Netherlands Organisation for Applied Scientific Research (TNO), the Netherlands

Moderated by **Clive Cookson**, Journalist, Financial Times

Organised by Coordination and Support Action (CSA) PerMed, Seventh Framework Project (EU Grant No. 602139)



# DEPLOYING EHEALTH. THE TIME TO HESITATE IS OVER!

## TELEMEDICINE ♦ INTEROPERABILITY

### FORUM 5

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Written by Roberta Savli and Luk Bruyneel

#### Telemedicine

The first session of the forum on eHealth aimed to demonstrate the effectiveness of telemedicine in tackling chronic and other diseases through the presentation of a series of successful EU projects and best practice examples from Member States in implementing eHealth. Particular attention was paid to showing how telemedicine can be used in a cost-effective way, therefore providing strong evidence that has been missing so far and impeding its deployment. **Edwin Maarseveen**, Policy Officer in the eHealth Unit at DG Health and Consumers, European Commission, moderated the session.

**Peteris Zilgalvis**, Head of the Health and Well-Being Unit at DG CONNECT, European Commission, gave the audience an overview of the role of the European Union in the large-scale deployment of telemedicine, especially with the development of the eHealth Action Plan 2012-2020 in the framework of the Digital Agenda for Europe. European society today is characterised by the growing prevalence of chronic diseases, an increasing demand for health and social services and a scarcity of healthcare resources. Telemedicine has the potential to

improve disease prevention and diagnosis and improve patient treatment and rehabilitation, while being cost-effective.

**Claus Duedal Pedersen**, Head of the Department for Clinical Innovation at Odense University Hospital in Denmark (OUH), presented the example of eHealth services used in Denmark to treat patients affected by Chronic Obstructive Pulmonary Disease (COPD) in the framework of the four-year Renewing Health Project (2010-2014). Although the results of this project showed that patients valued the service in an extremely positive way due to eHealth technologies giving them a different feeling of participating in their treatment and managing their disease, the Danish healthcare system experienced a slight increase in costs due to expensive logistics and the lack of substitution with existing treatments.

Duedal Pedersen concluded by stressing that when a new technology is added to an old organisation, the result very often is simply a costly old organisation. He thus called on the European Commission to find evidence of cost-effective technologies and boost innovative organisations.

**Heleen Riper**, Professor of eMental-Health at VU University Amsterdam, the Netherlands, underlined the potential of the least known and developed eMental-Health by presenting the three-year project MasterMind (2014-2017), which focuses on adults suffering from mild, moderate, or severe depression in primary and specialised mental disorder treatment services in 11 European countries. Thanks to the link with Renewing Health, the project aims to cross-fertilise eHealth and eMental-Health with the objective of up-scaling the use of advanced technologies for the treatment of other disorders than depression. "Embedding eHealth into everyday practice among health service providers is the biggest challenge. eHealth needs to become a training focus for all healthcare professionals," said Riper.

**Ane Fullaondo Zabala**, Project Manager at the International Research Centre for Chronicity (Spain), presented the experience of the Basque country in preventing congestive heart failure through eHealth in the framework of the three-year project United4Health (2013-2015).

Building on the results and good practice from previous projects and trials, including Renewing Health, this project has the clear

# IT'S THE LATEST IN E-HEALTH! IT'S A DOCTOR IN A SUITCASE!

potential to improve the quality of life of patients, to increase the productivity of healthcare professionals through the daily use of technologies and to develop cost-effective and sustainable interventions. To overcome existing hindrances to the deployment of innovative telehealth services, such as highly stable healthcare practices and the lack of substitution of less effective former practices, Fullaondo Zabala concluded that the commitment of politicians is necessary, as well as the active involvement of managers and clinicians.

**Ernst Hafen**, Professor of Systems Genetics at ETH Zurich and former President of ETH, Switzerland, introduced the three-year MIDATA.COOPs project, which aims to allow citizens to retain full ownership and control over their health data, therefore empowering them to contribute to data integration and personalised medicine.

MIDATA.COOPs establishes personal health data cooperatives that are citizen-owned and citizen-centred, data are securely stored and voluntarily shared by cooperative owners with third parties (e.g. doctors, researchers) after payment of a fee, which is then re-invested in the cooperative itself. By aggregating different information in a unified manner, these cooperatives overcome the main limits of national healthcare systems, which have national efficiency as their highest priority, produce data in incompatible silos and subject the secondary use of data to national data protection laws.

**Peeter Ross**, Associate Professor at the Tallinn University of Technology (TUT), Estonia, and expert at the Estonian eHealth Foundation, analysed the situation of eHealth services in Estonia, where a nation-wide health information system has been available

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for citizens and healthcare providers since 2009, and 97% of prescriptions are issued in electronic form. Building upon the best practice of other European countries and projects, the Estonian government has recently initiated research on the wider implementation of telemedicine and the secondary use of digital medical data, two services missing in the Estonian system.

Ross concluded that three fundamental steps should be taken by governments to set up solid eHealth infrastructures: telemedicine and eHealth possibilities should be considered when developing strategic plans for all health and care fields, an organisational model should be created to develop and agree upon the clinical processes and technical standards of telemedicine services, and, finally, suitable models for evaluating and testing

telemedicine services should be supported. The case for the deployment of eHealth was clearly made by all speakers. It was underlined that there is already enough scientific evidence for the usefulness of telemedicine in Europe, both the audience and the speakers thus emphasised the urgent need to act and implement available eHealth solutions.

The involvement of patients in the design of innovative eHealth solutions was presented as crucial as it will allow them to become user-friendly and correspond to unmet needs.

The main bottlenecks related to telemedicine were identified as the lack of a multidisciplinary trained workforce, the need to redesign laws and payment systems set up for face-to-face care, and to find ways to keep patient data secure and private. As

it was shown that telemedicine may even increase costs if added to old routines rather than replacing them, Zilgalvis concluded that “if you have a chaotic system and add technology, you get a chaotic system with technology.”

## Synergistic effects between eHealth and interoperability.

### Increasing opportunities to deliver care that is independent of place and time

In the second session on eHealth, Maarseveen set the tone for this forward-looking debate on eHealth interoperability and standardisation activities for an increasingly digital European society. Such activities present an opportunity for wider eHealth implementation and streamlining of services to improve the quality and safety of patient care. During this session, the perspectives on interoperability from various stakeholders showcased its multifaceted nature, including legal, organisational, semantic, and technical notions. Making interoperability happen is an incubator for the wider implementation of eHealth, and vice versa.

**Marcello Melgara** of Lombardia Informatica S.p.A., Milano, Italy, highlighted the achievements of the epSOS project (European patients – smart open services). This Information and Communication Technology policy support project ran from 2008 to 2014 and included 26 Member States. In preparation for the EU Directive on the application of patients’ rights in cross-border healthcare, this large-scale project aimed to design, build and evaluate a service infrastructure that would demonstrate cross-border interoperability between electronic health record systems in Europe. It provided the building blocks for a European infrastructure that enables secure access to patient health information among different European healthcare systems. Melgara’s experience with this project confirmed that secure access to patient health information across European healthcare systems is not only a question of technical interoperability: legal, organisational, semantic and technical aspects of interoperability are all at play at the European level and are strongly interrelated. As a final take-home message, he stressed that “deployment must be just around the corner.”

**Ib Johansen**, Deputy Manager at MedCom, a Danish non-profit health data network organisation that facilitates the cooperation between authorities, organisations and private firms, presented the Antilope project (2013-2014). This project aims to promote the use of standards and profiles for eHealth interoperability and foster their adoptions across the EU. The outcome will be a common approach for testing and certification of eHealth solutions and services in Europe, to be presented at its final conference in January 2015.

KSYOS TeleMedisch Centrum in the Netherlands delivers health services only by means of IT, with the starting point of more efficient care in terms of lower costs and faster services. The health institution is active in TeleDermatology, TeleCardiology, TeleOphthalmology and TelePulmonology. KSYOS founder and director **Leonard Witkamp** used this opportunity to showcase telemedicine deployment from a clinician’s point of view. His illustration of concrete cases of TeleDermatology received much acclaim during this session.

By connecting primary and secondary care, the implementation of TeleDermatology has already led to large reductions in both physical referrals to dermatologists and in the costs of regular dermatological care. Next steps are to have interoperable patient record systems with hospitals and to expand the KSYOS model to other countries.

As Head of the Unit Hospital Financing, DRG, Semantics at the Austrian Ministry of Health, **Peter Brosch** presented a health authorities’ view on interoperability. He offered a great number of reasons why health authorities should be interested in the interoperability of eHealth instruments, including but not limited to: improving health services, quality of care and patient safety; supporting seamless communication between healthcare providers and organisations, and archiving good quality data for planning, steering and reimbursement.

Austria took early decisions on technical standards in the ELGA project to secure interoperability, thereby setting up technical, semantic and organisational standardisation in eHealth. Regarding the legal barriers to interoperability at play at the international level, he called for EU interoperability recommendations to be binding instruments.





The way we produce health in Europe is like creating massive traffic accidents.

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Claus Burci Nielsen

Magdalene Rosenmöller from the IESE Business School, took a helicopter view on interoperability, focusing on the management of interoperability attempts and introduced excellent business models applicable in this regard. While the technical aspect is important for interoperability, the “softer” factors around leadership, strategy and incentives are the real enablers that must be addressed to successfully deploy eHealth. Moreover, she strongly emphasised the need to view patients as allies and as an important driving force behind eHealth, therefore she suggested patients apps as pulling strategies.

Interoperability is very hard to sell, according to Claus Burci Nielsen, Vice Chair of Continua Health Alliance Europe, a global non-profit, open industry organisation of healthcare and technology companies collaborating to improve the quality of personal healthcare, where competitors join forces in trying to get fragmented mHealth solutions to be upscaled and mainstreamed for serious health purposes.

It is not a question of having certified devices measuring everything from your sleep, weight, or even your ECG and current heart rate - as shown live-streamed from his

heart via a patch wirelessly communicating the ECG to a tablet during his engaging presentation - no, they are already out there. But we need a more holistic approach in EU Member States for the real uptake of interoperable personal connected health solutions. Nielsen posed critical questions such as “Why do we allow reimbursements of non-interoperable products, e.g. glucose meters?” and “Can we make it mandatory for EU public tenders to recommend or mandate for example Continua Certification?” Norway and Denmark are moving in that direction, which shows a concrete action point for the new Commission to take up in the interoperability discussion.

In conclusion, within the EU healthcare systems function nationally and have national efficiency as their highest priority. The fragmentation of health information associated with stand-alone systems is a barrier in achieving sustainable eHealth deployment. During this session, panel members from various backgrounds illustrated that aligning eHealth deployment with a clear vision on interoperability works synergistically, with benefits for our citizens, SMEs and industries. As interoperability is currently at the heart of the EU's eHealth

Action Plan 2012-2020, the outlook is positive for all stakeholders involved to cross the legal, organisational, technical and semantic boundaries.

Beyond the specific and interrelated ways of enabling interoperability and making eHealth happen, both the panellists and the audience (through plenary discussion) unanimously agreed on the timeline: The time for hesitation is over - we need to create a sense of urgency and employ eHealth now.



## FORUM 5

2 October 2014

**Peteris Zilgalvis**, Head of the Health and Well-Being Unit, DG CONNECT, European Commission

**Claus Duedal Pedersen**, Chief Innovation Officer, Odense University Hospital, Denmark

**Ane Fullaondo Zabala**, Project Manager, International Research Center for Chronicity (Kronikgune), Spain

**Heleen Riper**, Professor, VU University Amsterdam, the Netherlands

**Peeter Ross**, eHealth expert, eHealth Foundation, Estonia

**Ernst Hafen**, Professor, ETH Zurich, Switzerland

Chaired by **Edwin Maarseveen**, Policy Officer, eHealth Unit, DG Health and Consumers, European Commission



## FORUM 5

3 October 2014

**Marcello Melgara**, Lombardia Informatica S.p.A., Milano, Italy

**Magdalene Rosenmüller**, Associate Professor, IESE Business School, Barcelona, Spain

**Edwin Maarseveen**, Policy Officer, eHealth Unit, DG Health and Consumers, European Commission

**Leonard Witkamp**, Director, KSYOS TeleMedisch Centrum, the Netherlands

**Claus Burci Nielsen**, Vice Chair, Continua Health Alliance, Denmark

**Peter Brosch**, Head of Unit, Hospital Financing, DRG and Semantics, Federal Ministry of Health, Austria

**Ib Johansen**, Deputy Manager at MedCom, Danish Health Data Network, Denmark and Coordinator of The Antilope Project

Moderated by **Peteris Zilgalvis**, Head of the Health and Well-Being Unit, DG CONNECT, European Commission

Sponsored and organised by DG CONNECT,  
European Commission



# HEALTH SYSTEM PERFORMANCE

## WHAT SHOULD BE ON THE EU MENU?

### FORUM 6

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Written by Susan Spillane, Clemens Sigl, Elżbieta Buczak-Stec and Julia Röttger

The Opening Plenary of EHFG 2014 made several references to health system performance. The keynote speech by George Papandreou, reflecting on the economic crisis, highlighted the inter-dependence of the EU and stressed the importance of transparency. Speakers in the subsequent high-level debate described the need to reduce Euroscepticism through assuring citizens that lessons have been learned. This includes the importance of developing a clear strategy on sharing tools, policies and best practices, and identifying and learning from strengths and weaknesses.

In the first part the relevance of health system efficiency to the EU was discussed, followed by the scope for action on health system performance at EU level, and consideration of how performance may be best measured. The second part focused on assessment and valuation of health technologies, including harmonisation of HTA and discussion of pharmaceutical policy.

The sessions were facilitated by **Matthias Wismar**, Health Policy Analyst, European Observatory on Health Systems and Policies, and **Boris Azaïs** Director Public Policy Europe and Canada, MSD.

#### Health system efficiency - Does the EU care? Does it dare?

This provocative question was put to **Martin Seychell**, Deputy Director-General, DG Health and Consumers, regarding the role the EU takes in considering health system efficiency.

He first stated that in health we should really be talking about performance and not just efficiency. Performance incorporates the true improvement of population health, equity, and meeting patients' expectations. As a good health system provides guardianship of the financial protection of citizens (through improving citizens' health), the EU must care about the performance of health systems. This is in addition to the concept of the health system being at the heart of the European social model.

In relation to the EU's actions regarding health system performance, Seychell discussed three overall objectives:

- ◆ strengthening effectiveness, e.g. reducing the variation in health system performance across Member States;
- ◆ increasing accessibility, e.g. reaching all citizens through a minimum basket of care;
- ◆ improving resilience, e.g. enhancing the stability of funding mechanisms.

Various EU responses to the respective objectives were described, including setting up an expert group on performance assessment, the Cross-border Healthcare Directive, and improving governance, information flows, and costing of health services.

#### Cutting through the silos: Health system efficiency across EU policies

**Peter C Smith**, Imperial College London, spoke on improving health system efficiency in the EU and referred to the 2007 WHO Framework for Action on Strengthening Health Systems to Improve Health Outcomes. This report identified six building blocks, or indicators, of a good health system, including good health services, a well-performing health workforce, well-functioning health informatics, equitable access to essential medical technologies, good health financing, and leadership and governance. Smith described the key issues and constraints regarding these indicators. These included the need to improve training and retirement policies in the health workforce, to develop information systems to the standard of

sectors other than health, and to consider public-private partnerships to facilitate innovation. Aspects that may have not been incorporated within the framework were also identified, such as the role of preventive services, social determinants of health, and the health effects of non-health policies (e.g. employment, research, financial and industrial policies).

Conclusions from this discussion included the importance of sharing best practice, handling market failures in health technologies, and advocating for consideration of the health implications of all European policies.

### The critical path for better performance measurement - Are we measuring the right thing? Does it improve performance?

Following on from the previous presentations, Francesca Colombo, Head of Health Division, OECD, discussed how health system performance is measured and how we can improve it, pointing out that there are abundant indicators of health outcomes but few accurate indicators of performance. Three ways to improve performance measurement were suggested. These included gaining better capture of patient-reported outcomes (and thereby recognising the importance of quality of life and patient-centredness), achieving more granularity in our data, i.e. capture of data at institution and physician level, and gaining a better understanding of patient care pathways, including linking existing patient data, though problems in addressing privacy must first be overcome.

Liisa-Maria Voipio Pulkki, Ministry of Social Affairs and Health, Finland, echoed the previous calls for more comprehensive and relevant data in her reflections on measurements needed to assess the Finnish health system. We require measurements on the combined effects of health and social care interventions, and continuous evaluation of outcomes using information provided on a daily basis by patients. Describing a simple, logical framework for health system performance, the measure of a good system may be determined by the following domains: prevention and health promotion activity; service delivery; satisfaction and trust and international comparability.

### Variations in Health Technology Assessment (HTA) - Unity in Diversity?

Finn Bøerlum Kristensen, Secretariat Director, EUnetHTA, opened the second part of the session on health system performance with a presentation on HTA in Europe.

HTA was introduced by first stressing that it is a context-specific decision tool. While we may share, for example, systematic reviews, and develop common methodologies for HTA at EU level, the information must be used for decision-making at national or regional-level, and, while informing decisions, must remain non-directive in decision-making processes.





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Some Member States are still struggling to identify where exactly HTA should fit into their health system, which led to an explanation of the European network for Health Technology Assessment (EUnetHTA). This network promotes and facilitates scientific and technical cooperation in HTA and has achieved much through the Joint Action 2 projects (2012-2015) alongside the EU 7<sup>th</sup> Framework Research Programme HTA projects. In addition to EUnetHTA, the recent Cross-border Healthcare Directive has necessitated the establishment of the “HTA Network” by the European Commission in 2013. The HTA network will be supported by a scientific and technical cooperation mechanism, performed by EUnetHTA until the end of 2015.

Challenges discussed during the following question and answer session included incorporation of the public or patients in HTA processes, the handling of Quality-Adjusted Life-Years (QALYs) and Incremental Cost-Effectiveness Ratios (ICERs) in HTA considerations at EU level, and the need for EUnetHTA to challenge the HTA Network in priority setting, e.g. regarding the Cross-border Healthcare Directive.

### **European pharmaceutical market - One market, access for all?**

The component of the forum focusing on the European pharmaceutical market began with a presentation by **Sabine Vogler**, National Public Health Institute, Austria. This presentation described the results of a recent stakeholder survey of prioritisation of policy objectives and pricing or reimbursement measures in relation to pharmaceuticals. This research was commissioned and published by the

DG Health and Consumers sub-group on the “cost-effective use of medicines.” The survey included stakeholders in eight groups (consumers, patients, authorities for pricing and reimbursement, public payers, the generic medicines industry, the research-based industry, doctors, and pharmacists) in the 28 Member States. Results found that equitable access to medicines was considered to be the most important policy objective overall, followed by timely access and long-term sustainability.

However, conflicting objectives were also identified. For example, generic industry favoured competition, while payers favoured cost containment. When policy measures were ranked according to stakeholder preferences, pharmacoeconomic evaluation was ranked first, followed by value-based pricing and the reimbursement process (emphasising a transparent, fair process). Generic substitution and external reference pricing were ranked second-last and last place, respectively.

**Dermot Glynn** took up the previous discussion by presenting the case for reform of the EU market for patented medicines in relation to the use of external reference pricing (ERP). Research commissioned by MSD Europe and performed by Europe Economics compared the present price levels for medicines subject to ERP with prices that would be charged under alternative measures of affordability, e.g. national incomes per capita. Results suggested that ERP and parallel trade have increased the cost burden for the relevant

medicines in low-income Member States. Also, new medicines appear to be launched later in low-income countries, an effect which was linked to ERP and parallel trade. It was argued that the existing system does not reflect the ability to pay and has thus reduced both access for patients and return on investment.

### **Conclusion**

The importance of assessing health system performance was clearly outlined in this forum and the inter-dependence of health and other policy areas (e.g. finance) was a common theme. The need for better capture and use of data in assessing health system performance was raised by all of the speakers in the first part of the forum, and tied in with other sessions of the conference which discussed the rapid increase in the availability of personal health data and the relevance to improving patient outcomes.

The late afternoon presentations provided a very timely discussion of health technology evaluation and pharmaceutical policy issues in light of the recent controversy regarding the transfer of the pharmaceutical portfolio to DG Enterprise and Industry.

It is encouraging that the pharmacoeconomic assessment was described overall as the most appropriate reimbursement policy in the results of the pharmaceutical policy stakeholder survey presented by Vogler. With the recent establishment of the HTA Network and the upcoming conclusion of EUnetHTA activities, it appears that Europe

is making strides in this issue, though other aspects of ensuring appropriate health system performance remain challenging.

## EU Health Commissioner-designate's address

The overarching topic of the session was the role of the EU in supporting Member States in health system performance assessment. This was discussed through three major topics of the Friday session: the European workforce in healthcare, the European patient and sustainable financing of health systems.

Health Commissioner-designate **Vytienis Andriukaitis**' first statement was to remind us that the European Union is a commitment to key European values: peace, democracy, social justice and prosperity. Andriukaitis emphasised the importance of health system performance assessment as well as the constant improvement of the performance of health systems. In that sense, performance assessment is necessary to understand healthcare and to improve health. Efforts from Member States to measure performance as well as to provide high quality care should thus be pooled to improve health and save lives.

Making the link with the topic under discussion, he named the shortage of healthcare professionals, the right skill-mix and efficient teamwork as part of the challenges facing European healthcare systems.

He also mentioned the importance of person-centred care as well as the challenge to measure patients' pathways in performance assessment.



EU Commissioner-designate for Health and Food Safety, Vytienis Andriukaitis, opening Forum 6

### The European workforce – Right numbers? Best allocation? Optimal skill mix?

Wismar gave a short introduction to the topic underlining its high relevance. The health workforce is a key component of health systems. EU Member States face various challenges regarding the health workforce, including serious workforce shortages as well as changes in healthcare needs.

A first input was given by **Michel van Hoegaerden**, Joint Action on Workforce Forecasting and Planning. He emphasised the importance of health workforce planning as well as the importance of research on health workforce planning and forecasting.

The moving workforce between different countries is a fact; hence, planning is needed at an international level. In addition, good practice guidelines for workforce planning and forecasting are needed. Experiences from different countries and projects should be gathered and transferred into good practice guidelines for workforce planning and forecasting. Ideally policy-makers use the knowledge of other countries and apply the knowledge to their own health system. Yet, all planning is worthless without taking the necessary actions. According to van

Hoegaerden, "planning the workforce" means to look at trends, at factors influencing the trends and eventually to take responsibility. A strong emphasis was put on the need for health workforce planning. According to van Hoegaerden, "not to plan but to let go" is not an option, as this will eventually decrease the responsiveness of health systems.

Azaïs followed up by raising the topic of creating new professions in healthcare and asked how healthcare systems are advancing in this. According to van Hoegaerden the reaction is still very slow. Both **Ellen Nolte**, Director, Health and Healthcare, RAND Europe, and **Peter Groenewegen**, Director, NIVEL, commented on the topic.

Nolte emphasised the core role of the patient who should be seen as part of the workforce and the changing patient role should also be acknowledged in training and planning the health workforce.

Groenewegen underlined changing healthcare needs, the increase in multi-morbidity as well as the importance of person-centred care. All these points lead to changes in the way healthcare is or should be conducted, e.g. in the doctor-patient interaction. Education is seen as the most

promising entry point to implement new professions or the needed changes in the roles of “old” professions. It was estimated that it would take a few generations until changes in professional roles are accomplished.

Based on these inputs, it was pointed out in the discussion that people tend to protect their profession which makes it more difficult to implement skill-mix. The crisis may have been of help to make changes to professional roles possible. The high percentage of physicians who are going to retire can also be regarded as an opportunity to implement changes to professional roles, e.g. to introduce standardised teamwork. Yet these changes, i.e. by broadening the responsibilities or leading to further specialisation, may make an adaptation of the remuneration system necessary. In the final round-up, the importance to see planning of the health workforce not in isolation but as a part of the healthcare system was emphasised.

### The European Patient – Can you verstehen lo qué je dicho?

Azaïs introduced the fourth topic of the forum. Stanimir Hasurdjiev, Chair, National Patients Organisation of Bulgaria, highlighted the importance of person-centred care to improve outcomes. Despite the relevance of person-centred care, well-planned structured approaches are still missing. Elisabeth Fiedler, a representative from ÖMCCV, an Austrian patient group, spoke about the project “Travelling with IBD (inflammatory bowel disease)” which aims to help people with IBD who are afraid of travelling because of their disease, e.g. by providing contact information, information

on hospitals in various countries as well as information on country-specific food.

Both speakers underlined that patients are experts in their conditions and should be seen as such by health systems. Patients have a unique expertise as they travel across the different parts of their health system. Patients’ experience as well as their expertise should thus be taken into account when the performance of health systems is assessed and be used to further strengthen health systems.

In the subsequent discussion the main topic was the inclusion of the patients’ perspective in performance assessment. It was underlined that approaches are needed to assess the patient experience throughout the entire path of care. As in the previous discussion on workforce planning, the core role of the patient (especially of chronically ill and multi-morbid patients) not just as users of healthcare but rather as co-producers of his/her own health was emphasised.

### Sustainable financing - Who holds the purse? Who sets limits?

In the introduction to this part of the session Azaïs stated that, as a result of the economic crisis, European countries are subject to very strict economic governance, in particular through the European Commission’s fiscal recommendations to Member States.

The topic was elaborated by Nathalie Chaze, (then) Head of Healthcare Systems Unit, DG Health and Consumers. Chaze gave an overview of the European semester process and how it impacts healthcare policy. She highlighted that national healthcare systems in the EU are solidarity-based models supported by large government spending. When it comes to healthcare systems, the

coordination between the Commission and Member States is critical, in particular because the delivery and the organisation of the healthcare system is the responsibility of the Member States. However, EU-led policy also applies to healthcare, for example through the Cross-border Directive, patient mobility, recognition of qualifications, and the Working Time Directive.

### Economic policy governance does apply to health

Before the economic crisis, healthcare systems already faced numerous challenges which required system reforms. The economic crisis made such reform agenda ever more pressing. Those countries that started reforming their healthcare systems before the crisis resisted much better and are now in a better position. Under the European semester, recommendations are proposed by the Commission and adopted by the Council. Recommendations are not solely focused on financial and fiscal aspects. As the purpose of healthcare systems is to provide access to quality care, Member States are also asked to improve the cost-effectiveness of the healthcare system, to improve efficiency and quality of public healthcare expenditures. There is advocacy for better-integrated models of care, accessibility and quality.



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## Investment in health is investment in your economy

John Bowis, former Member of the European Parliament (UK), asked what power the EU has to provide specific recommendations, such as pointing out whether specific cost-cutting measures are inappropriate or if specific spending is not sustainable. Chaze reminded us that Member States are in charge of healthcare delivery. Under the European semester, the role of the Commission is only to give recommendations, which can be fairly general, e.g. a recommendation to improve cost-effectiveness.

However, in order to provide better guidance to Member States, the Commission can also be more specific, e.g., by recommending to improve access to health services, improve integration, develop an IT system, etc. Eventually, the ultimate decision lies with Member States.

Scott L Greer, University of Michigan, stated that health is an investment in human capital and in reverse cuts in health will harm the economy for years. He stressed that the major elements of European health policy are not coming directly from the health treaty articles but are rather related to internal market, competition law and now

fiscal governance. He emphasised that, given the level of healthcare spending, we cannot have a fiscally healthy state without a fiscally healthy healthcare sector. Greer argued that European policy-makers need to focus on actual health targets, such as smoking rates, and not only fiscal targets. We should also incorporate our own ideas that come from technical reports because they will become recommendations to implement within healthcare systems.

At the end of the debate, Chaze concluded that all actions connected to health system performance assessment are necessary because this will give us proper information to make recommendations for specific countries. Wismar clarified the linkage between assessing health system performance, workforce, patients and financial governance. Azaïs recalled a previous statement from Josep Figueras, Director of the European Observatory on Health Systems and Policies, that the economic crisis should be seen as an opportunity to reform healthcare systems towards greater performance.

# LAISSEZ-FAIRE IS SO LAST YEAR!



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## FORUM 6

2 October 2014

**Martin Seychell**, Deputy Director-General, DG Health and Consumers, European Commission

**Peter C Smith**, Imperial College, UK

**Francesca Colombo**, Organisation for Economic Co-operation and Development (OECD)

**Liisa-Maria Voipio Pulkki**, Ministry of Social Affairs and Health, Finland

**Finn Boerlum Kristensen**, EUnetHTA

**Sabine Vogler**, National Public Health Institute (Öbig), Austria

**Dermot Glynn**, Senior Policy Analyst, Europe Economics

Facilitated by **Boris Azaïs**, Director Public Policy Europe and Canada, MSD;

**Willy Palm**, European Observatory on Health Systems and Policies

**Matthias Wismar**, European Observatory on Health Systems and Policies



## FORUM 6

3 October 2014

**Vytenis Andriukaitis**, Commissioner-designate for Health and Food Safety

**Scott L Greer**, University of Michigan, USA

**Michel Van Hoegaerden**, Joint Action on Workforce Forecasting and Planning

**James Buchan**, Professor, Queen Margaret University, UK

**Elisabeth Fiedler**, Patient group representative from ÖMCCV

**Stanimir Hasurdjiev**, MD, Chair, National Patients Organisation of Bulgaria

**Nathalie Chaze**, Head of Healthcare Systems Unit, DG Health and Consumers, European Commission

**Scott L Greer**, University of Michigan, USA

Facilitated by **Boris Azaïs**, Director Public Policy Europe and Canada, MSD;

**Willy Palm**, European Observatory on Health Systems and Policies;

**Matthias Wismar**, European Observatory on Health Systems and Policies

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# FROM MDGS TO THE POST-2015 AGENDA

## REVIEWING THE PROGRESS BUILDING FOUNDATIONS

### FORUM 7

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Written by Joyce Browne and Alexander Kentikelenis

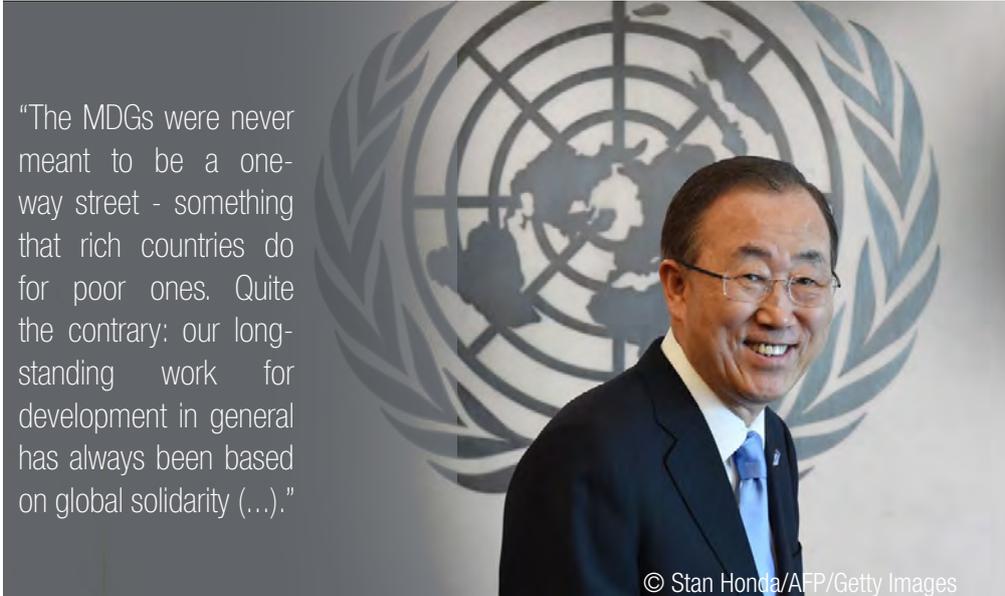
This year, the Millennium Development Goals (MDGs) framework - a hallmark of international cooperation - will come to an end. Since the goals were agreed upon in 2001, tremendous global progress has been made on pressing issues like maternal mortality, child mortality, and the reduction of communicable diseases, such as HIV/AIDS, tuberculosis (TB) and malaria. These trends have been noted in the European region of WHO as well, however, areas remain in which action has stagnated and health inequities persist. A source of concern is the rising incidence of HIV in Eastern Europe among socially marginalised populations with structural barriers to healthcare, including injecting drug users, men who have sex with men, migrants, transgender populations, sex workers, prisoners and others. Also, while the MDG targets related to TB incidence and prevalence are likely to be achieved, the region is not on track to halve TB mortality by 2015.

Looking ahead, over the coming year, countries will negotiate and finalise the post-2015 agenda for sustainable development goals that will cover the period up to 2030.

As **Bosse Pettersson**, Senior Adviser Public Health Policy at the National Board of Health and Welfare in Sweden, noted, “these goals should always be more ambitious than what we think we can manage, but they have to be understood as achievable.” The process for developing and agreeing upon the post-2015 health goals entails extensive dialogue and consultations, but key components will include maximising health outcomes

at all stages of life, including meeting the unfinished MDGs, and addressing new challenges (like non-communicable diseases and sexual health), with Universal Health Coverage being both a means to the end of achieving these outcomes and a desirable end in itself.

As **Nedret Emiroglu**, Deputy Director of the Division of Communicable Diseases, Health



“The MDGs were never meant to be a one-way street - something that rich countries do for poor ones. Quite the contrary: our long-standing work for development in general has always been based on global solidarity (...).”

UN Secretary-General Ban Ki-moon, in his closing remarks to the MDG Summit, 22 September 2010

Source: <http://www.un.org/en/globalissues/briefingpapers/mdgs/index.shtml>

Photo: <http://alj.am/1qPpjE9>

Security and the Environment, and Special Representative of the Regional Director on MDGs and Governance at the WHO Regional Office for Europe, noted “the objective will be better health, but also equitable and sustainable health systems,” in line with Health 2020: the European policy for health and well-being, which will set the ground for implementing this new vision in the region.

The international community has reflected on the successes and failures of MDGs, and acknowledges there is much more to be done. In particular, systemic issues, like equitable access to care, deserve more attention. For example, donors fixate on cost-effectiveness, and “often chase the low hanging fruit, whilst the greatest rewards are

not necessarily the easiest to reach,” noted **Frazer Goodwin**, Senior Advocacy Adviser of Save the Children’s EU Office. Other limitations of the MDG approach include the fragmentation of stakeholder initiatives, the vertical disease-based approach, and insufficient attention to inequity in health.

Taking these issues on board, the European Union committed to the MDGs beyond 2015. **Kevin McCarthy**, of the Development and Cooperation Directorate-General of EuropeAid, stated “health system strengthening is at the core and requires long-term investment in building health systems and capacities.”

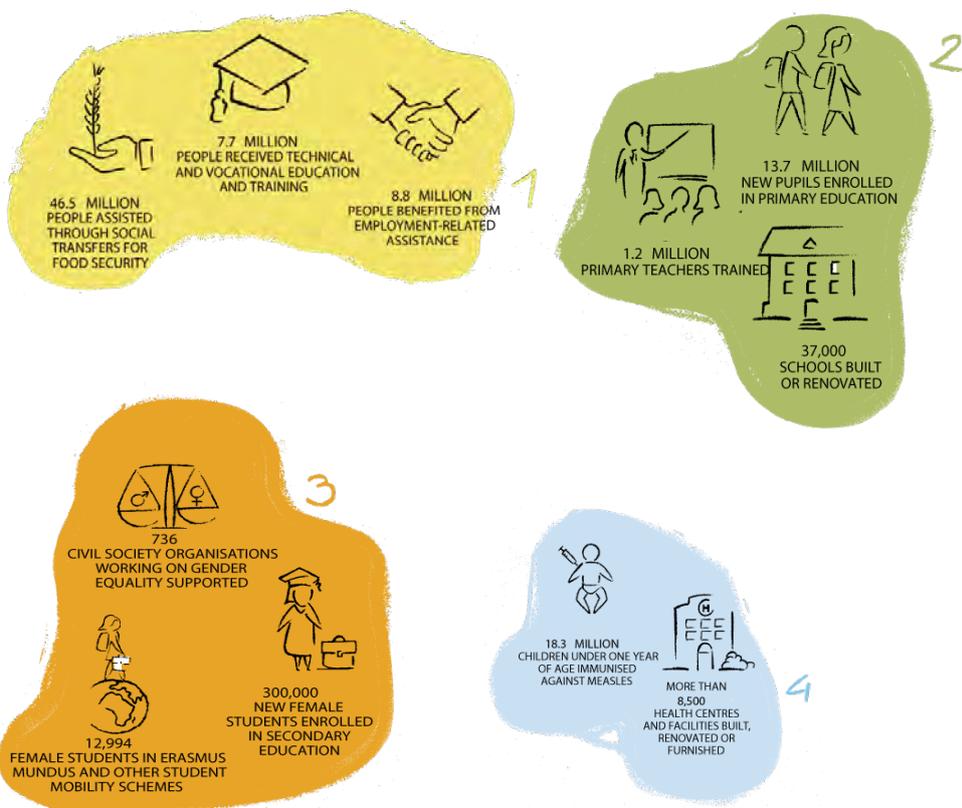
Country perspectives provided further insights into progress achieved thus far. The

MDGs provided important benchmarks for countries in their epidemiological transition. **Svetlana Cotelea**, Deputy Health Minister of Moldova, highlighted that “MDGs served as a guide on the country’s ambitious transition journey towards developing a strong welfare system and they were helpful in designing and meeting national and sectoral policies.” The broader issue of country ownership was a recurring concern of national representatives. Governments are crucial in coordinating national efforts and translating global goals to local policies. For example, the methodological and technical assistance by the WHO, UNICEF, UNFPA and other organisations was praised by **Karine Gabrielyan** from the Armenian Ministry of Health, who also stressed the



UN Millenium Development Goals

Source: <http://www.un.org/millenniumgoals/poverty.shtml>



EU contribution to the MDGs.

Key results from European Commission programmes

Source: [http://ec.europa.eu/europeaid/documents/mdg-brochure-2013\\_en.pdf](http://ec.europa.eu/europeaid/documents/mdg-brochure-2013_en.pdf)

importance of a focus on health system sustainability. In this process, well-trained public health personnel are an irreplaceable pillar of welfare systems and more work is necessary for ensuring a match of expertise and incentives in order for the public sector to retain well-qualified individuals.

The post-2015 sustainable development agenda will have to tackle a range of challenges. This process will require the active engagement of all stakeholders in setting out a clear vision of the future of development. Addressing health-related challenges entails developing a holistic approach, developing efficient, equitable, and sustainable health systems, and tackling the social determinants of health. Universal Health Coverage and access, which combines access to health services (promotion, prevention, treatment and rehabilitation), the living conditions needed to achieve good health, and financial protection to prevent ill health from leading to poverty, is the key contribution by the health sector to achieving health goals and targets and to improving population health more broadly. What is certain is that the role of national governments will be crucial, and due attention has to be devoted to building countries' knowledge, commitment, ownership and leadership for health within the post-2015 agenda.

EU contribution to the MDGs.

Key results from European Commission programmes

Source: [http://ec.europa.eu/europeaid/documents/mdg-brochure-2013\\_en.pdf](http://ec.europa.eu/europeaid/documents/mdg-brochure-2013_en.pdf)

**FORUM 7**

2 October 2014

**Nedret Emiroglu**, Deputy Director, Division of Communicable Diseases, Health Security and the Environment, and the Special Representative of the Regional Director on MDGs and Governance, WHO Regional Office for Europe

**Bo Goran Pettersson**, Senior Adviser, Public Health Policy, National Board of Health and Welfare, Sweden

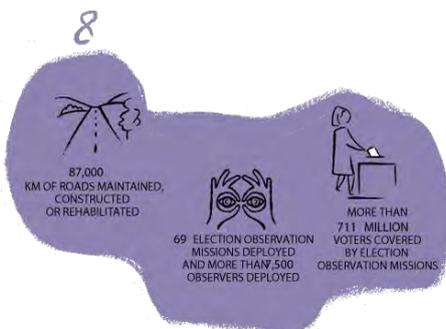
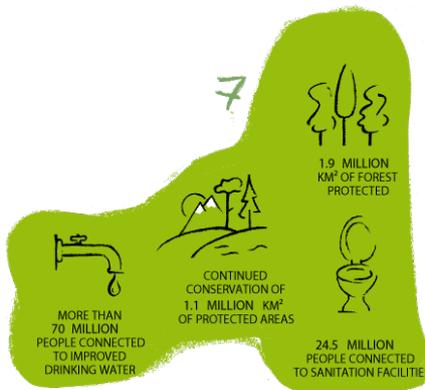
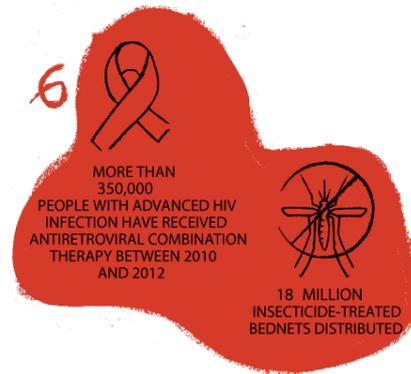
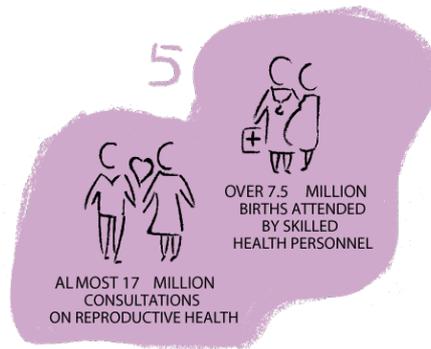
**Kevin McCarthy**, DG Development and Cooperation - EuropeAid, European Commission

**Frazer Goodwin**, Senior Advocacy Adviser, Save the Children, EU Office

**Svetlana Cotelea**, Deputy Minister of Health, Ministry of Health, Moldova

**Karine Gabrielyan**, Public Health Chief Specialist, Ministry of Health, Armenia

Organised by the World Health Organization Regional Office for Europe



# MOVING FOR HEALTH AND WELL-BEING

## CHALLENGES AND BENEFITS

### FORUM 8

Written by Mathilde de Calan and Eleonore Brooks

Physical activity is a crucial component in reducing the incidence of lifestyle-related, non-communicable diseases, which present significant social and economic costs. Hosted by representatives from the European Commission's Directorates General for Research and Innovation, Health and Consumers, and Education and Culture, this Forum examined ways of promoting physical activity and discussed the challenges and benefits of reducing sedentary behaviour.

The first half of the session saw presentations from four EU FP7-funded research projects, which have sought to increase physical activity in targeted communities.

**Maria Luisa Brandi**, Professor of Endocrinology, University of Florence, Italy, presented the Credits 4 Health (C4H) project, which uses peer support, external partnerships, patient empowerment and the "nudge principle" to improve lifestyles and activity in the Mediterranean.

**Sally Wyke**, Professor, Institute of Health and Well-being, University of Glasgow, UK, shared the experiences of the EuroFIT project, which, based on the successful experience in working with elite football

clubs in Scotland to establish healthy lifestyle programmes for their male fans, is now extending its work into other countries.

**Joan Duda**, Professor of Sport and Exercise Psychology, University of Birmingham, UK, gave an overview of the completed 'PAPA' project which successfully reduced youth intentions to drop-out of sport by training coaches in European grassroots football clubs to create more empowering climates and thereby promote more autonomous motivation in youth sport participants.

Finally, **Christian Schweizer**, Technical Officer, World Health Organization, presented some first experiences from the PASTA project, which builds on the WHO's health economic assessment tool to assess the impact of sustainable transport and active mobility upon health and well-being.

The projects highlighted a number of common challenges, including the lack of indicators and measures of effectiveness, difficulties in monitoring and challenges in generating sufficient motivation and incentives.

The main finding, however, was that a difference can be made and behaviour can

be affected, if the right motivational triggers and access points are used. Even in groups that are traditionally difficult to reach, such as adult males in the EuroFIT project, positive results can be achieved with the appropriate levers.

In the second half of the session, three break-out groups held discussions on

- ◆ inter-sectoral and interdepartmental collaboration,
- ◆ multi-sector collaboration and
- ◆ environmental settings which enable empowerment.

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TO DO HEALTH PROMOTION!



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Focusing on the discussion held in break-out group 1, the challenges seen in the previous projects were mirrored in further examples from the UK, France, Belgium and Italy. The group proposed that in order for projects to be successful in increasing physical activity, targeted partner-sectors must be encouraged to be engaged, for instance by giving them leadership responsibilities or by generating competition with other initiatives in different cities or regions. Furthermore, it was suggested that incentives could be offered to those targeted by the project. In young people, it was found that making more active behaviours “cool” amongst peers is a key factor. An example of pregnant mothers who were given financial incentives in the form of vouchers proved more likely to quit smoking. It is important to note, though, that some projects i.e. the PAPA project (Empowering Coaching) highlighted in the first half of the session, challenge the use of incentives in terms of long term engagement and instead

encourage ownership over the activity and focus on participants engaging out of choice and for its own sake.

Finally, penalisation of unhealthy behaviours can be effective in some cases, though a balance is clearly needed.

The presented projects and discussions which followed highlighted the importance of health as an issue which chimes with European citizens and is of equal concern across the EU. The challenges faced were similar across countries and the innovative solutions, which were presented offered valuable examples of best practice and peer learning. Friendly competition between cities and regions was shown to be highly beneficial, whilst empowerment of local and regional organisations was also found to contribute to successful outcomes. Innovative partnerships with business and industry were also explored and the importance of health in ensuring sustainable societies was clearly demonstrated.



## FORUM 8

3 October 2014

**Maria Luisa Brandi**, Professor of Endocrinology, University of Florence, Italy

**Sally Wyke**, Professor, Institute of Health and Well-being, University of Glasgow, UK

**Joan Duda**, Professor of Sport and Exercise Psychology, School of Sport, Exercise and Rehabilitation Sciences, University of Birmingham, UK

**Christian Schweizer**, Technical Officer, Transport and Health, World Health Organization

Moderated by

**Barbara Kerstiens**, Head of Public Health Sector, DG Research and Innovation, European Commission;

**Philippe Roux**, Head of Health Determinants Unit, DG Health and Consumers, European Commission;

**Olivier Fontaine**, Policy Officer, Sport, Erasmus+ Unit, DG Education and Culture, European Commission

Sponsored and organised by DG Research and Innovation, European Commission



# EBOLA SESSION

## FAILURE OF GLOBAL HEALTH AND INTERNATIONAL DEVELOPMENT

### LATE-BREAKING TOPIC

Written by Joyce Browne, Thomas van Cangh and Gabriele Pastorino

The largest Ebola outbreak the world has ever seen is a systemic failure of global governance and the international community to anticipate and organise a rapid response. This is the overarching conclusion of the special Ebola session at the European Health Forum Gastein 2014. Together with the affected West-African countries, we are at the crossroads to turn the course of events and reverse the million deaths the most recent projections prophesie.

The panel, with representatives from the World Health Organization (**Nedret Emiroglu**), Médecins Sans Frontières (**Mario Thaler**), the European Centre for Disease Prevention and Control (**Marc Sprenger**), and Graduate Institute of International and Development Studies (**Ilona Kickbusch**), and moderated by **José M Martin-Moreno** from the University of Valencia, pointed towards necessary action the global community and the EU should take.

With the current count at more than 7.000 cases and over 3.400 deaths, pledges of good will from various countries need to be translated to immediate action for “the response speed to catch up with the

virus spread speed,” as Kickbusch puts it. Importantly, figures are likely under-reported, with expectations that there will be over 5.000 cases a week in the near future. This means scaling-up investment of resources by up to 20 times the rate of current investments to assure sufficient isolation centres, beds, equipment and diagnostics. Given the impact of Ebola on the already existing human resource shortage in the affected countries, the deployment of well-trained health staff should happen simultaneously and be channelled through organisations working on the ground. The urgency of the situation is illustrated by MSF’s Thaler “Patients with Ebola symptoms bang on the door, but we have to send them away because we do not have the capacity, knowing full well that we send them back into their community, facilitating the spread. It runs against everything we stand for as a medical community.”

Consensus existed about the encouraging development of the vaccines, with two vaccines entering a phase I trial soon. However, sounds of caution against silver bullet-thinking were issued by the panellists: vaccines will likely not be available in large quantities, and difficult discussions about allocation will have to follow. In the future, the international community will have to consider new incentive schemes to encourage vaccine development in the future; the fact that Ebola after decades does not have a readily available vaccine or treatment points towards deep market failure.

Importantly, we are in the acute phase of the response, but need to already start considering the medium- and long term. This will include strengthening of the health systems, with basic structures in place to



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Mario Thaler, Nedret Emiroglu, Jose M Martin-Moreno, Ilona Kickbusch

resist crises in the early phases. However, it will also mean revisiting our international development paradigm and how we approach global health governance. It will mean reflecting and revisiting our own work as a global health, public health and health policy community. SARS was a wake-up call for the implementation of the International Health Regulations (IHR), the guidelines for the international community to prevent and respond to acute public health risks. Hopefully Ebola will be a wake-up call for reform of our global health governance and approach.

## Facts

- ◆ At least 375 health professionals were infected and 200 have died from Ebola (as at 2 October 2014).
- ◆ Required investments in the next six months: 1 billion, to cover all aspects of the response (incl. other sectors than health).
- ◆ 3 million sets of Personal Protective Equipment are needed in affected areas.
- ◆ WHO actions up to now include: establishment of an Ebola Coordinating Center (Mid July 2014), contribution to the UN Ebola Response Headquarters in Accra, Ghana (Oct 2014),
- ◆ Action at the EU level up till now includes: an extraordinary EU council meeting to discuss coordination among MS and EU to mobilise extra resources (Aug 2014); 150 million euro was pledged; the European Commission provided mobile laboratories to affected countries.
- ◆ Concerns are that Ebola will not only be a catalyst for an economic crisis, but also for social and political crises.
- ◆ Unmeasured collateral damage: consequences of a failing health system: rise in maternal deaths, neonatal and infant mortality and overall mortality due to infectious and chronic diseases.
- ◆ Young Gasteiners propose an additional indicator: Ebola collateral damage.

Detailed session information and materials



### LATE-BREAKING TOPIC

2 October 2014

**Marc Sprenger**, Director, European Centre for Disease Prevention and Control (via video-message)

**Ilona Kickbusch**, Director, Global Health Programme, Graduate Institute of International and Development Studies, Switzerland

**Mario Thaler**, General Director, Médecins Sans Frontières, Austria

**Nedret Emiroglu**, Deputy Director, Division of Communicable Diseases, Health Security and Environment at World Health Organization

Moderated by **José M Martin-Moreno**, University of Valencia, Spain

Organised by International Forum Gastein



# OUR HEALTH IN 2040

## FOUR SCENARIOS ON FUTURE PUBLIC HEALTH

### WORKSHOP 1

Written by Henriette Jacobsen (EurActiv) and Hedinn Svarfdal Björnsson

Many EU governments have made deep cuts to healthcare spending during the recent financial crisis. But changing demographics mean drastic change is around the corner, with four challenging objectives. As life expectancy continues to rise, more people are expected to suffer from age related chronic diseases, putting pressure on healthcare systems.

The Dutch National Institute for Public Health and the Environment (RIVM) has mapped out future health outcomes for the Netherlands, based on four objectives. “None of these perspectives will be the reality,” warned **Henk Hilderink**, Senior Scientific Researcher, RIVM, as he presented the scenarios during this EHFG 2014 workshop.

The workshop, moderated by **Nick Fahy**, Director, Nick Fahy Consulting Ltd., engaged the audience in a thought-provoking process of considering “Our Health in 2040” by envisaging four scenarios presented through four short, dynamic videos that explored the ramifications of each of the suggested scenarios before presenting the Public Health Status and Foresight Report. **Annemiek van Bolhuis**, Director, RIVM, revealed the premise of the report, which

is to try to make sense of all the relevant information and data available to contribute to the public health policy cycle and thereby assist in the application of best practice within the field.

The scenarios are meant to force incumbent politicians to determine the kind of healthcare system they want for future generations, as “having it all” will be impossible, Hilderink said. The goals are:

- ◆ To keep people healthy as long as possible and to cure illness promptly;
- ◆ To support vulnerable people and enable social participation. For persons with low levels of education, life expectancy averages six years shorter than for people with high levels;
- ◆ To promote individual autonomy and freedom of choice. This will involve engaging local communities and patients in managing their own care, with support from technological and e-health resources;
- ◆ To keep healthcare affordable. Quality care is relevant and cost-effective as determined by the health ministry and insurance companies.

Hilderink explained that the Netherlands currently spends 83 billion euro per year, or 14% of its GDP, on health, a figure which is expected to rise to 20% in 2030 due to the growing rate of chronic diseases, as well as changing demographics. “No one knows what our health systems will look like in the future,” Hilderink said as he presented the four perspectives. He suggested that

#### In the Best of Health



|                                   |  |
|-----------------------------------|--|
| Concerns and motivations          | <ul style="list-style-type: none"> <li>&gt; Long, healthy lives</li> <li>&gt; Healthy lifestyles</li> <li>&gt; Protection from health hazards</li> <li>&gt; Effective prevention and care</li> </ul> |
| Health                            | You're healthy if you do not have a disease; a healthy lifestyle is a healthy diet, sufficient exercise and not smoking.   |
| Prevention and care               | Care consists of prevention and curative treatment.  |
| Definition of health care quality | Quality care means curing the ill and preventing premature death.  |

#### Everyone Participates



|                                   |  |
|-----------------------------------|--|
| Concerns and motivations          | <ul style="list-style-type: none"> <li>&gt; Protection and support for vulnerable people</li> <li>&gt; No person excluded</li> <li>&gt; Social participation by people with health problems</li> <li>&gt; Prevention and care targeted at vulnerable groups</li> </ul> |
| Health                            | You're well if you participate.  |
| Prevention and care               | Care extends beyond medical care and includes services for welfare, occupational health, mental health and rehabilitation.   |
| Definition of health care quality | Quality care enables social participation, with a particular focus on the vulnerable.  |

Source: N. Hoeymans, et al.; A healthier Netherlands: Key findings from the Dutch 2014 Public Health Status and Foresight Report



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Monika Kosinska

rather, the future would in all probability be a mixture of the four perspectives and possibly others. Furthermore, some elements may even be conflicting, thereby forcing some potentially difficult choices. Since not everybody will benefit from future healthcare systems, policy-makers can use the different perspectives to obtain an idea of which groups in society will win or lose if only one perspective is carried out.

Joining the discussion as panellists were **Caroline Costongs**, Managing Director, EuroHealthNet; **Scott L Greer**, Associate Professor of Health Management and Policy, School of Public Health, University of Michigan, and **Monika Kosinska**, Programme Manager Governance for Health, World Health Organization Regional Office for Europe.

They raised some interesting points and thereby set the scene for a lively discussion, during which it became clear that there is, in fact, no real consensus on what the future reality will be.

Costongs commented that governments should respond not only by targeting risk groups, as suggested in the second scenario, as that would fail to narrow health gaps. “We have to make sure that these groups improve on health at a faster rate than the rest. But if you only target the most vulnerable people, you may miss those who in the long run will be unable to sustain a

healthy life. None of the perspectives can stand alone. They are all interlinked and need to be tackled,” she said. With regards to vulnerable groups, it was suggested that there is room for greater diversity and that freedom of choice and autonomy could well leave certain groups behind. There was no doubt, however, that supporting vulnerable groups certainly improves population health.

Greer suggested that the Dutch researchers had done a “mean thing” by forcing people to make a choice between objectives that are all positive, and unarguable. “It’s a nice way to express divergence and different priorities. Instead of just always using scary scenarios for people who smoke or are obese, we can also talk about what kind of public health policy we want,” Greer said.

As the discussion continued, various illuminating points were made and engaging questions raised by both panellists and audience members alike. One such point was regarding scenario three (personal control), which was that autonomy within the sphere of healthcare doesn’t materialise automatically and that improving health and longevity could, in fact, potentially put pressure on said autonomy and shared decision-making.

Kosinska added that some parts of the perspectives were already visible today, but overall the scenarios are “enormous goals”. “These are four aspects of the holy grail

## Taking Personal Control



|  |  |
|--|--|
| <b>Concerns and motivations</b>          | <ul style="list-style-type: none"> <li>&gt; We know best what is good for us</li> <li>&gt; The quality of our own lives is the prime concern</li> <li>&gt; Government enables individual initiatives</li> <li>&gt; Health care providers listen to us</li> </ul> |
| <b>Health</b>                            | Health primarily means quality of life; individuals determine for themselves what that involves.   |
| <b>Prevention and care</b>               | Prevention and care are broad notions that may include alternative medicine and life coaching.   |
| <b>Definition of health care quality</b> | Quality care ensures well-being, as determined by each individual.   |

## Healthy Prosperity



|  |  |
|--|--|
| <b>Concerns and motivations</b>          | <ul style="list-style-type: none"> <li>&gt; Prosperity for both current and future generations</li> <li>&gt; Government retains wherewithal for education and other public services</li> <li>&gt; Insurance premiums stay affordable for individuals and employers</li> <li>&gt; Cost-effective care for those who really need it</li> </ul> |
| <b>Health</b>                            | You’re healthy if you generate no costs for curative or long-term care.  |
| <b>Prevention and care</b>               | Collectively funded care is narrowed to essential services.  |
| <b>Definition of health care quality</b> | Quality care is relevant and cost-effective, as determined by the health ministry and insurance companies.   |

Source: N. Hoeymans, et al.; A healthier Netherlands: Key findings from the Dutch 2014 Public Health Status and Foresight Report

in terms of health systems and well being. They imply a huge amount of change. I think this is a wonderful way for us to look at what we are trying to achieve and articulate all the time. In actual terms, we are not heading anywhere at the moment, though we know that if we don’t do something now, and something quite dramatic in terms of the way we are organising our care, we will certainly not be at any of these four scenarios,” Kosinska said. She reminded the workshop participants that business as usual was not an option in order to achieve even just one of the scenarios, as many decisions are being taken outside the health sector, and

that one goal for 2040 should be to suspend the siloed approach of public health. “It’s an aspect which we need to bring into this discussion. One thing we do know about 2040 is that the world will be a different place. The impact of climate change is going to have ever more presence, with shocks delivered to our systems. There will be many different ways we will develop as a society. For example, demographic change is one of the things we will look at differently in 2040, I suspect,” the WHO representative said.

Whatever the future holds, those present at the Our Health in 2040 Workshop appeared to be in agreement that at the heart of the health system is a person and that we want to live in an environment which allows us to be as healthy as we can be.



## WORKSHOP 1

1 October 2014

**Annemiek van Bolhuis**, Director, National Institute for Public Health and the Environment (RIVM)

**Henk Hilderink**, National Institute for Public Health and the Environment (RIVM)

**Caroline Costongs**, Managing Director, EuroHealthNet

**Scott L Greer**, Professor, University of Michigan, USA

**Monika Kosinska**, Programme Manager, Governance for Health, WHO Regional Office for Europe

Moderated by **Nick Fahy**, Director, Nick Fahy Consulting Ltd, UK

Organised by the National Institute for Public Health and the Environment (RIVM), Ministry of Health, Welfare and Sport, the Netherlands



National Institute for Public Health  
and the Environment  
*Ministry of Health, Welfare and Sport*

# PREVENTABLE BLINDNESS

## OPENING EUROPE'S EYES TO A GROWING CHALLENGE

### WORKSHOP 2

Written by Louise Boyle

Around 4% of the global population (roughly 250 million) are visually impaired and 0.5% are totally blind. The underlying question of the session was: Why are these diseases not a healthcare priority?

Ian Banks, Chairman of the European Forum Against Blindness (EFAB) and President of the European Men's Health Forum opened the workshop which looked at how eye diseases and preventable blindness impact society and how to mitigate this impact through prevention, timely diagnosis and early intervention.

#### Prevent what can be prevented

Glendon Harris, AMD Alliance International and Board Member of EFAB, described how the EFAB was launched, including the bodies it is composed of, its key objectives and the aspirations and the achievements since it came into being. It was brought together in 2012 by four organisations (AMD Alliance International, IDF Europe, European Men's Health Forum, European Council of Optometry and Optics) committed to making rapid improvements to eye health, particularly in relation to preventable blindness. Data collection on the topic

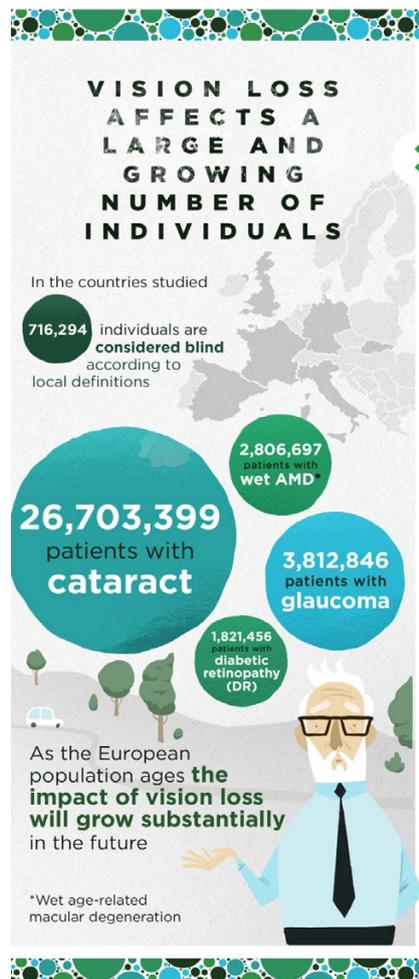
revealed three key points:

- ◆ There is likely to be an increase in eye diseases over time, related to demographic changes.
- ◆ A significant percentage of blindness is preventable.
- ◆ It makes financial sense to undertake interventions to prevent blindness.

These findings led to a focused EFAB Call to Action to address preventable blindness in Europe. An aspirational goal is, in time, to convince the European Commission and European Parliament that a European initiative may help to guide nations to marshal the resources necessary for reducing or eliminating preventable blindness.

Following Harris' presentation, Banks posed a few questions. He asked why there is such a commonly held view that we cannot treat age-related macular degeneration (AMD), and what is stopping us from acting?

A decade ago it was true that there was no treatment for the condition, however now it is a question of raising awareness with patients and health professionals that treatment is available. Both suggested that discrimination in the form of ageism was a barrier here, with the notion that treating people advanced in years was considered by some to represent poor value for money, especially at a time when health budgets are financially constrained. However when considering the productivity gains that could be made, as well as the fact that it is going to become normal for people to live until



The Cost of Blindness - European Infographic

Source: <http://www.efabeu.org/resources/>

they are 100, this is clearly a short-sighted way of thinking.

## Cost and burden of preventable blindness study

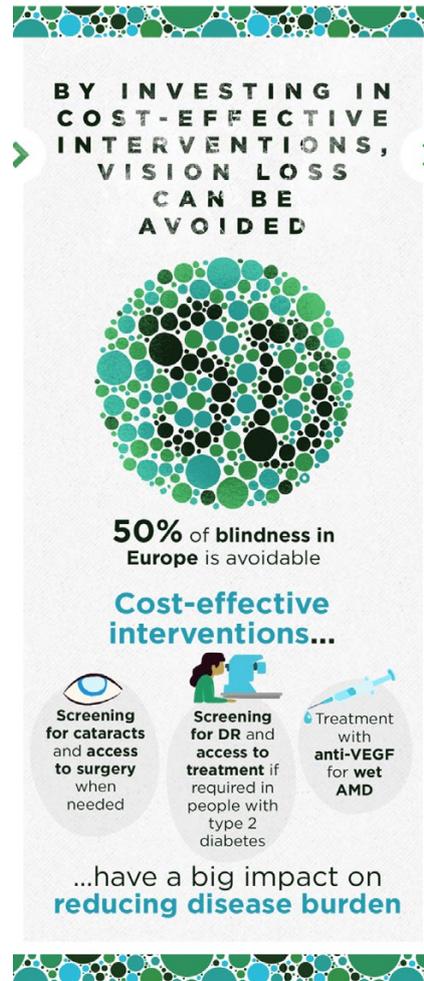
Next at the podium was Ömer Saka, Director, Market Access Strategy and Health Economics Group at Deloitte, to present the results of a comprehensive study quantifying the economic impact of blindness and vision loss on a number of countries across Europe.

Key headlines from the study were that between 9.292 and 218.513 individuals are blind per country; the healthcare costs for eye diseases are 18 billion euro per year and for blindness 1.7 billion euro per year in the EU-11 countries involved in the study, and finally that cost-effective interventions offset economic costs in the range of 2 billion to 3.5 billion euro.

Ultimately blindness and eye diseases cost society a lot of money, but the burden of healthcare expenditure can be reduced, productivity increased and patient quality of life improved and the burden on care-givers decreased by introducing appropriate, cost-effective interventions.

As Banks commented - this is a no-brainer, so why is it not happening, and why are employers in particular not taking the burden of disease (and its associated impact on productivity) more seriously? The answers were similar to those given by Harris, that there is an awareness issue as blindness is perceived to be something that happens to a small group of people who are relatively invisible and retired from public life, and without a strong political foothold to campaign for change.

In addition Saka envisaged an increased role for health professionals who should be alert



The Cost of Blindness - European Infographic

Source: <http://www.efabeu.org/resources/>

to at-risk patients they are treating for other conditions and refer them on for screening. He ended on a positive note though by saying that some of the social security institutions who had been presented with the study data were interested in taking action if national governments remained passive on this issue, as there was an obvious incentive for them in terms of mitigating future healthcare costs for this group of diseases.

## How to inform the right people in the right way at the right time?

In the presentation and discussion that followed, Elio Borgonovi, SDA Bocconi-University, Italy and President, Research Centre of Health and Social Service

Management (CERGAS), himself a Retinitis pigmentosa patient, identified a number of the key challenges facing preventable blindness: one being the lack of timely and appropriate information reaching the right people, be it patients, professionals or others. Specifically with regard to health professionals such as optometrists, a couple of key barriers to them facilitating patient treatment would appear to be ignorance about what treatments/technologies are available (which was illustrated by a brief discussion about the percentage of optometrists that are aware of retinal implants), as well as a mindset of acceptance of visual impairment: that unless a patient is totally blind the improved quality of life that the patient could benefit from can be underestimated. Borgonovi also outlined five different groups of stakeholders: patients, professionals, policy-makers, managers and industry, all facing different pressures, from how to manage different priorities to how to deal with financial constraints. He purported that a key challenge was how to find solutions that meet the expectations of all these groups of stakeholders and creates win-wins for all.

Renate Heinisch, Member of the European Economic and Social Committee (EESC), former MEP and pharmacist, discussed the impact of vision loss with particular reference to ageing. She pointed out how vision is a major factor determining quality of life, and that when older people lose their eyesight they lose access to 80% of the information that used to be at their disposal, with obvious significant impacts on physical and mental well-being. This can potentially destroy their ability to live independently, with implications both for themselves, their families and society. The role of older



Ian Banks and Elio Borgonovi

people and their continued contribution to society past retirement age has changed dramatically over the past few decades. The main message emphasised was that aside from the fact that preventing these diseases should be a major part of a healthy ageing strategy, it is well worth the investment to prevent avoidable blindness and treat vision impairment in this section of society.

### Take-home messages

The panel discussion reflected on a number of key themes from the presentations. Firstly that prevention and awareness are key - in particular there were calls for better, more joined-up referral processes including a plea to involve paramedical staff such as opticians or pharmacists in the onward referral process. Allied to this was a call for better partnership working and understanding amongst the different actors involved in tackling preventable blindness - from civil society, to policy-makers, to science and academia and industry. Early intervention in tackling preventable blindness was also highlighted as a take-home message, either to treat the condition or prevent it from happening in the first

place. And finally, it is clear that preventing or treating avoidable blindness is highly cost-effective. What is really required is the insight, political will and courage on the part of politicians to take action.



The Cost of Blindness - European Infographic  
Source: <http://www.efabeu.org/resources/>

Detailed session information and materials

### WORKSHOP 2

1 October 2014

**Glendon Harris**, Board Member, European Forum Against Blindness (EFAB)

**Omer Saka**, Director, Market Access Strategy and Health Economics Group, Deloitte, Belgium

**Elio Borgonovi**, SDA Bocconi University, Italy and President, Research Centre of Health and Social Service Management (CERGAS)

**Renate Heinisch**, Member of the European Economic and Social Committee (EESC), former MEP

Moderated by Ian Banks, Chair of European Forum Against Blindness (EFAB) and President of European Men's Health Forum

Organised by the European Forum Against Blindness (EFAB)

Supported by Novartis, Alcon and Second Sight Medical Products as a service to medicine and patients

**European Forum Against Blindness**



# REAL WORLD PATIENT DATA

## ENABLING TECHNOLOGIES FOR BETTER PATIENT OUTCOMES

### WORKSHOP 3

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Released by Vital Transformation<sup>1</sup>

How to use data from the real world to speed the development of new medicines, improve diagnosis and provide better treatments?

Medicines developed in clinical trials under controlled circumstances may perform differently for patients in the real world. To a large extent this is because clinical trial protocols exclude relevant groups, for example, the over 60s, those taking other drugs, people with co-morbidities. Technologies now exist for capturing and analysing real world data that reflect real world responses and experiences of patients, to bridge this divide. However, there is much to be done at a policy and at a practical level to pull the strands together and harness real world data to boost health and increase the sustainability of Europe's healthcare systems.

This workshop brought together some of the leading policy-makers to exchange views and discuss examples of best practice from projects and live implementations that are lighting the way in the use of real world data towards improving healthcare.

**Martin Seychell**, Deputy Director-General in the Health and Consumers Directorate-General, European Commission and other leading policy professionals agreed that it was critical for the incoming European Commission to create an environment for real world and big data to become mainstream use.

"The next five years are absolutely crucial. The key challenge is to optimise healthcare systems," Seychell said. Currently there is a time lag between when the evidence is gathered and when a decision is taken. "We can't afford to keep doing it like this," Seychell told delegates. "We need to capture data and make the best use of it."

While there are multiple sources of real world data relating to health, one of the fastest growing and most potent is data gathered by individuals on mobile phones and other internet-linked mobile devices.

But mHealth apps also raise significant issues of data protection, patient safety, liability and the need for international standards.

"There is a lot of hype, but what are the real possibilities?" said **Peteris Zilgalvis**, Head of Unit, Health and Well-Being, DG Connect. The European Commission is currently assessing responses to an open

consultation on mHealth and will publish its findings in November 2014. "There are problems and we hope to solve these with colleagues," Zilgalvis said.

mHealth is a key component of improving healthcare as a whole, believes **Nathalie Kayadjanian**, Senior Scientific Officer, Science Europe. The real world data setting makes it possible to capture information on other dimensions of a patient's experience that cannot be gathered in clinical trials. "This is important because complex diseases cannot be explained with one dimension. You need to integrate biology with the environment in which a human being is living," Kayadjanian said.

mHealth creates the opportunity to collect data, but there are challenges to its effective use. These include dealing with the volume of data, avoiding spurious correlations, knowing how to interpret data, and at a policy level developing a supportive ecosystem, Kayadjanian noted.

Real world data is important for research into new medicines, but also has huge potential to help in making the best use of existing drugs, assisting in issues such as compliance and managing co-morbidities,

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<sup>1</sup> Source: <http://goo.gl/AR8VaX>



Mary Baker, Nathalie Kayadjanian and Peteris Zilgalvis

said **Mary Baker**, Former President of the European Brain Council and a Board Member of the European Alliance for Personalised Medicine. "There is a real need to invest in data collection and work on it to understand the inefficiencies of [healthcare] systems. That's where we will make the savings," Baker said.

**Richard Torbett**, Chief Economist of the European Federation of Pharmaceutical Industries and Associations, argued that by enabling value-based judgements, real world data would make healthcare systems more efficient. It will also help in the development of better-targeted therapies.

In addition, adaptive licensing, in which a medicine is licensed for a small patient population and the approval extended to more patients on the basis of real world data, calls for a new approach to clinical trials. "For the pharmaceutical industry, real world data are a source of scientific and cultural change," Torbett said.

### How is Europe doing in mHealth?

The context was set by **Wendy Currie**, Professor of Information Systems at Audencia Nantes University in France, who has been following the adoption of mHealth across Europe since 2009.

Her analysis points to four clusters of

countries - front runners, followers, leapfroggers and laggards. "Throughout Europe there are digital divides, and politicians need to look at where to put taxpayers' money to develop mHealth and eHealth," Currie told delegates.

At present, the market for mHealth is commoditised, with lots of free and low-cost apps that are being downloaded but not being used, and not providing quality, Currie said, noting that while there are estimated to be 100.000 health, lifestyle and well-being apps, only 100 have US Food and Drug Administration endorsement.

### Showcasing best practice in data capture and usage

**Brian Rothman**, Medical Director of Informatics at Vanderbilt University Medical Center, described a system that is currently up and running and capturing real time data at the Center. Here, a desktop computer application for monitoring patients in the operating room has been ported to a smartphone and tablet platform, increasing the usefulness and flexibility of what was already acknowledged to be an important tool in protecting patient safety.

Rothman told delegates, this provides anaesthesiologists with the full "situational awareness" that they lack unless they are face-to-face with a patient. The system

delivers real life data on vital signs of patients under anaesthesia. It also streams a live video of the operating room. "You can be in the moment and define the next steps," Rothman said. "I'm in one operating room now, which operating room am I required in next?"

The goal is to improve outcomes by the proactive identification of any emerging problems, providing the opportunity to mitigate or eliminate an emerging deleterious event. This is not changing the standard of care or the level of direct human supervision.

**Ifty Ahmed**, founder and CEO of POW Health, described how in common with a number of mHealth start-ups, POW Health has taken the model of popular social media sites such as Facebook, as the basis of services that are both consumer-focused in providing access to medical information and allowing patients to share experiences with others with the same conditions, but also bring mHealth within the ambit of formal healthcare systems, allowing users to monitor their health through connected devices, to interact with their doctors and to provide consent for their data to be used for research.

**John Crawford**, Healthcare Industry Leader, IBM Europe, discussed how to take all the



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Wendy Currie and John Crawford

data coming from the real world and tied up in medical records and sources such as medical images and the scientific literature, and apply analytics to interpret it.

IBM's Watson system has the capability to digest and interpret vast amounts of unstructured data. It can, for example, read scientific journals, using the information to create and then test hypotheses, learning as it goes. Watson can also be used to predict events and take action beforehand. For example, by analysing the outputs of devices monitoring premature babies, it is possible to anticipate an infection before it has taken hold and the physical symptoms are manifest. Watson is currently under test in a number of healthcare settings. "The feedback we are getting is that it augments the experience of doctors," Crawford said.

Detailed session information and materials



### WORKSHOP 3

1 October 2014

**Martin Seychell**, Deputy Director-General, DG Health and Consumers, EC  
**Peteris Zilgalvis**, Head of Unit, Health and Well-Being Unit, DG CONNECT, European Commission

**Nathalie Kayadjanian**, Senior Scientific Officer, Science Europe

**Mary Baker**, former President, European Brain Council and Board Member, EAPM

**Richard Torbett**, Chief Economist, EFPIA

**Wendy Currie**, Professor of Information Systems, Audencia Nantes University, France

**Brian Rothman**, Medical Director Informatics, Vanderbilt University Medical Center

**Ifty Ahmed**, Founder and CEO, POW Health Website

**John Crawford**, Healthcare Industry Leader Europe, IBM

Moderated by **Duane Schulthess**, Managing Director, Vital Transformation

Sponsored by EFPIA with the support of the Fellowship of Post Graduate Medicine and EAPM and organised by Vital Transformation



# HEALTHCARE PARTNERSHIPS IN AUSTRIA

## BETTER TOGETHER

### WORKSHOP 4

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Written by Chaska Armbruster

The goal of the workshop was to provide an introduction and overview about current healthcare partnerships using the example of Austria, recognising the rising demand of any population targeting healthcare services under normal circumstances rises with public budgets and existing healthcare structures often being a barrier for reforms. Therefore the know-how and experience of main stakeholders and their will to improve healthcare systems further are key success factors for any reforms.

The workshop was moderated by **Robin Rumler**, President of the Association of the Austrian Pharmaceutical Industry (Pharmig) and **Jan Oliver Huber**, Secretary General, Pharmig. The moderators stated that the industry shares the common concern to deliver better health for all and plays its part as an active stakeholder in the Austrian healthcare system.

The workshop introduced three case studies of healthcare partnerships, including two focusing on paediatrics initiated by Pharmig in conjunction with the Austrian Ministry of

Health, and one by Pharmig in conjunction with the Main Association of Austrian Social Security Institutions.

#### **OKIDS - Austrian Network of Paediatric Research**

The first partnership model was introduced by **Pamela Rendi-Wagner**, Director General of Public Health, Austrian Ministry of Health, and Huber.

They explained that 50 - 90 % of medicines used in the paediatric sector are not authorised or adequately studied in children. The main objective and idea of OKIDS is that children need adequately researched and safe medicines, which would necessitate a measurable increase in paediatric trials. Therefore, as part of a public private partnership, OKIDS was created as a network for the development of medicinal products for children and juveniles in Austria.

The project was launched in 2013 and the partners involved in the start-up financing are the Austrian Ministry of Health and the pharmaceutical industry. With this financial aid, high-quality clinical trials can be conducted more quickly.

The establishment of a one stop shop which offers the following services with outstanding quality and performance for the conduct of paediatric trials plays a central role:

- ◆ Clear, rapid processes through one point of contact: feasibility studies, contracts, establishment of harmonised standards, reporting systems, quality assurance;
- ◆ Sufficient resources and know-how, including study personnel, trainings and cooperation with other networks;
- ◆ Predictable patient recruitment: compliance with commitments, establishment of databases, integration of referring physicians.

In terms of numbers, OKIDS has defined eight milestones, including for example the goal to increase the percentage of paediatric trials by up to 15% per year, and gain acceptance into the EU network EnprEMA - European Network of Paediatric Research at the European Medicines Agency.

Overall, the project should bring faster access to new therapies, access to know-how and excellence in research, as well as stronger links between paediatric physicians and academia.

## EnprEMA - European Network for Paediatric Research

**Christoph Male**, Austrian representative at Paediatric Committee (PDCO) at the EMA European Medicines Agency and Paediatrician, Medical University of Vienna, explained the goals and contents of Enpr-EMA.

EnprEMA is a network of research networks, investigators and centres with recognised expertise in performing clinical studies in children. According to its mission statement, the agency aims to facilitate studies in order to increase the availability of medicinal products authorised for use in the paediatric population. Furthermore, the European Medicines Agency wants to be a “network of networks”. The main stakeholders include the pharmaceutical industry, CROs, patients, parents and patient organisations. The advantage for industry is to gain access to academic partners through collaborations and gain access to networks that can help facilitate the recruitment of patients for clinical trials. Research centres on the other hand can join networks, save resources, share skills and expertise in research. EnprEMA visualises itself as the pan-European voice for promoting paediatric research.

## Pharma Master Agreement

**Alexander Hagenauer**, Deputy Director General, Main Association of Austrian Social Security Institutions gave a quick introduction and some current numbers on Austrian social health insurance, which consists of pension insurance, health insurance and accident insurance. The Pharma Master Agreement, begun in 2008, is a contract between Pharmig, other associations and the pharmaceutical companies, wholesalers



Pamela Rendi-Wagner and Jan Oliver Huber

and social health insurance organisations to support the performance of patient-focused health insurance. Based on this contract, pharmaceutical companies and wholesalers will pay a voluntary solidarity contribution of 82 million euro until the end of 2015. A part of this total amount, 6.75 million euro, is earmarked for joint projects in the field of child health and prevention. Approximately 1.5 million euro are invested annually for the funding of innovative healthcare projects. For the stakeholders, the joint projects are a key success factor and a driver for reforms, as they see more value in working together. Since 2012, there have been more than 200 project submissions. The submitted projects are professionally reviewed and undergo an evaluation. Selected projects are intended to serve as models for improved health services to politicians and other partners in the healthcare sector. This initiative conducted in collaboration between the pharmaceutical industry and social insurance carriers, which is probably unique in Europe, supplements the efforts of state healthcare policies to advance the healthcare system.

The workshop concluded with a discussion round covering questions on aspects of the different health partnerships discussed in the session.

Detailed session information and materials



### WORKSHOP 4

1 October 2014

**Pamela Rendi-Wagner**, Director General, Public Health and Medical Affairs Section, Federal Ministry of Health, Austria

**Alexander Hagenauer**, Deputy Director General, Main Association of Austrian Social Insurance Institutions

**Christoph Male**, Professor of Paediatrics, Medical University of Vienna, Austria and European Paediatric Network EnprEMA representative

Chaired by **Robin Rumler**, President, PHARMIG

Co-chaired by **Jan Oliver Huber**, Secretary General, PHARMIG

Organised by Association of the Austrian Pharmaceutical Industry (PHARMIG)



# HEARING LOSS

## THE NEGLECTED PUBLIC HEALTH CHALLENGE

### WORKSHOP 5

Written by José Pulido Manzanero

The aim of this workshop was to increase awareness about the reality of hearing loss (HL) in the European Union, especially among vulnerable patient groups, such as children and the older population, and about the consequences for EU citizens and families.

The workshop was divided into two parts: speaker presentations by three professionals with significant experience in the study of HL coming from different scientific areas which resulted in a session combining issues from the social sphere and from healthcare; and the discussion with the audience.

#### Numbers

Pierre Anhoury, CEO, Agir Pour L'Audition, highlighted the main figures regarding the problem of hearing loss around the world:

- ◆ Over 360 million people (5.3%) in the world suffer from some type of HL.
- ◆ For 1 million people with HL: 60% need subtitles while watching TV; 40% need hearing loops, hearing aids, technical support; 14% need rehabilitation, lip-reading, community support; 1.5% need sign language interpreters and some 1% (children) need specialist deaf education.

- ◆ Chronic ear infections are a leading cause of HL.
- ◆ Between 0.5-5/1000 infants are born with or develop in early childhood disabling HL.
- ◆ About 20% of people with HL need hearing aids in developing countries.
- ◆ The incidence of patients with HL increases with age: some 20% of people aged 41-50 years are affected; 30% of people aged 51-60 years; 50% of people aged 61-70 years; 70% of people aged 71-80 years and 90% of people aged >80 years.

#### Hearing is no luxury

Bruno Frachet, Hôpital Rothschild, France, made a brief introduction to the different levels of hearing loss (mild, moderate, severe or profound) depending on the number of decibels (quantitative classification). He paid special attention to the problem of presbycusis, a progressive bilateral symmetrical age-related sensorineural hearing loss that affects both men and women equally (30-50% among people aged >65 years, 80% among people aged >80 years). A grid was shown for identifying the three stages of presbycusis, using feedback we can receive from our inner circle, friends or co-workers and our own experiences.

Three concepts are very important: deficiency (physical dimension), disability (functional dimension) and handicap (social dimension). The same deficiency will not necessarily result in the same handicap. In this context, the handicap is, as opposed to the deficiency, a result of social organisation. Social treatment of deafness as a handicap gives us two options: "to amend society" (for instance, by certain new laws) and/or "repair the deficiency" (e.g., Cochlear implantation).



## Consequences

Deniz Baskent, University Medical Centre Groningen, the Netherlands, addressed in greater detail several problems related to hearing impairment, providing results of some studies that evaluated the association between these problems and hearing loss:

- 1) language development,
- 2) behavioural problems,
- 3) neuropathology,
- 4) school/work,
- 5) social withdrawal, isolation,
- 6) depression,
- 7) cognitive decline, dementia,
- 8) early retirement.

Most people with severe to profound hearing loss before retirement age will earn 50 to 70% of their normal-hearing peers. This is the main individual cost. The societal cost of hearing loss in Europe is from 2.200-11.000 euro.

At the end of his presentation, he made a call for action in various fields:

- ◆ Implement early and universal screening and intervention
- ◆ Raise awareness of the consequences of hearing loss
- ◆ Increase research for better understanding of the causes and consequences of hearing loss, its interactions with other factors, best rehabilitation
- ◆ Development and dissemination of evidence-based guidelines for clinicians, caregivers, schools, workplaces
- ◆ Industry partnership for affordable assistive devices



Deniz Baskent

## Solutions

In his presentation, **Jens Kofoed**, General Manager, William Demant Holding, France, showed the different "solutions" that are applied at present, not only related to hearing ("in the ear", "behind the ear" and "bone anchored" hearing aids; cochlear implants; connectivity devices, etc), but psycho-social problems and mild cognitive impairment. Hearing aids are a good investment, for individuals as well as for governments.

However, too many people worldwide suffer due to a lack of access to the appropriate health technologies (WHO, 2012). Hearing loss is the second leading cause of "years lived with disability." On the other hand, successful fitting of a hearing aid is not just delivering an instrument (access), but assuring full and appropriate rehabilitation. This is true in developed as well as in developing countries. It is a frequently made mistake to see hearing aid technology in isolation from the general health system - it is one part of a big puzzle. They are inter-linked. The target is a long-term sustainable appropriate hearing healthcare set-up including awareness, diagnostics, delivery, rehabilitation and service.

In terms of policy recommendations, Kofoed mentioned:

- 1) Harmonisation of the use of tools, measurements and methods;
- 2) An innovative and coherent EU policy and regulatory framework;
- 3) A global allocation of the necessary frequencies for wireless services;
- 4) Work towards fulfilling the need for a sufficient number of well-educated hearing aid professionals in each member country.

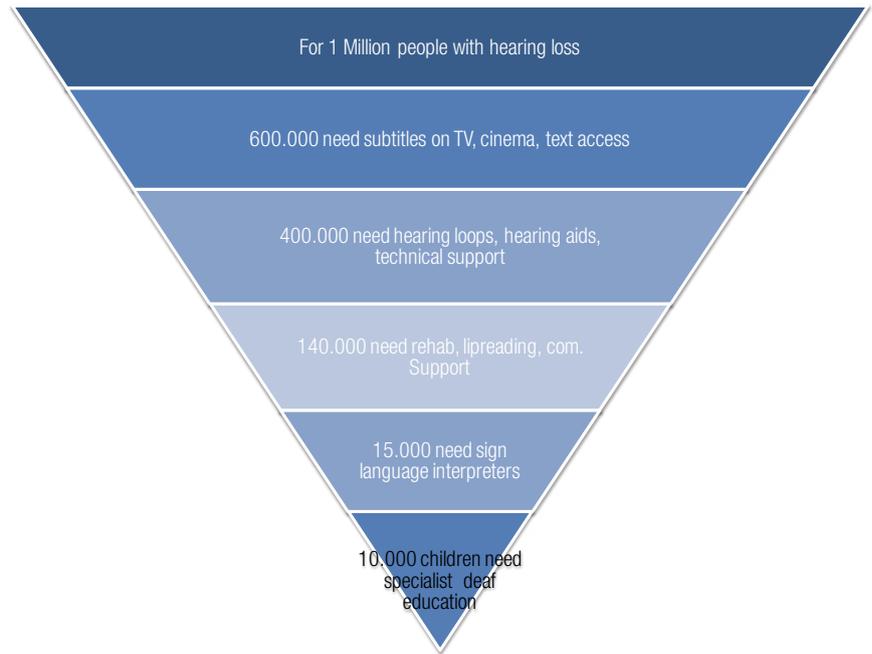
He also made a new call for action: to improve awareness about the benefits of hearing care for both the individual and for society.

## Discussion

In the course of the discussion the audience formulated several actions to protect European citizens:

- ◆ Increase our knowledge about hearing loss in the EU (EU-coordinated epidemiology studies)
- ◆ Launch an EU campaign to protect the hearing of the youth
- ◆ Organise early screening of HL for all (with a focus on EU citizens 60+)

- ◆ Raise awareness of the consequences of hearing loss
- ◆ Promote research for better understanding the causes and consequences of HL, its interactions with other factors, best rehabilitation and early rehabilitation
- ◆ Improve awareness about the benefits of hearing care for both the individual and for society
- ◆ Implement the EU quality norm EN15927 in all Member States for services offered by hearing professionals
- ◆ Develop and disseminate evidence-based guidelines for clinicians, caregivers, schools and workplaces
- ◆ Develop industry partnerships for affordable assistive devices
- ◆ Offer new economic models through a more competitive market



The global picture of hearing loss

Source: HRF, Sweden's national association for hearing impaired people

Detailed session information and materials



## WORKSHOP 5

1 October 2014

**Deniz Baskent**, University Medical Center Groningen, Rijksuniversiteit Groningen, the Netherlands

**Jens Kofoed**, General Manager William Demant Holding, France

**Pierre Anhoury**, CEO, Agir Pour l'Audition

Chaired by **Bruno Frachet**, Hôpital Rothschild, France

Organised by Agir Pour l'Audition (Acting for Hearing)

 **AGIR POUR L'AUDITION**  
Recherche et prévention pour la santé auditi

# EUROPEAN INTEGRATION AND SOCIAL HEALTH INSURANCE

## IMPACT, RESPONSES AND FUTURE PRIORITIES

### WORKSHOP 6

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Written by Joreintje Mackenbach

There is an overall need to improve efficiency and financial sustainability of health systems. Statutory health insurers play an important role in improving the performance of European health systems, though their role may be undervalued by the EU.

During this workshop, the visions of several social health insurance stakeholders were explored. The session was moderated by **Willy Palm**, Dissemination Development Officer, European Observatory on Health Systems and Policies, who introduced the main goal of the session as being to explore a social health insurance perspective on priorities for healthcare systems and how those relate to the EU's priorities.

To start the workshop off, **Ewout van Ginneken**, WHO Collaborating Centre for Health Systems Research and Management, gave a comprehensive presentation on the key trends in European health insurance systems. He focused on four main themes, namely the context of social health insurance, trends in insurance markets, trends in purchasing, and challenges for

health insurers. After a short description of the multiple actors involved in social health insurance, the audience was shown the evolution of total health expenditure in European countries. Health expenditure increased in all European countries, with the Netherlands at the highest expenditure and Croatia and Lithuania at the lowest expenditure. In all countries, high expenditure is mainly due to high hospital costs. In some countries, there is insurance competition for cost control and efficiency. However, health insurers take various roles, ranging from passive (e.g. reimbursing) to strategic (e.g. purchasing). The main discussion points arising from the presentation were:

- ◆ Do we have the tools for strategic purchasing? How can insurers stimulate primary/outpatient care, and how can they negotiate pharmaceutical prices?
- ◆ How to pay for quality, and not for volume, when meaningful performance indicators are lacking, raising the question about the need for better data systems?
- ◆ How do we make it attractive to invest in prevention?

- ◆ How does European regulation and influence conflict with the objectives of the health insurers?

**Franz Terwey**, Director, European Social Insurance Partners (ESIP), presented the EU policy agenda for social (health) insurance. From his role as director of ESIP he explained that his mission was to reinforce solidarity in health insurance systems in Europe. EU healthcare policy is often focused on fiscal and growth related aspects, but ESIP advocates a focus on access to healthcare services and their quality and efficiency. Terwey briefly reflected on five key topics on the EU policy agenda, including:

- ◆ healthcare products (i.e. medical devices, pharmaceuticals);
- ◆ long-term care (there is an enormous diversity between European countries);
- ◆ data protection (new European rules);
- ◆ VAT-reforms (ESIP advocates for keeping VAT rules as they are) and
- ◆ free trade agreements (from which ESIP believes social insurance should be excluded).

Concluding, Terwey challenged the incoming European Commission President Juncker to

keep his word that the EU will be bigger and more ambitious, but also smaller and more modest on small things. He commented that the EU should respect the principles of subsidiarity and proportionality and stated that the European Parliament should, first and foremost, represent the interest of EU citizens, rather than the interest of industry, and that the EP should be a balanced counterpart to the EU.

“  
Healthcare policy  
should be focused  
on **access to  
healthcare services,**  
their quality and  
efficiency.



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Franz Terwey

### Panel discussion

Following this, a panel discussion took place, involving representatives from six European countries: Austria, Belgium, Croatia, France, Germany, Lithuania and the Netherlands.

All health insurance experts were asked their opinion on the biggest challenges for the coming years. Many European countries received country-specific recommendations from the European Commission on financial cuts to different healthcare sectors.

For all panellists, the financial sustainability of national health systems was raised as a key issue. Following the presentation by van Ginneken, panellists mainly reflected on the difficulties associated with financial cuts in hospital care. Decreasing the number of hospitals is politically difficult because it means reduced access to healthcare.

Additionally, given the general consensus within the panel that the current financial problems are not caused by the social security system but by the financial crisis, the panellists agreed that without economic recovery, meeting the targets for healthcare savings would be difficult. However, for Germany, there is also no political pressure to meet the targets, given the surplus in the healthcare system. An additional discussion point was the lack of clarity and transparency on what country-specific recommendations are based, emphasised by the fact that, for example, Belgium did not receive country-specific recommendations. It should be clarified why countries receive country-specific recommendations, and also, who is monitoring the effects of these recommendations.

The panellists noted that ideally there would be enough transparency and enough data to have a more risk-based approach in the healthcare system. However, that requires data on the value of health, a topic of ongoing debate. The panellists agreed that clear organisation of care is of increasing importance and that it might be necessary for hospitals to create networks and to financing these networks jointly. This would involve developing appropriate structures such as linking with home care organisations in order to be able to save on hospital care. The panellists agreed that ensuring financial stability requires investment and that any significant cuts should be made as a last step: if you cut budgets first, creating structures required for future development is hindered.



## WORKSHOP 6

2 October 2014

**Ewout van Ginneken**, WHO Collaborating Centre for Health Systems Research and Management, Berlin University of Technology, Germany and European Observatory on Health Systems and Policies

**Franz Terwey**, Director, European Social Insurance Platform (ESIP)

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

**Jo De Cock**, General Administrator, National Institute for Health and Disability Insurance, Belgium

**Dominique Polton**, Advisor to the Director General, National Health Insurance Fund for Salaried Workers (CNAMTS), France

**Doris Pfeiffer**, President of the Board, National Association of Statutory Health Insurance Funds, Germany

**Patrick Jeurissen**, Chief Strategy and Knowledge Management Group, Ministry of Health, Welfare and Sports, the Netherlands

**Gintaras Kacevicius**, Director, Health Insurance Department, National Health Insurance Fund of Lithuania, Lithuania

**Dijana Cimera**, Assistant Minister, Ministry of Health, Croatia

Facilitated by **Willy Palm**, Dissemination Development Officer, European Observatory on Health Systems and Policies

Organised by the European Observatory on Health Systems and Policies and the International Forum Gastein

Supported by the Main Association of Social Security Institutions of Austria, the National Institute for Health and Disability Insurance of Belgium, the National Health Insurance Fund for Salaried Workers of France, the National Association of Statutory Health Insurance Funds of Germany and the Celsus, academy for sustainable healthcare in the Netherlands



# HEALTH FOR JOBS AND PROSPERITY IN SOUTH EAST EUROPE

## SEE 2020 GROWTH STRATEGY

### WORKSHOP 7

Written by Andrea Schmidt

Adriana Galan, National Institute of Public Health, Romania, opened the workshop by introducing the South-eastern Europe Health Network (SEEHN), an inter-governmental organisation with ten member countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, the Republic of Moldova, Romania, Serbia, the Former Yugoslav Republic of Macedonia, and Israel). It is a multi-governmental forum for regional collaboration on health and health equity, health systems and public health, based on the understanding that a healthy population constitutes an important element for achieving fair and inclusive growth. Additionally to being an economic good, a healthy population and the health sector itself are public goods which are societal goals of solidarity and sustainable development.

The Network was established in 2001, with the support of WHO Europe, Council of Europe, Council of Europe Bank of Development, and many other partners, the EHFG being one of them. The network has grown fast and now constitutes an independent, self-financed organisation with headquarters located in Skopje, Macedonia.

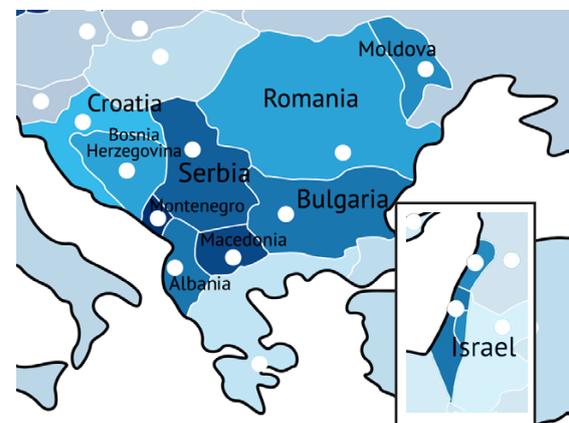
Following the introductory comments two panel discussions took place within the workshop, moderated by Christine Brown, Programme Manager, WHO Venice Office.

#### Regional cooperation for health-supported inclusive growth in SEE - the political imperative and policy opportunities

Nand Shani, Senior Expert on Inclusive Growth, Regional Cooperation Council

Goran Cerkez, Assistant Minister for International Cooperation and Coordination of Strategy Development, Federal Ministry of Health, Bosnia and Herzegovina; Chair of the SEEHN Executive Committee

In 2010, the SEEHN became the official regional dimension coordinator with responsibility for consultation and development of health objectives within the SEE2020 Growth Strategy. As a dimension coordinator the SEEHN also has the role to support regional action plans which aim to complement and further strengthen national level strategies, policies and interventions to improve health, specifically linked to



SEEHN member countries

the SEE2020 goals of inclusive growth. The SEE2020 Growth Strategy is funded through the European Commission's DG Enlargement strategy and is coordinated by the Regional Cooperation Council (RCC).

A key focus of the discussion was the rationale for the reasons actions to improve health were included as specific objectives within the SEE2020 Growth Strategy. One of the main reasons for including health is the role it plays in enabling inclusive growth. The relationship between good health and participation in employment and labour market performance is well documented. The health actions in SEE2020

aim to improve overall levels of health in the population of participating countries but also to reduce gaps in health within and between countries. This is informed by the commitments of Member States of Health 2020 (the new European Policy for Health and Well-being) and underpinning evidence on how reducing inequities is an important approach to strengthen social cohesion and also to ensure inclusive growth i.e. to ensure that all citizens benefit from GDP growth.



Christine Brown

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Overall, the speakers stressed that the SEEHN has helped to create dialogue and stronger relationships between the economic, development and health sectors. This has been achieved through various means including policy briefs on health and growth, joint meetings and dialogues with other stakeholders and sharing concrete examples of how health is a) an enabler of inclusive growth and b) a partner in policies and investments that bring benefits for health and other sectoral outcomes.

During a recent meeting of the SEE2020 regional dimension coordinators for social, environmental, health and economic issues, health as a sector and an objective surfaced as a key enabler and as a partner of several major multi-sectoral action plans for sustaining regional growth. Also included were tourism, security, social entrepreneurship and employment.

The panel discussants shared how the sustainability, growth and development targets of each member country can be achieved, through taking actions to improve health and reduce inequities, and by recognising the added value to development goals that can be achieved by taking into account health-related aspects. For

example, tourism could be identified as a priority sector for growth in the SEE Region where “sustainable tourism” links aspects of environment, agriculture, transport, employment, and health. Similarly, the market for information technology (IT) has a lot of potential, which can be harnessed for the benefits to health, and to the employment opportunities of the populations in the SEE region e.g. eHealth, mHealth, thus contributing to achieving both economic and health targets. Finally, a well-functioning health system, including early warning and rapid response systems to threats, has been proven internationally to be important to create consumer confidence, especially in the tourist sector, as it enables higher levels of a sense of security and safety among the industry and consumers when coming to the region.

A debate arose on the involvement of multilateral bodies. Within the network, international organisations (such as UN agencies, EU and WHO) are strongly involved and have made important contributions to past and current progress. However, there is some scope for improvement regarding the coordination of these partners and also for a better approach to “learn and see” first rather than telling countries which steps to

take. In addition, for many the accession to the EU is a main driver for policy reforms, which could also have positive effects on progress in the health of the population and the health sector per se. This is despite the fact that health has a low profile in the EU2020 high level targets and goals. The EU overall and the DGs Health and Consumers and DG Enlargement specifically should be more aware of their important role and responsibility in leveraging the gains to development from improving health and from reducing health inequities e.g. by supporting the exchange of learning and fostering promising practices with EU Member States. This is already underway through the TAIEX mechanism. However, there is a need to make stronger headway through bringing health more sharply into the accession process, through instruments such as the national and regional plans for pre-accession and the related funding mechanisms e.g. agenda of candidate countries, in which health is currently not a priority.

**Caroline Costongs**, Managing Director, EuroHealthNet, put forward the suggestion for the future to include social affairs and strengthen partnerships with the social sector as is already practiced, for example,

through the EU Social Investment Package. It was acknowledged, nevertheless, that a lot of progress has been made in the past years on solidarity through health, peace and stability building “health-in-all-policies” in the SEEHN.

### **Health as an entry point for national and local development and well-being**

**Tatjana Buzeti**, Centre for Health and Development, Murska Sobota, Slovenia

**Andrej Vršič**, Director, Local Tourist Board, Slovenia

**Adriana Galan**, National Institute of Public Health, Romania

**Natasa Terzic**, Director, Centre for Health System Development, Institute of Public Health, Montenegro

The panel discussed good practice examples from three countries on how health and economic growth can be combined. The first example referred to Slovenia, where a win-win strategy was implemented by promoting sustainable tourism in the North-eastern wine region, which has a long tradition in health spa tourism, by focusing rather on active free time, cycling and walking than the wine road's promotion within the agro-tourism framework. That part of Slovenia is now known as an “active” region (rather than as a “wine road” or destination to merely drink alcohol). A win-win situation has been achieved for tourists as well as the public health sector by investing in human capital and infrastructure in order to redefine and reposition a tourist destination as well as influence the lifestyle of inhabitants. There is continuous support from the Slovenian Ministry of Health (MoH), even though more investments would be

needed to extend cycling and hiking routes and wellness tourism. Considering the relatively small budget for prevention within Slovenia's health budget (ca. 3%), the MoH is predominantly investing in human capital and capacity development, while funds for infrastructure are coming from other sources (ERDF and other EU funds, national and local funds for infrastructural development). The main objective was to try a “health-in-all-policies” approach in one of Slovenia's least developed regions, involving local communities and different stakeholders in the project. This has produced beneficial effects also on local culture, where physical exercise (e.g. Nordic walking) is now seen as a possibility to enhance well-being.

The second example came from Romania, with the example of a project focused on vulnerable groups in rural areas to help them make the links between health and employment. The communities were provided with entrepreneurial skills to set up their own businesses, resulting in 40 start-ups to this date. In the future, partnerships between the healthcare sector with social and education sectors are planned, with one of the goals being to overcome the emigration of medical doctors and address existing gaps in the healthcare system.

Finally, in Montenegro a platform for sustainable development was created in which health was included. One of the aims was to strengthen the perception of health as a tool for growth in other sectors, such as employment. Health was brought to the agenda for the first time in such a context. It was acknowledged that many of the challenges related to health (such as demographic ageing, health inequalities) cannot be solved by the healthcare sector

alone. Also, tourism is seen as a sector with potential for health promotion. However, it was stressed that one of the priorities has to be to strengthen the healthcare system per se first before collaborating with other sectors to enhance prosperity.

### **Concluding remarks**

**David Hunter**, Professor, Health Policy and Management, Durham University, UK, made some concluding remarks. He stressed that research plays a vital role in how the experience from the network itself and from other sectors are captured. In order to maximise the impact of research, the relationship with policy-makers needs to be kept in mind at all times. Finally, it was suggested to involve academia for evaluating the network's experiences.



## WORKSHOP 7

2 October 2014

**Goran Cerkez**, Assistant Minister for International Cooperation and Coordination of Strategy Development, Federal Ministry of Health, Bosnia and Herzegovina and Chair of the Executive Committee, South-eastern Europe Health Network (SEEHN)

**Tatjana Buzeti**, National Centre for Health and Development, Murska Sobota, Slovenia

**Andrej Vrsic**, Director, Local Tourist Board, Slovenia

**Adriana Galan**, National Institute of Public Health, Romania

**Natasa Terzic**, Director, Centre for Health System Development, Institute of Public Health, Montenegro

**David Hunter**, Professor, Health Policy and Management, Durham University, UK

**Neda Milevska Kostova**, Executive Director, CRPRC Studiorum

**Elke Jakubowski**, Programme Manager, WHO Regional Office for Europe

**Caroline Costongs**, Managing Director, EuroHealthNet

**Nand Shani**, Senior Expert on Inclusive Growth, Regional Cooperation Council

Moderated by

**Christine Brown**, Programme Manager, Office for Investment for Health and Development (WHO Venice Office), WHO Regional Office for Europe

Organised by South-eastern Europe Health Network in conjunction with WHO Regional Office for Europe

Supported by EuroHealthNet, CRPRC Studiorum, Regional Cooperation Council and International Forum Gastein



SOUTH-EASTERN EUROPE  
HEALTH NETWORK



**World Health  
Organization**

REGIONAL OFFICE FOR **Europe**



# ACTIVE AND HEALTHY AGEING

## WORKSHOP 8

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Written by Alexandra Percă

The session was opened by **Martin Seychell**, Deputy Director General for Health and Consumers, European Commission and a video summarising the European Commission's work in the area of active and healthy ageing.

The Commission has gathered and analysed over 70 concrete good practice cases being implemented at a regional level in different EU Member States, and a reflection is going on how to best scale them up. "It's important to understand what elements can be transferred between countries, as the collaboration in Europe is based on good practices becoming standard practice across the EU," emphasised Seychell. He also pointed out that such projects could provide a better understanding of how to tackle difficult situations as well as facilitate the transfer of knowledge, practice and experience between countries. As a next step, DG Health and Consumers is finalising a comprehensive strategy that could be applied across Europe aimed at turning challenges into opportunities.

Leocadio Rodriguez Mañas, Head of the Geriatric Unit, University Hospital Getafe Madrid, Spain, was invited to share the outcome of a successful initiative and presented the Global Management of Frailty in Clinical Settings. The idea at the basis of

this project is that increased life expectancy has led to a greater number of disabilities; therefore we need to focus on increasing also the quality of life for EU citizens in order for them to benefit from more healthy life years. "After centuries of trying to live longer, the time to live better has come," added Mañas. The programme implemented in Spain is based on a multidisciplinary approach, benefiting from the participation of different stakeholders and political support. As a result of this initiative, frailty was declared one of the five priorities to be tackled in the Spanish National Programme against chronic diseases.

The examples of good practice continued with **Jacqueline Kuppens**, Consultant for Slimmer Leven 2020 in the Netherlands, who presented the Circles of Care Project. This initiative re-unites 18 care organisations working together to offer night care to over 640.000 inhabitants in the Netherlands. This model is based on using remote surveillance and supports eCare Centre staff caring for people with disabilities. The process is growing with small steps and requires strong commitments from several leaders of care organisations, in order to offer long-term benefits. Therefore, the success of this project is based on the ability to innovate



“  
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Martin Seychell

and to adapt to challenges, as well as to scale up the initiative.

**Toni Dedeu**, Director of Research and Exchange Knowledge, Digital Health Institute, Scotland, and Chair of the European Regional and Local Health Authorities (EUREGHA), talked about the role of regions in the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA). The Partnership, in place for three years, brings together a wide range of stakeholders working in a collaborative way to keep people active, independent and healthy for as long as possible. This is an on-going process, with continuous communication and dissemination of good practices between Member States and EU regions. According to Dedeu, this approach will lead to an effective European scaling up strategy on active and healthy ageing, with long-term commitment from different stakeholders for the benefit of citizens.



## WORKSHOP 8

2 October 2014

**Martin Seychell**, Deputy Director-General, DG Health and Consumers, European Commission

**Leocadio Rodríguez Mañas**, Head of Geriatric Unit, University Hospital Getafe Madrid, Spain

**Jacqueline Kuppens**, Slimmer Leven 2020, the Netherlands

**Toni Dedeu**, Director Research and Exchange Knowledge, Digital Health Institute, Scotland; Chair of EUREGHA

**Petra Leroy Cadová**, Policy Officer, Innovation for Health and Consumers, DG Health and Consumers, European Commission

Organised by DG Health and Consumers, European Commission



This workshop is part of the 17th EHFG conference which has received funding from the European Union, in the framework of the Health Programme (2008-2013).

# EU HEALTH PROGRAMME 2014-2020

## WORKSHOP 9

Written by Andrius Kavaliunas

In this workshop participants had the opportunity to hear more about the Third EU Health Programme 2014-2020 - a cutting edge possibility to improve health across the Union. **Michael Hübel**, Head of Unit, Programme Management and Diseases, DG Health and Consumers, European Commission, presented the programme's main goals, objectives and funding instruments.

The first Programme for the Community Action in the field of health came into force in 2003 and lasted till 2007, integrating all other previous small-scale programmes into one. This was followed in 2008 by the Second Programme which ran from 2008-2013. The current Third Programme for the Union's Action in the field of health (2014-2020) supports the overall Europe 2020 Strategy and the EU Health Strategy Together for Health, with a budget of about 450 million euro for the upcoming seven years, and is the only EU programme dedicated to health.

Its main objectives are:

- ◆ to promote health, prevent disease and foster supportive environments for healthy lifestyles;
- ◆ to protect citizens from serious cross-border health threats;



Health objectives of the Third Programme 2014-2020

Source: [http://ec.europa.eu/health/programme/docs/ev\\_20141104\\_co01\\_en.pdf](http://ec.europa.eu/health/programme/docs/ev_20141104_co01_en.pdf)

- ◆ to contribute to innovative, efficient and sustainable health systems;
- ◆ to facilitate access to better and safer healthcare for Union citizens.

The four areas are supplemented by their main 23 thematic priorities, addressing tobacco, alcohol, physical inactivity, chronic diseases, HIV/AIDS, tuberculosis, eHealth solutions, active and healthy ageing, cross-border healthcare, European Reference

Networks, rare diseases, patient safety and many others.

A key concept of various actions is a Union added value that can be demonstrated:

on the basis of exchanging good practices between Member States;

- ◆ supporting networks for knowledge sharing or mutual learning;
- ◆ addressing cross-border threats and certain issues relating to the internal market;

- ◆ unlocking the potential of innovation in health;
- ◆ actions that could lead to a system for benchmarking to allow informed decision-making at Union level;
- ◆ improving efficiency by avoiding a waste of resources due to duplication and optimising the use of financial resources.

The Programme will be implemented on the basis of Annual Work Programmes through calls for grants and tenders. Financial contributions by the Union will be in the form of:

- 1) Grants (for projects);
- 2) Joint actions (with competent authorities in Member States);
- 3) Operating grants (for NGO's);
- 4) Direct grants (for cooperation with international organisations);
- 5) Public procurements (for studies, evaluations, etc.).

Grants paid by the Union cannot exceed 60% of eligible costs for an action relating to an objective of the Programme or for the functioning of a non-governmental body. In cases of exceptional utility, the contribution by the Union may be up to 80% of eligible costs. Public procurement is of course covered 100%.

Different types of beneficiaries are entitled to receive funding these include legally established organisations, public authorities, public sector bodies (e.g. research and health institutions, universities), non-governmental bodies, international organisations, private companies (for public procurements). Third countries (particularly EFTA/EEA countries, acceding countries, candidate countries and potential candidates, neighbouring

countries) also have possibilities to participate in the Programme.

The Regulation of the European Parliament and of the Council on the establishment of the Third EU Health Programme (No 282/2014 of 11 March 2014) also describes the monitoring, evaluation and dissemination of results in the light of its objectives and indicators. The mid-term evaluation should be completed by 2017, followed by the evaluation of the long-term impact and the sustainability of its effects.

## CHAFEA

Jacques Remacle, Head of Health Unit, Consumers, Health and Food Executive Agency, European Commission, presented the newly formed Consumers, Health and Food Executive Agency (CHAFEA), formerly Executive Agency for Health and Consumers (EAHC) during 2008-2013 and Public Health Executive Agency (PHEA) during 2005-2008. CHAFEA is one of six agencies through which the European Commission execute their complex programmes and tasks. Located in Luxembourg, it has around 50 employees to implement the EU Health Programme, the Consumer Programme and the Better Training for Safer Food initiative. Remacle also highlighted the differences between Directorate General Health and Consumers, that sets the priorities, and CHAFEA that is responsible for the implementation of the EU Health Programme and managing grant agreements and procurement contracts; managing relationships with partners and working with diverse types of beneficiaries. He informed workshop participants that by the end of the first call (25 September 2014) 50 proposals were submitted and they are now being evaluated.

## Conclusions

- ◆ It is possible to contribute as an evaluator by registering in the experts' database (in this case you will also appear in the Horizon 2020 experts' database);
- ◆ Finally, the great news for all applicants: the new on-line submission system is now working (so no more paper)!
- ◆ For more information about the EU Health Programme and participation in it you can also contact National Focal Points in your country.

Detailed session information and materials



### WORKSHOP 9

2 October 2014

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

**Jacques Remacle**, Executive Agency for Health and Consumers, European Commission

Organised by DG Health and Consumers, European Commission



This workshop is part of the 17th EHFG conference which has received funding from the European Union, in the framework of the Health Programme (2008-2013).

# NON-COMMUNICABLE DISEASES AND THE PRIVATE SECTOR

## BREAKING THE IMPASSE

### WORKSHOP 10

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Written by Dimitrios Skempes

How can global institutions, governments and the private sector effectively address the epidemic of non-communicable diseases (NCD)? What best practice models exist that can inform future collaborative action between health institutions and the business sector? What impact do globalisation and financial capital flows have on current responses to the NCD epidemic?

These fundamental questions were explored by more than 40 participants. The workshop was organised by the World Health Organization Regional Office for Europe and brought together academics, policy-makers and senior executives from the private sector across Europe. Their presentation and discussions yielded important insights into the role of the private sector in tackling non-communicable diseases across the globe.

#### The world's biggest killers

Non-communicable diseases are the world's biggest killers. More than 36 million people die annually from NCDs (63% of global

deaths). Low- and middle-income countries already bear 86% of the burden of premature deaths from NCDs, which will result in cumulative economic losses of 7 trillion dollars over the next 15 years and millions of people trapped in poverty. Therefore, Heads of States and Governments committed themselves in the UN Political Declaration on NCDs to establish and strengthen multi-sectoral national policies and plans for the prevention and control of NCDs<sup>1</sup>.

Specifically, the World Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020<sup>2</sup> in May 2013. The Action Plan provides a road map and a menu of policy options for all Member States and other stakeholders, to take coordinated and coherent action, at all levels, local to global, to attain the nine voluntary global targets, including that of a 25% relative reduction in premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 2025. The main focus of this action plan is on four types of NCDs - cardiovascular diseases, cancer, chronic respiratory diseases and diabetes - which

make the largest contribution to morbidity and mortality due to NCDs, and on four shared behavioural risk factors - tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. It recognises that the conditions in which people live and work and their lifestyles influence their health and quality of life.

#### The workshop

Non-state actors such as businesses have a range of obligations and responsibilities to respect and protect universally established fundamental human rights including the right to health<sup>3</sup>. Private enterprises can play an important role in improving population health and this has significant implications for the global effort to prevent and control non-communicable diseases.

**Gauden Galea**, Director of the Division of NCDs and Lifecourse at WHO Regional Office for Europe moderated the workshop and in his introductory remarks explained the important role of partnerships in building a more effective response to NCDs. He began by outlining how WHO supports

governments and other stakeholders in tackling NCDs, noting that this workshop is part of a larger initiative which aims to “create space for constructive debate on the role and positive contribution of the private sector in combating the NCD epidemic, particularly in low and middle income countries.” In relation to the above, **Oleg Chestnov**, Assistant Director General at WHO, who was attending the workshop, added that “collaboration with non-state actors including enterprises is being mainstreamed as an important element of the activities of the WHO to tackle the challenge of NCDs in order to enhance their impact.” Moreover, he observed, there is a need to strengthen the dialogue between all actors who share the same vision for global health and to identify optimal models of communication and collaboration.

**Mette Peetz- Schou**, Head of Secretariat of the Danish Forum of Responsible Food Marketing Communication to children<sup>4</sup>, presented an innovative self-regulatory approach for the control of marketing of foods to children. This approach represents a best practice model of collaboration between industry partners aiming to protect children from consuming snacks and beverages harmful for their health. She explained the modus operandi of the Danish Forum which is a voluntary across-industry initiative. Through its ethical marketing code it serves to ensure a focus on marketing of foods with high sugar, fat and salt content in all stages of the marketing process across children’s media. All members of the Forum (hotels and restaurants, advertisers, retail grocers, media, food and drink producers) carry out regular spot checks of food advertisements in children’s media, and are obliged to react if they discover any



Mette Peetz- Schou

“  
Key to our  
success?  
High degree  
of commitment,  
self-policing  
and participation.”

advertisement in violation of the Code. Responding to participants’ questions regarding the criteria for success, she listed five key factors: vision of the platform, commitment of the partners, participatory approach, trust between the platform and the public and effective management of expectations. Furthermore Peetz-Schou presented in detail how the Forum works actively to raise awareness of the Code through seminars and public campaigns.

**Trevor Gunn**, Senior Director of International Relations in Medtronic USA, noted during his presentation that despite the fact that the highest prevalence of NCDs is observed in low and middle income countries only 1-3% of the total ODA (Official Development Assistance) is directed to NCDs, thus pointing to the conflicting public health priorities which limit the resources available to communities for managing NCDs, and this in consequence hinders progress in implementing fully the WHO Global Action Plan.

Moreover, Gunn identified the lack of political

commitment accompanied by proper investment in the fight against NCDs as the “fifth risk factor” for NCDs after genetics, the environment, health behaviours and health systems. He further explained how Medtronic’s corporate social responsibility model covers this resource gap in many countries and defended the partnership of philanthropic institutions and businesses as a strategy of choice for addressing this challenge in limited resource settings.

In contrast to Gunn’s observations regarding the high burden NCDs are putting on developing countries, **Ilona Kickbusch**, Director of the Global Health Programme, Graduate Institute of International and Development Studies, argued that NCDs “present an equally serious public health challenge for developed countries with huge financial costs for governments which cannot be simply ignored.” She noted that many of these diseases like diabetes, cardiovascular diseases and cancer are linked to certain behaviours like smoking, unhealthy diet and lack of exercise which are exacerbated by the strong commercial

interests of the private sector.

Responding to the fundamental question of what steps can be taken to tackle this priority issue of global public health, Kickbusch suggested that we need to better understand the economic drivers of NCDs and address the complexity of financial capital flows which serve commercial interests at the expense of global public health. In this respect, “the establishment of a global experts panel on the commercial determinants of health - which should act in parallel with the global monitoring mechanism on NCDs - should be examined.”

Concluding her remarks with advice about future directions, Kickbusch highlighted the need to strengthen good and effective governance for health through a mix of regulation and persuasion as well as the active engagement of the private sector in an orchestrated effort to prevent and control non-communicable diseases.



## WORKSHOP 10

3 October 2014

**Gauden Galea**, Director of the Division of NCDs and Life-Course, WHO Regional Office for Europe

**Trevor Gunn**, Senior Director, International Relations, Medtronic, USA

**Mette Peetz-Schou**, Head of Secretariat, Danish Code of responsible food marketing communication to children, Denmark

**Ilona Kickbusch**, Director, Global Health Programme, Graduate Institute of International and Development Studies, Switzerland

Organised by the World Health Organization  
Regional Office for Europe



<sup>1</sup> Political Declaration of the UN High-Level Meeting on the Prevention and Control of Non-communicable Diseases (NCDs):Key Points

Source: <http://goo.gl/yt67Ag>

<sup>2</sup> Global action plan for the prevention and control of non-communicable diseases 2013-2020.

Source: <http://goo.gl/wDbdEc>

<sup>3</sup> Guiding Principles on business and human rights. OHCHR. United Nations. 2011

Source: <http://goo.gl/kwu2kn>

<sup>4</sup> Danish Forum for Responsible Food Marketing Communication to children

Source: <http://goo.gl/wXOMms>

# UNDOCUMENTED MIGRANTS

## WALK THE PUBLIC HEALTH TALK: ACCESS TO HEALTHCARE FOR UNDOCUMENTED MIGRANTS

### WORKSHOP 11

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Written by Jorunn Evandt

It is estimated that there are between two and four million undocumented migrants in Europe. Although numerous human rights instruments state that everyone has the right to healthcare, undocumented migrants are a group that are marginalised in this respect. No EU Member State specifically forbids access to healthcare for this group, but the inadequate and varied level of service offered today across Europe is one of the key challenges for EU health politics.

This workshop was organised by the Platform for International Cooperation on Undocumented Migrants (PICUM), a Brussels-based non-governmental organisation (NGO) and network currently representing 160 organisations and 180 individual advocates working with and for the rights of undocumented migrants. **Lilana Keith**, Programme Officer at PICUM, moderated the session. The other panellists were **Frank Vanbiervliet** from Médecins du Monde International (Doctors of the World), a humanitarian organisation that provides healthcare to those who face barriers in

the mainstream healthcare system across Europe and **Carina Spak** from AmberMed, an outpatient health centre providing medical care to undocumented migrants in Vienna, Austria.

#### Undocumented migrants

There are various reasons for becoming undocumented. Research shows that the majority of undocumented migrants in Europe entered regularly. Many have had a work permit previously, but have lost it because their contract of employment has ended, often due to exploitation. Others have had their application for international protection denied, but cannot go back to their home country.

The panellists stressed that it is a common mistake to refer to undocumented migrants as “illegal migrants” as it is not illegal to stay in a country without a residence permit in most countries, and where it is a legally a crime, it is not one against a person or property, so should not be. Therefore the expression is not only inaccurate, but also discriminatory and criminalising. In order to mitigate the stigmatising effects of these words, PICUM

has produced a leaflet on this topic called “Words matter!” where alternatives to the expression “illegal migrants” are given in the EU languages alongside some reasons why “undocumented” or “irregular” are more accurate and appropriate.

#### Healthcare for undocumented migrants

The topic of healthcare rights for undocumented migrants was introduced by showing a video produced by PICUM, available at [www.undocumentary.org](http://www.undocumentary.org).

This video illustrates the healthcare situation for undocumented migrants in the two EU Member States Sweden and Italy. At the time the video was produced (2011-2012) undocumented migrants in Sweden were only entitled to access emergency care and were expected to pay the full costs.

For example, a visit to a doctor could cost around 200 euro and giving birth to a child, without complications, could cost 2.000-3.000 euro. These prices are of course unrealistic for someone with minimal resources. Until a reform in 2013, Sweden was one of the worst EU countries for

undocumented migrants to live in, when it came to healthcare rights.

In Italy, on the other hand, undocumented migrants are entitled to a range of healthcare services. However, implementation by the different regional governments in Italy is very varied, and alongside numerous practical and administrative barriers, and fear of deportation and imprisonment, access to healthcare services remains very difficult in practice. The video showed how healthcare professionals in both countries strived through volunteer networks and clinics, to both uphold their medical ethics and provide health services for undocumented migrants on the basis of need, and carry out advocacy work to improve their inclusion in the mainstream health system.

### Emergency care is expensive

In the majority of EU Member States, undocumented migrants are only entitled to access emergency care. Though they are expected to pay the costs in many of these countries, legally emergency care cannot be denied at the point of need.

Giving emergency care is very expensive, so waiting this long to treat a patient is not profitable - neither for the patient nor for society. By treating the patient at an earlier stage, one would save the patient a lot of unnecessary suffering and health systems the significant resources necessary in administering acute medical treatment. It also raises public health concerns, as people living in and contributing to European communities are not able to access preventative and curative care, including for infectious diseases.

### The myth of health migration

A reason that governments give for being hesitant to improve healthcare rights for undocumented migrants is the fear that people will migrate to a country with the intention of accessing treatment their country of origin does not offer. However, according to Médecins du Monde fear of this kind of "health migration" is unfounded because only a very small proportion of migrants travel to another country for health reasons. Furthermore, the migrants that use their health services often present themselves for treatment after having resided in the country for some time, and once their conditions are already quite progressed. The pattern of use of health services by undocumented migrants suggests minimal use of even the services they are entitled to and lack of knowledge of their entitlements. Further, migrants are often young and healthy, and suffer the same health problems as citizens, though they face a number of vulnerabilities or risk factors due to their irregular residence status.

### Undocumented migrants - a vulnerable group

Undocumented migrants are made vulnerable by policies that restrict their rights. Being undocumented puts you in a position for exploitation and discrimination, because you cannot report crime, including physical and sexual violence to the police, nor enforce your labour rights. Furthermore, poor living and working conditions, inability to access preventative and curative care, and constant fear of deportation, can take a significant toll on mental and physical health.

## / 2013 IN FIGURES /

### Of the individuals seen

- 15.6% were completely isolated and had no-one they could turn to
- 34.8% felt their housing was affecting their health or their children's health
- 2.3% had migrated for health reasons
- 64.5% had no healthcare coverage
- 76.3% reported having experienced violence at least once
- 27.6% said their mental health was bad or very bad

### Among pregnant women

- 65.9% had no access to antenatal care
- 42.8% received care too late
- 70.0% required urgent or semi-urgent care according to the doctors

### Among children

On average, only 50% had been vaccinated against tetanus.

On average, 70.0% had not been vaccinated or did not know whether they had been vaccinated, against hepatitis B, measles and pertussis (whooping cough)

## / KEY FIGURES /

Access to healthcare for most vulnerable groups

Source: Chauvin P, Simonnot N, Douay C, Vanbiervliet F. Access to healthcare for people facing multiple vulnerability factors in 27 cities across 10 countries. Report on the social and medical data gathered in 2013 in eight European countries, Turkey and Canada. Paris: International network of Médecins du monde, 2014. URL: <http://goo.gl/rN5uuq>

### Pressure on NGOs

The way the public health system is organised today puts an enormous pressure on health professionals and NGOs working to help undocumented migrants with healthcare services.

"We have reached the maximum capacity!"

Spak informed that AmberMed has now reached its maximum capacity: patients

might have to wait for up to three hours to see a doctor, and doctors are often forced to prioritise those who are most in need of care. Access to medicines is also a problem for the clinic as it is reliant on getting medicines donated from pharmacies and pharmaceutical companies.

### You can only cure if you understand the patient

Language barriers between healthcare personnel and patients is a challenge in all health institutions providing care to migrants, including undocumented migrants.

Spak put it this way: "You can only cure if you understand the patient."

Interpreters are therefore in great demand and AmberMed uses interpreters in various languages. An issue regarding interpretation in health settings is whether one should use friends or relatives who know both the language and the patient well, or an outside interpreter that does not know the patient.

At AmberMed, they try to avoid using relatives as interpreters. In cases where children are used as interpreters, they might be exposed to information that children usually are shielded from, which could cause mental strain on the child.

### Create awareness

Near the end of the workshop Vanbiervliet posed a very hands-on question: "What can you do to help undocumented migrants with their rights to healthcare?"

Some participants committed to create awareness around the issue by publishing about it and trying to debunk the myths around undocumented migrants. Hopefully



“  
You can only  
cure if you  
understand the  
patient.”

Carina Spak

such initiatives will influence policy-makers. In Sweden, undocumented migrants' rights to healthcare have improved substantially since the video by PICUM was produced. Following an extensive enquiry, a new law from 2013 entitles undocumented migrants to healthcare "that cannot be postponed" for a price of 6 euro per visit to a doctor. Undocumented children are entitled to access the same level of healthcare services as nationals.

The new system is perhaps not flawless - the evidence in the enquiry suggested equal access to health services for all residents for medical, financial, ethical and legal human rights reasons - but it is definitely a step in the right direction.

This law change is also a great example of the changes that can be effected when existing systems are challenged.

[Detailed session information and materials](#)



#### WORKSHOP 11

3 October 2014

**Frank Vanbiervliet**, Médecins du Monde International (Doctors of the World)  
**Carina Spak**, MedeAmberMed, Austria

Moderated by **Lilana Keith**, Programme Officer, Platform for International Cooperation on Undocumented Migrants (PICUM)

Organised by the Platform for International Cooperation on Undocumented Migrants (PICUM)

  
PLATFORM FOR INTERNATIONAL COOPERATION ON  
UNDOCUMENTED MIGRANTS

# ACCESS TO HEALTHCARE FOR THE MOST VULNERABLE IN A EUROPE IN SOCIAL CRISIS



**16,881**  
PATIENTS\*  
SEEN IN  
**25**  
CITIES  
IN **8** EUROPEAN  
COUNTRIES

## VULNERABLE GROUPS

 **2/3**  
**285** PREGNANT WOMEN  
HAVE NO ACCESS TO  
ANTENATAL CARE

 **1,703**  
CHILDREN SEEN  
ONLY **1** IN **2** CHILDREN  
HAS BEEN VACCINATED AGAINST TETANUS

**93%** ARE LIVING BELOW  
THE POVERTY LINE

**ONLY 2.3%**

## MIGRATE FOR HEALTH REASONS

**15.6%** OF PATIENTS ARE  
**COMPLETELY ISOLATED**



 **63.1%**  
OF PATIENTS HAVE A  
**DETERIORATED HEALTH**

**26.1%**  
SAY THEIR HEALTH IS  
BAD OR VERY BAD

**34.3%**  
HAVE AT LEAST ONE  
**CHRONIC CONDITION**

**27.6%** SAY THEIR  
**MENTAL HEALTH**  
IS BAD OR VERY BAD



 **5.4%**  
OF PATIENTS  
EXPERIENCED  
**RACISM**  
IN A HEALTHCARE SETTING  
DURING THE LAST YEAR

**77.3% OF MEN**  
**42.4% OF WOMEN**  
HAVE LIVED IN A COUNTRY  
**AT WAR**

**47.0% OF MEN**  
**26.8% OF WOMEN**  
HAVE EXPERIENCED  
**HUNGER**

**10% OF WOMEN**  
REPORT HAVING BEEN  
**ASSAULTED**

**76.3%** say they have  
EXPERIENCED  
**VIOLENCE**  
at least once



 **62.4%**  
OF PATIENTS ARE LIVING IN  
**TEMPORARY ACCOMMODATION**

**34.8%**  
OF PATIENTS  
DECLARE THEIR HOUSING TO BE  
HARMFUL TO THEIR HEALTH

**11.4%**  
OF PATIENTS ARE  
**HOMELESS**

# HEALTH PROFESSIONAL MOBILITY IN EUROPE

## BETWEEN PLANNING, MANAGING AND FREE CHOICE

### LUNCH WORKSHOP 1

---

Written by Simona Gailiute

Most European health systems are faced with the complex phenomenon of health professional mobility. Health professional mobility is affecting the size and composition of the health workforce in countries and the performance of health systems.

Recent research has demonstrated that health professional mobility is rapidly changing. It is also affecting countries, professions, health systems and patients in further different ways. Health workforce mobility, recruitment and retention are therefore topics that are of high political relevance for policy-makers in Europe.

**Josep Figueras**, Director, European Observatory on Health Systems and Policy, chaired this workshop and started the discussion with a question: "Why nowadays is it important to look at health workforce mobility? Why are health professionals moving to other countries at all?".

Explaining what motivated the Swiss Federal Office of Public Health to co-organise the workshop, its Director General **Pascal Strupler** pointed out that Switzerland is

well aware of its economic attractiveness for foreign workers in general and health professionals in particular. Knowing that this "pull factor" may drain health workers from other European countries and increase human resource disparities, Switzerland would like to be part of a "European solution" to this challenge and is looking for promising policy options to improve the cost/benefit ratio of health professional mobility.

Switzerland has already taken some measures to increase the number of trained doctors and to improve the retention of its health personnel, and the country believes it is essential to assure a dialogue and a spirit of cooperation among all key partners in order to meet such challenges together.

At the domestic level, the objective is to reduce Switzerland's current dependence on foreign workers and to move towards greater self-sufficiency in order to comply with the WHO Global Code of Practice on the International Recruitment of Health Personnel. **Strupler** commented that he assumes that the motivation for mobility is mostly economic. People are moving due to better salaries, better professional opportunities and better working conditions.

But they are also facing a lot of challenges in their destination countries, such as language barriers, professional language gaps, cultural aspects and working modalities. Integration into daily working life can be very difficult, especially for older professionals.

**James Buchan**, Professor, Queen Margaret University, UK, kicked off his presentation with a real example which showed how Indian doctors were being flown into Scotland on a regular basis in order to cover certain shifts in Aberdeen hospitals, just to return to India afterwards. He also suggested that it is nowadays normal to face such problems such as your paediatrician moving to Texas, your dentist to Dubai and you optician to Stockholm.

**Gilles Dussault**, Director, WHO Collaboration Centre on Health Workforce Policy and Planning, Portugal, noted that health workforce mobility and permanent migration is not a new phenomenon. Doctors have been moving from east to west, from south to north for years and we cannot and should not stop them, however countries should work together to improve the gap between

wealthier and poorer Member States. Mobility is a policy solution for some Member States with workforce deficits, but at the same time the poorer Member States are facing a brain drain in the health sector. **Francesca Colombo**, Head of Health Division, Organisation for Economic Cooperation and Development, highlighted that countries should invest in health professionals and provide attractive salaries and working conditions. Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country. The OECD has been working on this topic since 2007 and will publish a new study and set of data in 2015.

It was highlighted several times during the session that countries cannot develop effective workforce policies solely at the national level - and that they need to cooperate internationally in order to be able to tackle all the social and economic implications.

At the EU level, a Joint Action on health workforce planning and forecasting has been initiated by the Member States, showing that there is a pronounced need by the countries for more collaboration. This Joint Action aims to establish a set of best practices about recruitment and retention of

health personnel, according to the principle "one size does not fit all". Globally, the WHO Code of Practice on the international recruitment of health personnel from 2010 addresses this issue; and all countries have agreed to adhere to a certain set of ethical standards in the recruitment of their health workforce.

Buchan highlighted that national health workforce policy cannot be "isolationist", but countries should accept that mobility is inevitable and ever changing. The WHO Code should be used as a catalyst for a whole of government approach and not only as a tick box exercise. Indeed the discussion clearly showed that the image of a unidimensional "food chain" in terms of health professional movements does not reflect reality, which looks more like "a complex ecosystem".

All the panellists agreed therefore that in a globalised world, workforce mobility becomes increasingly relevant for all countries' healthcare systems and subsequent planning activities. Mobility will continue, people will move, so policy-makers should not think in a too linear way because the health environment will change in the future. The policies should primarily seek to mitigate any detrimental effects of mobility on healthcare quality and service delivery.

## LUNCH WORKSHOP 1

2 October 2014

**James Buchan**, Queen Margaret University, UK

**Pascal Strupler**, Director-General, Federal Office of Public Health, Switzerland

**Francesca Colombo**, Organisation for Economic Co-operation and Development (OECD)

**Miklós Szócska**, former Secretary of State for Health, Semmelweis University, Hungary

**Pascal Garel**, Secretary-General, European Hospital Federation

**Gilles Dussault**, Director, WHO Collaborating Centre on Health Workforce Policy and Planning, Portugal

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

Sponsored by the Swiss Federal Office of Public Health and organised in collaboration with the European Observatory on Health Systems and Policies



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# EQUITY AND ACCESS

## KEY DRIVERS FOR PATIENT EMPOWERMENT

### LUNCH WORKSHOP 2

---

Written by Milda Urnikiene

During the economic downturn high deficit and debt levels were threatening European countries, and budget constraints seemed to be necessary measures. Health systems were encountering difficulties in order to ensure universal access to high-quality healthcare for all their citizens. The need for European countries to improve the efficiency of their health systems is inevitable. Now it is the right time to refocus both on principles and values of solidarity and universal access and explore what could be done to proactively support equity and access.

The aim of the workshop, chaired by **Tamsin Rose**, Director, Progress Works, was to address access to and equity in healthcare as powerful drivers and elements of patient empowerment and to look at this issue from different perspectives: the patients', the politics' and the industry's.

The meeting, in cooperation with Sanofi, was organised as a panel discussion with presentations from and response discussion with the following speakers: **Ilona Kickbusch**, Director, Global Health Programme, Graduate Institute of

International and Development Studies; **Stanimir Hasardzhiev**, Board Member, European Patients' Forum; **Ian Banks**, President, European Men's Health Forum; **Natalie Chaze**, European Commission; **John Bowis**, former MEP; **Milena Richter**, Senior Director, European Affairs, Sanofi and **Nicola Bedlington**, Executive Director, European Patients' Forum.

#### Challenges

The workshop revealed the main challenges in the field of patient empowerment:

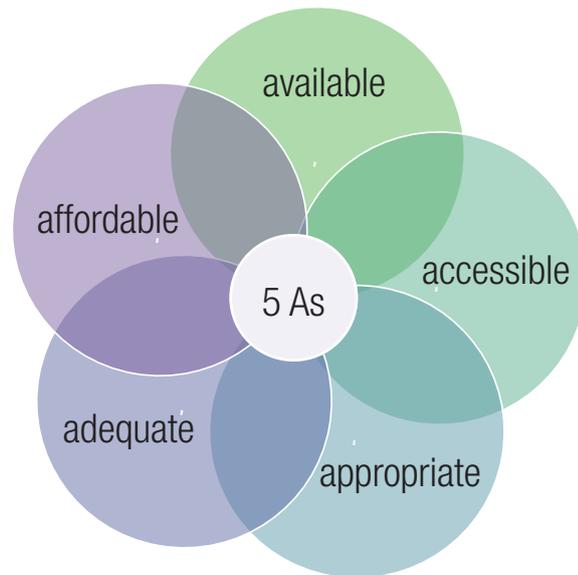
- ◆ Ensuring that health systems are more democratic and equitable. As it was stated in the Opening Plenary "Health is a political choice", that is why it is crucial to ensure that democratic institutions value health.
- ◆ In terms of democratising the healthcare systems organizational restructuring in order to meet people's needs is essential.
- ◆ Respecting patients' rights and establishing a dialogue with people who are using healthcare services and for whom the reshaped healthcare system would make difference in their lives.

- ◆ Strengthening health literacy, creating health literate organisations and putting the light on the transparency of information. It is critical to provide information on healthcare as well as to provide information on how to get healthcare.
- ◆ Focusing on the most vulnerable groups with major risk factors and reaching those who are more disadvantaged in the society.

In this context, the participants of the workshop mentioned some fundamental principles and identified the possible solutions that could improve patient empowerment.

Firstly, effective governance helps to strengthen democracy and human rights. It is important to understand that governance can be effective if it is participatory. It can be accomplished through the enhanced notion of co-production of health between different stakeholders. Building healthcare system and creating access and equity on the notion of co-production has synergetic outcomes: it brings greater satisfaction, strengthens political engagement and social participation, reduces costs and also the

health outcomes. It is very important that the healthcare systems learn the language of patients, incorporate patients' participation and increase their role in all phases of development. Patients with their unique expertise is the powerful way of expressing and showing the problem. The voice of those who are vulnerable is absolutely critical. Patients have to be a part of their definition - patient empowerment must be based on joint-decisions and participatory element needs to be strengthened. However, shared decision-making is only possible when there is some level of trust in the healthcare system.



Patient empowerment - seeking for 5 As.

All pillars representing different stakeholders agreed that collaboration and open partnerships is absolutely essential. The round table discussions should be organised both on national and European level. In the context of the new European Parliament and the new European Commission there is a tremendous opportunity to restate the case, to reintroduce the concepts and to ensure that equity and access issues are properly presented in the political agenda.

During the workshop the new European level initiative - Stakeholders' Partnership on Equity of Access to healthcare - was presented. The origin of the establishment of the initiative lies in the challenges of access to healthcare services. National patients' organisations in Bulgaria, together with European Patients' Forum has been working on enhancing the collaboration on European level between the different stakeholders in order to address health inequalities and access to healthcare. The initiative aims to be multi-stakeholder platform to facilitate the dialogue between the patients, European policy-makers, the Member States, the

healthcare professionals and the industry in order to search for solutions that will work now and will save lives of patients. What is more, the concept of 5 As was presented: seeking for 5As - **Available, Accessible, Appropriate, Adequate, Affordable** - assuring equitable access to sustainable and high-quality healthcare.

It is considered of great importance to take into account that there has been a lot of work done on equity and access in the academic field and on the European Union institutions level. Relating to that it is very important not to reinvent the wheel in improving the patient empowerment. Further policies and initiatives should be built on what has already been done as a very good starting point. Most importantly, improvements and developments of efficient, inclusive, sustainable healthcare systems should be made from the patients' point of view who need the changes desperately and urgently.

## Conclusions

To sum-up, the patient empowerment could be defined in three main areas:

- ◆ health literacy and information to patients;
- ◆ dialogue between patients and stakeholders and
- ◆ the area of self management, meaning that patients are able to take a key role in managing their own health.

Clearly, there is a link between patient access and patient empowerment. These are two core pillars of patient centered healthcare system and the creation of health in everyday life. Mobilising politicians and policy-makers, inclusively engaging other stakeholders should be a priority in order to achieve common objectives: to ensure access to proper healthcare for all patients and to reduce health inequalities across Europe.

A strong and united patients' voice is a drive to a better health in Europe - the Europe We Want!



## LUNCH WORKSHOP 2

2 October 2014

**Ilona Kickbusch**, Director, Global Health Programme, Graduate Institute of International and Development Studies, Switzerland

**Stanimir Hasardzhiev**, Board Member, European Patients' Forum

**Ian Banks**, President, European Men's Health Forum

**Milena Richter**, Senior Director, European Affairs, Sanofi

**Nicola Bedlington**, Executive Director, European Patients' Forum

**Nathalie Chaze**, Head of Unit, Healthcare Systems Unit, DG Health and Consumers, European Commission

**John Bowis**, former Member of the European Parliament

Chaired by **Tamsin Rose**, Progress Works

Organised by the European Patients' Forum  
in cooperation with Sanofi



# HEALTH LITERACY

## MAKING INFORMED HEALTH CHOICES

### LUNCH WORKSHOP 3

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Written by Christian Boehler

Empowering citizens to make informed choices to sustain and foster their health is the primary objective when attempting to improve health literacy. To progress further towards this goal, however, a multitude of questions ought to be considered.

A highly distinguished group of panellists discussed some of those issues, including:

- ◆ the role of different organisations to improve health literacy;
- ◆ how health literacy can contribute to reducing inequalities in health and the access to healthcare at different levels; how to engage with vulnerable groups (such as migrants), and
- ◆ issues relating to mobility, the Cross-border Healthcare Directive and a single market for health.

The discussion further evolved around questions related to the reliability of existing health information, and ultimately, how information and communication technologies can contribute to further improve health literacy.

The workshop was hosted by **Kristine Sørensen**, Assistant Professor, Department of International Health, University of

Maastricht, and moderated by **Peter O'Donnell**, Associate Editor, European Voice, who stimulated a lively discussion and gave plenty of opportunity to the audience to bring in their views and impressions.

In her opening statement, **Kaisa Immonen-Charalambous**, Senior Policy Advisor, European Patients' Forum, stressed the importance of patient organisations to improve health literacy. Due to their proximity to, and constant communication with patients, these organisations have enormous expertise in translating scientific information into more comprehensible language, which is adequately tuned for the medical lay person. This makes them a natural access point for health information. However, patient organisations are usually limited by their tight budgets and strongly dependent on volunteer work, which somewhat restricts their ability to improve health literacy on a wider scale.

**Ramazan Salman**, Director, Ethno-Medical Center Hannover, supported this position, and emphasised that in order to improve health literacy, especially amongst vulnerable groups, it is essential to build up further capacities. Even the best healthcare

systems fail to generate benefits for those who do not know how to access them. He further stressed the importance of tailoring information to specific target groups. Factors such as religion, education or language need to be considered when approaching people, and rather than choosing a paternalistic approach, it is essential to build up a trustful partnership with the recipients of health information.

**Karin Kadenbach**, Member of the European Parliament (S&D, Austria), added that despite having implemented various policies for improving health literacy in Austria, results are lagging behind expectations. According to her, the best lever for improvement may be in identifying appropriate target groups. Rather than delivering health information to those who are already experts in their respective disease areas, efforts should focus on the most vulnerable groups, such as migrants or people living in remote areas. Furthermore, she stressed the importance of conveying health information in the target group's jargon, and to make sure that this information is delivered in a comprehensible format and not too sophisticated for the intended audience.

**Sylvain Giraud**, Head of Unit, Strategy and International Unit, DG Health and Consumers, European Commission, emphasised the relevance of health literacy when developing health policies on a European level. Inequality arises out of the fact that there appears to be a positive correlation between social status, poor health and poor health literacy. This needs to be taken into account when developing health policies, and as part of the Commission's wider approach on tackling the social determinants of health, health literacy is a key factor.

**Immonen-Charalambous** highlighted the importance of collaboration between different DGs within the European Commission, such as Health and Consumers, CONNECT and MARKET. She further emphasised that health should not be regarded as a consumer good, and healthcare should not be marketed. Rather than increasing the internal market for health, existing health inequalities should be tackled. With respect to mobility and the Cross-border Healthcare Directive **Salman** argued that, with the prospect of more than 100 million migrants across Europe in the near future, further efforts would be required to integrate those groups better into existing healthcare services and future service development. Even though the Cross-border Healthcare Directive may promise better access to healthcare outside the home country, this also raises new challenges for health literacy, as people need to know and understand their rights in order to be able to execute them.

**Peteris Zilgalvis**, Head of Unit, Health and Well-Being, DG CONNECT, European Commission, focussed on the role of information and communication technologies as an efficient vehicle to deliver

health information. Both the professional user and the empowered citizen should be the focus when improving eHealth literacy: citizens cannot be empowered to manage their own health if they do not have access to the appropriate tools, or do not know how to use them - but eHealth literacy also needs to be improved amongst medical professionals, for instance by developing a curriculum for ICT skills for the health workforce. With respect to digital health literacy, **Zilgalvis** cited results from the Eurobarometer, which shows that 77% of European citizens tend to agree that the internet can improve health knowledge; however, 41% have never used it for this particular purpose. Of those who did use it, 40% did not believe that the information obtained came from a trustworthy source, raising particular concerns with respect to the reliability of available health information. **Kadenbach** agreed, stating that there is too much misleading information around, which also spreads easily through social media. Of particular concern are so called advertorials, which are advertisements disguised as health information. Unfortunately, it was not possible to achieve a majority in the European Parliament to ban this practice. Therefore, she highlighted, as a minimum requirement, people should be able to distinguish easily between advertisements and genuine health information. **Zilgalvis** mentioned that the E-commerce Directive provides a means of control at European level. However, he concluded that national authorities should also be involved to guide citizens in order to find trustworthy health information.

"When Columbus set sail, he did not know where to end up; and once he returned, he did not know where he had been."

In her closing remark, **Sørensen** used this analogy to demonstrate the importance of health literacy, and highlighted the pivotal role of information for making better health choices, and to navigate more successfully through the complex systems of health and care delivery across Europe.

Detailed session information and materials



### LUNCH WORKSHOP 3

2 October 2014

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

**Ramazan Salman**, Director, Ethno-Medical Center Hannover (MiMi Project)

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

**Peteris Zilgalvis**, Head of Unit, Health and Well-Being Unit, DG CONNECT, European Commission

Moderated by **Peter O'Donnell**, Associate Editor, European Voice

Organised by Maastricht University and MSD Europe, Inc.

 **Maastricht University**



# PERSON-CENTRED CARE

## TOWARDS A SAFER AND SMARTER FUTURE

### LUNCH WORKSHOP 4

---

Written by Laura Schang

What is person-centred care? In this Lunch Workshop, organised by DNV GL in collaboration with the Young Forum Gastein, participants took this important yet abstract concept and approached it from an innovative perspective.

**Stephen Leyshon**, Deputy Programme Director, DNV GL, first set out a key challenge faced by health systems worldwide: confronted with rising financial pressures and limited workforce capacity, how can we ensure services that meet the changing health and social care needs of individuals and populations? The message: to be sustainable, health systems will need to put the person at the centre of the care provided.

To explore what such person-centred care might look like, a video introduced the individual stories and journeys of real-life patients and carers - Mary, Alec, Sue, Casey and Anne - through the health system. They experienced health services as a result of very different conditions, including being diagnosed with borderline personality disorder syndrome, caring for an elderly mother suffering from dementia, managing multiple complex chronic diseases such

as diabetes, heart failure and asthma, or coping with a sudden diagnosis of breast cancer. In the video, patients revealed what was important to them in their experience of healthcare, ranging from trust-based relationships to the quality of basic amenities including good food in hospitals.

Interactive groups of five to eight participants, moderated by Young Forum Gastein Scholars, then explored a number of interrelated questions:

- ◆ How can these individuals be involved as co-designers of their care?
- ◆ How can emerging technology be used in person-centred care?
- ◆ How do we use real-time feedback (as opposed to retrospective feedback)?

**Nick Fahy**, Director, Nick Fahy Consulting Ltd., moderated the discussion that followed to synthesise the learning across the individual groups. From this plenary discussion, a number of cross-cutting themes emerged:

#### **Listen to patients**

Participants recommended the expansion of a „Chief Listening Officer“ or „Patient Support Officer“ scheme whose primary task is to listen to patients - no more and no less. In a time-pressured environment, where health professionals' time is shrinking, workshop participants felt that this will be vital to ensure good patient experience of care.



### Focus on both social relationships and technology

This dual theme of the human and the technical emerged as key themes across the groups. Face-to-face interactions with health professionals and technology-enabled co-production of healthcare will be key. Thus, patients may learn through apps and other novel technologies, as well as through personal advice and support from health professionals.

### Support two-way interactions

Patients could use apps, websites and other telehealth tools to send their data to health professionals. At the same time, patients could use these tools to, for example, actively request and book appointments. For that purpose, investments in health literacy will also be important. Apps could be used on smart phones to enable better engagement of patients. Experience suggests that diaries, for instance, are often lost or forgotten by patients, whereas smart phones are often kept close by.

### Stimulate culture change

Health professionals should not simply tell patients what to do but rather - following motivational interviewing - ask patients: „What is your goal? What do you want to achieve?“ This will be critical as patient adherence is often low, resulting in waste or harmful use of medications and other health services. The individual's preferences and wishes should be at the centre of the care provided. A key challenge will be to generalise these approaches across the health system.

### Foster real-life feedback and ensure that feedback is acted upon

Real-life feedback where doctors, pharmacists and other health professionals exchange, on a daily and ideally automatic basis, information about patients. This would involve innovative approaches, that are easy to use by health professionals and do not impose additional bureaucratic burdens. This could be done with, for example, automatic exchanges via smart phones when touching computer screens. However, there will be little incentive for people - service users and their carers - to provide feedback unless they can be sure their feedback will be taken up. It will be important to design mechanisms that ensure feedback is listened to, and that the results of these actions are fed back to patients.

### Co-create healthcare

Move from providing services to patients to designing and delivering services with service users. True co-creation means that the role of the professional needs to shift from being fixers who focus on problems to becoming catalysts who focus on abilities. This extends to health policy-makers who need to engage with communities as service users who are partners that bring a different but equally valuable insight into local health and social care needs and how these can best be met.

Detailed session information and materials



### LUNCH WORKSHOP 4

2 October 2014

**Eva Turk**, Senior Researcher, DNV GL, Norway

**Stephen Leyshon**, Deputy Programme Director, DNV GL, Norway

Young Forum Gastein alumnus: **Hédinn Svarfdal Björnsson**, Project Leader, Determinants of Health, Directorate of Health, Iceland

Moderated by **Nick Fahy**, Director, Nick Fahy Consulting Ltd, UK

Organised by DNV GL and Young Forum Gastein Network



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