

# 19TH European Health Forum Gastein

**Demographics & Diversity in Europe**  
New Solutions for Health

CONFERENCE REPORT



**EUROPEAN  
HEALTH FORUM  
GASTEIN**

# EHFG 2016 Conference Report

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Dear Colleague,

We are pleased to share with you the 2016 Conference Report of the 19th European Health Forum Gastein.

Over 500 participants, including ministers of health and senior experts from public and private sectors, research and academia and representatives of civil society gathered once again for three days from 28th to 30th September in Bad Hofgastein, Austria to discuss highly relevant issues for Europe's future.

This year's European Health Forum Gastein delved into the very core of Europe's insecurities by exploring some of the perceived threats of demographic change. With life expectancy reaching a new high and internal and external migration leading to greater diversity, demographic change is without a doubt being experienced in Europe. We took a closer look at issues such as the challenges of dementia and other chronic diseases for health systems, and the promises of telemedicine and eHealth when it comes to relieving these.

The latest expression of outspoken Euroscepticism was also on our agenda this year, from several sessions exploring topics related to inclusive health systems and overcoming intercultural and systemic barriers to integration to a session dedicated to "Brexit and beyond". Also, the refugee crisis is not beyond us and is still waiting to be appropriately addressed.

We experienced some lively and controversial discussions on the topics of targeted health interventions for specific patient groups and affordable access to innovation – these all continue to play an important role when it comes to creating sustainable and shock-proof health systems.

In this document, you will find a comprehensive summary of each session that took place during the #EHFG2016 divided into two thematic groups: Demographics & Diversity and New Solutions.

We would like to thank all our speakers and panellists, programme planners, sponsors and organisers for contributing to such an interactive, informative and successful event! A special thank you goes to the 2016 Young Forum Gastein scholars who strongly contributed to this report – your input is highly appreciated.

Enjoy browsing through our extensive report and let us know what you think. We appreciate your feedback!

Your EHFG Team



# European Health Forum Gastein

## EHFG 2016

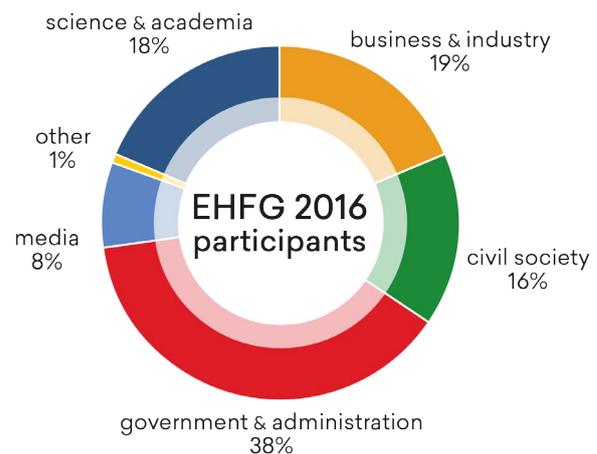
28-30 SEPTEMBER 2016 | BAD HOFGASTEIN, AUSTRIA

The European Health Forum Gastein (EHFG) was founded in 1998 as a European health policy conference and has become the leading annual health policy event in the EU. With its wide-ranging three-day programme, the Forum offers an unparalleled platform for decision-makers in various fields of public health & health care representing government, business, civil society, academia and the media.

Integrating various national, regional and European perspectives, the Forum facilitates the exchange of views and experience amongst key actors and experts from the 28 EU members, the EU candidate and EEA countries, but also from the rest of the 53 countries of the WHO European region.

The EHFG guarantees a discussion by the major stakeholders in the European health arena: (1) politicians and public servants; (2) representatives of business and industry; (3) advocates of citizens' and patients' concerns; (4) scientists and members of the academic community on key health issues on a level playing field. It aims to establish a broad basis for health policies and to lay out a framework for European health policy in the 21st century.

### EHFG 2016 IN NUMBERS



### MAIN REASONS TO ATTEND THE EUROPEAN HEALTH FORUM GASTEIN CONFERENCE

#### NETWORKING

Networking opportunities were selected as the most rewarding activity.



#### INFLUENCE

Influence on the European health policy is a reason to attend the EHFG conference.



#### TOPIC CHOICES

Two thirds attended because of the programme - timeliness & choice of topics.



Numbers are based on the results of the EHFG 2016 evaluation survey.



Günther Leiner, Helmut Brand, Ingo Raimon, EHA Winner 2016 - European Antibiotic Awareness Day (EAAD) initiative, represented by Andrea Ammon & Giovanni Mancarella, Pamela Rendi-Wagner.

## European Health Award

The European Health Award honours initiatives aiming to improve public health or healthcare in Europe.

It was established to promote cross-border cooperation, multi-country working and the development of sustainable, innovative and transferable initiatives which address current challenges such as disparities in health status, access to services and the provision of treatment within Europe.

### JURY MEMBERS 2016

Martin McKee, LSHTM, UK

Terje Peetso, DG CONNECT, European Commission

Ingo Raimon, Austrian Research-based Industry Association (FOPI)

Albert van der Zeijden, European Health Forum Gastein

Peter Brosch, Austrian Federal Ministry of Health and Women's Affairs

### AWARD SPONSORS 2016

The prize money of €10,000 is supported by the Austrian Federal Ministry of Health and Women's Affairs and by the Austrian Research-based Industry Association (FOPI), which brings together Austria's research-based pharmaceutical and biotechnology companies.

### EUROPEAN HEALTH AWARD WINNER 2016:

#### *European Antibiotic Awareness Day (EAAD)*

The EAAD is a health initiative coordinated by the European Centre for Disease Prevention and Control (ECDC), which aims to provide a platform to support national campaigns on the prudent use of antibiotics. The goal of EAAD is to provide the participating countries with evidence-based tools, as well as technical and political support for their campaigns.

**EAAD WEBSITE  
PRESS RELEASE**



**EUROPEAN  
HEALTH AWARD  
2016**



## Young Forum Gastein

### Network for junior professionals in public health

**In 2016 the Young Forum Gastein Network (YFG) celebrated its 10th anniversary.**

The initiative was established by the Gastein Forum with the support of the European Commission in 2007. The project brings together promising young health professionals from different backgrounds and with diverse professional experience, to participate in learning and networking activities in the sphere of health.

This year 70 young professionals working in the field of health from EU Member States and beyond were invited, supported by the European Commission, WHO Regional Office for Europe, ASPHER, ECDC, Forum Alpbach, Going International and the European Health Forum Gastein.

The Young Gasteiners have a busy schedule during the EHFG conference which includes participating in the general conference programme, as well as attending specific Young Forum Gastein meetings and working groups. In addition, informal meetings and workshops between the scholars and EU Commissioner Vytenis Andriukaitis and WHO Regional Director for Europe Zsuzsanna Jakab took place. This year Young Gasteiners met with DG CONNECT representatives for a career talk, attended numerous mentoring sessions with senior EHFG delegates representing our four pillars, and a skills-building workshop on facilitation.

Young Gasteiners participated as co-organisers, speakers, panellists or moderators in a number of sessions of the #EHFG2016. Three Network members evaluated the applications for the 2016 European Health Award and moderated the award ceremony.

The Young Forum Gastein Network offers a unique opportunity to:

- Learn about the latest health developments in Europe and across the world;
- Develop important public health competencies such as the ability to build alliances and partnerships, learn advocacy and persuasion skills and develop presentation and communication skills;
- Network and make new contacts with an enthusiastic young international, inter-cultural and inter-professional peer group as well as senior experts in the sphere of health;
- Have privileged access to senior policymakers and academics in special closed workshop sessions dedicated to Young Forum Gastein;
- Participate in tasks related to the EHFG, such as undertaking interviews, writing session reports, working on social media activities, or acting as speakers or session rapporteurs;
- Become part of the Young Forum Gastein Network and draw on the support of around 400 members working all over the world, as well as receiving year-round special opportunities to participate in workshops, summer schools and conferences.



Following the development of a Young Forum Gastein strategy in early 2016, the Young Gastein Network continues to go from strength to strength, with the young health professionals participating in a range of summer schools, conferences and workshops throughout the year.

We look forward to further building on the initiative throughout 2017. Thanks to all members of the growing Young Forum Gastein Network who contribute so enthusiastically during the conference and throughout the year.



**YOUNG FORUM  
GASTEIN**

# Organisers & Sponsors

## Organiser



International Forum Gastein

## Co-organiser



Federal Ministry of Health and  
Women's Affairs, Austria

## General Sponsorship 2016



European Federation of  
Pharmaceutical Industries and  
Associations (EFPIA)

## Main Sponsors & Supporters 2016



DG Communications Networks  
Content and Technology  
(DG CONNECT)

DG Health and Food Safety  
(DG SANTE)

DG Research and Innovation  
(DG RTD)



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



International Peace Institute  
(IPI)



Main Association of Austrian Social  
Security Institutions



MSD



Open Society Foundations  
(OSF)

## Main Sponsors & Supporters 2016



Austrian Medical Chamber  
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Forum of Research-based  
Pharmaceutical Industry in Austria  
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Communities Bad Hofgastein and Bad  
Gastein; Kur- & Tourismusverband Bad  
Hofgastein and Bad Gastein;  
Gasteiner Tourismus GmbH

## Organisers & Sponsors

We would like to thank the following institutions, organisations and companies for their expertise, generous support, sponsorship and fruitful cooperation which makes the European Health Forum such a successful event and without whom we would not have been able

to realise our goals. We are looking forward to continuing these partnerships on our way towards

*CREATING A BETTER FUTURE FOR HEALTH IN EUROPE*

### Fora and Workshops organisers, co-hosts and contributors

- Alliance for Maternal Health Equality
- Bristol-Myers Squibb
- DG Communications Networks, Content and Technology (DG CONNECT), European Commission
- DG Health and Food Safety (DG SANTE), European Commission
- DG Research and Innovation (DG RTD), European Commission
- European Agency for Safety and Health at work (EU-OSHA)
- European Centre for Disease Prevention and Control (ECDC)
- European Federation of Allergy and Airways Diseases Patients' Associations (EFA)
- European Federation of Pharmaceutical Industries and Associations (EFPIA)
- European Health Futures Forum (EHFF)
- European Public Health Alliance (EPHA)
- European Public Health Association (EUPHA)
- European Social Insurance Platform (ESIP)
- Federal Ministry of Health and Women's Affairs, Austria
- Federal Office of Public Health, Switzerland
- Health Insurance Fund, Estonia
- Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C.
- ICARE4EU, financed from the Health Programme 2008– 2013 of the European Union
- International Foundation for Integrated Care (IFIC)
- International Peace Institute (IPI)
- London School of Hygiene and Tropical Medicine, UK
- Main Association of Austrian Social Security Institutions
- MED-EL Medical Electronics
- MSD
- MSD for Mothers
- National Institute for Health Disability Insurance (NIHDI), Belgium
- Open Society Foundations (OSF)
- Roche Diabetes Care
- Swiss Contribution Office in Hungary together with the Government of Hungary
- World Obesity Federation



## Archive EHFG 2016

FINAL PROGRAMME  
(download PDF)

PHOTO RELATION  
EHFG 2016

WEBCASTS PORTAL  
#ehfg2016 on demand

EVALUATION REPORT  
EHFG 2016 Survey

APP GASTEIN 2016  
Satellite Event

European Health Award  
Winner & Shortlisted Projects

EHFG 2016 INTERVIEWS  
Video #1

YOUNG FORUM GASTEIN  
Video #2

EHFG 2016 RECAP  
Video #3



*Save the date*

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**20TH**  
**European Health Forum**  
Gastein

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4–6 October 2017

# **Health in All Politics - a better future for Europe**

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## **EHFG 2017: 20 Year Anniversary Edition**

While efforts to foster inter-sectoral cooperation on health have been successful at times, real challenges remain. The discussions at the 20th European Health Forum Gastein will aim to dig deeper, taking the technocratic concept of Health in All Policies to the political level of policy implementation – Health in All Politics.

A better future for Europe? European (indeed global) politics is currently at a crossroads with a rise in support for populist, authoritarian politicians coupled with post-factual democracy. The impact of such politics on health could be (negatively) transformative, be it in a direct manner – e.g. on health access – or indirectly, through channels such as climate change, migration, and trade and the championing of big business. Peace and democratic stability, arguably the major achievement of the European project, are at the forefront of concerns for European citizens. Health diplomacy can potentially contribute to the continuity of peace in Europe.

Throughout its history, discussions at the EHFG have been guided by the European values of universality, access to good quality care, equity and solidarity. The challenge to the EHFG on its twentieth anniversary is to build bridges between the different policy areas, and we invite you to explore recommendations for action on some of the most pressing political, economic and social concerns of our time.



# EHFG 2016 Outcomes

As discussed in Gastein...

# As discussed in Gastein ...

## EHFG 2016 Outcomes



**Background:** The EHFG 2016 took place against a backdrop of concerns about the future, both in terms of the European political landscape and the challenges posed by demographic change - including population ageing, the rise of multimorbidity, increased societal diversity and migratory pressures. However, demography is not destiny and the conference enabled the proactive consideration of both challenges and neglected opportunities presented by demographic change, in order to better steer and influence its outcome.

## Future of Europe

**Wanted - new leadership for a VUCA world:** This year's edition of the EHFG went beyond core health topics and considered contemporary social and political issues in what currently seems to be a VUCA world – Volatile, Unclear, Complex and Ambiguous. The political landscape remains rather unstable with a few crucial turning points ahead in The Netherlands, France and Germany. Europe is experiencing increased diversity in many ways: cultural and ethnic, between open (pro-European) and closed (protective) societies. There was acknowledgment that we need to work not only on inter-, but also on intra-country problems. Delegates considered that a “social Europe” will be demanded by citizens as part of a new EU narrative, but that Europe's leaders need to listen first and discuss health and society in a more direct way. And all this requires leaders with a certain skillset and the ability to devise a new, positive European narrative and communicate it with the passion and emotion desperately needed to combat the disconnections, lies and falsehoods which have thus far encouraged fear and populism.

**The tip of the iceberg – Brexit and what it stands for:** Brexit is not the end of the European Union, it was asserted. But the Brexit vote can be seen as a proxy for growing inequalities in the UK and Europe. It is part of a trend which highlights societal divides: between the “haves” who have benefited from globalisation and the “have-nots”, and between the young and old. It was purported that it was the pace of change rather than the level of change itself which may have been the most significant cause of alienation and disaffection. Rapid social change means that many people have felt left behind and governments and the European institutions have not responded to these concerns, thus losing the trust of people. Greater societal equity is essential.

**Nothing about us without us:** As reflected at past EHFGs, there were renewed calls for putting people at the centre of policies. Keywords highlighted as conference takeaways by delegates were equity, solidarity, relevance, participation and leadership. Citizens need to be part of the design of healthcare; part of policy conversations; encouraged to engage, vote and to believe that their input makes a difference. Just how the so-called “establishment” can rebuild trust and reconnect with the “disenfranchised” was a much discussed issue during the EHFG 2016. Honest, open and improved local level communication about key issues such as jobs, health, education and security; refocussing European structural funds and bolstering social protection were just a few of the ideas put forward.

## Demographics and Diversity

**Demographic change means we need to act early, on time and together:** The share of the older (over 65) population is growing and by 2050 will account for 28.1% of the population of the EU-28 (compared to 18.9% in 2015). The oldest-old (those aged 80 years or over) are the fastest growing components of many national populations and in the EU-28 their numbers are projected to more than double from 5.3% to 10.9% between 2015 and 2050. Crucially the demographic old-age dependency ratio is likely to almost double between 2015 and 2050, implying that the EU-28 will move from having four to having around two working-age people for every person aged over 65 years<sup>1</sup>. Therefore a key question for EHFG delegates this year was whether we are prepared for

<sup>1</sup> [http://ec.europa.eu/eurostat/statistics-explained/index.php/Population\\_structure\\_and\\_ageing](http://ec.europa.eu/eurostat/statistics-explained/index.php/Population_structure_and_ageing)



both the challenges and opportunities this unprecedented demographic phenomenon will pose? The answer: yes, as long as we act early, act on time, and act together.

**Let's add life to years:** People are living longer but they are not necessarily living healthier lives. Susceptibility to chronic diseases increases with age, with circulatory diseases (especially heart disease and stroke) and chronic lung disease being the biggest killers, and ageing the biggest risk factor for cancer. Health throughout the life-course is achievable, but such an aim needs a major shift in resources and policy and more upstream work on the social determinants of health. Personal investment in health in younger years will be needed for people to reap the benefits later. Attitudinal change is necessary so that older people can be seen as an asset and the silver economy (the third largest in the world) developed further. And we need to think outside the box: shift from reactive to proactive care; create jobs by improving the housing stock so that the elderly can remain longer in their homes; design and build age-friendly cities which both stimulate the economy by providing jobs and create better living and working conditions, enhancing health and well-being and enabling people to enjoy longer working lives. Taking such a horizontal approach with a Health in all policies (HiAP) lens might also prevent further silo-working approaches.

**Migration – a part-solution to Europe's demographic challenge:** Following last year's EHFG, it was reasserted that there are no diseases related to migration, just vulnerabilities. Worldwide, one in seven people is a migrant and migrants constitute 7% of the total population of EU member states.<sup>2</sup> Migrants and refugees need to be an integral part of communities – now is the time for action and for governments to holistically plan them into societies, recognising that they can be drivers of peace, growth and wealth. The health sector will play a vital role here, as it represents 8% of the European workforce.<sup>3</sup> Indeed migration is part of the solution to our demographic challenge: the introduction of young, healthy migrants into Europe can mitigate some of the challenges of Eu-

rope's ageing populations. However, we also need to remember that we have different trajectories for different groups, for example there is a clustering of migrants in 3D (dirty, demanding and dangerous) jobs. A failure to address this could lead to further political and social instability.

**Let's think of a different kind of diversity:** The ability to work depends on lots of factors and retirement will not stop people from being "economic agents". As a society we must enable older workers to have the right to continue to work if they wish while giving blue collar workers the dignity to retire if that is what they prefer.

## New Solutions

**Significant macroeconomic challenges, but some solutions available through best practice sharing:** We heard from Nobel Laureate Paul Krugman that the real challenge faced by advanced economies is to break out of the low inflation, less than full employment, low growth trap we are experiencing: essentially how we manage macroeconomic policy between now and 2020, not how we manage things in 2030 or beyond. His potential solution, a combined monetary and fiscal boost, is not intellectually hard to grasp but politically extremely challenging to implement. On the other hand, he proposed that while the growing ratio of older people to working-age people was serious it was not insurmountable, and indeed there might be some grounds for optimism. Across Europe countries differ when it comes to both health and pension expenditure as a share of GDP. However, increased expenditure does not automatically translate into better general health outcomes in the different systems. And when considering pension systems, there are huge variations which are not related to a country's welfare state provision but affected by incentives, path-dependency and how the systems were set up. Such elements should be easier to change than inefficiencies rooted in cultural understandings, Krugman suggested. Denmark was singled out as an example of a country that shows that it is possible to keep the older population in work while also having a high level of social security. So some of the answers to our demographic challenges can already be found amongst ourselves if we are open to new possibilities, communicate better and learn from each other.

**Tackling inefficiencies requires innovative solutions:** Urgent action is therefore needed to address what seems to be a global problem of highly fragmented and hospital-centric approaches contributing to inefficient healthcare service provision. Digital

<sup>2</sup> <http://www.iom.sk/en/about-migration/migration-in-the-world>

<sup>3</sup> [http://ec.europa.eu/health/workforce/policy/index\\_en.htm](http://ec.europa.eu/health/workforce/policy/index_en.htm)



solutions can help here, however we must overcome obstacles for deployment of ICT in support of care such as financing, inadequate knowledge of change management and lack of political engagement. We should look for solutions in policies that tackle upstream health determinants and that are supportive of innovation. Some suggestions: move to a focus on prevention and person-centred, integrated and proactive care; provide care at home where possible; consider where we can learn from the private sector; promote the use of time-banks.

**New partnership models for accessible pharmaceutical innovation:** It makes sense to embrace and promote access to medical innovation, both in terms of today's health challenges and for the future where there seems to be consensus regarding the importance of drug development for highly prevalent diseases linked to demographic change. However, what about rare and neglected diseases? There were passionate exchanges in a number of sessions regarding the high price of innovative medicines, re-

strictions on access and unmet patient needs, with arguments for accountability on all sides. The payer side may be accused of sending mixed signals to industry regarding acceptability of high prices, or avoiding common HTA across Europe, while industry is criticised for selling expensive drugs with little upfront evidence of value. Longer-term drug financing methods or payment-for-result pricing models may present some possible solutions. Ultimately there was agreement that a new model of working is needed that includes risk sharing and a need to work in public-private partnerships, with AMR offering an opportunity to experiment with such new models of inter-sectoral partnerships. This debate needs to be continued, with the recognition that all sides need to meet in the middle and find mutual benefits.

## Conclusion

**Health at the centre of European politics:** Events such as Brexit have shown the importance European citizens attach to health – a core part of our most basic solidarity with each other. It is time that we put health firmly at the centre of European policy-making. Through collaborative working on cross-border health issues, through communicating and seizing the opportunities represented by demographic change, through reasserting the common foundations of peace and stability that we all enjoy and how central these are to our health and well-being, “Health” offers a lens through which all of us can be ambassadors for demonstrating the benefits of a strong and united Europe.

**Cartoons:** © Floris Oudshoorn - ComicHouse / EHFG

# Demographics & Diversity

## PART 1



# Demographics & Diversity in Europe

## New solutions for health

OPENING PLENARY

### Introduction

Helmut Brand, President of the European Health Forum Gastein, welcomed the delegates to the 19th European Health Forum Gastein and invited them to consider three things over the course of the Forum. Firstly, they should acknowledge that policymakers' anticipation of the challenges related to ageing and low fertility has allowed them to take relevant actions, the successes of which are just starting to emerge. Secondly, to realise that Europe is now facing new demographic challenges, such as the refugee crisis, large-scale migration and Brexit. Thirdly, that this is an era of post-truth politics, where European citizens' trust in experts has been eroded, with consequences for the advancement of evidence-based policy. Despite these difficulties, he stressed that there is a window of opportunity for Europe to reflect on common goals and solutions.

### Demographics & Diversity in Europe

#### New solutions for health

Josep Figueras, Director of the European Observatory on Health Systems, introduced the session outlining that there is a new kind of diversity in the world. After dealing with the effects of successive crises and fast paced globalisation, citizens question the added-value of the EU with many of their concerns related to health. In an interactive quiz the delegates were more positive towards diversity than the general population in many European countries.



Helmut Brand

**Overall, do you think increased ethnic diversity makes your country...**  
(Please choose one option)



These results are based on the answers of 160 participants.

**In your opinion what makes people most concerned about increasing cultural and ethnic diversity?**  
(Please choose one option)



These results are based on the answers of 150 participants.



Nick Fahy

## Input Speech

Nick Fahy from the University of Oxford invited delegates to reflect on the effects of demographic shifts and their impact on the sustainability of health systems.

Globalisation is changing society and many citizens feel that they are being “left behind”. In parallel, not enough is being done to help those depressed communities that have lost the most in terms of housing, education, employment and overall well-being. This disconnect can have serious consequences, most recently seen in the UK vote to leave the EU.

According to Fahy, the Brexit vote was not simply a reflection on the EU or an issue of communication, but more of a backlash. It was a reaction to the failure to address the underlying challenges of globalisation. The fast pace of change combined with too little social protection has undermined solidarity. For example, a key issue for voters in the UK was access to medical care and the perceived strains on the NHS, an area of national rather than EU competence. Fahy was however optimistic that Brexit is also an opportunity to address underlying issues of global protection. He called on the EU to ensure that open markets are accompanied by strong social safety nets, including serious investments in health and well-being within communities, starting with providing better support locally. The EU may not have been the reason that British voters chose to vote “Leave”, but it must now take direct action to ensure that the growing divisions between and within European societies are addressed. This is crucial, said Fahy, to ensure that Brexit is an isolated case and not one of many.



The delegates were asked about their impressions of the impact of globalisation on health and well-being, with just under 50% saying that it was good for health and many unsure of the impact (nearly 30%). Advancing global health was felt by delegates to be best achieved through the Sustainable Development Goals and investment in health and development.

### Overall, what impact do you think economic globalisation has on our health and well-being?

(Please choose one option)



These results are based on the answers of 101 participants.

### What should be the priority strategies to advance health at the global level i.e. Global Health Governance?

(Please choose one option)



These results are based on the answers of 78 participants.



Helmut Brand and Zsuzsanna Jakab

## Question & Answer session with Zsuzsanna Jakab

Zsuzsanna Jakab, Regional Director of the WHO Europe, agreed with Nick Fahy that decision makers must address the social inequalities which trigger and sustain unhealthy lifestyles. Although there is global cooperation in health on issues such as non-communicable diseases, health security, and antimicrobial resistance, Jakab said there was a need for putting social inequality on the global agenda in fora such as the G7 and G20.

“Health and equity is a political choice”, stressed Jakab. The WHO Europe has made good progress in addressing equity and solidarity but the absolute level of inequality is still too high between and within European countries. There is a need for more investment in the social determinants of health. Austerity policies in Europe have looked solely at economic growth and not sufficiently at individuals, she argued. Engaging politicians is essential for addressing issues of inequality and Health 2020 can help to achieve this aim. Another piece of the puzzle is the vital role that communities play in ensuring health. There should be good vertical and horizontal integration, which requires transparent discussion among policymakers and clear communication with the public.

Regarding the refugee crisis, Jakab said that WHO Europe is leading the work to integrate migrants in Europe and preparing a global strategy on migration and health. This includes guidelines on maternal health and immunisation but also work on the ground to help Member States assess their response to migrants, such as strengthening the pre-

paredness of Balkan countries. Jakab also urged Member States to broaden their scope and consider the short and long term implications of investing in the countries of origin of migrants.

## Panel Discussion

Martin Seychell, Deputy Director-General for Health and Food Safety of the European Commission, argued that the core values of Europe are still in place; the social model of Europe is not being called into question, but rather, how to ensure social values and healthcare in Europe. Globalisation has put strain on societies and the EU must help Member States to deal with its effects. One of the big advantages of the EU is that it has the tools to act at every level. The EU must, however, work on concrete actions rather than simply guidance, stressed Seychell.

Pamela Rendi-Wagner, Director General for Public Health and Chief Medical Officer at the Austrian Federal Ministry of Health and Women’s Affairs, agreed that globalisation has left some people behind, and perhaps European social systems have not been able to keep up. She underlined that to meet the needs of the disenfranchised it is paramount to get closer to people’s daily lives and concerns. This means looking at employment, social security and, of course, health. According to Rendi-Wagner, too much emphasis has been placed on what social security can do for health and not enough on the value of health for social security and employment. Health 2020 is a key to change this mindset as it sets the stage for shared goals among Member States, for example in addressing inefficiencies such as patterns of expenditure on pharmaceuticals. In Austria, there has been a lot of work to convince all policymakers that health is important and there are now five intersectoral health targets in implementation.

Zsuzsanna Jakab agreed that strong intersectoral governance is the basis of achieving health targets. Jakab also added that there is a need for greater focus on life satisfaction and well-being as well as the appropriate tools to measure them. At the WHO, there is now good potential to look at the effects and impacts of globalisation on health, with indicators beyond classic measures of disease and GDP. Investment in health must mean more than simply “infrastructure”, it is also important to look at health preven-



**OPENING PLENARY**

Welcome & introduction

HELMUT BRAND, European Health Forum Gastein

Input speech

NICK FAHY, University of Oxford

Panel discussion with:

ZSUZSANNA JAKAB, Regional Director, WHO Regional

Office for Europe

MARTIN SEYCHELL, Deputy Director-General for Health and

Food Safety, European Commission

PAMELA RENDI-WAGNER, Director, Federal Ministry of

Health and Women's Affairs, Austria

HELMUT BRAND, President, European Health Forum Gastein

Moderated by JOSEP FIGUERAS, Director, European

Observatory on Health Systems and Policies

Newsroom

WILLY PALM, Policy Analyst, European Observatory on Health  
Systems and Policies

KATE O'REGAN, Member of the Young Forum Gastein  
Network

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**ORGANISED BY**

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



# Greying baby boomers – a twofold challenge

THURSDAY PLENARY

The second day of the European Health Forum Gastein promised to reveal the problems of the decline in the working-age population and how it influences European and world economics. Age, shrinking populations, migration and consistently growing inequalities were stated to be the current main challenges for the governments and welfare states.

The plenary session began with a keynote speech by Paul Krugman, a well-known economist and the Laureate of Nobel Memorial Prize in Economic Sciences in 2008. His starting point was the current demographic situation in most advanced countries that is characterised by a dramatic slowdown or even reduction in population growth. Krugman compared the United States of America to Europe and noted that since population growth in the USA is still positive, the country has a somewhat easier demographic situation than Europe where the population is shrinking. However, the reduction in growth has been as strong as in the European Union.

Krugman explained that the first challenge of this is related to supply, namely, that there will be fewer workers supporting the ageing population that in turn has a higher number of multimorbidities. Welfare expenses on health and social care simply exceed income. The second important, albeit less discussed, challenge is related to demand, meaning that there must be enough spending, and, therefore, full employment to secure a stable economy. If and how the demand could be raised so that welfare states and health-care systems as we know them will still be a reality in the future was at the core of his keynote speech.



Paul Krugman

It seems that traditional macroeconomic mechanisms fall short when addressing the demand-side consequence of shrinking populations. Krugman pointed out that the understanding that lower interest rates automatically raise demand as money is cheap cannot be used because interest rates have been low for a while. Thus, the normal tool to ensure full employment is not available. Furthermore, the low interest rates are probably already related to shrinking populations and Japan is an example of this. Japan has experienced population shrinkage and, consequently, low interest rates for a while. Thus, according to Krugman, the immediate challenge we are facing is not how do we pay for healthcare in the future, but how do we get enough investment into our economies.

Before turning back to macroeconomics, Krugman demonstrated that the level of different countries' expenditure on healthcare and pensions varies and, perhaps



Paul Krugman, Mojca Gobec, Fabio Pammolli, Martin Seychell and moderator Anya Sitaram

somewhat surprisingly, there are reasons for optimism. Firstly, the countries that have the highest spending on healthcare – most notably the USA with almost 16% of gross domestic product (GDP) compared to Italy's 8.8% – or on pension coverage – Italy spends 15% of GDP, while the USA spends only 6.7% – can learn from others' best practices and reduce their system inefficiencies. Secondly, the countries with higher overall expenditures on pensions tend to spend less on healthcare and vice versa. This in turn probably means that high spending is related to system design. Many healthcare systems were developed in the 1960s, and thus designed when countries experienced economic expansion and population growth. Therefore, it is somewhat inevitable that these structures struggle when populations shrink. However, according to Krugman, the positive side of this is that inefficiencies in system design are likely easier to change than those deeply rooted in cultural factors.

Krugman then turned to solutions and first debunked the old-fashioned macroeconomic understanding that fiscal instruments of cutting expenditures and raising taxes would increase the interest rate and demand. He argued that we have seen recent experiments testing these ideas, namely when some European countries implemented harsh austerity measures while others didn't. According to Krugman, the results leave no doubt: the more austerity, the greater the economic contraction.

One solution, Krugman claimed jokingly, would be to make him a dictator of the world for a couple of years. What

is needed, he argued, is a temporary fiscal stimulus that would raise inflation, and only after that introduce fiscal consolidation that especially targets inefficiencies of the welfare state. The solution is not intellectually difficult to grasp, but politically very challenging to implement.

The second part of the session comprised a panel discussion between Paul Krugman, Fabio Pammolli, Professor, IMT Institute of Advanced Studies, Lucca, Italy and health policy representatives Mojca Gobec, Director General at the Ministry of Health, Slovenia, and Martin Seychell, Deputy Director-General for Health and Food Safety (DG SANTE) in the European Commission.

Martin Seychell elaborated on Krugman's notion that Europe has more efficient healthcare systems than the USA. However he claimed, Europe has seen a rise in life-expectancy, but not in healthy life years and this has to do with Europe having reactive healthcare systems and not preventive. There are inefficiencies if we must wait until people become severely ill.

Mojca Gobec gave an overview of the current situation in Slovenia. Her statements were surprisingly optimistic as she explained that even though the Slovenian population is among the oldest in Europe, health policy is well-established and does not face big problems. Furthermore, Slovenia does not experience overwhelming migration of healthcare professionals. Nevertheless, the overall atmosphere of discussion placed a question mark over her report.

Martin Seychell's statements were clear and even inspirational, such as: "Retirement does not mean the disappearance of people from the economy". He emphasised the necessity to identify sectors where there is a need to change expenditure policy. As an example he suggested housing adaptation as a way to create jobs, improve elderly care and decrease social care expenses.

Naturally, the panel also discussed the problem of Brexit, the issue of globally growing inequalities and migration. Seychell's statement, which fully reflected the title of this year's Forum Demographics & Diversity in Europe: New Solutions for Health, called for more responsive and adaptable systems as he emphasised the need to reconsider current pension systems in developed countries as these must incorporate the effects of migrants on the workforce/pensioners ratio. Variety in cultures, life philosophy, and family traditions will influence the future share of the labour pool, he claimed.

The panel seemed united on the need to have open borders while admitting that this causes some challenges. For instance, Gobec claimed that it is difficult to communicate the benefits of immigration to the wider public and Krugman commented on the young generation leaving Southern Europe. On the other hand, Pammolli noted that it is impossible to have persistent growth and find innovative solutions without new people. This is evident in Italy, where 99% of professors are Italian. Seychell asked rhetorically, where would Europe be without migration when we have whole sectors that are dependent on migrants? He doubted though that Europe is adapted to the new demographic changes as its migration policies are primarily designed for dealing with emergencies.

The discussion also touched upon medical education. Pammolli emphasised the importance of educational development despite the global issue of the migration of medical professionals. The problem of inefficient use of health education resources can be solved by implementation of better working conditions and by optimisation of inefficiently used resources. The concept "Sharing for caring", if rationally implemented in health service reformation, might become a "life vest" for many economies, because it helps to optimise use of existing resources that are crucial in the current situation.



What to conclude from the keynote and the panel debate? Perhaps that it will only be possible to fulfill fundamental human needs to live longer and healthier lives if efficient changes in pension and healthcare systems will be introduced. And that elevating Paul Krugman to the position of the dictator of the world would speed up the process!

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Written by KADRI MIARD & OKSANA GOROSHCHUK

**THURSDAY PLENARY**

## Keynote

PAUL KRUGMAN, Professor of Economics and Distinguished Scholar at The Graduate Center, City University of New York, Winner of the 2008 Nobel Prize in Economics

## Panel debate with:

PAUL KRUGMAN, Professor of Economics and Distinguished Scholar at The Graduate Center, City University of New York  
MARTIN SEYCHELL, Deputy Director-General for Health and Food Safety (DG SANTE), European Commission  
MOJCA GOBEC, Director General, Ministry of Health, Slovenia  
FABIO PAMMOLLI, Professor, IMT Institute for Advanced Studies, Lucca

Moderated by ANYA SITARAM, Founding Director and Executive Producer, Rockhopper TV

## Newsroom

MAGGIE DAVIES, Executive Director, HAPI  
EDWIN MAARSEVEEN, Ministry for Health, Welfare and Sport, The Netherlands

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European Health Forum Gastein and supported by European Federation of Pharmaceutical Industries and Associations



# Demographics & Diversity in Europe

## New solutions for health

CLOSING PLENARY

Building on the main discussions and outcomes of the EHFG 2016, the Closing Plenary addressed the quest to achieve sustainable health systems, with a focus on health system performance and Europe's changing demographics. It also considered the health priorities of the current presidency trio of the Council of the European Union: the Netherlands (January - June 2016), Slovakia (July - December 2016) and Malta (January - June 2017).

### Video introduction

Tamsin Rose, Non-resident Fellow, Friends of Europe, introduced two of the EHFG 2016 conference films in which health policy experts, including Young Gasteiners, gave their views on how policymakers, researchers and practitioners could best address the challenges of Europe's changing demographics and ageing populations. In the films, Zsuzsanna Jakab, Regional Director, WHO Regional Office for Europe stressed the importance of the Sustainable Development Goals 2015-2030 and making sure that citizens are not "left behind" despite our changing societies. Pamela Rendi-Wagner, Chief Medical Officer and Head of Public Health and Medical Affairs Section at the Austrian Ministry of Health and Women's Affairs, noted the importance of multi-stakeholder engagement and intersectoral cooperation. Vytenis Andriukaitis, EU Commissioner for Health and Food Safety, called for better efficiency, accessibility and resilience in our health

systems. Anna Gallinat, Saverio Bersani and Sofia Ribeiro, Young Gasteiners advocated for reducing health inequalities and increased communication between policymakers, healthcare providers and users. Helmut Brand, President of the European Health Forum Gastein, recognised the importance of health throughout the life cycle.

### "I have Europe in my pocket"

Tania Dussey-Cavassini, Ambassador for Global Health and Vice-Director General of the Federal Office of Public Health, Switzerland, moderated the plenary. She raised the following issue: "People in Europe can feel disconnected from the European institutions. How can the EU convince citizens of the value of the discussions in Brussels and Strasbourg?"

Commissioner Andriukaitis reached into his pocket and pulled out his identity card, he said "I have Europe in my pocket." With this gesture, he indicated that we are all European citizens, able to travel easily the borders of continental Europe within the Schengen area, which is very valuable: this opens doors. The challenge is to convince citizens of the value of the discussions in Brussels and Strasbourg by breaking down barriers between stakeholders and generations.

The Commissioner emphasised the importance of a life-course approach to health: from newborn to old age, and finding strength in diversity. He reminded delegates that to achieve the best health outcomes in Europe, instruments should be orchestrated around the "4 Ps" of Prevention,

EHFG 2016  
Video 1

EHFG 2016  
Video 2

Protection, Promotion and Participation. He praised the example of Ireland, the first country to have a Minister of Health Promotion as well as a Minister of Health. Andriukaitis also referred to the European Reference Networks (ERNs) which will provide, starting from 2017, supranational systems for healthcare and services. Their implementation testifies to Europe’s agenda of increased cooperation between Member States (MS).



## Addressing priorities for health

Next ensued the panel discussion. Commissioner Andriukaitis and the Ministers of Health, Tomáš Drucker for Slovakia, Christopher Fearn for Malta, Marianne Donker, Deputy Director General for Health and Director for Public Health, The Netherlands, and Gudrun Mosler- Törnström, President of the Congress Chamber of Regions and Vice-President of the Congress of the Local and Regional Authorities at the Council of Europe discussed:

- The Trio’s priorities for health
- Ways to embrace the challenges of ageing societies
- How to restore trust in the added-value of the EU

Through an interactive voting system, delegates advised on priority health topics for the next Presidency beginning in 2017. The panellists agreed that whereas some topics can be addressed at national level, there needs to be monitoring of risk factors and outcomes at a higher European level, to assess and learn from each other’s different practices. Issues especially requiring EU level action include: AMR, NCDs, access to medicines, environmental health and eHealth. Andriukaitis and Fearn also urged delegates to consider the aggressive advertising of the food industry, food reformulation and childhood obesity. Mental health is also an issue that the panellists acknowledged required more attention.

### If you were to advise on priority health topics for the next Presidency trio beginning summer 2017, what would you choose to focus on?

(Please choose two options)

NCDs	30%
Environment & health issues	29%
AMR	24%
Access to medicines	24%
Personalised medicine	20%
Mental health issues	19%
mHealth/eHealth	17%
Ageing-related issues	16%
Health workforce issues	14%
Other	0%

These results are based on the answers of 62 participants.

### Thinking now about the conference theme of demographics & diversity, what in your opinion is the most urgent issue in the context of demographic change that we need to address?

(Please choose one option)

Boosting employment – more jobs and longer working lives of better quality	26%
Guaranteeing adequate, health, long-term care and pensions through sustainable public finances	25%
Receiving and integrating migrants into Europe	17%
Investment in education and research to raise productivity and economic performance	16%
Better conditions for families and better work and family-life balance	16%

These results are based on the answers of 79 participants.

### How can we re-establish trust in the EU project?

(Please choose two options)

Develop a social Europe	48%
Stronger political leadership at EU level	48%
Better partnership working between EU MS	31%
Reform and simplify the EU	29%
More flexible architecture of EU-Institutions & policy making with opt-outs and opt-ins (incl. Non-Member States)	14%
Better handling of the migration crisis	12%

These results are based on the answers of 52 participants.



Marianne Donker, Tomáš Drucker, Vytenis Andriukaitis, Christopher Fearn and Gudrun Mosler-Törnström

## Antimicrobial Resistance & Non-communicable Diseases

Donker discussed the main priorities of the Dutch presidency: the EU policy on antimicrobial resistance (AMR), pricing of medicines and innovation, and the legislative agenda on environmental hazards. Further on AMR, she added that MS need to act firmly now. She stressed that global cooperation is needed as infections and AMR cross borders and the required medicines cannot be developed by one country alone.

Drucker commented on the major health goals of the Slovakian presidency: AMR, but also tuberculosis resistance, non-communicable diseases (NCDs), vaccination, and medicine shortages. He underlined that it is our joint responsibility to preserve the effectiveness of antibiotics for future generations and vulnerable populations. He put forth that issues surrounding NCDs are also closely related to issues around vaccination, as emerging counter-streams can jeopardise community immunisations.

Fearne underscored the importance of using an intersectoral approach, particularly regarding AMR. He gave the example of the increasingly unauthorised use of antibiotics for cattle and livestock which warrants action from at least both the agricultural and the medical sectors.

## Access to medicines & negotiations with the pharmaceutical sector

Mosler-Törnström reminded delegates of the role and priorities of the Council of Europe. The European Directorate for the Quality of Medicines and Healthcare has been serving public health in Europe since 1964. Through harmonisation, health legislation, and legally-binding instruments, the Council of Europe works to promote good

health by holding stakeholders to account from 47 European countries.

In this context, Fearne pointed out that the cost of drugs and access to medicines is not only a developing world issue; European countries also suffer from pricing differentiation. He referred to countries' "Prisoners' Dilemma" when negotiating with the pharmaceutical industry. He urged MS to communicate with one another, procure together and incorporate wider social aspects in their negotiations with the pharma industry. He advised making national research and health information more profitable to stabilise prices. Donker further remarked that procurement requires MS to think about what types of research are made available to pharmaceutical companies and what types of research is needed to invest in national health systems. Fearne made a strong closing point stating that current priorities of the finance and health ministries should be aligned and focused on people's health, not figures.

## Restoring citizens' trust in the added-value of the EU

In the final part of the Closing Plenary, the panellists shared their ideas about restoring citizens' trust in the added-value of the EU.

Fearne recommended to build on the sharing of services between European centres of excellence. For the youth, a successful example of the added-value of the EU is the ERASMUS programme, and Fearne asked delegates to consider the possibility of extending this programme at the postgraduate level.

Donker emphasised the importance integrated local care with approaches addressing primary healthcare needs, the environment, education and housing. In the Netherlands,

efforts are made towards improving people's resilience and self-management. The goal is to help citizens participate and lead rewarding lives within their communities, and this is especially meaningful for the refugee population.

Mosler-Törnström agreed that "If a project is successful at a local and regional level, then you have a big chance for it to succeed at (the) national level." She recognised that the migrant crisis is one of the core issues that the Council is dealing with; in 2015, the Council was approached by many mayors looking to adapt their healthcare services to the specific needs of undocumented migrants. She pressed for closer cooperation and dialogue between the European Commission and the Council of Europe.

Drucker concluded on the importance of a "generous dialogue" between MS. He noted that many successful national health initiatives could be scaled up at an EU level, and reaffirmed that the Slovakian Presidency aims to address best practices in such areas across Europe.



Tania Dussey-Cavassini and Vytenis Andriukaitis

## Closing remarks

Helmut Brand, President, European Health Forum Gastein, rounded-up the EHFG 2016 conference by calling on delegates to reflect on the values of social change and innovation. The European community must work together on a more social Europe and focus on the added value that the European Union can bring. Inequalities need to be addressed to prevent political and social instability, but diversity can also be a driver of health, growth, and peace. Delegates chose the word 'solidarity' as the main take home message from the conference, and the way to create a better future for Europe.

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Written by **MARIEKE KROEZEN & MARIE DELNORD**

**CLOSING PLENARY**

Introduction and round-up of the conference

HELMUT BRAND, President, European Health Forum Gastein

Video reflection

TAMSIN ROSE, Non-resident Fellow, Friends of Europe

Interview with VYTENIS ANDRIUKAITIS,

EU Commissioner for Health and Food Safety

Panel debate with:

VYTENIS ANDRIUKAITIS, EU Commissioner for Health and Food Safety

TOMÁŠ DRUCKER, Minister of Health, Slovakia

CHRISTOPHER FEARNE, MP, Minister of Health, Malta

MARIANNE DONKER, Deputy Director General for Health and Director for Public Health, Ministry of Health, Welfare and Sport, The Netherlands

GUDRUN MOSLER-TÖRNSTRÖM, President of the Congress Chamber of Regions, Vice-President of the Congress of the Local and Regional Authorities at the Council of Europe

Moderated by TANIA DUSSEY-CAVASSINI, Ambassador for Global Health, Vice-Director General, Federal Office of Public Health, Switzerland

Newsroom

MATTHIAS WISMAR, Policy Analyst, European Observatory on Health Systems and Policies

KOLIA BENIE, Global Health & European Public Health

Advocate and Member of the Young Forum Gastein Network

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European Health Forum Gastein



# Life-course and intersectoral approaches to public health

FORUM 1

A modern response to public health needs across the life-course requires a focus on providing a healthy start early in life, intervening at critical points and transitions, and the shared life experiences of cohorts.

Critical points present themselves at defined social transitions in life, from adolescence to the transition between work and unemployment, whether experienced in isolation or in cohorts. From research examples as well as experiences and lessons learned from national programmes, the speakers and panellists of this forum explored compelling arguments for early intervention in many areas of public health, from promoting early childhood development to policy and regulatory issues such as the role of governments, civil society and the private sector.

The forum was chaired by Monika Kosinska, Programme Manager, Governance for Health, World Health Organization (WHO) Regional Office for Europe.

## Addressing the need for coherence in action across sectors, settings and governments

Mihaly Kokeny, Consultant, WHO Europe, started the session by providing an overview of where we are today in terms of the development of life-course approaches and intersectoral action. Health 2020 was developed as a framework to improve health and well-being in the WHO European Region. However, despite the fact that countries have different starting points they experience the same challenges in spurring life-cycle approaches across sectors. Health 2020, launched in 2012, has a two-pronged vision to enable people to achieve their full health potential,

through reducing inequalities and improving governance in health. The core issues at hand are to implement the right to health and universal health coverage within Europe. These could be achieved through governments addressing the social determinants of health-equity, improving governance for health, and strengthening public health. By applying sound evidence on the economics of health promotion and prevention, health gains and losses will not be passed on to the next generation.

Kokeny focused on the basics of a homogeneous understanding of the life-course approach for health, which can be found in the Ottawa Charter for Health Promotion, combining the two definitions of life-course and health promotion. Moreover, the Minsk Conference held in October 2015 contributed greatly to the understanding of

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*A life-course approach for health and well-being is built on the interaction of multiple promotive, protective and risk factors throughout people's lives. This approach adopts a concurrent and societal perspective on the health of individuals and generations, including intergenerational determinants of health. A life-course approach is an investment in health and well-being.*

*The life-course approach encompasses actions that are taken early, appropriately to transitions in life and together as a whole society. This approach confers benefits to the whole population across the lifespan, as well as accruing to the next generations.*

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the multifaceted term of life-course approach by merging science and policy.

The resulting Minsk Declaration highlights three principles:

- acting early,
- acting appropriately during life transitions,
- acting collectively.

In his conclusion, Kokeny linked the issue to Agenda 2030 for Sustainable Development by highlighting that achieving the goals is critical for health and health equity underlines most of the Sustainable Development Goals (SDGs). In short: as a prelude to the Paris COP21 Conference in December 2016, we should foster intersectoral cooperation for health, see cooperation as a shared process, and build bridges.

The second speaker, Vesna-Kerstin Petric, Ministry of Slovenia, discussed national examples to highlight Health 2020 as a process by which every country's contribution is crucial by tackling the life-course approach through the inclusion of all sectors. At national level, Slovenia has implemented programmes looking at the development of children and youth, aiming for access to health, education and basic social security. Moreover, Slovenia is now working on a proposal focusing on the elderly as well as "working people" and vulnerable groups in society. Petric pointed out the challenge for intersectoral cooperation in the alcohol sector, which Slovenia overcame by involving other sectors, thus achieving success in the prevention of drinking and driving.

Petric also highlighted that success is the result of having identified strong policy leaders open to cooperation with other sectors. In the case of Slovenia, the public sector is strong but the potential of primary healthcare located in the community is underutilised. By recognising this bottleneck and overcoming the gap, implementation at community level has yielded the most success.

Petric's message to the audience was to be open to the inclusion of the community in primary healthcare programmes. Moreover, she pointed out three areas to be utilised:

- 1) **Funding:** funding for health care may benefit from foreign investment, which is often underestimated and difficult to translate to politicians and fund holders. (i.e. tobacco);

- 2) **Human resources:** beyond close cooperation with ministries and subsequent funding provided to NGOs, they may develop their full potential once adequate guidance is provided and a serious partnership is established. This needs to be applied at the vertical level;
- 3) **Communication:** the media should be considered as our partners and be engaged to reach the target groups with the right messaging.

An intersectoral approach to public health is incomplete without the active participation of civil society. Nina Renshaw, Secretary General, European Public Health Alliance (EPHA), stated that there is a lot of work to be done within the whole-of-society approach. The importance of civil society is already recognised by governments as involving civil society leads to better decision-making, improves results and reinforces the aspect of legitimacy of a health issue.

According to Renshaw, every member of society is connected to public health as a health professional, a patient, a parent or a carer, among others. Even though this is known in theory, certain groups of society are not called upon to be part of the discussion, including unemployed people, refugees and migrants. The "Nothing about us without us", policy discussions must include those who are being affected, as civil society is the voice of those groups.

*Health is the killer argument,  
everyone is affected and included  
in this debate, health impacts everyone.*

Nina Renshaw, European Public Health Alliance

Looking at specific subjects, Renshaw highlighted the need to integrate civil society actors in the antimicrobial resistance discussion and when tackling commercial determinants of health. This approach has a track record of success, for example in areas such as cancer prevention, air quality, tobacco control and road safety. Although the transformative effect of dialoguing with civil society is recognised, they are being excluded from debates, partly because non-governmental organisations are seen as foreigners in some countries.

## Focusing on coherence in acting early and at critical points throughout the life-course

The second part of the session began with a presentation by Marija Raleva, Professor, University Clinic of Psychiatry, Macedonia on early Adverse Childhood Experiences (ACE). ACE such as abuse and neglect have an impact upon children and are associated with poorer health and behavioural outcomes. The study showed significant association between ACE and health-harming behaviours. Physical abuse, mainly domestic violence, was the most reported ACE. Other types of behaviour associated with ACE include smoking, the harmful use of alcohol and drug abuse. What happens in childhood influences the life-course. There is an imperative to ensure the prevention of child maltreatment, and health and social interventions (e.g. home visiting and parent training) are cost-effective. Enhanced intersectoral cooperation and work between health, social, education and criminal justice agencies is needed.

The second speaker, Veronika Toffolutti, Postdoctoral Researcher in Health Economics, Department of Sociology, University of Oxford, explained the relationship between the concept of time-discounting and unhealthy behaviours. Time discounting incorporates a relative valuation at different time periods: some people prefer smaller more immediate rewards, whilst others are able to wait for larger rewards. This relationship has been studied in relation to smoking, Body Mass Index (BMI), physical activity and substance use. High discount rate is associated with smoking (smokers discount the future more than the present) and obesity. Age and socioeconomic factors influence discount rates as, for example, when people age they think more about the future. Toffolutti also presented a study looking at the effect of atheism on smoking in the 'German Separation Experiment'. This aimed to explain how cultural aspects influence unhealthy behaviours.

Laurent Chambaud, Member of Executive Board, Association of Schools of Public Health in the European Region (ASPHER) and the Director of the School of Public Health, Rennes and Paris, France reiterated the important role for a partnership between civil society and the media. He directly asked the stakeholders, how, within the complexity of the early 2020s, they perceived their role in supporting public health stakeholders to achieve the essential goals in the Health 2020 agenda?



Laurent Chambaud and Veronika Toffolutti

He urged the audience of the necessity to capitalise on the knowledge that early action prevents negative life course influence and that a deadline should be determined of when intervention makes sense. In contrast, Chambaud cited the example that many countries see an increase in vaccination resistance, which is 40% in France. In his opinion, one must look at the public health issues in a broader sense, beyond the means of the health care system, to community mobilisation and the opportunities beyond. Taking up Raleva's point, he agreed that programmes must be planned for the long-term as generations could be affected by non-prevention of ACE. Chambaud saw the future in research as a mix between sound data and results from quantitative and qualitative studies, to invest in training (distinguish between what is public health and what is the public health evidence obtained to date). He also recommended to focus more on civil society and offer public health expertise and knowledge sharing, to utilise proven and functioning cost effective interventions and most importantly, to show success stories to the decision-makers. He concluded by saying that the sectoral silo approach was no longer sustainable and should be replaced by positive and result-oriented intersectoral cooperation.

Throughout the forum all speakers defended a life-course approach to health, recognising the relevance and the impact of key stages in people's lives. Understanding our assets, including all partners in the discussion, investing in effective interventions and strengthening local communities, are some of the aspects to reflect on that can sustain the modern response to public health needs across the life-course.

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Written by **GESINE KNOLLE & RITA SÁ MACHADO**

**FORUM 1**

## Part 1

VESNA-KERSTIN PETRIC, Ministry of Health, Slovenia

MIHAIL KÖKÉNY, Consultant, WHO Regional Office for

Europe

NINA RENSHAW, Secretary General, European Public Health Alliance (EPHA)

## Part 2

MARIJA RALEVA, Professor, University Clinic of Psychiatry, Skopje, Macedonia

VERONICA TOFFOLUTTI, Postdoctoral Researcher in Health Economics, Department of Sociology, University of Oxford

LAURENT CHAMBAUD, Member of Executive Board, ASPHER; Director, EHESP School of Public Health, Rennes and Paris, France

Chaired by MONIKA KOSINSKA, Programme Manager, Governance for Health, WHO Regional Office for Europe

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**ORGANISED BY**

World Health Organization Regional Office for Europe



# Desperate migration & health

## Impact and remedies

FORUM 4

The number of migrants worldwide has grown rapidly and their health needs must be addressed. The forum, chaired by Walter Kemp, Senior Vice President of the International Peace Institute, aimed to explore the links between migration and health, discussed the challenges of meeting health-related needs, and considered ways in which we can respond to these challenges.

### Historical perspective

The first speaker, Jessica Reinisch, Director of the Centre for the Study of Internationalism, University of London, started with a brief historical overview of migration in Europe. 'People on the move' has been the norm throughout history, and public health is a useful prism for reflecting on the history of refugees in Europe. For instance, refugees have always been perceived as a dual threat of contagion, to public health on the one hand and the political establishment in the receiving countries on the other hand. The fear of refugees as a health threat was a key factor in the creation of the earliest international architecture for their protection and a catalyst for international cooperation: the first multinational attempt to tackle the spread of infections were the 19th century sanitary conferences. Eventually, the shared international field of communicable diseases produced a whole body of rules and international health organisations. At the same time, public health is a useful reminder that refugees have been consistently excluded by international mechanisms, and concerns about disease and health have long justified discriminating against specific groups of refugees.

### Current international perspective

Davide Mosca, Director of the Migration Health Department, International Organization for Migration, presented the current international picture on migrants and their health. He reminded us that over the past 15 years, global migration increased by 41 percent. Today, there are around 65 million forced migrants globally, including 21 million refugees, 3 million asylum seekers and about 40 million internally displaced persons.

Migration has increased due to the unprecedented number of unresolved conflicts and crises. At the same time, the fear of migrants has grown because of factors such as economic and political crises, terrorism and insecurity, and related negative populist narratives. Although over time the discourse around migrants has shifted from the focus on disease risks to emphasising the vulnerabilities linked to people being on the move, there is still limited understanding of the problem, and limited political will to address it.

While several international documents recognise the right to health for everyone, and Universal Health Coverage is an often-cited goal, very few countries provide migrants with the same access to healthcare as their nationals.



*We see the arrival of migrants as a crisis, but the actual crisis is our unpreparedness to recognise a trend and accept it, keeping pace with the change of reality.*

Davide Mosca, International Organization for Migration

To end on a more positive note, Mosca marked the year 2003 as a turning point in the search for international collaboration, seeing the launch of the UNHCR document on Co-operation to Address the Irregular Movement of Asylum-Seekers and Refugees: Elements for an International Framework. Before, migration had largely been a matter of national policymaking. The issue of health however is still nearly absent from international discussions. Mosca insisted that the health sector can do a lot - health bridges for peace. He pointed out that health responders are the most sympathetic and able to understand the public health interest of non-exclusion, but that collectively we have not yet succeeded in creating a momentum that can help our societies respond pragmatically to problems.

As part of our efforts to do so we need to change the narrative surrounding migrants into a positive one, create win-win situations and focus on more inclusive health policy development.

## Diversity in migration and health needs

People who migrate are very diverse. They come from different countries, cultures, have different reasons why they are on the move and have diverse health needs. Julie Lyn Hall, Director for Health and Care, International Federation of Red Cross and Red Crescent Societies, proposed a categorisation of seven distinct groups – three with visible, four with less visible health needs - of people affected by migration (please refer to the next page).

## Mismatch between health services and actual health needs

Taking into account the diversity of migrants and their different health needs, Miriam Rabkin, Associate Professor for Epidemiology and Medicine at Columbia University Medical Center, discussed the difficulties of care delivery for migrant populations. She identified three broad themes that illustrate the disconnect between actual and perceived health needs:

- There are misperceptions about the burden of disease, particularly the prevalence of NCDs tends to be underestimated.
- There is the issue of protracted displacement – how to ensure continuity of care when there is no continuity of location?

- While camp settings bring their own challenges in terms of delivery of care, urbanisation also becomes increasingly important: how to reach people that are immersed into cities?

These and other factors need to be considered when thinking about the design, evaluation and implementation of disease programmes, particularly for chronic diseases. The way forward may involve looking at lessons-learned from care delivery in LMICs and to engage refugees and other displaced people in the process.

## Actions to take forward

Migration is not going to stop. As Kemp said, “we need to accept the fact that people are on the move and will keep moving”. Indeed, the complexities of health needs of those seven groups affected by migration will increase as well. Bernd Rechel, Researcher at the European Observatory on Health Systems and Policies, focused on how the mentioned mismatch could be reduced. According to Rechel, health systems could improve the provision of health services to migrants by reducing formal and informal barriers to access, such as legal restrictions, bureaucracy, user fees, discrimination and unfamiliarity with health systems. The collection of disaggregated data, evaluation of interventions, and replication of good practice would be extremely beneficial. Measures to overcome aforementioned barriers are e.g. interpretation, translation and cultural support staff like health mediators, or staff training to develop of intercultural skills.

Discussions during the session centred around what steps should be taken in the short and medium term. Panel speakers suggested a number of actions, including more longitudinal studies looking at long-term outcomes of migration, integration of displaced health workers in health-care provision, involvement of more actors from fields such as education and employment, and speaking up against the populist and nationalist narratives and media campaigns.

Both panel speakers and the audience agreed that a short-term crisis approach is not going to answer the health needs of the various groups affected by migration. Right now, we need to do much more long-term planning, with stronger international leadership.

## PEOPLE ON THE MOVE

CATEGORY	DESCRIPTION	VISIBILITY	HEALTH NEED	RISK/ REQUIREMENTS
<b>IN TRANSIT</b>	Migrants on the move/ in transit to a destination country.	VERY HIGH	Mostly acute, mixed with some longer-term needs.	This group is at risk through dangers arising directly from the journey, such as exploitation, drowning and violence. Mobile and close health facilities are required.
<b>SETTLED</b>	Migrants settled or resettled, with housing and other essential needs met.	HIGH	More long-term (mental health issues, NCDs).	Once settled, evidence shows that in the 10 years following relocation migrants continue to have a different range and higher number of health needs than local populations, often due to the trauma of the move. Health system planning is required to support this group effectively.
<b>STUCK</b>	Migrants who are stuck in camps or at borders.	HIGH	Complex - mix of acute and long-term.	This population is increasing in numbers, as is the length of time they are stuck. The requirement to address a mix of acute and long-term health issues including NCDs and psychosocial issues caused by uncertainty about the future is apparent.
<b>RETURNEES</b>	Migrants who are sent back to their country to origin or who choose to return.	LOW	More long-term, a mix of health risks and needs.	Re-entry culture shock and the stress associated with it is quite significant. Also, returnees will have adapted different risk behaviours - support for those coming back is needed.
<b>HOST COMMUNITIES</b>	Communities who accept migrant populations.	LOW	Significant	Increasing frustration and fears in host communities, perceived or real inequalities in healthcare access for themselves and perception that health needs are not being well-met. Good planning and communication is required to mitigate this.
<b>LEFT BEHIND</b>	Those left in areas of high levels of migration, often those less able to travel.	LOW	High health needs dating from before when migration started.	With increasing migration this group has less ability to meet its health needs, due to the erosion of health infrastructure in the country of origin, and requires the continuation of health services.
<b>SUPPORT WORKERS</b>	Those who provide support to migrant populations	VERY LOW	Significant	Support workers require assistance due to the distressing nature of the work they carry out.

**FORUM 4**

MIRIAM RABKIN, Associate Professor for Epidemiology and  
Medicine, Columbia University Medical Center

JULIE LYN HALL, Director for Health and Care, International  
Federation of Red Cross and Red Crescent Societies

BERND RECHEL, European Observatory on Health Systems  
and Policies

JESSICA REINISCH, Director, Centre for the Study of  
Internationalism, University of London

DAVIDE MOSCA, Director, Migration Health Division,  
International Organization for Migration (HQs Geneva)

Chaired by WALTER KEMP, Senior Vice President,  
International Peace Institute

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**ORGANISED BY**

International Peace Institute



# Work & Health

## WORKSHOP 4

We spend much of our adult lives at work. The work environment – both physical and psychosocial – has an impact – positive or negative – on our health. It can contribute to the development of adverse health outcomes through exposure to workplace hazards, a fact which is not sufficiently acknowledged.

The workshop was introduced by Tim Tregenza, Network Manager, European Agency for Safety and Health at Work (EU-OSHA). Its aim: to highlight the impact of work on our health. By discussing the policy context, drawing a picture of health and safety at work in the EU in 2016, and raising issues such as how work and workplace can be a forum for health development, the session addressed three main questions:

- Is a negative impact of work on health being taken seriously enough?
- Why are there health inequalities across work places?
- Can workplaces be a positive driver for health?

Four experts from Europe and the US contributed to the session and shared insights.

## EU actions on health & safety of the ageing workforce

Zinta Podniece, Policy Analyst, DG Employment, presented the European Commission's EU Occupational Safety and Health (OSH) Strategic Framework 2014-2020.

It was developed based on an evaluation of previous strategies, discussions with key stakeholders and a public consultation. Podniece made clear why when talking about OSH, we also need to consider demographic change: the

working age population aged 55-64 is expected to expand by about 10% between 2013-2030. This means older workers will become more important for the labour market, and we need to ensure their safety and health in the best possible way to keep them in the workforce for longer. Currently many of the older workers leave before pension age due to – sometimes work-related - health reasons, and few workplaces have measures in place to support their older workers. Thus, demographic change has been identified as one of the main challenges in relation to health and safety at work. Proposed actions include the identification and exchange of best practice when it comes to improving OSH conditions for older workers, the promotion of rehabilitation and reintegration measures, and awareness raising.

Podniece highlighted the strong potential for synergies with other policy areas, e.g. public health, as one instrument for tackling these challenges, as well as the use of EU funds such as the European Social Fund or Horizon 2020. Also relevant is the currently ongoing work of the Juncker Commission on a European Pillar of Social Rights, designed to set out several principles to support well-functioning and fair labour markets and welfare systems.

## Work, mortality and morbidity

In the EU in 2014 about 192 200 deaths were estimated to be attributable to work – a number somewhat difficult to ascertain. While some cases, e.g. accidents, are easy to trace back to the working environment others are more complex: should for example lung cancer (possibly) caused by the working environment be included in these numbers, or not?

When looking at costs especially non-fatal accidents are a large burden for EU healthcare systems; back pain alone is put at 12 billion, work-related stress at about 63 billion a year.

In order to lower work-related mortality and morbidity, Tregenza introduced the following action points: generating better OSH data and pursuing an integrated and life-course approach, starting even before a person enters the labour market – an injury suffered at 20 may force a worker to retire at 50.

## Health inequalities, work, and demographic change

Turning to the issue of health inequalities, Katalin Sas, Project Manager, EU-OSHA, pointed out that a negative impact of work on health is more often reported by so called blue collar workers than by white collar workers, what also has implications for job sustainability. This ties in with the observation that usually, people with higher education enjoy better health than people with lower education. The differences can be considerable, up to a 17-year gap in life expectancy at age 30 by educational level for men (Czech Republic). Of course, education is linked to more aspects than work. But the numbers presented by Sas supported the assertion that the workplace is an ideal arena for reducing health inequalities, e.g. by improving working conditions - particularly in jobs with the highest level of exposure and strain and in which unhealthy lifestyles are common. Another point made was that health inequalities matter especially when assessed against the background of ageing and the aspiration of policymakers to keep people in the workforce for longer.

***70% of the audience indicated that, given the amount of time they spend at work, work affects their health negatively. Only 30% saw a positive effect.***

Perhaps unsurprisingly no one indicated there was no impact: 92 120 hours over a lifetime are spent at work (numbers for the UK), which equates to 35% of our total waking hours over a 50-year working life.

## Productive ageing and holistic approaches for workers of all ages

Juliann Scholl, Co-Director of the National Center for Productive Aging and Work (NCPAW), started off with a quote by Victor Hugo: “forty is the old age of youth; fifty is the youth of old age”.

She presented the work of NCPAW, which emphasises the positive aspects of growing older and how workers can continue to make important contributions, thriving optimally at all ages. The NCPAW model is characterised by a four-tier approach, consisting of a lifespan perspective, a comprehensive, integrated framework, recognising priorities and goals of both workers and organisations, and a supportive culture for multi-generational issues. Strategies to enhance productive ageing include workplace flexibility, the matching of tasks to abilities, avoiding prolonged sedentary work, and hazard management.

Against the background of the panellists’ presentations one of the main concerns raised by the audience and touched upon a number of times throughout the session was how to bridge the gap between policymaking and real life. In reply, the experts emphasised that on the one hand, good quality data to generate evidence is crucial, to show that the implementation of OSH measures pays off. On the other hand, agencies like EU-OSHA need to go beyond the provision of information, but also provide tools that e.g. enable companies to carry out risk assessments. Also mentioned several times was the importance of aligning interests and social dialogue between partners.

What became clear: the challenge is to provide a safe and healthy work environment for any worker, including vulnerable groups such as (undocumented) migrants, at any age. Central to achieve this are a life course perspective and the recognition that we only have one health – not one for each area of life – and that thus an integrated, holistic approach is needed. Then yes, the workplace can be an arena for improving health.

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Written by **MARIEKE KROEZEN**

**WORKSHOP 4**

TIM TREGENZA, European Agency for Safety and Health at Work

KATALIN SAS, Project Manager, Prevention and Research Unit, European Agency for Safety and Health at Work

JULIANN SCHOLL, National Institute for Occupational Safety and Health (NIOSH), USA

ZINTA PODNIECE, Policy Analyst, DG EMPL, European Commission

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**ORGANISED BY**

European Agency for Safety and Health at Work (EU OSHA)



# Healthy Ageing: West meets East

FORUM 6

The global population is ageing rapidly. Projections show that by 2030 the number of people aged 65 and over is expected to increase by more than 60% to around 1 billion, equivalent to 12% of the total global population. Population ageing has profound consequences for service provision, city design, environment, health and social care systems.

This session aimed to explore and discuss actions and different approaches between Asia and Europe to support healthy ageing, and was facilitated by Martin McKee, Professor of Public Health at the London School of Hygiene and Tropical Medicine.

## Global Ageing Quiz

An introductory quiz of 11 questions opened the session, to assess how much delegates already knew about the demographics of ageing, and throw in a few surprises. Delegates were able to input the answers through their smartphone and McKee used the answers to highlight some facts related to global ageing, for example did you know that:

- By 2020 for the first time in human history, people aged 65 and over will outnumber children under the age of five, an unprecedented demographic phenomenon.
- Japan is currently the oldest nation in the world and is projected to retain this position until at least 2050.
- In 2050, Slovenia and Bulgaria are projected to be the oldest European countries.
- About 75% of older people's health is determined by physical and social environmental factors, and 25% by genetic factors.

- Over the next 15 years, the number of older persons is expected to grow fastest in Latin America and the Caribbean, which will see a 71% increase in the population aged 60 years and over.

East Asia and the Pacific are ageing faster than any other region in history. This implies elevated risks for sustaining healthcare delivery, public finances and economic growth, and requires a “womb to tomb” approach to policymaking.

## Built environment and active ageing - evidence and actions

Yuan-Nian Hsu, Director General of the Health Bureau of Taichung City Government in Taiwan, discussed the efforts to build an age-friendly environment in a country facing one of the fastest-growing ageing populations in the world.

In Taiwan, the over 65 population has doubled during the last 25 years from 7% to 14%, and is expected to grow to 20% by 2025, when it will become a super-aged society. 86.6% of over 65s have at least one NCD. Under the combined pressures of a changing population ageing structure and an increasing burden of chronic disease, he explained that the focus is to build an environment in which active and healthy ageing can be fostered and a coordinated, and a harmonised health and (long-term) care system established.

According to Hsu, a proactive approach to an active ageing environment needs to be focused on four key elements:

- Establishing disease management and preventive services
- Set up a system of age friendly services
- Enhance community health promotion for elderly people
- All citizens work together towards an age-friendly society

Taiwan have set-up a working framework for an age-friendly society with policy guidance and system design based on WHO guidelines. Taiwan's Health Promotion Administration acts as an advocator, mediator and enabler to promote age-friendly cities. In the final part of his presentation, Hsu illustrated a number of examples of how important it is that as people become less mobile their environment needs to remains accessible and "friendly". Design is very important to help older people continue to live a healthy and mobile life. He provided a case study about Taichung City's age-friendly policies, and showed some before and after photographs of how simple facilities can be better-designed taking into context an age-friendly approach – street pavements, barrier-free spaces, clean and accessible public toilets, age-friendly social housing and transport.

Serena Girani, an architect from the firm Arup, continued this theme, presenting results from research carried out in ten European cities that offers a comparative overview of their ageing populations and observations made under the lenses of society, mobility, built and digital environment. Two main research questions emerged: Are our cities ready to face the challenge of ageing? How does the city structure respond to the ageing trend?

Girani suggested this huge societal change in population structures can be compared to the impact of the industrial revolution. If you think about how the industrial revolution changed cities, it is very important to understand also how ageing trends might impact the city environment, particularly as in Europe about 75% of the population lives in urban areas.

In understanding how European cities are responding geographically to the changes they are experiencing, the Arup research mapped the density of the population aged over 65, and overlapped this with information on infrastructure, transport networks and the digital environment. The distribution of the older population reflects city-specific

**AGED NEIGHBORHOODS**



**LONDON** | DAGENHAM

**AMSTERDAM** | BUITENVELDERT

**AGED HOUSING TYPES**



building height | 2-3 floors  
open spaces | private green spaces  
street front | inactive

**LONDON** | DAGENHAM



building height | 4 floors  
open spaces | semi-public green spaces  
street front | 20% commercial

**AMSTERDAM** | BUITENVELDERT

Examples from the Shaping Ageing Cities - 10 European case studies presentation by Serena Girani.

geographies, for example concentrated in the suburbs such as in London and Berlin, spread around urban areas in Milan and Lisbon or concentrated in specific areas or districts like in Amsterdam.

Results show that mobility, accessibility, proximity and safety are the most important factors which influence quality of life for the over 65 inhabitants, while the digital environment has an under-exploited potential. The design of neighbourhoods, including housing type, has a great impact on quality of life, and whether we can design better shaped neighbourhoods should be a topic more closely considered in the future.

## Developing age-friendly health and social care systems

According to data presented by Liang-Kung Chen, Director of the Center for Geriatrics and Gerontology from Taipei Veterans General Hospital, by 2030 NCDs are projected to cause 85% of all deaths in East Asia and the Pacific while 51.1% of cases of dementia and 60.3% of hip fractures will occur in Asia overall. Ageing is considered a national crisis in Taiwan. Facing these challenges, he highlighted the need for the creation of one integrated healthcare and outpatient service.

Chen emphasised that “fragmentation” is the major barrier to building up healthcare services for older people in developed countries, and the lack of resources is the major challenge in developing countries. Japan, South Korea and Taiwan are the most rapidly ageing countries in Asia, with the common features of longevity and a low fertility rate. These three countries also share some common phenomena in healthcare services, which include universal health insurance systems with a high coverage rate, lack of well-established referral systems, and highly specialised care service provision. These conditions have resulted in some adverse outcomes for older people, including frequent physician visits, polypharmacy, high utilisation of potentially inappropriate medications, and difficulties in caring for patients with multiple complex needs.

To address long-term care needs, Japan introduced a long-term care insurance in 2000, followed by South Korea in 2008. Taiwan introduced a taxation-based long-term care plan in 2008. Since the introduction of national long-term care services, the new challenge facing these coun-



Yvonne Doyle

tries are the integration of healthcare and social services. A number of solutions are currently being trialled: Japan, Korea and Taiwan have launched several collaborative networks in frailty and sarcopenia research, dementia care, and healthcare system reform. Japan plans to reshape its healthcare system by reducing the number of acute care beds and increasing community-based provision. Taiwan will take a similar approach by increasing reimbursement for post-acute care, community care and home medical care services.

There were a number of other positive stories concerning collaboration and best practice sharing, including that Taiwan established world first national standards for age-friendly healthcare facilities, which other countries in the region are interested to learn more about. There is also strong international collaboration on dementia care, in the form of the Orange Platform, which will take place in late 2016, in which Japan, the United Kingdom, Taiwan and Thailand have already participated. Finally the US have also modelled their geriatric specialist training on that adopted by the Taiwanese.

Yvonne Doyle, Regional Director for London from Public Health England, firstly considered the ageing process and societal attitudes towards older people. She emphasised the importance of re-framing older people as an asset to society and not a burden, thus calling for

a fundamental change in societal attitudes towards ageing. She also spoke about healthy ageing occurring throughout the life-course and the impact of ageing being reflective of healthy lifestyle choices earlier in life, as well as key drivers of health in our environments, comparing the cities of Paris, London and New York in terms of various health risks such as air quality, obesity and smoking.

Ageing is not just about being healthy, but about having goals too, so if we want to have a peaceful, secure and equitable society we need to make sure that older people's contributions are not left behind. It is crucial to tackle isolation and engage older people in activities in order to promote well-being, and Doyle provided some examples of international efforts to achieve this, for example multi-generational centres in Germany, a companionship telephone line in Portugal, and specially designated meeting spaces in Switzerland.

In line with previous speakers, Doyle also supported the importance of creating an age-friendly environment, both in terms of the physical environment as well as making our health and care systems fit for an ageing population. She considered the holistic approach being undertaken by Japan of a "total care" future through localised comprehensive and integrated health and social care, as a good global model.

## Conclusions

The following are a number of conclusions and policy recommendations from the session:

- Old age is no longer a time of 'retirement' from life, it is a time for active engagement. Individuals, family, clinicians, local government and national policy makers should do everything to support social, economic and physical activity, well into old age.
- There is a societal component too which will be influenced in the future by the environment, housing, technology, training, continuity with community, and mutual aid between older people.
- To support the resilience of older people and carers, equitable access to integrated health and social care is vital.
- When designing healthcare policies or planning cities it is vital to involve older people and consider their needs. Our ageing and urban population can be seen as an opportunity for urban regeneration but it needs a strong vision and multidisciplinary approach, enabling people to maintain a high quality of life independently in their older age.
- International collaboration and best practice sharing on these issues are crucial.

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Written by **JULIA SALLAKU & ROBBIE STAKELUM**

**FORUM 6**

## Part 1

MARTIN MCKEE, Professor of Public Health, London School of Hygiene and Tropical Medicine

## Part 2

YUAN-NIAN HSU, Director-General, Health Bureau of Taichung City Government, Taiwan R.O.C.  
SERENA GIRANI, Architect, Arup, Italy

## Part 3

LIANG-KUNG CHEN, Director, Center for Geriatrics and Gerontology, Taipei Veterans General Hospital, Taiwan R.O.C.  
YVONNE DOYLE, Regional Director for London, Public Health England

Facilitated by MARTIN MCKEE, Professor of Public Health, London School of Hygiene and Tropical Medicine

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**ORGANISED BY**

Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C. in cooperation with London School of Hygiene and Tropical Medicine, UK



# Life-course vaccination

## Finding the balance

LUNCH WORKSHOP 1

The aim of this workshop was to prompt reflection on the value that a life-course approach to vaccination could bring to public health in Europe today, describe the challenges faced by healthcare systems to adopt such an approach and identify potential solutions.

As indicated in the introductory speech by moderator Andrea Ammon, Acting Director, European Centre for Disease Prevention and Control (ECDC), a life-course approach to vaccination is especially significant in the context of recent changes to the EU's demographic structure and the extension of life expectancy. Furthermore, herd immunity through vaccination contributes to the topic of solidarity which was identified as an emerging theme in this conference.

Wolfgang Philipp, Deputy Head of Unit, DG SANTE, European Commission, provided his input on life-course vaccination from a policy perspective at EU level. He acknowledged the benefits of vaccines at both individual and population levels and identified vaccination as one of the most cost effective health interventions.

Vaccine hesitancy in Europe was flagged as a serious matter of concern which has contributed to the miss on targets like eliminating measles and rubella in certain EU/EEA countries. Enhancing confidence in vaccines among the general public and also healthcare workers is one of the main challenges that need to be addressed. Other identified challenges to the sustainability of vaccination programmes included issues related to budgeting, insufficient resources and infrastructure for surveillance and data collection and vaccine shortages.



Andrea Ammon

Closer cooperation and strengthening the dialogue between the European Commission and member states were identified as important steps in developing solutions to these challenges which would enable the Commission to find ways how to better support and work together with member states.

Lucia Pastore Celentano, Head of the Vaccine Preventable Disease Programme, ECDC, underlined the fact that the adult population in the EU/EEA is increasingly being affected by diseases that are typically considered to be childhood diseases, such as measles. She also indicated that the burden of pneumococcal disease is highest in the population aged 65 years and over.

Pastore Celentano went on to emphasise that a wide heterogeneity exists across member states with respect to the basket of vaccines available for adults, funding mechanisms and vaccination strategies for the same vaccine. In fact, not all Member States have as yet adopted a life-course approach to vaccination. Reasons for this include variations across countries in disease epidemiology and the scientific evidence available, differences in goals of vaccination programmes and variations in historical traditions that shaped the development of vaccination schedules. The available infrastructure, resources and political commitment also play a major role in the decision-making process leading to the introduction of vaccines and vaccination programmes in a particular country.

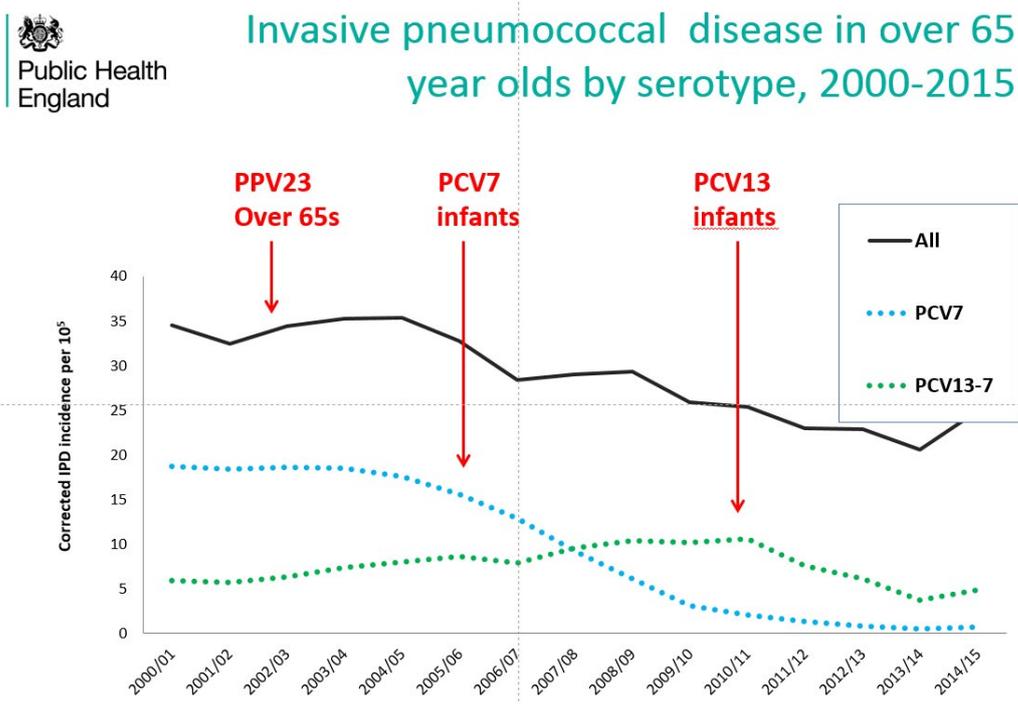
This heterogeneity creates challenges and in this respect, the need for evidence-based mechanisms and criteria for prioritisation, both generic and country-adapted was deemed necessary. Furthermore, the recent influx of migrants who need to be vaccinated and protected, coupled with the shortage of vaccines has created an additional challenge that needs to be addressed.

From a physician's point of view, Gaetan Gavazzi, Geriatrics Professor, University Hospital of Grenoble, sought to make the case for vaccines as a component of a healthy ageing process. He described the adverse impacts of vaccine-preventable diseases like influenza, pneumococcal disease

and herpes zoster on the elderly population. Such impacts include the contribution to acceleration of functional decline. He also expressed the need to assess the effect of vaccines not only on incidence of and mortality from vaccine-preventable diseases but also on complications such as disability caused by the disease particularly in the elderly population.

Mary Ramsay, Head of Immunisation, Public Health England, described the UK's experience in adopting a life-course vaccination approach.

The high coverage achieved by adult vaccination programmes in the UK was attributed to universal free access to general practice, supported by comprehensive information systems. A key observation made by Ramsay was on the importance of childhood vaccination in optimising the protection of older people. As an example, she described how the introduction of PPV23 for the over 65-year-olds in 2003 had a less profound impact on invasive pneumococcal disease rates in this age group when compared to the impact achieved by the introduction of PCV7 for infants in 2006, which was subsequently replaced by PCV13 in 2010. This stresses the value of a whole population approach to vaccination in optimising the protection of older people, with indirect protection from vaccinating children at times being more effective than direct vaccination of older age groups.



Mary Ramsay, Life course vaccination - the UK perspective (September 2016).

Marianne Donker, Deputy Director General for Health and Director for Public Health, Ministry for Health, Welfare and Sport, The Netherlands, used the Dutch experience to shed light on the challenges faced by policy-makers at national level when deciding upon which vaccines should be made available, which population groups should be targeted and how the vaccine will be funded. This built on the reflection made by Pastore Celentano regarding the heterogeneity of vaccination programmes across member states and the need for generic and country-adapted criteria for prioritisation. Furthermore, Donker emphasised the need to step up education on vaccines.

In conclusion, Ammon summarised the main outcomes of the session as follows:

- There is a need to come to a common knowledge base and criteria to support policy-makers across member states in decision-making with respect to vaccines. These can then be adapted to the needs and characteristics of a particular country.
- Disability is a potential outcome indicator of vaccines and ways how this could be measured should be sought.
- Communication strategies to address vaccine hesitancy need to be enhanced with health care workers being the primary target group given that they are the first point of contact for patients seeking information on vaccines.

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Written by ANNALISE BUTTIGIEG

#### LUNCH WORKSHOP 1

WOLFGANG PHILIPP, Deputy Head of Unit, DG SANTE (C3), European Commission

MARIANNE DONKER, Deputy Director General for Health and Director for Public Health, Ministry of Health, Welfare and Sport, The Netherlands

LUCIA PASTORE CELENTANO, Head of the Vaccine Preventable Disease Programme, ECDC

GAETAN GAVAZZI, Member of the French Haut Conseil De La Santé Publique; Geriatrics Professor, University Hospital Of Grenoble

MARY RAMSAY, Head of Immunisation, Public Health England

Moderated by ANDREA AMMON, Acting Director, ECDC

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#### ORGANISED BY

European Centre for Disease Prevention and Control (ECDC)



# Facing the challenge of Alzheimer's and other dementias

FORUM 10

Dementia is a crucial issue to consider when talking about demographic change in Europe, as it will put considerable pressure on our health systems and society in the coming years. Are we ready for this unprecedented challenge?

In recognising that efforts to address dementia should commence with active dialogue between a wide range of stakeholders, the European Health Forum Gastein became such a platform under the guidance of the two moderators Boris Azais, Director of Public Policy, Europe and Canada, MSD and Matthias Wismar, Health Policy Analyst at the European Observatory on Health Systems and Policies. They ensured that stakeholders present were able to describe the challenges and opportunities for action, as perceived from their unique vantage points, and that the audience was able to interact with the panellists in order to influence and contribute to the discussions.

Living with dementia, the stigma and fighting for rights  
Helen Rochford-Brennan from the European Working Group of People with Dementia gave her personal and touching story about living with Alzheimer's. She struggles with daily activities that seem simple for other people and lives with the knowledge that a lot of the things she does today, she will not remember tomorrow. Moreover she also has to live with the stigma of the disease. She strongly highlighted that in order to fight stigma, we need awareness! Helen received her diagnosis at the age of 62, which means that it was difficult to find support because it is only offered to people at the age of 65+. So, in addition to the disease burden, she has also had to fight for her rights to receive adequate support.

## Measuring the challenge

The demographic changes that we face are estimated by the OECD to precipitate an increase in the number of people with dementia by 50% within the next 20 years, from an estimated starting point of 9.6 million people today.

Tim Muir, Policy Analyst, OECD, highlighted the need to be able to estimate the burden of dementia to effectively address the problem. Lack of data on dementia means that we are not able to measure the impact of dementia policy, which makes it difficult to improve policy and adapt health and social care systems. Some of the questions we would like to be able to answer are:

- What proportion of people with dementia has a diagnosis?
- Can people with dementia continue to live independently in the community?
- Are the families and carers of people with dementia effectively supported?
- Are health and long-term care services for people with dementia of good quality?

## Civil society, support and action

The role of civil society was highlighted by Tania Dussey-Cavassini, Vice-Director General, Federal Office of Public Health, Switzerland.

Governments wake up when they see the alarming numbers and costs of the disease, and the Alzheimer's societies have done a fantastic job in creating awareness and

highlighting the consequences of the disease. WHO has now developed an action plan for dementia, which will be presented for adoption in May 2017 in Geneva. But why do we need a WHO action plan for dementia? Only 25 out of 199 countries have so far developed a national action plan, so only 25 countries recognise the importance of the problem and globally we need to act together. The vision of the action plan is “a world in which people can live well with or without dementia, and receive the support they need to fulfil their potential with dignity, respect and equality” and the goal is “[...] to decrease the impact of dementia on individuals, families, societies and countries”.

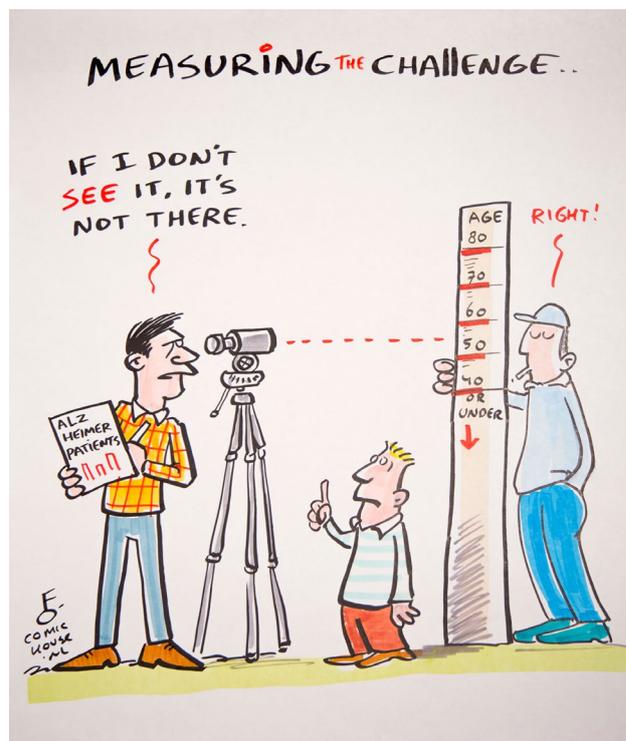
Dussey-Cavassini emphasised the need to talk about dementia and the people who are affected by it. Furthermore, we need to face the false statements that stop us from taking action – it is of great importance to create dementia friendly societies and communities to improve the integration of people with dementia. These are a serious challenge for their families and as long as we do not have a cure, we need to create good conditions for the care and carers of people with dementia and mobilise resources to find a cure.

## Where should we put our hopes and priorities?

The aim is to find a cure – but treatment is complicated. Peter Dal Bianco, Professor of Neurology and Psychiatry, Clinic for Memory Disorders, Vienna General Hospital, explained how Alzheimer’s affects the brain and outlined currently available treatments. In the absence of a disease modifying treatment, he proposed to work towards delaying dementia symptoms for as long as possible (ideally past the point of death). This remains a crucial goal of clinical intervention and he described the potential of intervening preventively on the asymptomatic population at risk.

## Awareness

Wiebe Clossen from Into Dementia presented a virtual reality headset which allows the wearer to experience what it feels like to have dementia. The tool can help to create awareness and information about how people with dementia experience the world. The tool has mainly been used at care institutions but also in banks and supermarkets. By spreading this awareness of how it feels to have



dementia, it creates an understanding on how to handle and help people with dementia in the best possible way.

## Informal carers

The burden that lies on the family members of people with dementia was addressed by Antonia Croy, President, Alzheimer Austria, which is a family network and self-help group.

There are both physical and mental pressures on family members of dementia sufferers, especially if the person is living at home. This pressure is a burden for the family members and can cause serious health problems.

**1 out of 4 caregivers suffer from depression.**

Antonia Croy, Alzheimer Austria

More attention needs to be dedicated to the role of informal carers and to ensure they are supported. Carers take on their role out of love and duty, and most carers do not even see themselves as carers and therefore do not seek any help. This issue was taken up by Elizabeth Hanson, Vice President at Eurocarers and Research Director at the Swedish Family Care Competence Centre.

We need to reach out to carers and support them with emotional help, training, and financial support. Informal carers can also be helpful in identifying appropriate treatment for the dementia sufferer, as they can contribute with detailed information about the patient.

## A call to action

The session ended with round-table discussions in small groups, giving all attendees the opportunity to debate with the panellists.

Herta Adam, representing DG SANTE and Karin Kadenbach, Member of the European Parliament, gave concluding interventions. They summarised the considerable challenges lying ahead and the decisive European policy response in support of tackling the burden of Alzheimer's disease and other dementias.

Adam highlighted the EU-level health policy actions on dementia from the strategy "European Initiative on Alzheimer's Disease and other forms of Dementia" (2009). The strategy falls nicely in line with some of the main aspects that were also discussed during the session with the four action points in the strategy being:

- Early (timely) diagnosis of dementia and promoting well-being with age
- Better understanding of dementia, epidemiological knowledge and coordination of research
- Best practise in care for people with dementia
- Respecting the rights of people with dementia

In order to achieve this, we need joint action!



***People with dementia and their carers are not forgotten at the parliament.***

Karin Kadenbach, Member of the European Parliament

## Conclusion

The aim is to find a cure for dementia but we are far from that goal so, in the meantime we need to focus on the things that we can influence here and now to improve conditions for people living with dementia and their families.

In the present we need to focus on increasing awareness of the disease; improving the availability and collection of good quality data; allocating resources to find treatments and a cure; establishing dementia friendly societies and ensuring better conditions and support for informal carers.

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Written by STINE BAGGE KEINICKE

**FORUM 10**

## Part 1

HELEN ROCHFORD-BRENNAN, European Working Group of People with Dementia

TIM MUIR, Policy Analyst, OECD

TANIA DUSSEY-CAVASSINI, Ambassador for Global Health, Vice-Director General, Federal Office of Public Health, Switzerland

## Part 2

PETER DAL-BIANCO, Professor of Neurology and Psychiatry, Clinic for Memory Disorders, Vienna General Hospital

Panel discussion with:

ANTONIA CROY, President, Alzheimer Austria

SIOBHAN O'CONNOR, Lecturer, University of Manchester and Young Forum Gastein Scholar

ELIZABETH HANSON, Vice-President, Eurocarers; Research Director, Swedish Family Care Competence Centre

WIEBE CNOSSEN, Into D'mentia

## Part 3

KARIN KADENBACH, Member of the European Parliament (S&D, Austria)

HERTA ADAM, Deputy Head of Unit DG Health and Food Safety (DG SANTE), European Commission

Facilitated by

MATTHIAS WISMAR, European Observatory on Health Systems and Policies

BORIS AZAÏS, Director, Public Policy Europe & Canada, MSD

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**ORGANISED BY**

European Health Forum Gastein and supported by an unrestricted educational grant from MSD



# Health literacy

LUNCH WORKSHOP 4

The Swiss Federal Office for Public Health, in collaboration with the European Observatory on Health Systems and Policies, hosted a session on health literacy (HL) in Europe. The workshop presented existing surveys and initiatives on HL and aimed to build on the existing evidence for further interventions and establish intersectoral accountabilities.

In his introductory speech, Helmut Brand, President of the European Health Forum Gastein (EHFG), pointed to the fact that health literacy has been in the programme of the EHFG over the last ten years. He argued that HL is deeply rooted in the health policy approach and that there are two basic levels of health literacy – individual and institutional.

In her keynote speech, Gillian Rowlands, Professor at Aarhus University in Denmark, introduced the concept of health literacy and its different aspects, presented HL surveys conducted so far in Europe and suggested future actions for research. Rowland's main conclusions were:

- HL is a balance between competencies & environment.
- Surveys:
  - tell us if there is a problem;
  - identify areas for interventions;
  - but they do not lead directly to healthy outcomes.
- Survey data can be imputed within countries but not between countries.
- People with lower HL are sicker and die earlier.
- People with high HL feel better.
- We should make currently existing data publicly available for secondary analyses.
- We should consider requesting follow-up interviews to turn surveys into cohorts.
- We should include HL measures in future general literacy surveys.

The moderator, Tania Dussey-Cavassini, Ambassador for Global Health and Vice-Director of the Swiss Federal Office of Public Health encouraged the audience to view HL like a piece of fine art:

- The more we look at it (available data), the more we will find out.
- It has to inspire us to act.

“International comparison made it clear that the problem was real”, said Christina Dietscher, from the Austrian Ministry of Health and Women's Affairs, commenting on the fact that the EU-HL Survey showed that health literacy in Austria was more similar to the one in Bulgaria than the one in Netherlands. Following reasons were identified:

- Fragmented healthcare system;
- Multitude of different providers;
- A lot of choice for patients.

Kai Kolpatzik, from the German health insurance provider AOK, pointed out that the first results from Germany motivated AOK to produce an action plan but also to act immediately by offering simplified versions of Cochrane systematic reviews in plain language for patients.

“Health literacy should be understood, and accordingly tackled in the context of broader literacy – the one of knowledge, skills, media literacy”, urged Monika Kosinska, from the WHO Regional Office for Europe.

Switzerland, as a non-EU Member State, which was not included in any of the EU-wide HL surveys, decided to replicate the EU-HLS study in 2015 and is currently analysing the data. Preliminary results show that the problem of HL in Switzerland is “broad but not deep”, commented Salome

von Greyerz, Deputy Head of the Health Policy Directorate at the Swiss Federal Office of Public Health. The largest identified problem is the lack of literacy regarding prevention and vaccinations.

“Data came at the right time. We were just in the process of developing the Austrian health targets so we added HL as a target. The aim is to develop health literate healthcare organisations by investing in professional and institutional capacity building”, commented Christina Dietscher. Austria also initiated a health literacy platform, which, through a Health-in-All-Policies approach, includes social partners such as the Ministry of Families and Youth and the Ministry of Education.

Von Greyerz raised the question whether we needed another action plan, working group or additional structure for HL or whether HL could be integrated as a priority area into the existing national plans. The Swiss approach determines influencing factors (social status, age or migrant background) before planning interventions.

Audience questions and discussion on the topic of HL concluded:

- “We only began with HL as a topic. Take care to design the right tools for the people that need them the most. Apps are cool, but are we reaching the target groups with apps?”
- “Organisational HL can help create opportunities for people who are most in need. Follow the US example of building organisational HL.”
- “Countries not included in the HL surveys so far (and there are many of them) might not be aware of problems related to HL.”
- “Patients are not customers. They are stakeholders.”
- “The biggest room in the world is still the room for improvement.”

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Written by DAMIR IVANKOVIC



**LUNCH WORKSHOP 4**

Introduction

HELMUT BRAND, President, European Health Forum Gastein

Keynote by GILLIAN ROWLANDS, Professor for Public Health, Institute for Public Health, Aarhus University, Denmark

Panel discussion with:

MONIKA KOSINSKA, WHO Regional Office for Europe

PAMELA RENDI-WAGNER, Head of Public Health and Medical Affairs Section, Federal Ministry of Health and Women's Affairs, Austria

KAI KOLPATZIK, AOK Federal Association, Germany

SALOME VON GREYERZ, Deputy Head of Health Policy Directorate, Head of Health Strategies Division, Federal Office of Public Health, Switzerland

Facilitated by TANIA DUSSEY-CAVASSINI, Ambassador for Global Health, Vice-Director General, Federal Office of Public Health, Switzerland

Summary by MATTHIAS WISMAR, European Observatory on Health Systems and Policies

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**ORGANISED BY**

Swiss Federal Office of Public Health in collaboration with the European Observatory on Health Systems and Policies



Schweizerische Eidgenossenschaft  
Confédération suisse  
Confederazione Svizzera  
Confederaziun svizra

Swiss Confederation

Federal Department of Home Affairs FDHA  
**Federal Office of Public Health FOPH**

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

# Maternal healthcare in Europe

## Making it a reality: measuring maternal healthcare performance

FORUM 5

### Introduction

Maternal mortality and health issues related to complications in pregnancy are sometimes viewed as problems which affect only women in the developing world. However, as we heard at this session, 1,800 women in Europe die every year and thousands more suffer long term health issues because of complications associated with pregnancy and child birth. Almost all these deaths and complications are preventable and equal access to quality maternal care for all women in Europe is the solution to this problem.

The forum aimed to present and validate a matrix that will help “evaluate how national health systems are performing on maternal health, based on several relevant factors, while examining how these factors apply to both the EU supra-national and the national levels”. The presentations and discussions that took place were both comprehensive and examined the general perceptions of maternal health held by the audience.

### Setting the scene

Jacqueline Bowman-Busato from the Alliance for Maternal Health Equality gave the first presentation that introduced the themes to be discussed in the forum.

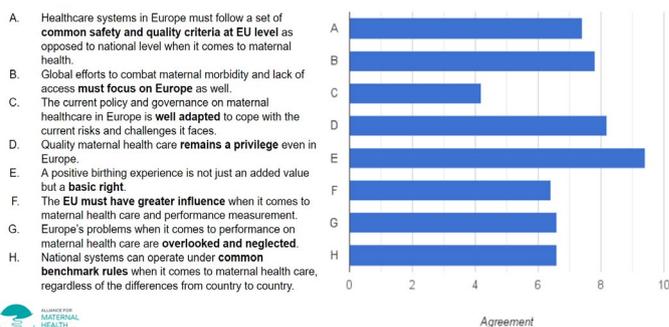
She emphasised that policy initiatives must now move towards empowering women and all relevant stakeholders must focus on the ‘how’: How useful are existing health systems for women and maternal health? The Alliance for Maternal Health Equality have produced a matrix focusing on five equally important pillars that can be applied to

national health systems performance measurement:

- person-centric approach,
- timeliness and accessibility,
- equitability,
- resilience and efficiency, and
- safety, quality and standards.

The introductory presentation was followed by an interactive session where the participants evaluated eight statements about maternal health. The statement “positive birthing experience is not just an added value but a basic right” was widely agreed upon, while the statement “The current policy and governance on maternal healthcare in Europe is well adapted to cope with the current risks and challenges it faces” was met with the strongest disagreement and “Quality maternal healthcare remains a privilege in Europe” was also widely agreed upon. These statements reflect the general agreement among the presenters and audience that there is considerable social injustice and inequities when it comes to maternal health and healthcare in Europe.

#### Results of the whole room: agreement with each question



Results of a survey conducted during the session.

## Measuring the performance

During the second part of the session, the Alliance for Maternal Health Equality introduced a health systems performance measurement matrix focusing on several different but equally important aspects of maternal healthcare, with the goal of connecting maternal health with the broader picture and relevant factors. Through structured World Café discussions, session attendees discussed the health systems performance measurement matrix under five key pillars, each comprising three main factors (please refer to the table below).

The following points represent aspects of the discussions held during the second part of the session, as well as some of the more striking examples that the speakers touched on during their presentations.

Mervi Jokinen, President, European Midwives Association: Investing in maternal and newborn health saves women and children's lives, strengthens health systems and improves economies. We shouldn't build our policy on pathological pathways but have a wider women-centered approach. It is also crucial to include all relevant stakeholders in the discussion, especially in a Europe of differing

health systems. We recognise this can be difficult, for example midwives have different levels of involvement in the German system, as compared to systems in Central and Eastern European countries.

Ciara O'Rourke, Director of Public Policy (Europe & Canada), MSD for Mothers: Access to quality services also means access to patient-centred, integrated care. This is especially valid when it comes to young women in vulnerable circumstances. The issue across Europe is the lack of knowledge of the scale of the problem and the need for a coordinated approach across EU Member States to ensure that all women in Europe have equal access to quality maternal healthcare. For example, in Romania, one is five times more likely to die from pregnancy related complications than anywhere else in Europe and the poverty and lack of access to care is endemic.

Francois Fille, European Advocacy Coordinator, Doctors of the World International: Leaving the most destitute migrant and minority pregnant women deprived from proper antenatal care in Europe constitutes an unacceptable assault on human rights and the condition of women. Integrated healthcare is a new tool that we must use. Member States should offer systematic prenatal care for all pregnant

### HEALTH SYSTEMS PERFORMANCE MEASUREMENT MATRIX

SAFETY, QUALITY & STANDARDS	TIMELINESS & ACCESSIBILITY	RESILIENCE & EFFICIENCY	EQUITY	PERSON-CENTRIC APPROACH
Mervi Jokinen	Ciara O'Rourke	Francois Fille	Ramazan Salman	Daniela Drandic
Safety must be interlinked with patient experience.	The rural-urban divide in many European countries must be addressed.	Maternal healthcare systems benefit from a high skilled workforce.	Social determinants must be considered to boost equitability of the system.	Birthing traumas are reported regularly.
Integrated care must become the norm for maternal healthcare.	Minority women often face bigger challenges with timeliness and accessibility.	Funding mechanisms are clear to navigate.	Maternal health must be introduced in all relevant legislation and policy.	Informed decision-making trumps accepted practice.
Safety, Quality and Standards must be communicated properly to the general public	Navigating the healthcare system remains a challenge.	The system is adapted to risks and current challenges (e.g., the refugee crisis).	Healthcare plans and payments must be adapted to individual needs.	Relationship with HCP is encouraged and maintained before, during and after pregnancy.

women and for their unborn children in accordance with WHO recommendations.

The German case: Ramazan Salman, Executive Director, Migrants for Migrants and Agnieszka Luczynska, Migrant Mediator, Health with Migrants for Migrants. Salman and Luczynska introduced the “With Migrants for Migrants – Intercultural Health in Germany” programme which recruits, trains and supports intercultural mediators to help migrant communities navigate the German health system and related health topics. The issue goes beyond the refugee crisis, also touching on several difficulties that women coming from EU Member States (e.g., Poland) face: often pregnant migrant women struggle with a language barrier, have problems communicating and reaching out to their HCP and receive insufficient insurance information.

Daniela Drandic, Head of Reproductive Rights Campaign, RODA, stressed that there should be a wider approach to quality assessment, not just an analysis of the maternal survival rate. Importantly women need to be able to make an “informed choice”. This can be implemented if there are components like quality of care, access, system accountability, privacy, safety, evidence practices, autonomy and reliable statistics. Informed consent means also the right to refuse – if a woman cannot refuse a proposed intervention, this is not informed choice.

## Take-home messages

The following are some key conclusions from the session:

- Today’s Europe has so far failed to provide adequate maternal healthcare to immigrant and minority women.
- There are regulations, declarations, rights, laws, strategies and a myriad of scientific evidence on this topic. But what is lacking is translating the discussions and policy drafts into action.
- Maternal health goes beyond health itself – when focusing on the issue we must avoid thinking in silos and take a holistic view, considering the broader picture (education, vulnerable groups, chronic conditions, quality of life).
- A person-centred approach would also help overcome a lot of the current obstacles – e.g., the rural-urban barriers to access that are present in many European countries.
- Access to quality services also means access to integrated care, medicines, and information.

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Written by DIANA KOERNA & KADRI MIARD



**FORUM 5**

JACQUELINE BOWMAN-BUSATO, Policy Lead, Alliance for Maternal Health Equality

MICHAEL CREEK, Senior Advisor, Third-i bvba

DANIELA DRANDIC, Head of Reproductive Rights Campaign, RODA

MERVI JOKINEN, Board Member, European Midwives Association

AGNIESZKA LUCZYNSKA, Migrant Mediator, Health with Migrants for Migrants (MiMi)

RAMAZAN SALMAN, Executive Director, Health with Migrants for Migrants (MiMi)

CIARA O'ROURKE, Lead in Europe, Director, Public Policy (Europe & Canada), MSD for Mothers

FRANÇOIS FILLE, European Advocacy Co-ordinator, Médecins du Monde

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**ORGANISED BY**

Alliance for Maternal Health Equality and MSD for Mothers



# Project Session

FORUM 7

Johan Hansen, Senior Researcher at NIVEL, moderated this session, which was created due to several organisations wanting to showcase their work and disseminate the results of their projects at the European Health Forum Gastein.

The four projects highlighted were quite diverse, although there were some common threads running through them:

- a focus on health prevention and promotion;
- tackling chronic diseases and
- targeting more vulnerable segments of the patient population.

The projects are presented on the following pages.

**Asthma Adolescent Project**

**DAPHNE Project**

**General Practitioners' Cluster**

**ICARE4EU Project**

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Written by PHILIP HINES

## Asthma Adolescent Project

Active & healthy ageing starts in childhood

Healthy ageing requires health during youth, yet many adolescents with chronic diseases often do not adhere to treatments. This can have damaging health repercussions in later life. This is exemplified by asthma - the most common chronic childhood disease in Europe – which can cease by adulthood with adequate treatment.

To better understand non-adherence in adolescent (12-17 years of age) asthma patients, the EFA conducted a survey in four European Union (EU) Member States: Germany, France, Spain and the UK (N=200). The results of this survey were discussed by:

ERKKA VALOVIRTA, Professor, University of Turku, Finland; Paediatrician and Paediatric Allergist, Terveystalo Turku  
KARIN KADENBACH, Member of the European Parliament, Austria.

The survey was administered by paediatricians between July and October 2015, and included items on 'Health Status', 'Asthma Severity', 'Attitude', 'Treatment', 'Role of physicians', 'Daily impact', 'Social support', 'Asthma confrontation' and 'Health Literacy'.

The survey revealed that there was no difference in non-adherence across the demographics measured, including age and gender.

German adolescents had the highest rate of adherence; although, in all the countries surveyed the majority (82%) did not experience any problems in taking their asthma medication as prescribed by their physician. Participants' 'Attitude' towards treatment and the perceived 'Daily Impact' of treatment were the two strongest measures, explaining up to 80% of non-adherence measured in the study (R<sup>2</sup>=0.46). 'Attitude' also showed a weak but significant interconnection with health literacy. Therefore, improving health literacy may indirectly improve adherence.



Karin Kadenbach

The survey also revealed that adolescents have a high level of trust in healthcare professionals.

The particular items which explained almost 90% of treatment adherence (R<sup>2</sup>=0.57) were (in order of importance):

**Forgetfulness:** "Sometimes I forget to take my medicine" (24%)

**Rebellion:** "I don't do what the doctor tells me" (22%)

**Good days:** "When I feel better I stop taking my asthma medicine" (14%)

**Support:** "My Doctor encourages me to deal with my asthma" (11%)

**Carelessness:** "I don't take my asthma serious" [sic] (10%)

**Ignorant:** "I am aware of not taking my asthma medicine" (7%)

After a discussion involving the audience, policymakers were encouraged to facilitate the development of mHealth tools to reduce forgetfulness, advance health literacy and improve the involvement of carers. It was suggested that rebellion could be reduced through the persistent involvement of the parents and a psychologist, as well as issuing immediate rewards for adherence.

Policymakers should work to develop multi-disciplinary care coordination – including parents – for patients of all ages requiring chronic care. Improving adherence amongst the young will lay stronger foundations for the top-heavy societies of the future.

### ORGANISED BY

European Federation of Allergy and Airways Diseases Patients' Associations (EFA)

## DAPHNE Project

Can wearable devices help in the clinic?  
And provide Big Data on patients?

Obesity is on the rise amongst European youngsters, damaging their health across the life-course.

The EU FP7 funded DAPHNE project aimed to develop wearables which would monitor patients and provide lasting motivation to lose weight. The results of the project were discussed by:

MELANIA MANCO, Director, Research Unit for Multifactorial Diseases, Obesity and Diabetes Bambino Gesù Pediatric Hospital, Rome

TIM LOBSTEIN, Director of Policy, World Obesity Federation.

The wearables and associated mobile and web applications monitor information on activity (heart rate, movement, and temperature), diet and stress (psychological status), passing the information onto the patient's clinician.

The most significant challenges in developing the pilot were:

- creating the sensor devices;
- developing user-friendly software for the patient and clinician containing intelligent algorithms that recognise behaviour associated with obesity;
- data storage in a newly built secure cloud;
- data-security through developing a secure and ethical platform, and
- achieving demonstrable benefits in terms of patient compliance.

After producing the sensors and platform, a pilot trial was conducted amongst 12-17 year olds in Italy (N=8). Whilst they were able to advance far in four out of the five areas, the study suffered from a small patient group and poor compliance, preventing any demonstrable benefits.



The small patient group was due in part to the difficulties in navigating privacy concerns and gaining acceptance for clinical trials amongst children, as well as the limited range of mobile phones able to run the software. Poor compliance (2.2 days per week of sensor usage) was related to technical issues with the prototype, language barriers in the software and the trial taking place over the summer holidays. Nevertheless, the surveys from the patients and clinicians revealed an underlying appreciation of the usefulness of the Daphne system and its data security.

This positivity was shared by the audience who expressed interest in the potential of this system. However, there were some views raised that eHealth and mHealth may not deliver in practice as much as they promise in theory. There were also concerns raised about the need to secure funding for the DAPHNE system in order to reduce its technical limitations and conduct a larger RCT to properly assess its efficacy. There was also a discussion around the need for the EU to follow-through on its projects and ensure their upscaling.

### ORGANISED BY

World Obesity Federation



## General Practitioners' cluster Hungarian GPs' clusters model

Primary-care acts as the gatekeeper to different care pathways, but all too often patients are not placed on an efficient path. The traditional model of primary care is becoming seen as too overburdened and limited: only involving GPs, nurses and associated administrative staff. To address this, the WHO has called for an integration of public health staff within this model, and Hungary as part of its Swiss-Hungary cooperative programme is seeking to advance this by trialling an innovative GP cluster model.

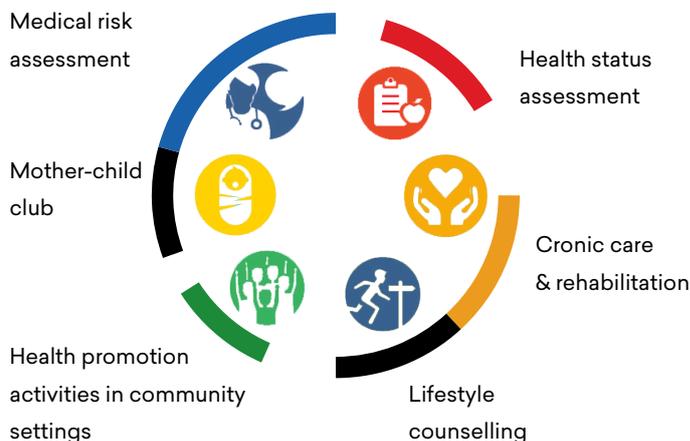
The model and Hungary's progress were presented by: RÓZA ÁDÁNY, Senior Adviser of the GP Cluster Project; Department of Preventive Medicine, Faculty of Public Health, University of Debrecen, Hungary  
MAGOR PAPP, Coordinator of the GP Cluster Project; National Institute for Health Development, Primary Care Department, Hungary

A GP cluster model is a more holistic, integrated model whereby a diverse range of primary-care practitioners work in a centre together to provide ordinary primary-care along with preventive care through employing a range of health professionals and health mediators. These include public health practitioners, physiotherapists, health psychologists and dieticians. Health mediators from the Roma communities were also included to support provision of care to the local Roma community.

The scale of the cluster model allows it to improve engagement with other care services, local government and local communities. It is also being used to improve accountability and reform primary care financing away from capitation to a more quality-based approach.

The cluster model allows the provision of several novel services to its 'clients'.

### New services provided by the cluster to the clients



The cluster model screens the patients for their needs before referring them to the relevant in-house health professional – putting fewer patients on outpatient pathways. The preliminary results of the model, mainly focussing on participation within the additional services of the cluster model, were encouraging; for example, there was an 80% rate of participation in the health status assessments.

The audience – comprised of many stakeholders in the public health arena – were very interested in the preventive focus of the model. There was also interest in the health mediators to improve access to healthcare in the Roma community.

This model was recognised as particularly relevant to the European Health Forum Gastein's theme of demographics and diversity as it allows for the life-course approach to be pro-actively integrated into care pathways at a level that is local to the patient.

### ORGANISED BY

Swiss Contribution Office in Hungary and the Government of Hungary

## P4 - ICARE4EU Project

Innovating care for people with multiple chronic conditions

It is estimated that 50 million people in Europe live with multimorbidity and this number is set to rise as our population ages.

The ICARE4EU project was presented by:

EWOUT VAN GINNEKEN, Hub Coordinator, European Observatory on Health Systems and Policies - Berlin University of Technology

WILM QUENTIN, European Observatory on Health Systems and Policies - Berlin University of Technology and member of the Young Forum Gastein Network's.

The project sought to tackle the following questions: How to strengthen financing mechanisms, patient-centredness and integrated care for people with (chronic) multimorbidity? How can eHealth improve care for people with chronic multimorbidity?

ICARE4EU sought out examples of care for patients with chronic multimorbidity in 31 European countries. Despite the sparse top-down establishment of multimorbidity programmes, 101 practices to improve care for people with multimorbidity were identified. ICARE4EU examined the target group of patients, the professional disciplines involved, the systems and procedures used, as well as the financing arrangements.

### AIM OF THE PROJECT

*To contribute to the innovation of care for European citizens with multiple chronic conditions by increasing and disseminating knowledge about potentially effective and efficient patient-centered, multi-disciplinary care approaches, that are developed and implemented in European countries or regions.*

Quentin presented the existing models of payment for patients with chronic diseases, including patient, provider and service characteristics. He then outlined the ways payments could be incrementally restructured towards multimorbidity care: financing coordination between multi-disciplinary teams; broader payments through, for example, bundling payments together. However, these methods require complicated case-mix and quality adjustments and thus strong political will and governance.

The audience debated aspects of the findings, bringing in perspectives from across Europe, and recognised the complexity seemingly required for integrated multimorbidity care. They were keen to see the final report properly disseminated to European policymakers, as integrated multimorbidity care will undoubtedly be crucial in the sustainable care of our ageing demographics.

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### ORGANISED BY

ICARE4EU, financed from the Health Programme 2008–2013 of the European Union



# Refugee health

## A journey, from arrival to integration

WORKSHOP 7

Refugee health is an increasingly important topic. It is frequently mixed with migrant health, even though problems and solutions usually differ: the involved population, their expectations and health situation are distinct. Even if refugees are not a homogeneous group, they encounter similar problems of access, understanding and integration.

This workshop, moderated by Isabel de La Mata, Principal Adviser for Health and Crisis Management, DG SANTE, European Commission, covered a refugee's journey from arrival to relocation and integration into the destination country.

On the panel, there were representatives from NGOs, international organisations and national authorities who have worked with refugees at the three afore-mentioned moments in time, and refugees who have been through the experience themselves. The focus of the discussions: the main challenges during a refugee's journey, considered from the health perspective.

True to the "Nothing about us without us!" motto, the panel started with an inspirational and passionate statement from Abdelhakim Asnabla, a refugee from Morocco who has been fully integrated in Slovenia.

He talked about the difficulties arising in refugee camps, like the large number of people arriving at the same time, combined with the lack of medical caterers – which is partly due to the fear some staff has of Islam and 'foreigners'. As Health and Cultural Mediator in a refugee camp he worked on improving access to healthcare. One measure is providing training for public service providers, but also cultural service mediation training for refugees.

Asnabla made clear: those arriving can help, too. Refugees are able people and often have a lot to contribute. To illustrate his work and the importance of mediation, Asnabla gave an example where he could save the life of a child: he did so by communicating the risk of death if the child were not given immediate treatment, which would not have been understood if he had not been translating and explaining the medical issue to the parents.

François Fille, Médecins du Monde (MdM) introduced the perspective of a healthcare provider at the point of arrival. He referred to three main challenges: Working in Greece on the Island of Lesbos, the changed work environment after the EU-Turkey deal was utterly difficult. Firstly, he highlighted the lack of training of healthcare professionals to deal with the reality of refugees in detention centers as opposed to a camp situation. Secondly, before the deal most of the refugees were in transit. After the deal, with people being stuck, psychosocial needs increased due to factors such as uncertainty about the future, poor information on upcoming administrative procedures, posing an additional challenge for counselling staff. The third challenge is related to the provision of a medical and psychological



*This is not a refugee crisis, this is a crisis  
of the European Union's people.*

Vytenis Andriukaitis,  
EU Commissioner for Health and Food Safety

assessment which is mandatory at reception points in any refugee situation. The medical staff has to differentiate between “vulnerable” and “non-vulnerable”. Because the vulnerability status brings a lot of advantages for those receiving it, there is a lot of tension beyond the medical work. Also, Fille pointed out that 8% of patients of MdM clinics have been victims of violence when already in Europe. He concluded that guidelines, trainings and psychosocial support for medical and support staff is needed, but above all more solidarity.

Turning to the situation of already relocated people, Marina Habiby, another refugee fully integrated in Austria and working in refugee camps on behalf of AmberMed and Diakonie Refugee Service, talked about the difficulties of communication between patients and healthcare workers. She emphasised that while last year, the Austrian government granted health insurance to refugees, important barriers to access remain. In particular language is a barrier which can create problems up to the point that people are sent away by local healthcare providers.

In the camps pregnancy and unsafe sex are a growing problem. Habiby underlined that this is most probably due to the lack of access to information on sexual and reproductive health, and the fact that people do not want to talk about it.

Another challenge is the need to provide adequate care for longer term health problems as opposed to the more acute needs upon arrival, especially since Habiby reported that there is sometimes reluctance in addressing this kind of needs: It is costlier for the system and the refugee may move to another location shortly, where treatment could also be provided.

She underlined the positive and important contribution of volunteers and emphasised that while people tend to ask for big projects, we should remember that “sometimes, with small steps, we can achieve a lot”.

Working in relocation, Tamara Berberovic, Chief Medical Officer of the International Organization for Migration (IOM) in Athens named as main challenges: bureaucracy, lack of translators and cultural mediators, and - contrary to the general perception - chronic diseases that need to be followed up, rather than infectious diseases. The basic challenge is to sensitise the health system. Stereotyping is a problem; medical staff has not been exposed to cultural differences to this extent before. Thus, support and



Vytėnis Andriukaitis and Abdelhakim Asnabla

training is needed to assist them. She introduced some of the work that IOM is doing to improve refugee health and to make relocation as easy as possible, e.g. the sharing of medical records with focal points in receiving countries in order to ensure continuity of healthcare.

Nina Ismail started her intervention with a strong statement “I have been in Sweden since 1984, so I consider myself Swedish”. She provided insights into the Swedish healthcare system, focusing on the management of trauma, which she considers the main health problem refugees take with them. Sweden has a unique and accessible health system but the problem it faces is the large number of refugees. Each refugee center has a screening program, treatment protocol and a psychologist for traumatic disorders. Ismail made clear: refugees are not different from local people; they are only traumatised.

Bernadette Nirmal Kumar, University of Oslo, talked about the situation in Norway and referred to lacking leadership and coordination as one of the main problems at point of arrival, also because the healthcare sector was not adequately involved.

Another major challenge is sharing of health information to not duplicate services. When it comes to relocation one of the issues, particularly in remote regions, is the capacity of health professionals to provide services to an increasing number of patients. She underlined that refugees are currently not or too little involved in the process of integration. We need to ask them about their needs to ensure these are adequately met and to avoid provision of unnecessary services. Refugees need to be part of the system, she concluded, as healthcare should be universal, regardless of where someone is from.

But how can we tackle this issue at the EU level?

The European Commission is committed to supporting refugees and the countries which take them in, and to show solidarity. Commissioner Vytenis Andriukaitis emphasised that it is our common duty to help fellow human beings in need, and that input and recommendations on how to improve from organisations that work on the ground, like MDM, is greatly appreciated.

Commissioner Andriukaitis called for the definition of minimum standards for healthcare coverage, to improve our actions, to provide funds and to also hear the refugees. It is important to remind all Member States of their obligation as EU nations. Asylum seekers have the right to health, including mental health, and we need to encourage Member States to strengthen their capacity to provide this healthcare and to share best practice. The EC has called for refugees to receive the same standard of care as EU nationals, including prevention.

Several interesting points were raised during the ensuing discussions. For improving the refugees' health during their journey the panel pointed out the role of local authorities in listening to and engaging with refugees. The cultural mediator role is a necessity to ensure clear communication and understanding. Finally, refugees need somebody who empowers them and this requires the collaboration and contribution of all stakeholders.

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Written by JONILDA SULO

#### WORKSHOP 7

VYTENIS ANDRIUKAITIS, EU Commissioner for Health and Food Safety

NIMA ISMAIL, Medical Doctor, Female Genital Mutilation Consultant

TAMARA BERBEROVIC, Chief Medical Officer, International Organization for Migration, Athens

MARINA HABIBY, Health Mediator, AmberMed and Social Worker, Diakonie Refugee Service

FRANÇOIS FILLE, European Advocacy Co-ordinator, Médecins du Monde

BERNADETTE NIRMAL KUMAR, Medical Doctor, Centre for Migration and Health, Norway and University of Oslo

ABDELHAKIM ASNABLA, Health Mediator

Moderated by ISABEL DE LA MATA, Principal Adviser for Health and Crisis Management, DG Health and Food Safety (DG SANTE), European Commission

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#### ORGANISED BY

DG Health and Food Safety (DG SANTE),  
European Commission



# Beyond “BrExit”

FORUM 11

The British referendum on 23 June 2016 revealed inter-generational, geographical and socioeconomic gaps in UK society. The 19th European Health Forum Gastein contributed to the debate, considering the potential consequences for health if Brexit goes ahead.

## Divided Societies

Britain has historically been more sceptical of the European Union than many European countries, and dissatisfaction had been steadily growing since the early 2000s, stated Stephen Clarke, Research and Policy Analyst, Resolution Foundation, UK.

The Resolution Foundation conducted research on the importance of place in explaining the characteristics underpinning the Brexit vote, using data on the characteristics of people living in 378 of Britain's 380 local authorities.

The key findings were as follows:

- Economics is a particularly important factor.

The employment rate was a better predictor of the Leave vote than other factors such as median pay, change in pay or manufacturing changes, suggesting deep-seated economic problems had an important effect.

- Demographics mattered: areas with higher numbers of students posted lower Leave votes after controlling for other factors, while older areas voted to Leave.

Importantly, the pace of change of the UK-born population in an area was a good predictor of whether an area would vote to Leave or not.

- Culture was an important predictor, with areas statistically less likely to vote to Leave when reporting higher levels of local cohesion. Areas with high home-ownership were more likely to vote to Leave.
- Some regional effects were apparent even after controlling for everything else, suggesting perhaps more local factors at play which are difficult to explain purely through the researchers' model.
- Education was the strongest predictor of a vote to Remain, and is likely to embody cultural and economic factors.

Following Clarke's presentation, an audience vote was held, to ask "if a referendum on EU membership was held in your country, do you think there would be a vote to Leave?" 56% of the audience said no, with 33% saying yes and 11% being unsure.

Lauren Ellis, Public Health Practitioner, Public Health Wales and Member of the Young Forum Gastein Network, gave her perspective as a resident of Wales, where 52% of those who turned out to vote opted to Leave.

In preparing for her intervention, she had talked widely with people in her networks about their voting choice. She suggested motivations for a vote to Leave were the issue of migration, which was most often heard from front-line clinical staff who cited pressures on the system from migrants without extra resources to manage them. Sovereignty was also an issue, with some thinking the EU wasn't working in the best interests of the Welsh people. Others, who voted to Remain, valued the freedom of movement and opportunities offered by the EU.

Lauren also noticed that those who had a closer “proximity” to the EU, working closely in a role that involved EU matters, for example, meant an individual was much more likely to vote to Remain.

Marianne Donker, Deputy Director General Health and Director Public Health, Ministry of Health, the Netherlands provided a Dutch perspective, arguing that such populist sentiments exist all over Europe with different “strengths and flavours”.

The Netherlands is a far smaller country, heavily depending on trade and international cooperation. Dutch citizens are amongst the most optimistic and satisfied citizens in the EU, therefore the idea that the Dutch want to, or could “go it alone” is far less present, she suggested. Citing very recent figures, she stated that 46% of Dutch people support the EU and would like to retain membership (compared to 39% one year ago) and the number of people who don’t support the EU has dwindled. 50% were against a “NExit” and 20% were in favour. Researchers blamed a “Brexit” effect.

Donker asserted that public health is a good showcase for exhibiting the value of EU cross-border cooperation in protecting people. Health threats specifically are an area where EU cooperation is easily accepted as necessary by Dutch citizens, with multiple recent cross-border examples: fighting AMR, food safety, medicines safety. However the Netherlands is also experiencing rising populist sentiments, and some of the population are scared and feel the Dutch government has not done a good job of protecting them from real and perceived threats.

## Key challenges for health and social care in a United Kingdom outside the European Union

The second panel focused on the key challenges for health and social care in light of Brexit.

Martin McKee, Professor of European Public Health, London School of Hygiene and Tropical Medicine, gave a presentation on the potential impacts of Brexit on several areas including UK science, intellectual property, business investments, policy, regulations and more. He began his presentation by stating that Brexit, if it happens, will be a disaster for the UK, and anyone who thinks that being outside the EU might represent an opportunity for UK cit-

izens that they didn’t already have as members is deluded or dishonest. He condemned the lies that were fed to the British public during the referendum campaign, and also the British media whom he reprimanded for failing to do their research and challenge politicians on untruths and contradictory statements during interviews.

The EU (excluding the UK) is home to 2.3 million British people. Reciprocal arrangements for providing access to a country’s healthcare system may also in time cease. This will impact people retiring, but also people working, even temporarily, in an EU Member State. For instance, France and Spain have a high number of British residents, while tourists travel all over. McKee suggested the British public should think about their “red lines” and suggested that UK citizens travelling to the EU will need to take out expensive travel insurance in lieu of their EHIC card if a British exit does occur.

The UK is a major participant in EU research funding rounds. Life sciences research particularly benefits from EU funding. Academics in the UK may become third country researchers after Brexit. While the UK is currently an attractive place for researchers, the gradual erosion of this position is likely if UK researchers lead fewer major research programmes and universities are unable to recruit from the EU - again, mutual recognition of qualifications may also be a challenge. In the same direction, European



institutions based in the UK, like the European Medicines Agency, will need to relocate to within the EU. The risks undermine the current attractiveness of the UK for pharmaceutical companies, with a potential ripple effect for the wider UK medical research environment. Brexit is likely to change the picture of UK and makes it a less attractive place to live, study and work.

Moreover, public health is also under threat. International collaboration is needed, and the EU has established several important alert, coordination and response mechanisms, many operated through the European Centre for Disease Prevention and Control. Any country in isolation cannot effectively tackle what are transnational threats and the UK is part of multiple healthcare networks, from research communities, to health technology assessment, to rare diseases and public health surveillance, all contributing to ensuring the health and safety of British people.

John Middleton, President, UK Faculty of Public Health (FPH), discussed that the most immediate Brexit threat is a workforce threat.

For example, there are UK shortages of certain specialties of junior doctors and of midwives, so the UK National Health Service is currently unable to meet its workforce requirements without relying on overseas medical staff. Middleton explained that the FPH was one of the most strident in supporting a Remain vote, and the literature produced by the Faculty to support this position will now be turned into a risk register for those areas of health that need defending. He emphasised that one of the biggest contributions of the EU is to peace and stability in Europe, while economics and regulations are secondary.

Middleton was not uncritical of several inconsistent and poor EU policies that impact on health, questioning why the EU gives money to big sugar and why at least 10 of the top 30 beneficiaries of the CAP are organisations like the UK's Tate and Lyle and the Dutch Nestle? Why hasn't the EU adopted the WHO standard on air pollution (because of the German car industry)? There was no justification for these policies, he stated, however the UK should be lobbying to change them from within the EU and will be much less successful as a non-member.

Vladimir Gordeev, Assistant Professor, London School of Hygiene and Tropical Medicine and Member of the Young Forum Gastein Network, reported that he already had colleagues who had chosen to live outside the UK following the referendum decision. The scientific community is particularly concerned, especially those working on European public health which is highly dependent on EU grants. Will nationality or place of residence determine eligibility for receipt of such funding, he questioned? Healthcare professionals from EU countries who are currently living in the UK feel threatened regarding the uncertainties about recognition of their qualifications and stability of employment. In contrast, foreign individuals acquiring new qualifications from UK colleges, for instance, will not be certain that those qualifications will be recognised if they return to the EU.

The audience were asked another voting question: as a health professional, does the Brexit vote make the UK a less attractive place in which to live, study and work? 41% said the vote would make them more cautious to go to the UK, 13% thought the UK was still a prime destination and it wouldn't change their mind, 6% did not plan to go there anyway and 2% had no strong view either way.

**As a health professional, in your opinion does the Brexit vote make the UK a less attractive place in which to live, study and work?**  
(Please choose one option)

Yes – I am more cautious but would still apply for jobs/to study there.	41%
Yes - I wouldn't consider going there any more.	38%
No - the UK has world class universities and institutions and is still a valuable place to work.	13%
No - I wasn't planning to go there anyway.	6%
I have no strong view either way.	2%

These results are based on the answers of 45 participants.

## What's next for the future of Europe?

Another vote was held before the final panel kicked off, asking the audience whether they were optimistic or pessimistic about the future of Europe. 41% said quite optimistic, followed by 30% who were quite pessimistic, and 19% who were neither way inclined. 3% were very optimistic and 7% very pessimistic.



Shada Islam, Tamsin Rose, Philip Hines, Helmut Brand and John Bowis

The third panel reflected this topic and discussed the challenges of a Brexit on the future of the EU project.

Shada Islam, Director of Europe and Geopolitics, Friends of Europe, talked about the need to bring “passion and emotion” into the EU debate. The EU has been successful, she stated, but it is now at a crossroads and action is needed to progress the European project further. Populists such as the Visegrad 4 are the real danger to the EU, peddling as they do narratives based on lies, fears and falsehoods – but our current leaders amplify their messages rather than confronting them with an effective, equally powerful counter-narrative. A technical blueprint won’t counter it: passion and emotion is what is needed, Islam stated.

As an accidental European, she extolled the virtues of Europe, suggesting Europe is not lost but it’s leaders are lost. Leaders and policymakers in Brussels don’t talk about the benefits of European cooperation, and today’s EU citizens don’t feel involved or connected to the current EU. Leaders should engage citizens better, she suggested it was time for them to discuss important issues with national governments and citizens directly, and take this “golden opportunity” to rethink the future of Europe and make it more social and participative.

Session moderator Tamsin Rose, Non-resident fellow, Friends of Europe, purported that we are experiencing an unprecedented period of economic and political uncertainty. We live in a VUCA world (Volatile, Unclear, Complex and Ambiguous), and therefore need EU leaders with a certain skill-set to guide us through these times.

Philip Hines, Programme Assistant, European Policy Centre and Member of the Young Forum Gastein Network, suggested that if we were to ask historians 15 years ago about their political expectations following a deep, protracted global recession and economic stagnation across Europe, they would have predicted a rise in insecurity, distrust in the establishment to deliver benefits, and an associated rise in populism and the far-right. In his opinion, Brexit is just an acute manifestation of this. He cautioned against taking solace from reports of reduced Euroscepticism across the EU following the UK referendum result, saying that if Brexit was successful this would crystallise hard Euro-scepticism as a viable political choice. He said that the way forward in his opinion was for the EU to build bridges which directly improve the lives of its citizens.

Helmut Brand, President, European Health Forum Gastein, commented that the UK has always had a bit of a love-hate affair with Europe. He thought the decision to join in 1973 was more of a calculated cost-benefit analysis, and now UK citizens feel the costs are too high and have made a rational decision to Leave. Will others Leave? Brand thought not. Let’s see how elections in France and Germany pan out, he suggested. He also posited that Wales and Scotland might Leave the UK, and perhaps London will choose to Remain in the EU.

Ultimately, he outlined, EU leaders must be aware that the future of the EU is likely to be decided at the local level. They need to discuss with people at a grassroots level how European policies positively affect them. His final thought was that “a Brexit represents the beginning of a new chance for a Europe of the regions.”

A final vote asked the audience whether the EU was fit for purpose, and demonstrated a certain amount of scepticism from the audience with 52% believing it is not and requires reform, 36% believing the EU is fit for purpose but nevertheless can adapt and reform, 6% convinced that no reform is necessary and 6% undecided.

Ultimately panellists agreed that the EU is suffering from a big narrative deficit. It needs a grassroots movement to survive. Do we need to rip-up the rule book? Many panellists thought that despite the probable negative impact of a Leave vote on the UK, for the rest of Europe this was a golden opportunity to think the unthinkable, reassess where we do and don't need to work together, and consider a new way of working involving local level meetings and a bottom-up approach. EU institutions probably also need to be reformed.

Summing-up the session, John Bowis, Honorary President, Health First Europe, said EU legislative processes need to be better understood, national parliaments and local governments need a role and to feel ownership, but Europe and its history needs explaining and its mission, including its future, selling. His final comment was that our current situation is not fatal and not final, but all those who believe in Europe have to work very hard that we all can contribute to each other's future, because that is why we are European. Let's all fight to Remain European.

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Written by JOSEP M GUIU

#### FORUM 11

##### Panel 1

STEPHEN CLARKE, Research and Policy Analyst, Resolution Foundation, UK

MARIANNE DONKER, Deputy Director General Health and Director Public Health, Ministry of Health, the Netherlands

LAUREN ELLIS, Public Health Practitioner, Public Health Wales and Member of the Young Forum Gastein Network

##### Panel 2

MARTIN MCKEE, Professor of European Public Health, London School of Hygiene and Tropical Medicine

JOHN MIDDLETON, President, UK Faculty Public Health

VLADIMIR GORDEEV, Assistant Professor, London School of Hygiene and Tropical Medicine and Member of the Young Forum Gastein

Network

##### Panel 3

SHADA ISLAM, Director of Europe and Geopolitics, Friends of Europe

HELMUT BRAND, President, European Health Forum Gastein

PHILIP HINES, Programme Assistant, European Policy Centre and Member of the Young Forum Gastein Network

Moderated by TAMSIN ROSE, Non-resident Fellow, Friends of Europe

Wrap-up and closing remarks by JOHN BOWIS, Honorary President, Health First Europe

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#### ORGANISED BY

European Health Forum Gastein



New Solutions  
PART 2



# Guiding patients to the “Best Point of Service”

FORUM 2

Guiding patients to the best point of service is crucial to improve quality of care and potentially to reduce costs when facing budget constraints and demographic changes. But, how to make the best use of digitally supported information systems (DSIS)?

Chaired by Josep Figueras, Director, European Observatory on Health Systems and Policies, the session reviewed the current experience of DSIS's use and covered the challenges faced by patients while looking for health information, leading to a debate on who should provide DSIS. At the beginning of the session, Josef Probst, Director General, Main Association of Austrian Social Security Institutions, gave a keynote speech on the forum topic from the Austrian perspective. While developing current healthcare reforms, Austria has established ten national health targets. However, too many people are still lying in hospital beds and the focus of intervention has to shift to maintaining good health itself rather than relying on healthcare services.

## Impact & current use of DSIS

The first question posed to the audience during the session was: Do you think that DSIS can have a major impact on improving health outcomes and especially on hospital and accident and emergencies services? 74% of the audience said yes.

## HEALTH TARGETS FOR AUSTRIA

*The health targets are based on a number of guiding principles. The most relevant are: orientation towards health determinants, health-in-all-policies approach and promoting health equity.*

- Target 1** To provide health-promoting living and working conditions for all population groups through cooperation of all societal and political areas
- Target 2** To promote fair and equal opportunities in health, irrespective of gender, socio-economic group, ethnic origin and age
- Target 3** To enhance health literacy in the population
- Target 4** To secure sustainable natural resources such as air, water and soil and healthy environments for future generations
- Target 5** To strengthen social cohesion as a health enhancer
- Target 6** To ensure conditions under which children and young people can grow up as healthy as possible
- Target 7** To provide access to a healthy diet for all
- Target 8** To promote healthy, safe exercise and activity in everyday life through appropriate environments
- Target 9** To promote psychosocial health in all population groups
- Target 10** To secure sustainable and efficient healthcare services of high quality for all

Peter C. Smith, Emeritus Professor of Health Policy, Imperial College London, gave a comprehensive presentation of why patients use hospital accident and emergency services and how they navigate the health system in search of appropriate providers and services.

Panellists raised that searching for information is a burden for patients. Patients have concerns, they feel that information is missing, they need to identify a health professional to talk to and mainly they need answers to a great range of topics: symptoms, opening hours and the accessibility of a hospital or names of doctors.

In the context of an increased-technology environment, the sources of health information are numerous and will probably continue to grow in the coming years. This will make it even more difficult for a patient to immediately find the relevant information they require.

Abundance of DSIS might lead to contradictory information and confuse patients who are scared of not making the right choice. How can we be sure the DSIS provide accurate information? Panellists agreed that there is mistrust of digital information in comparison with brochures, flyers and booklets.

The issue of mistrust is definitely a challenge to be addressed. DSIS are based on algorithms, however, can one trust a machine on such a hot topic than one's health or the health of a close family member? Can the information provided be wrong due to statistical error, and do more harm than good? Without trust, patients will look for other sources of information, which might lead to more confusion and misinformation.

The high number of emergency visits was also addressed by Smith. Emergency visits are costly and studies have shown that not all of them were necessary. Indeed up to 27.1% of all cases entering the emergency department could be handled elsewhere.

By providing patients with accurate information, DSIS could precipitate a cut in hospital emergency visits. We have to keep in mind that different groups among the population have different capabilities. For example, phone lines are favoured by elderly people. Deprived groups might use digital services more often than other groups, which might lead to a reduction of inequity. DSIS can however be an essential method of reaching those people who have not yet been reached through national awareness campaigns or other communication channels.



## Confidentiality and transparency

DSIS are highly demanded by patients. And there is a wide range of expert tools (web-tools, expert systems, tele-consultations, phone-apps including real-time bio-medical monitoring) to guide patients to find the best referral point. But patients want to use safe DSIS meaning that their data remain private. Once again, the issue of mistrusting digitally-provided information was discussed among the panellists and the audience.

The market of DSIS is mostly composed of private entities with commercial interests. Transparency regarding the service provider is not always clear to patients, which lead to the fear of them losing control of their personal data and reinforcing mistrust of the DSIS. However, a possible solution emerged during the session: accreditation by a public authority. Questions then arose among the panellists, does a public authority have the right to accredit such a service? Or should it be dealt with at a national or even European level?

The variety of DSIS is large and so is their level of quality. Some of the providers have put in place training for their staff managing the triage system and/or ongoing quality processes. To date, evidence that DSIS improve health-related outcomes is still limited.

Their effectiveness is indeed difficult to evaluate. It is not clear if they lead to cost reductions or efficiency savings. Besides, the benefits might vary greatly depending on the type of DSIS. Consequently, the issue of responsibility was addressed by the panellists. Should the responsibility be shared by the provider or the patient? What if the decision was shared and the patient got involved in the decision-making process?

The session furthermore emphasises that information is just one part of the whole system, and a different kind of primary-care landscape is needed.

Socioeconomic factors play a more essential role than type of disease. Patients are looking for information on where to go, how urgent the situation is and what kind of treatment is needed. While websites are most often very impersonal, many patients tend to be in favor of more personalised advice.

## Conclusion & take home message

Electronic information sources will increase in importance in the future and are demanded by patients and caregivers. DSIS offer the potential for more focused and intelligent use of health services, improved effectiveness, and increased personalisation. Demographic changes mean greater demands for healthcare coupled with a shortage of medical personnel. Thus, DSIS has the potential to be one essential technical solution to address this European challenge.

When asked about the take home message of the session, Martin McKee, Professor of Public Health, London School of Hygiene and Tropical Medicine, summarised that “digitally supported information systems definitely have the potential to improve access to health information. However, it is fundamental to consider a number of preconditions. It is crucial to build patient collaborations, develop a high level of population health literacy and ensure better regulation and accreditation of DSIS. Integration and collaboration with regulators and providers are probably the most important key issues”.

Written by JULIE DELEGLISE & ANNA-SOPHIA BILGERI

### FORUM 2

Introduction

JOSEF PROBST, Director General, Main Association of Austrian Social Security Institutions

Keynote

PETER C SMITH, Emeritus Professor of Health Policy, Imperial College London

Expert panel and interactive discussion with:

ANDREAS MEER, Executive Manager, in4medicine AG, Switzerland

HAY DERKX, Consul, Medicinfo, The Netherlands

KAISA IMMONEN-CHARALAMBOUS, Director of Policy, European Patients' Forum

ELLEN NOLTE, European Observatory on Health Systems and Policies

JOAKIM RAMSBERG, Chief Scientific Officer, Health

Economist, Agency for Health and Care Services Analysis (Vårdanalys), Sweden

Closing remarks

CLEMENS MARTIN AUER, Director General, Federal Ministry of Health and Women's Affairs

Chaired by JOSEP FIGUERAS, Director, European Observatory on Health Systems and Policies

### ORGANISED BY

Austrian Federal Ministry of Health and Women's Affairs and Main Association of Austrian Social Security Institutions in cooperation with European Observatory on Health Systems and Policies



# ICP 4 co-morbid patients

## Integrated care pathways (ICP) supporting multi-morbid patient journeys

LUNCH WORKSHOP 3

### Supporting multi-morbid patient journeys

The interactive workshop aimed to raise awareness and create practical results for the improvement of care for patients dealing with multiple chronic health conditions.

The moderator, Tamsin Rose, Non-resident Fellow at Friends of Europe announced that the workshop results would be presented during the MedTech Europe event in October in Brussels in front of the European Parliament.

The workshop was based on the “Design Thinking Process” method of actively involving the participants in the solution finding process. It is a methodology originally used by designers to solve complex problems and find desirable, innovative solutions relevant for their clients’ lives. The session focused on the development of ideas and solutions for care tailored to the needs and wishes of individuals living with chronic diseases.

### Re-organising care

The scene was set by Bert Vrijhoef, Professor in Health Services and Policy Research at the National University of Singapore and the National University Health System, visiting Professor at the Vrije Universiteit Brussels, and CIO of Panaxea B.V. in Amsterdam.

Vrijhoef described how integrated care has changed health care systems. Health systems all over Europe currently recognise that care organised around single diseases does not respond to the needs of patients who

suffer from multiple chronic diseases sufficiently. According to Vrijhoef everyone talks about the need for health-care to be more efficient and patient focused yet change is hard to achieve, particularly when dealing with chronic health conditions and their co-morbidities. Integrated care is recognised as the best way forward towards patient centred care but proves to be difficult to implement in practice. He pointed out that integrated care is not a simple intervention as it requires long-term care delivered by multiple disciplines. As a precondition for the design of integrated care for people with multiple chronic diseases the local context and specific health system characteristics have to be considered. It can perhaps best be classified as a complex intervention to improve the quality of life of persons with co-morbidities and to help them navigate through a often fragmented health care system. Moreover, he stressed that the goal of integrated care is to tailor it to the needs of persons with co-morbidities and to improve the quality of care and to keep them as independent as possible.

Thereupon Nick Guldemond, Associate Professor Integrated Care and Technology at the Institute of Health Policy & Management Erasmus University followed up by asking “how much patients benefit from integrated care and what are the success factors?”

He emphasised that a patient’s benefit depends on the re-organisation of care. Focus needs to be placed on providing information, tailored to the patients’ health literacy skills and information needs, and on the empowerment of patients to organise their own health journeys. Moreover, care for people with multiple chronic conditions requires integrated and patient-centred approaches to adequately

meet the complex needs. Providers need to rethink usual care provision as for example more time being needed to set up a care plan and IT-support. Furthermore, providers need to change their mindset to adjust care provision to the needs of people with multiple chronic diseases. These often need care from multiple providers and better care coordination compared to usual care, which requires teamwork. Guldemond also steered attention to the potential of eHealth to improve and enable new care services to be offered by primary and secondary care providers to patients with chronic conditions.

During their kick-off dialogue the experts provided their opinion on why integrated care is considered 'a good solution', how beneficial it is for patients and health systems across Europe, and what we need to do to facilitate its uptake in practical health care settings.

## Identifying care solutions for co-morbid patients

Thereafter the participants jointly developed a patient-centric care solution for a chronic disease patient by applying the design thinking method moderated by members of the Young Forum Gastein Network.

Every group had to take the point of view of a person living with diabetes to understand their daily challenges in managing the condition and propose solutions to overcome them. Each group received information about their patient's diagnosis, their differing medical needs and key needs, and a short life snapshot. Each group first came up with a number of ideas for their patient case while thinking about their medical needs as well as their life choice preferences. Finally, each group identified one key problem of the patient and developed a tailored and need oriented solution.

Ideas were broad, ranging from lifestyle and behaviour changes to more technically/ eHealth-oriented solutions. The latter included eHealth tools for the provision of support for self-management, electronic consultations and for communication between care professionals. Many ideas centred on active and assisted living.



From a patient perspective wearable and mobile solutions have the potential to support independence in daily life, quality of life, self-empowerment, and self-care. Each group presented their ideas in pitch presentations with the goal of convincing the other groups of the potential of their solution, why it would work and which benefits it would entail for the patient.

## Policy implications

Taking inspiration from real world examples of good practice, this workshop generated ideas to improve health outcomes by encouraging early uptake of ICT for integrated care. Thus, it seems design thinking can offer a new way of approaching complex health issues and translating ideas into real world solutions to improve care for people living with co-morbidities.

Customising care to the various and comprehensive needs of people with multiple chronic conditions and supporting patients to actively engage in the care process requires policies and strategies not only at a local or regional level, but also at the level of care organisations. There is often a disconnect between patients, regulators, and industry which needs to be overcome through collaboration and the involvement of patient representatives in the development of a shared vision. Different disciplines need to be involved to create integration and cooperation from the very beginning of the process.

**LUNCH WORKSHOP 3**

Keynote presentations by

NICK GOODWIN, International Foundation for Integrated  
Care (IFIC)

NICK GULDEMOND, Utrecht University

Break-out sessions moderated by

Young Forum Gastein Scholars:

SOFIA RIBEIRO

LISA PLOEG

SIOBHAN O'CONNOR

ROCCO FREIBEL

Moderated by TAMSIN ROSE, Friends of Europe

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**ORGANISED BY**

Roche Diabetes Care and European Health Futures Forum  
(EHFF) in cooperation with International Foundation for  
Integrated Care (IFIC) and others



# "Healthy" innovation

## Prioritising patient benefit over economic interests

FORUM 3

Martin McKee, Professor for Public Health at the London School of Hygiene and Tropical Medicine, moderated the Healthy Innovation Forum and opened by promising the audience revolutionary debates as things would be said that are often not discussed openly.

The aim of this session was to articulate the growing evidence on deficiencies of the current research and development models for pharmaceutical products and to explore potential remedies. The forum was divided into two parts, diagnosis and remedies, albeit there was synergy between the two.

### PART 1: DIAGNOSIS

## A need for new innovative drugs

Many medical needs remain unmet as some conditions are of less common and therefore of less economic attractiveness for the industry which is why research and development is nearly completely missing in these areas. Yet, there is intersectoral consensus that there is a need for new innovative drugs in order to sufficiently address unmet medical and public health needs.

However, deciding on the prioritisation on which diseases to address is proving to be challenging. For example, there seems to be consensus regarding the development of drugs for highly prevalent diseases linked to demographic changes, while at the same time there is no agreement regarding neglected diseases, for example sleeping disease.

Yannis Natsis, Policy Coordinator for Universal Access and Affordable Medicines at the European Public Health

Alliance (EPHA) and Member of the Young Forum Gastein Network, stressed the importance of the European Council conclusions and was delighted that the issue of Intellectual Property Rights was discussed in Brussels due to the Dutch EU Presidency initiative.

Natsis outlined the two dimensions of innovations in drug development: access and affordability, and the quality of innovations. Do we really have the innovations we need? According to Natsis, meaningful public health leadership is necessary and policymakers need to consider new solutions. Therefore transparency and public accountability are essential.





## Mismatch

The mismatch between the products that are authorised by national bodies, and the affordability of and access by the public to these drugs was addressed by participants. Instead of increasing shareholder value, new pharmaceuticals should increase health outcomes.

Beate Wieseler, Head of the Drug Assessment Department at the German Institute for Quality and Efficacy in Healthcare (IQWiG), briefly outlined the context of Health Technology Assessment (HTA) decisions. The existing provisions around market authorisation are based on a positive evaluation of risks and benefits. The question at hand is: Does the new drug have any added value compared to existing therapies?

The objective of HTA regarding innovative medicines is twofold. First, at individual level, every patient should be able to choose between the best options of therapy. Second, HTA aims at enabling the maintenance of sustainable health care systems.

## Added value

While there is a widely recognised need for innovative medicines, many of the new products that have been launched in the last years had little or even no added value, as compared to existing standard therapies. During the session there was discussion on how to prove the added value of a drug, as well as what the added value entails. Concerns were raised around the utility of Real World Data collection. It was argued that Real World Data may in reality be a euphemism used for non-randomised observational studies with limited validity.

Wieseler presented the results of the last five years of assessments in Germany, which demonstrated that in more than 50% of new approved drugs there is no evidence of an added value. This may have two reasons: either the data shows no added value or there is no data to analyse. While some successful new cancer treatments have been approved, the situation is less promising regarding some other indications, e.g. diabetes or neurological diseases. According to Wieseler, the reasons for these insufficiencies lie in the design of drug trials. Investigational drugs are often tested against placebos instead of standard therapies, or the endpoints are simply not meaningful, for example when looking at blood markers instead of mortality rates.

## The role of governments

Maurice Galla, Senior Policy Officer at the Directorate for Pharmaceuticals and Medical Technology at the Dutch Ministry of Health, provided the perspective of the negotiators in his presentation entitled “Strengthening the checks and balances in the EU pharmaceutical system”. He outlined the success that was achieved during the Dutch EU Presidency that led to the ground-breaking European Council conclusions on strengthening the balance in the pharmaceutical systems of June 2016. Early considerations included rapidly increasing prices, yet limited HTA results. Galla portrayed debates at EU level as often being frustrating as common problems were not addressed. Galla detected a lack of awareness among national officials that other Member States are faced with similar problems: governments act individually, while industry acts globally, which finally results in a veritable information asymmetry to the disadvantage of policymakers and in the end also patients.

## PART 2: REMEDIES

Els Torreele, Director, Access to Medicines and Innovation, Open Society Foundations (OSF), expressed her opinion that, although the nature of the problem could be debated, there is consensus that we have a problem with the affordability and quality of our current medical innovation system.

### Thinking outside the box

Torreele also spoke on behalf of Bernard Pécoul from the Drugs for Neglected Diseases Initiative (DNDi). DNDi was set up as a spinoff from Doctors without Borders by a range of stakeholders. The objective was to deliver new treatments for some of those neglected diseases for which the for profit sector did not undertake research & development. The approach taken was patient centred and started with a target product profile where the requirements of and usability for the patient were taken into account. At the same time access and affordability were part of the target profile. Recently DNDi has begun to look into Hepatitis C treatment, and a new initiative focuses on antimicrobial resistance (AMR) trying to adapt the model of neglected diseases to explore what needs to be developed and piloted to work towards AMR solutions.

Raf Mertens, Director, Belgian Healthcare Knowledge Centre, presented four possible future scenarios for drug development and pricing, which had been developed in two workshops. The scenarios he called “semi-utopian”, as their purpose was to open up the minds of all relevant stakeholders. **The first scenario** was a public-private-partnership, oriented on public needs, in which risks as well as profits are fully shared. **The second scenario** built on coalitions between European not-for-profit research institutes, payers, authorities and patient organisations, who decide on public health priorities and develop drugs independently from industry. **The third scenario** was a consortium of European countries which established a fund. The fund would scrutinise the research market for promising developments, then acquire patents, and launch a final product at a generic price level. **The fourth scenario** would turn drugs essentially into public goods; research and development would be fully under the control of the public.

## Risk sharing & regulations

John-Arne Rottingen, Professor of Health Policy, Department of Health Management and Health Economics, University of Oslo, addressed the role of the government. Rottingen noted that there is a need for innovation within healthcare and that it should not be left solely to the industry. He addressed the issue of governmental and policy failure of taking a consumer approach. It may be viewed as more convenient for ministers of health to wait and see what products emerge on the market and then decide “what they want to buy”, without taking a risk.

However, innovation is a risky investment and there are no simple solutions. Rottingen therefore urges ministers to be more risk prone, engage more with the private sector and contribute to the process. He pointed to the stark difference to the approach governments take with regard to defence, where they tend to have a much more active role in the development of products. Antibiotics were mentioned as a clear example where there is consensus both in the public and private sector that they need to work together on innovative solutions.

Rottingen addressed the important role the private sector plays as well as its need to make profit. However, at the moment regulations are in place that allow for high profits to be possible. Therefore, rather than simply blaming the industry there is also a need to review the current regulations.



## Concluding reflections

McKee concluded the session by calling for new solutions through public-private partnerships. He compared these partnerships to marriages - both require trust and transparency, and rules are needed. As these are missing for public-private partnerships at this point, McKee compared the current situation to being married with a partner who has a bank account without the other partner knowing about it.

A new model which includes risk sharing is required for the way forward in this debate. Recognition is needed on both sides to find somewhere where they can meet in the middle, where there is benefit for both. There is also no agreement on how some of the returns could be reinvested into the public sector to further drive innovation and development.

McKee stressed that the continuation of this debate is necessary as challenging the current model of research and development cannot be mere blaming of industry; instead he called for a constructive dialogue involving all stakeholders.

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Written by **MARJOLEIN DON & HOLGER LANGHOF**

### FORUM 3

#### Part 1

BEATE WIESELER, Head of the Drug Assessment Department, Institute for Quality and Efficiency in Healthcare (IQWiG)

MAURICE GALLA, Directorate for Pharmaceuticals and Medical Technology, Ministry of Health, Welfare and Sport, The Netherlands

YANNIS NATSIS, Policy Coordinator, Universal Access and Affordable Medicines, European Public Health Alliance (EPHA) | Young Forum Gastein Network

Moderated by MARTIN MCKEE, Professor for Public Health, London School of Hygiene and Tropical Medicine

#### Part 2

BERNARD PÉCOUL, Executive Director, Drugs for Neglected Diseases Initiative (DNDi) (last minute cancellation)

JOHN-ARNE ROTTINGEN, Professor of Health Policy, Department of Health Management and Health Economics, University of Oslo

RAF MERTENS, Director, Belgian Healthcare Knowledge Centre

Moderated by ELS TORREELE, Director, Access to Medicines and Innovation, Open Society Foundations (OSF)

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### ORGANISED BY

Open Society Foundations in collaboration with  
EPHA and EUPHA



# Reality meets Reality

FORUM 9

Europe is facing social and demographic changes - at the same time, there is a demand for better services and more innovative, expensive technologies. Are end-users' concerns about data interoperability, data protection and reliability of mHealth apps justified? How can these two realities be brought together?

In this forum experts from the technology field shared their experience with strategies and solutions to address health-care providers' and patients' needs.

The session was moderated by Terje Peetso, Policy Officer, Health and Well-being Unit, DG CONNECT, European Commission.

## Code of Conduct on data privacy of mHealth apps

To introduce the subject, Alexander Whalen, Manager of the Digital Economy Policy Group, DIGITALEUROPE, shared his presentation on the Code of Conduct initiated by the European Commission and led by DIGITALEUROPE together with a range of other stakeholders.

The Code of Conduct covers data protection principles that should be taken into account in the health app development process. The goal of the Code is to provide a guidance for app developers to ensure safe and reliable health apps. It has now been formally submitted for comments to the Art 29 Data Protection Working Party. Once approved by this independent EU advisory group, the Code will be applied in practice. Then app developers will be able to voluntarily commit to its rules, which are based on EU data protection legislation.

Hans Graux, Founding Partner of time.lex explained shortly that the main objectives were to make the Code accessible for people who cannot get any legal support while creating new technology. For this reason, the use of legal jargon was as much as possible avoided in the document. App developers should always try to ensure the confidentiality, integrity and availability of the personal data processed via their apps. Discussions on how to ensure the successful communication of the Code to app developers and the general public are already under way.

Questions by the audience addressed whether patients can benefit from the Code of Conduct, and what could be the major threats for people who use mHealth apps.



Whalen indicated that patients should not choose or decide themselves on the safety of apps. He stated that the Code was created mostly for app developers, not patients. Graux shared the example of an insurance company that collected their clients' health data to adjust their rates according to the information they discovered.

There was a discussion on health data portability, which is a new factor to be taken into account in the future. It gives citizens the right and the technical possibility to retrieve personal data from one application and transfer it to another. The audience seemed not to be aware of this, even though it is known that users already have the right to access their data and correct and/or delete it.

A WHO representative from the audience congratulated the idea of a Code of Conduct and providing practical guidance for app developers. Peetso underlined the importance of spreading the information about the Code to a wider audience.

## Guidelines on reliability & validity of mHealth apps' data

The second part of the session introduced the EU guidelines on the assessment of the reliability of mobile health applications. The aim of this document is to ensure the creation of "better apps for better healthcare".

The public consultation on the Green Paper on mHealth in 2014 identified safety and transparency of information as one of the main issues related to mHealth uptake. There are concerns about the consumers' ability to assess the many lifestyle and wellbeing apps available with no clear evidence on their quality and reliability.

In February 2016, the European Commission appointed a working group to draft mHealth assessment guidelines to assess data validity and reliability of mHealth apps. The group included representatives of patient groups, health professionals and providers, payers, industry, academia and public authorities.

The audience was reminded that health apps fall under the EU law for medical devices if they are intended for health purposes. If they bring some unintended health results they are categorised as wellness and well-being apps and fall within a grey zone which is currently not being regulated. The final version of the guidelines will be presented in December 2016.

Julie Bretland, Director/Founder, Our Mobile Health Ltd., explained the scope and the extended criteria of the guidelines including:

- Reliability
- Stability
- Effectiveness
- Usability
- Transparency
- Privacy & Security
- Safety
- Credibility
- Desirability

She stated that the guidelines should be provided to all healthcare providers as an indirect blue print of the standards required for development at the European level. The key issue in mHealth is the adoption and deployment of health apps by the "health system". Healthcare providers were identified as the gatekeepers of the mHealth app market.

Pierre Trudelle, Project Manager at the Department of Care Coordination, Appropriateness and Quality of Care, National Authority for Health (HAS) in France gave a presentation on innovative mHealth solutions and explained their risk assessment. Trudelle shared many examples of mHealth solutions that could not be dependable for patients. He stressed that possible dangers for end-users could include health advice being given by a physician from another part of the world, or medicines being prescribed by a physician using the geolocation method. Also, health data collected by your smartphone could be misinterpreted and give false instructions leading to possible health threats. Trudelle added that in France apps are categorised by the type of data they collect, resulting in a risk matrix.

Questions from the audience after the panellists' presentations included:

- How can health professionals choose a reliable mHealth app if there are so many available?
- Can they be sure that patients' data is not corrupted or used in a wrong way?
- What is the benefit of using mHealth apps for health professionals?

The debate touched upon the importance of digital health literacy and the increasing need to include digital education in health professionals' training programmes.

It was stated that apps should have some reliability mark, assessed by a higher institution.

The third and fourth parts of Forum 9 on Friday morning brought together a diversity of high level speakers to provide an in-depth view on EU projects focusing on the delivery of integrated care to the elderly European population.

Healthcare providers as well as professionals, citizens and policymakers are confronted with a rapidly changing, ageing society. This change results in marked slowdowns of fertility rates as well as an extraordinary increase in life expectancy, thus leading to perceptible increases in chronic diseases and frailty, significant deterioration of the dependency ratio and shortage of financial resources and personnel when compared to the rising demand.

## European Innovation Partnership on Active and Healthy Ageing

– focus on integrated care with sharing experience from implementing innovative solutions

The integrated care approach seeks a shift from reactive to preventive, proactive and patient-centered care, and the strengthening of community home-based care. The objective is to establish sustainable, efficient, and cost-effective welfare and healthcare systems through an adjusted and optimised use of resources. Integrated care models aim at harmonising and coordinating the management, organisation and delivery of the social and healthcare services needed especially by an ageing population.

But what are these adjustments and optimisations? Who should manage what? Are there different pathways, approaches to achieve the same goals? And what are the challenges integrative care has first to overcome to reap the benefits of multidisciplinary and well-coordinated care settings?

Representatives from two of three EU integrated care projects, namely CareWell, BeyondSilos and SmartCare, shared answers and lessons learned.

Funded by the ICT PSP (Policy Support Programme), the projects' aim was to deploy and evaluate with a rigorous methodology the impact of existing ICT solutions on sev-

eral health, economic and organisational indicators in 22 European regions. This resulted in the largest base of evidence for ICT impact on care currently available in Europe. The collection of this data provides care decision-makers with evidence and allows them to use their own financial resources to deploy ICT for improving care delivery.

Marco D'Angelantonio, Health Information Management, highlighted the barriers to a large deployment of Integrated Care in support of care. He referred to today's fragmented systems, where different providers deliver their social care and healthcare services separately, the burden of financing old models while at the same time displaying an innovation fatigue, an often inadequate knowledge of key-players on change management and strategies, and the lack of evidence on impact and cost/benefit ratio in order to effectively push and promote change. Only small adjustments to traditional care organisation and currently implemented processes would likely not suffice. Also, technology in itself would not provide a solution, but would only result in an expensive and outdated organisation. Changes in attitude and behaviour are important key factors for transformation, since healthcare is and will be built on effective relationships and the sharing of information.

Esteban De Manuel Keenoy, Clinical Director, CareWell Project, presented his project in more detail. CareWell supported the integration of care in six European regions and provided integrated care for frail elderly patients through ICT enabled healthcare services coordination, patient monitoring, patient self-management and informal care givers involvement, focusing on vertical rather than horizontal integration. After 3 years, when the project came to an end, the integrated care pathway was enhanced in:

- Identification of frail elderly patients
- Baseline comprehensive multidimensional assessment
- Patients' planned follow-up
- Increased role of nurses and GPs as care managers
- Coordinated hospital discharge: improved transition
- Better communication between professionals
- Improved data storage and availability

In addition, also the patient empowerment and support pathway changed positively with regards to:

- Personal health folders
- Personalised programmes of integrated care
- Mobile apps to access electronic health records for district & specialist nurses to use when they make visits to patients

- Tele-monitoring services
- Single databases with information for community services
- Education for patients, formal and informal caregivers.

Different types of facilitators will help implementation, such as the use of already existing technologies, co-design of new apps with end-users in order to achieve an appealing user experience and technical literacy, synergies amongst professionals, alignment with existing programmes or strategies, support and participation of top management with regard to intervention, support of policymakers as well as compliance with existing policies, laws and plans, co-funding and long-term business viability analysis.

Panagiotis Stafylas, SmartCare Project, talked about his project's limitations, especially the significant diversity in the needs of different populations, limited appropriate common indicators, short follow-up and the difficulties in data collection. Nonetheless he estimated that by applying the project's service for 10 years, while showing no difference in the effectiveness or quality of life, costs of 8.000 € per patient could be saved.

## Intermediate evaluation of the eHealth Action Plan 2012–2020

Carmen Laplaza Santos, Deputy Head of the Unit eHealth, Well-being and Ageing, DG CONNECT provided the European Commission's perspective on how the eHealth Action Plan may contribute to enabling smarter and more patient-centered healthcare systems and services.

The e-Health Action Plan entails a framework to link technologies, patients and healthcare workers. However, as Santos had already mentioned during previous discussions, only few are aware of it. Thus, Santos encouraged the audience to act as ambassadors for the Action Plan, to actively participate in the public consultation and work together towards bridging all the free flowing data.

After all, "communication is key, no matter whether you talk about integrated care or something else" highlighted the Young Gasteiner Christiaan Vis, Project Manager E-Compared.

The many emerging technologies, such as virtual reality devices and wearable devices with behavioural and diagnostic value, have to be put to their best use. This requires that we ask the right questions first, such as how and why these technologies might benefit healthcare systems. Furthermore, healthcare providers need proper training. People can and will not play a role if they do not know what this role entails. Simple user training, both for patients and professionals, might not be enough to overcome the hesitation of intertwining all available tools to deliver treatment to make better use of personnel and time resources.

## Take home messages

**eHealth reality today:** 500 million users, 45 000 publishers, 5% of the total app market and 3 billion downloads

**There are two types of developers:** The ones who develop apps because they want to help people and the others who are driven by making money. Only the second group is successful.

**Is it worth doing risk assessment before** addressing the technical obstacles? Should we not think about data portability before end users provide their health data?

**If you are not paying for mHealth apps,** how can these apps remain in the market?

**People want to have access to reliable information** and do not want to identify themselves with stigmatised groups, e.g. the elderly or patients.

**All stakeholders need to be accounted for** when defining new organisational models.

**New care pathways** must be integrated into everyday practice.

**Professionals' roles change** and require a reorganisation of tasks and new skills.

**Predictive modeling helps evaluation** and decision-making.

**Integrated care** is cheaper but not more effective.

**eHealth** has a lot of marketing and research potential to better understand health patterns.

**The interoperability of systems** is risky but without it the benefits of eHealth will be very limited.

**FORUM 9**

## Part 1

ALEXANDER WHALEN, Manager of the Digital Economy

Policy Group, Digitaleurope

HANS GRAUX, Founding Partner, time.lex

## Part 2

JULIE BRET LAND, Director/Founder, Our Mobile Health Ltd.,  
UK

PIERRE TRUDELLE, Project Manager, Department of Care  
Coordination, Appropriateness and Quality of Care, National  
Authority for Health (HAS), France

## Part 3

ESTEBAN DE MANUEL, Clinical Director, Carewell Project;  
Kronikgune (Research Centre on Chronic Diseases), Spain

PANAGIOTIS STAFYLAS, SmartCare Project; Aristotle  
University of Thessaloniki

MARCO D'ANGELANTONIO, Health Information  
Management (HIM)

## Part 4

CARMEN LAPLAZA SANTOS, Deputy Head of Unit  
eHealth, Well-being and Ageing, DG CONNECT, European  
Commission

CHRISTIAAN VIS, Project manager E-COMPARED, Faculty  
of Behavioural and Movement Sciences, VU University  
Amsterdam and Member of the Young Forum Gastein  
Network

Moderated by TERJE PEETSO, Policy Officer, Health and  
Well-being Unit, DG CONNECT, European Commission

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**ORGANISED BY**

DG Communications Networks, Content and Technology  
(DG CONNECT), European Commission



# Urban environments and NCDs

## Engaging multiple stakeholders & sustainable environments to nurture a life free from NCDs

WORKSHOP 1

Yvonne Doyle, Regional Director for London, Public Health England, chaired the session, and introduced Helmut Brand, President, European Health Forum Gastein and Oleg Chestnov, Assistant Director-General, Non-communicable Diseases and Mental Health, World Health Organization, who both made some introductory welcoming comments.

Pamela Rendi-Wagner, Director General, Public Health and Medical Affairs, Austrian Federal Ministry of Health and Women's Affairs, gave a presentation on the Austrian situation.

She outlined challenges faced by the Austrian system, specifically Austria's cost intensive health system where costs for health treatment are increasing at a higher rate than GDP. Despite this spending, the health output is unsatisfactory, as Austria is still below the OECD average for healthy life expectancy. While absolute life expectancy is increasing, there is a gap between this and healthy life expectancy, which for Austria is about 23 years.

Rendi-Wagner described the participatory approach of the recent Austrian health reforms. To achieve the reforms, leadership and political commitment was vital, as was a participatory, bottom-up approach and, self-evidently, resources. Being open to a dynamic process, allowing for trial and error and re-developing and re-inventing plans, plus having a monitoring system in place to learn from successes and failures, was essential. Being flexible regarding windows of opportunity was also important. Rendi-Wagner stated that the greatest single environmental health risk is air pollution, with Austria experiencing more than 7000 premature deaths annually due to this. There are national and international initiatives to combat this, and the Ministry

of Health collaborates with the Ministry of the Environment and other stakeholders to implement a new target to secure sustainable natural resources such as air, water and soil and a healthy environment for future generations.

Karolina Mackiewicz, Development Manager, Baltic Region Healthy Cities Association and Member of the Young Forum Gastein Network, spoke next, discussing the experience of healthy cities in the Baltic Sea region from a local perspective.

NCDs are the main problem in the Baltic Sea region, accounting for over 80% of mortality. The good news is that they are decreasing in all Baltic countries, however discrepancies in rates persist, both between sexes (with men dying much younger than women and experiencing double the burden of NCDs) and between countries, with the Russian Federation, Latvia and Lithuania experiencing the greatest burden of the countries in the region. Mackiewicz pointed out that HIAP is well-recognised at a national level, but at local levels there is a struggle to operationalise it. Similarly, there is lots of national or regional health data available, but it is not widely used locally for municipal decision making.

Continuing the HIAP theme, Mackiewicz provided case studies from three Baltic cities where a multi-stakeholder approach is being used within the urban environment to promote health and combat the causes of NCDs. In Turku, Finland, one example is a project promoting physical activity, particularly of disadvantaged segments of the population. In Riga, she highlighted a project promoting a healthy diet, and in Kuressaare, Estonia, the prevention of youth alcohol consumption, involving schools, nightclubs, the Police and many more actors.



Karolina Mackiewicz, Mariana Dyakova, Pamela Rendi-Wagner and Alexey Kulikov.

Up next was Mariana Dyakova, Consultant in Public Health, Public Health Wales and Member of the Young Forum Gastein Network, who gave a presentation entitled “Addressing NCDs is everybody’s business” from What? ...To How?” using the example of Wales.

She discussed the importance of good enabling legislation and principles, cross sector involvement and governance, and a multi-level approach to tackling NCDs, underlining that the economic, social and natural environment in which we grow up, live and work is a major determinant of our health and well-being and that of our children directly and indirectly. An upstream preventive approach was once more highlighted as key, offering good value for money and bringing short and long term benefits beyond the health system, across communities, society and the wider economy.

The final presentation was given by Alexey Kulikov, External Relations Officer, Secretariat of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, WHO.

He provided a UN perspective on what supranational support is being provided to countries to combat NCDs. He started by highlighting that in 2012 more than 14 million people between the ages of 30 and 69 died from NCDs, premature deaths which could largely have been prevented. In the 2030 Agenda for Sustainable Development, several targets pertaining to NCDs are included for the first time, committing governments to develop national responses. A UN Inter-Agency Taskforce on NCDs was established, to coordinate the activities of UN organisations to support the realisation of the commitments made in the 2011 Political Declaration on NCDs, particularly through the implementation of the WHO Global NCD Action Plan 2013-2020.

Kulikov described how low and middle income countries (LMIC) face particular difficulties in combating NCDs, where a vicious cycle exists consisting of increased exposure to modifiable risk factors leading to NCDs, limited access to effective and equitable healthcare services, and resulting in a loss of household income and poverty. And yet a very good case can be made for investing in preventive measures: the cost of inaction in LMIC has been estimated to be USD \$7 trillion, far outweighing the USD \$170 billion cost of action. An example from Barbados was given, whereby an investment of USD \$19 million over a five-year period would generate a return of USD \$290 million in increased productivity and health savings over a 15-year period. And even better rates of return than this exist. To further support intersectoral work, a set of seven policy briefs has been produced by the Inter-Agency Taskforce to enable different sectors outside health to identify their role and concrete actions in combating NCDs.

Kulikov outlined the recommendations from the Local Government brief, including straightforward (in theory) measures to restrict the consumption of tobacco and alcohol. These comprised restrictions on advertising and promotion; reducing affordability; regulating availability; working with private sector on food reformulation and public awareness programmes on diet and exercise. In practice, it seems that many of these measures are rather less straightforward to implement, for political and other reasons.

A discussion between the panel and audience ensued. One topic highlighted was that “consultation” processes have often been a way of deviating and diverting policies on alcohol and tobacco. How can a consultation be genuine and not be hijacked by vested interests? There were no easy answers to this.

There was frustration from the audience that at the EU level there remains a more traditional approach to the topic of combating NCDs, with silo-thinking and disease focused methods. How can we encourage those working on public health and health promotion at EU level to take advantage of innovation?

Rendi-Wagner commented that the new social pillar, announced by Jean-Claude Juncker, is a step in the right direction, but there is still no mention of health promotion and what better health can do for greater social security. In her opinion, the real output of EC working groups is not realised by MS. On the positive side, at a UN level with the SDGs we seem to have somewhat overcome the tendency toward silo-thinking.

In terms of spatial planning and city layout and design, one member of the audience emphasised that city planners have great capacity here to combat NCDs in an equitable way through city design. We need to align our thinking in terms of place, provider, assets, agreed Doyle. Mackiewicz responded that healthy urban planning is promoted as part of the Healthy Cities Network, and importantly it creates not only opportunities for improving health but also for building resilience and encouraging people to bond. Every city should be a part of the global healthy city movement. It is particularly important to empower those cities with the most limited resources. Significantly, at the end of the session, Günther Novak, the Mayor of the local town of Mallnitz, signed a Memorandum of Intent to join the Healthy City Network, declaring that he wanted to be the mayor of a city that provides and promotes health. Is the role of mayors vital in creating more political momentum, and will mayors be the stars putting NCDs on the map?

There was unanimous agreement that mayors have played a vital role at the recent Paris Climate Conference and are an excellent means of bridging intersectoral issues. Novak, Mayor of Mallnitz, suggested downloaded games could be used to disseminate health messages, with Mackiewicz describing how such a possibility has already been realised in Finland with Games for Health. Doyle mentioned that her role was to create opportunities and open new doors for health, through advising the London Mayor and local councilors and politicians, and through them reaching the people of London.

Zsuzsanna Jakab, Regional Director, WHO Europe, provided some closing words.

She highlighted the economic and social inequalities in the EU, declaring now is the time to act, as many of Europe's troubles stem from this. We need to have a public health dimension in austerity policies which mitigates their impact, and secure buy-in from political masters, she stated. If we can make progress on this then we can reduce the burden of NCDs. The Healthy City Network was started to address the determinants of health in the places where people live work and love, in cities and local communities. In Europe, this has helped usher in Health 2020. Health is a political choice, and social inequalities and their reduction is a political choice. Importantly, and echoed throughout the morning's session, health actions can only be realised intersectorally and in partnership with others.

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Written by **LOUISE BOYLE**

**WORKSHOP 1**

## Introduction

HELMUT BRAND, President, European Health Forum Gastein

## Panel discussion with:

BENTE MIKKELSEN, Head a.i. of the Secretariat, WHO Global Coordination Mechanism on the Prevention and Control of NCDs (WHO GCM/NCD)

YVONNE DOYLE, Regional Director, Public Health England

PAMELA RENDI-WAGNER, Director, Federal Ministry of Health and Women's Affairs, Austria

MARIANA DYAKOVA, Consultant in Public Health, Policy, Research and International Development, Public Health Wales

KAROLINA MACKIEWICZ, Development Manager, Baltic Region Healthy Cities Association, WHO Collaborating Centre for Healthy Cities and Urban Health in the Baltic Region

ALEXEY KULIKOV, World Health Organization/UN

## Closing words

ZSUZSANNA JAKAB, Regional Director, WHO Regional Office for Europe

Chaired by OLEG CHESTNOV, Assistant Director-General, World Health Organization Non-communicable Diseases and Mental Health Program

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**ORGANISED BY**

World Health Organization



# Innovative medicines

## The increasing tension between value, profit and accessibility

FORUM 8

This forum, examined issues relating to the affordability and accessibility of high-cost innovative medicines, how health systems have reacted to these developments and how, if at all, the pharmaceutical market should be regulated in the interest of citizens.

The session was chaired by David Rose, Director of LACS Training, and was introduced by Josef Probst, Director General of the Main Association of Austrian Social Security Institutions.

Probst referred to high pharmaceutical prices excluding people from treatment and destabilising public health systems even within wealthy countries. He called for a new two-way transparency directive, explaining how currently only state authorities are required to be transparent while no such requirement is placed on the pharmaceutical industry regarding the disclosure of investment in medical research and development (R&D). The question posed to the audience to reflect upon was "Is it acceptable and fair that vital and innovative medicines are so upscale in cost?"

### Is it acceptable and fair that vital and innovative medicines are so upscale? (1)

(Please choose one option)

No, because extremely high prices threaten financial sustainability of health systems or exclude people from necessary treatment.	40%
Yes, because any price is justifiable if it saves somebody's life or cures severe diseases.	27%
No, it's unethical – vital medicines can't be treated as goods like all others.	27%
I don't know.	2%

These results are based on the answers of 67 participants.

## A double failure

Elias Mossialos, Professor of Health Policy, Department of Social Policy, and Director of LSE Health, London School of Economics and Political Science, reflected on the main challenges of innovative medicines from a scientific point of view. The main premise of his keynote speech was that blame for unsustainably high costs of innovative medicines lies both with the pharmaceutical companies and the public payers, i.e. 'a double failure'.

Mossialos first presented information regarding the commercial success of the pharmaceutical market despite increasing R&D costs and factors such as the global financial crisis. Importantly, the maxim that the high prices reflect high R&D costs was challenged by figures that demonstrated pharma expenditure on marketing far exceeded expenditure on R&D.

The responsibility of the public payer regarding both drug prices and incentives for drug development was introduced by stating that government regulation, while costly, is necessary to ensure safety, efficacy and reimbursement of medicines. However, our current systems focus on static efficiency rather than dynamic efficiency, avoiding a long-term perspective on the value of medicines. Much of the market also continues to be dominated by non-generic products; this was seen by Mossialos as a failure both of regulation and of industry.

One key message delivered was that we need to improve on designing our regulatory and decision-making frameworks. For example, pricing and reimbursement decisions need to be linked to R&D decisions. That is to say, if products are developed which are found to address unmet

medical needs, authorities should be prepared to pay higher prices for these, and correspondingly reimbursement of “me-too” products should be refused. Consistent signals should be given to industry and transparency regarding market entry agreements should be increased.

The importance of placing a stronger emphasis on value and adopting a longer-term perspective is particularly relevant with regard to curative treatments and emerging personalised medicines. When approaching these challenges, longer term financing mechanisms should be introduced, e.g. consideration of alternative bond arrangements and conditional reimbursement on a pay-for-performance basis over a long time period.

Finally, the case was made for the need to consider other inefficiencies in the health system. Suggestions to increase efficiency included the use of real-world assessment and monitoring of our health systems, personalised or stratified medicine, decision support systems and integration of care models. Also, inefficiencies in our regulation should be addressed by increasing coordination among systems and processes of health technology assessment across Europe.

## The conflict between patent rules and public health

The second keynote, delivered by Els Torrele Director, Access to Medicines and Innovation, Open Society Foundations (OSF), viewed the topic from a civil society perspective.

Torrele first framed the current debate within the historical context of the campaign for access to HIV drugs during the 1990s and 2000s AIDS epidemic. She referred to how the crisis of funding AIDS drugs particularly affected developing countries while in 2016, treatments for Hepatitis C have been priced to an extent that even wealthy health systems have had to enforce rationing.

Torrele argued that increases in prices have become standard as a result of monopoly power and associated patent protections. The 1995 World Trade Organisation TRIPS (Trade-Related Aspects of Intellectual Property Rights) agreement and associated patent rules were discussed as the origin of the current problem. However, Torrele also referenced the Doha Declaration of 2001 in which all WTO members agreed that the TRIPS agreement should be used in a manner supportive of countries’



“right to protect public health and, in particular, to promote access to medicines for all”.

Incentives towards innovation were also discussed. Torrele argued that today’s pharmaceutical industry operates as a highly financialised model that is not compatible with improving public health. For example, the current system of rewarding innovation may be seen to encourage a “me-too mentality” in the pharmaceutical industry, stifling true innovation and creativity. Also, where the public sector has invested in early R&D of pharmaceuticals, financial speculation by the pharmaceutical industry, and associated venture capitalists, is eliminating the possibility of a public sector return on investment. Referencing Joseph Stiglitz, Torrele stated that we pay twice for our medicines; first for research and then again for the products.

In response to the problems as outlined, she quoted the UN High Level Plan on Access to Medicines. Cited recommendations include:

- 1) Utilise the flexibilities of the TRIPS agreement to overcome patent/pricing barriers and ensure affordable access for all.
- 2) Ensure public return on public research investments.
- 3) Increase transparency in R&D costs and pricing.
- 4) Break the link between how we finance R&D and the pricing of products.



Elias Mossialos, Els Torrelle, Richard Bergström, Karin Kadenbach and Ri de Ridder.

Finally, Torrelle posed the following question: Should medicines be considered social public goods, or as any other commodity? She then called for an alternative approach to pricing and incentives.

## Panel discussion

The keynote presentations were followed by a panel discussion and interactive debate including Richard Bergström, Director General of the European Federation of Pharmaceutical Industries and Associations (EFPIA), Ri de Ridder, Director General, National Institute of Health and Disability Insurance (NIHDI) and Karin Kadenbach, Member of the European Parliament (S&D, Austria), in addition to the keynote speakers.

Bergström referred to the surge of innovation that is due to emerge from industry pipelines, e.g. around dementia, which he sees as a positive challenge and asked for the R&D effort and real results to be rewarded. He urged that governments needed to become more 'intelligent customers', however, referencing NICE's Carole Longson. Bergström advocated pay-for-performance as a method to manage budgets. In answer to the question why drugs are so expensive, he suggested that prices set by companies reflect the value that is set out within cost effectiveness analyses; these analyses are requested as part of HTA processes which have been adopted in Europe in recent years.

Ri de Ridder countered Bergström's comment regarding 'rewarding innovation' by stating that high drug prices, such as those seen with novel Hepatitis C treatments, could not be ignored or defended on the basis of innovation: According to de Ridder, we are currently managing the treatment of this disease via rationing, which is unacceptable to patients. He also referred to conclusions of the European Council regarding orphan drug products referring to the pharmaceutical market as being "out of balance". The European Commission has been requested to review the state of play, which may lead to some changes.

Kadenbach expressed support for the arguments of Els Torreele, suggesting that medication should not be a part of the free market, and indicated that we do need a change to the legal framework for pharmaceutical regulation. She noted that many of the practices of the pharmaceutical sector may be legal but were possibly not ethical.

Torreele and Mossialos again pointed out that both governments and the pharmaceutical industry failed to address the issues outlined. Mossialos reiterated that we are sending inappropriate signals by funding ineffective medicines, 'me-too' products and under-funding generics. He also pointed to the failure of governments in having accepted the fact that transfer pricing and tax avoidance are a common practice. Mossialos supports the notion of a public-private mix for antibiotics, for example and suggest incentivises and payment for success models. Torreele showcased alternative approaches to patent laws, e.g. adopting a not-for-profit model of essential drug funding, which has already been shown to work in certain circumstances.

### What is the main reason for the high prices of certain vital, innovative medicines?

(Please choose one option)

Pharmaceutical companies have monopolistic power due to national and international patent rules.	53%
The expenditure on R&D for vital medicines is extremely high.	18%
Market forces - high prices underlie the law of supply and demand.	15%
It's a captive market because public health systems are obliged to buy vital medicines.	12%
I don't know.	2%

These results are based on the answers of 40 participants.

### What is the best strategy to cope with the challenge of extremely high prices for certain vital, innovative medicines?

(Please choose one option)

Shortening terms of patents and enhancing regulatory power of governments to reduce the monopolistic power of the pharmaceutical industry.	40%
Increasing transparency about the true costs of production.	36%
Providing research funding from national health care systems to reduce the high costs of development for companies.	12%
Continuing the current approach – there is no need for change.	6%
I don't know.	6%

These results are based on the answers of 40 participants.

## Closing remarks

The discussion was closed with a reflection from the moderator that we are in dire need of an open public debate and discussion of outside-the-box solutions regarding the pharmaceutical market and asked the industry representative for a final statement.

Bergström reacted to some audience questions. He strongly spoke out against compulsory licencing and confirmed his commitment to value-based drug development – you pay when you see the results. He finally supports Mossialos' point to the fact that not only are there monopolies on the industry side, but governments on the other end act as monopsonists.

Rose ended the session with a short comment: There is a wrong balance, yet it is not simply "bad pharma" but also governments need to tackle some issues. He finally made a call to action to the actors to move the debate forward and put into action some of the topics that were discussed in this session.

## Summary points

There exist enforceable, binding industrial policies, intellectual property rules and trade rules. However, a human rights/public health framework of rules does not exist to be enforced. This means we do not have a level playing field with regard to the cost of innovative medicines.

Choices need to be made regarding whether we prioritise industrial development or use our limited resources to maximise public benefit. Consideration needs to be given to how we subsidise areas of high public value, e.g. costly or neglected diseases.

Health systems represent a monopsony but need to work towards an agreement on issues, such as common HTA criteria and unmet medical needs. Governments also need to become smarter players in this arena.

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Written by **SUSAN SPILLANE & YANNIS NATSIS**

**FORUM 8**

Keynote presentations by

ELIAS MOSSIALOS, Professor of Health Policy, Department of Social Policy and Director of LSE Health, London School of Economics and Political Science

ELS TORREELE, Director, Access to Medicines and Innovation, Open Society Foundations (OSF)

Panel discussion and interactive debate with:

RICHARD BERGSTRÖM, Director General, European Federation of Pharmaceutical Industries and Associations (EFPIA)

RI DE RIDDER, Director General, National Institute of Health and Disability Insurance (NIHD)

ELS TORREELE, Director, Access to Medicines and Innovation, Open Society Foundations (OSF)

KARIN KADENBACH, Member of the European Parliament (S&D, Austria)

Chaired by DAVID ROSE, Director, LACS Training

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**ORGANISED BY**

Main Association of Austrian Social Security Institutions, Belgian National Institute for Health and Disability Insurance (NIHD) and Estonian Health Insurance Fund in cooperation with European Social Insurance Platform



Hauptverband der  
österreichischen  
Sozialversicherungsträger



The Social Insurers of Europe

# New frontiers in Health Technology Assessment

WORKSHOP 3

The workshop kicked off with Wim Goettsch, Director of the third Joint Action on Health Technology Assessments (EUnetHTA3) who gave an overview of the functioning of HTAs and outlined the timeline of the Joint Action. Launched as a project in 2006, this initiative has now reached its third and last edition, triggering a debate among Member States and the EU institutions as to whether and how to continue this collaboration after the end of EUnetHTA3 in 2020.

Goettsch pointed out that there are many benefits for countries in collaborating on HTA, particularly with a view to improving quality, consistency, timeliness and efficiency within healthcare systems. For example, having one single assessment available at the time of marketing authorisation might considerably reduce the time to access new drugs, while reducing duplication of work among countries. Numerous reports were produced already during Joint Action2, a figure which the 78 partners of EUnetHTA3 hope to increase in the next years. Such collaboration might prove to be particularly beneficial in the context of personalised medicines and early access schemes, designed to support the approval of these drugs in the future.

Panos Kanavos, Professor, Deputy Director, Health Department of Social Policy, London School of Economics explained the link between the regulatory landscape and the faster procedure under discussion at EU level. He talked about the much-discussed “adaptive pathways” pilot project run by the European Medicines Agency (EMA), whereby demonstration of safety and efficacy will be demonstrated through observational data, the so-called “Real World Data”. Such collection of data seems to be at the basis of some HTA bodies’ scepticism towards this pi-

lot project. In addition, Kanavos explained the differences between HTA bodies in interpreting evidence and dealing with uncertainty. In his view, this has to do with different considerations, related both to the type of diseases and their classification as well as the proposed treatments and related aspects (ADRs, indirect benefits, innovativeness etc.) According to Kanavos, one possible way to overcome these challenges would be the applicability of the multi-criteria decision analysis (MCDA) to HTA, whose methodological framework could be introduced within the work of EUnetHTA3. He emphasised that the MCDA approach presents the following advantages as compared to the current HTA models:

- it is comprehensive as it incorporates several dimensions of value in an explicit manner,
- it is transparent with a clear process for judgements and preferences elicitation, including criteria weights &
- it is encompassing i.e. it enables the inclusion of all relevant stakeholders in all stages.

The third presentation was made by Elmar Nimmesgern, Deputy Head of Unit from the DG RTD who presented the state-of-play of personalised medicine within the European Commission (EC).

He underlined the diachronic interest that the EC has in this topic. The EC’s involvement in this area was substantiated in 2010 and led to the launch of the International Consortium of Personalised Medicine (IC PerMed) in 2016. Overall, over 2 billion Euro has been invested in top research areas that will possibly pave the way to the success of personalised medicines: large scale data gathering and “-omics”, Technology development, Statistics, Diagnostics, Bio-markers to name a few. With regards to HTA, Nimmesgern commented on how the EC have been supporting

the development of HTA cooperation through projects funded by the Seventh Framework Programme (FP7). He also mentioned projects where the EC is currently working in collaboration with the pharmaceutical industry in the area of real world data, with projects such as Adapt Smart and Get Real by the Innovative Medicines Initiative.

Last but not least, he explained how IC PerMed will foster collaboration between research funders and policymakers across EU Member States, in order to set Europe as a global leader in personalised medicine research, support its science base through a coordinated approach to research, provide evidence to demonstrate its benefit to citizens and healthcare systems and ultimately pave the way for these approaches for citizens.

Iona Siska, Policy Officer, from the DG SANTE Medical products: safety, quality, innovation Unit, took the floor and offered a broad overview of the initiatives running at EU level with regard to HTA.

She referred to the structure and functioning of the HTA network, the political counterpart of EUnetHTA, and presented the strategy that HTA bodies will adopt to facilitate efficient access to effective, safe, innovative, and added value technologies while guaranteeing the sustainability and predictability for healthcare systems. In addition, she reiterated that the network is expected to focus on and develop a life-cycle approach to pharmaceuticals, namely from the pre-marketing phase (early dialogues/scientific advice) through to the post-marketing phase (real world data generation).

Finally, she presented the five policy options that the EC is evaluating in order to bring forward European cooperation after EUnetHTA which will come to an end in 2020. The spectrum includes both non-legislative and voluntary cooperation measures as well as more binding and legislative proposals. Similarly, in the case of mandatory cooperation, this might refer only to the clinical assessment of a health technology and thus include rapid relative effectiveness assessments (REA) or might entail both the clinical and economic assessment (Full HTA). Last but not least, she announced that the EC plans to launch a public consultation by the end of October 2016 in order to gain a preliminary understanding of the level of engagement that HTAs and other stakeholders are willing to accept.

Nicola Bedlington, Secretary General, European Patients' Forum explained that tailored healthcare solutions integrated as part of a holistic approach are needed. This means treating the person, not the disease. In her view, this should serve the purpose of achieving better health outcomes, and improving the quality of life and cost-effectiveness of resource use.

She then addressed the issue of access and stated that healthcare must be based on the fundamental values of equity and solidarity – but currently huge disparities in access to even basic healthcare persist. What is needed is a common way of assessing added-value of Innovative treatments – e.g. HTA – this MUST consider “value” from the patient's perspective (quality of life) and asked if we have really adequate measures for this (e.g. QALYs?). She spoke about the progress in personalised medicines and in genomics noting that these advances pose challenges in moving towards a new model of healthcare. In this respect, she highlighted the fact that HTA bodies do not always understand fully the specificities of the -omics technologies.

On the whole, she called for investment in research for patients' stratification and the systematisation of meaningful patient involvement in HTA processes. Last but not least, she underlined the significance of having communication and education strategies in place to increase patient and public awareness and health literacy.



Petra Keil, Head of European Public Affairs, Novartis International AG explained that healthcare systems in Europe need to be strengthened and modernised to provide higher value as well as greater access. To this end, smart investment and innovation in new technologies is needed. She noted that the future of HTA demands new approaches. In her view, new medicines should be funded based on tracked outcomes. She stressed that HTA can bring value to the patients by evaluating all types of technology that influence costs in the healthcare system, not only medicines. That is why she supported the view that society should not be rewarding input in health systems, rather the outcomes they produce.

During the brief Q&A that followed, Kanavos was asked if projects such as adaptive pathways could bring about affordable medicines while the European Commission representative was asked repeatedly about the extent of European harmonisation taking into account that HTA is a national competence issue. Kanavos replied by emphasising the value dimension as opposed to the high cost of treatments. The European Commission representative responded by saying that the Member States will decide on the extent of collaboration and that the European Commission respects the national prerogative.

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Written by **FRANCESCA CATTARIN & YANNIS NATSIS**

### WORKSHOP 3

WIM GOETTSCHE, Director of EUnetHTA JA3 Directorate, National Health Care Institute, The Netherlands  
PANOS KANAVOS, Professor, Deputy Director, LSE Health Department of Social Policy, London School of Economics  
ELMAR NIMMESGERN, Deputy Head of Unit, Innovative and Personalised Medicine, DG RTD, European Commission  
IOANA SISKA, Policy Officer, Medical products: safety, quality, innovation, DG SANTE, European Commission  
NICOLA BEDLINGTON, Secretary General, European Patients' Forum  
PETRA KEIL, Head of European Public Affairs, Novartis International AG

Moderated by JULIA SCHMITZ, Scientific Officer, Unit E3, Public Health Sector, DG RTD, European Commission

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### ORGANISED BY

DG Research and Innovation (DG RTD),  
European Commission



# Personalised prevention

## - the end of public health as we know it?

LUNCH WORKSHOP 2

The current trend towards patient-centred healthcare and the increasing focus on personalised medicine due to advances in genomic science are paving the way also for a more personalised approach to prevention. The aim of the workshop was therefore to discuss:

- How can lessons and knowledge from personalised medicine be used for making prevention efforts more targeted and effective?
- How can increased knowledge regarding genomics and risk groups be translated into effective preventive interventions?
- What is the role of the digital sector, Big Data and electronic applications?
- What are the barriers for ensuring a personalised prevention approach?

The session was moderated by Richard Bergström, Director General of the European Federation of Pharmaceutical Industries and Associations (EFPIA).

Tom Fowler, Director of Public Health, Genomics England commenced by presenting the 100,000 Genomes project that sequenced 100,000 genomes of around 70,000 NHS patients suffering from a rare disease, their families, and cancer patients. The four main aims of the project are to:

- 1) Create an ethical and transparent programme based on consent;
- 2) Bring benefit to patients and set up a genomic medicine service for the NHS
- 3) Enable new scientific discovery and medical insights
- 4) Kick-start the development of a UK genomics industry.

Fowler portrayed the 100,000 Genomes project to be all about focusing on DNA. Yet, in order to make personalised medicine possible we need to additionally digitalise health information and use big data effectively.

Personalised prevention takes into account individual susceptibility to disease risk and individual responses to treatment. Fowler defined personalised prevention as the personalisation of risk assessment and interventions for individuals of any age. To achieve that, a lot should be done in terms of sharing and having access to data and knowledge, and linking diagnostic information. Key aspects are also individual values, people willing to accept the concept of personalised prevention, and personal engagement. Besides cancer (according to Fowler, currently an estimate of 30% - 60% of cancer treatments in the UK do not actually work) and rare diseases, there are other areas where NHS is considering ways of applying the personalised approach. The example for the management of neonatal diabetes was presented. Newborns diagnosed with diabetes are often put on a lifetime regime of treatment while actually this is not even needed. This is where personalised medicine can make a real difference by reducing costs and improving the quality of care.

Fowler defined the strategy: Move from where we are now – a one-size fits all approach with limited use of genomic and molecular information – to an individually tailored approach. What will be crucial besides the genomic side will use of Big Data and patient reporting.

Angela Brand, Professor, Maastricht University, referred to the strong commitment on European Union and Member States level for personalised medicine and named three milestones:

- 1) The strategic innovation and research agenda for personalised medicine which was launched in June 2015 with five defined challenges: developing awareness and empowerment, integrating big data and ICT solutions, translating basic to clinical research and beyond, bringing innovation to the market and shaping sustainable healthcare.
- 2) Launch of an international consortium on personalised medicine (PerMed) of 22 EU members states and Canada, which has developed a road map and action points.
- 3) Personalised medicine was a topic under the Luxembourg EU Presidency and was mentioned in the Council conclusions in 2016.

The fact that we spend ten times more on personalised medicine in Europe compared to the US and that work on the topic was started already with the funding of bio-banks shows the high commitment. Brand also stressed the importance of primary prevention measures such as vaccinations and lifestyle choices and reminds of the fact that prevention has always been at the heart of public health on all population levels. Therefore she does not see personalised medicine as a contradiction to public health. For example, many cancers, like HPV and cervical cancer are contagious and infection related, and therefore can be avoided by primary prevention. Yet, overall, Brand sees the prediction of diseases in many cases a mission impossible as diseases occur randomly.

The private sector representative, Matthias Reumann, IBM Research, portrayed technology as a catalyst to save and improve lives and lower costs through cognitive computing. Reumann highlighted the benefits technology offers to patients and called for enabling the patient in connection with a more proactive and health-oriented approach instead of a disease-oriented one. Cognitive technology can provide assistive systems for doctors to deal with complex information that is available to make informed decisions and take action.

The private sector (private hospital networks and pharma, for example) is driving these developments and is ready to invest and work in integrated care. In this context Reumann used the somewhat provocative term of "Uberisation of healthcare". In order to move forward, we need informa-



tion that can be used at the governmental or state level which startups could provide, which requires collaboration of all players. This, according to Reumann, would entail payment by social insurance systems for the services that technology is able to provide and would require a culture change with both informed doctors and patients adopting technology.

Gaston Remmers, lifestyle coach, inspire2live, presented his personal experience with illness and lifestyle and how he would have benefitted from personal prevention. Remmers posed important questions about data protection and data possession: "Who has control over data? Who is in charge of data?" He also expressed concern about the sources of information and mentioned the example of the multitude of companies producing pedometers. How can we know which type of pedometers will give us the relevant information for research? Despite his concerns he expressed hope:

***If you make the citizens and patients interested in the process, you will speed things up.***

Gaston Remmers, inspire2live

Healthcare systems will need to realise that there are various paths to personalised interventive prevention apart from the known and currently practiced models.



Tom Fowler, Matthias Reuman, Richard Bergström, Angela Brand, Gaston Remmers and Daniel Forslund.

Daniel Forslund, Commissioner, Stockholm County Council, Sweden, continued by explaining how frustrating it is to hear about the smart solutions, the interactive online decision core systems or digital health tools that are used which are still not available in our healthcare systems. Digitalisation is moving on, while outdated tools and structures are used in healthcare.

This urgently calls for political and professional engagement and leadership in order to take charge of the digital transformation of healthcare. In order to better organise healthcare and make use of new technologies, we need to change some of the regulations at national and EU level, but mainly at the regional level (e.g. regarding public procurement and organisation of reimbursements).

Once again, he addressed the importance of the medical professionals' and patients' willingness to use the technology which will require a change of culture on handling information in healthcare. The importance of patients is illustrated by the diabetes and Parkinson's community on Twitter via the hashtag #WeAreNotWaiting, which represents a rally cry of patients who are taking matters into their own hands, developing platforms and apps, and reverse-engineering existing products when needed in

order to help people with diabetes better utilise devices and health data for improved outcomes. The days of only healthcare institutions producing data is over – nowadays patients themselves produce data, as well. Forslund referred to digital health as the new public health and called for an empowerment of patients to develop their own tools and share their data with their health systems if they wish. In conclusion, the entire panel agreed that the more information we share, the more chance we have to be diagnosed, treated and have a positive outcome and better results. Since we have the technology and the data for personalised prevention, we now need to make them transparent and acceptable for all involved. In this context, integrity and trust are important issues with patients having ownership of their own data. Also, it is now the right time to talk about the affordability of personalised medicine and whether it may be feasible mainly for rare diseases in the future. It was agreed that only together with different stakeholders we can succeed in accomplishing these objectives.

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Written by ZELJKA STAMENKOVIC

**LUNCH WORKSHOP 2**

TOM FOWLER, Director of Public Health, Genomics England

MATTHIAS REUMAN, IBM Research

GASTON REMMERS, inspire2live

ANGELA BRAND, Professor, Maastricht University

DANIEL FORSLUND, Stockholm County Council, Sweden

Charied by RICHARD BERGSTRÖM, Director General, EFPIA

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**ORGANISED BY**

European Federation of Pharmaceutical Industries  
and Associations (EFPIA)



# Capturing change

## Health information

WORKSHOP 6

The aim of this workshop was to address the need for good quality health information in ensuring a solid foundation of evidence for policymaking in a changing Europe.

The objectives were to:

**describe** the challenges faced by health information and research systems in the new European demographic situation and

**explore** which new types of information and evidence could support an understanding of the changing demographic landscape in Europe.

The workshop was moderated by Niek Klazinga Professor at the University of Amsterdam and Head of the Health Quality Indicators Project, OECD Health Division.

The high-level panel invited on this occasion consisted of: Christopher Fearne, Minister of Health in Malta; Claudia Stein, Director of the Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe; Anna Korotkova, Deputy Director, Federal Research Institute of Health Care Organization, Moscow, Russian Federation; and Caroline Costongs, Managing Director, EuroHealthNet.

At the beginning of the session, Stein pointed out that we have more health information and research systems today than ever before. However, there are still some key challenges for ensuring evidence-based policy making in a changing Europe, chiefly that there is currently a gap between scientific evidence and health policy. In order to bridge this gap, more and better health information is needed for evidence-based policymaking.

The following key challenges have been identified by the WHO:

- WHO's core mandate is to monitor health status internationally, yet health information in Europe is fragmented and expertise scattered.
- Member States' information is often incomplete, not harmonized with international standards, and reporting systems are not integrated.
- Networks are often ad-hoc & based on personal relationships.
- There is no single integrated health information system for Europe.

There are a number of other activities being undertaken to improve health information and explore different aspects that influence its quality.

WHO initiated the European Health Information Initiative, which aims to improve the evidence on which policy is based by providing guidance on health information activities in the WHO Europe region and ultimately to create a single health information system for Europe. Today there are 25 participating members in the initiative.

Cultural contexts of well-being are being explored in order to investigate the influence of culture on well-being measurement more systematically, and a Health Statistics App has been developed in order to make the collected data more accessible to the general public.

The Panorama peer-reviewed journal is issued four times a year to help with the dissemination of best practice and successful implementation of evidence-informed policies. Finally numerous health information networks are being established in Europe that provide the platform for ex-

change of good practices and help with harmonising data collection.

Exploring which new types of health information are needed for the future, several points were made by the panelists. Firstly, we see today greater use of private healthcare institutions across Europe. To monitor the quality of these providers and hold them accountable, we need key indicators for outcomes and performance. Secondly, several countries have significant data on volume indicators (i.e. patients treated), but lack data on health outcomes. Finally, we lack adequate data on migrant health and there is a need for international collaboration for tracking the health of this vulnerable patient group. Moreover, there is also a lack of adequate data on homeless people and prisoners.

One of the key points made in the discussions were the big opportunities presented by new health technologies (i.e. Apps and e-health) for better health information on the one hand, and the many unanswered questions on the other: how are we going to deal with new health technologies? What are the pitfalls? How can we make use of data stored in different types of health technologies? Is it possible to link these data with other types of data (social data, mortality data etc.)? And what about the balance between privacy and security?

Although a huge amount of work is being done to address the challenges in obtaining quality health information, other panellists and the audience reminded us that we must not forget to think about issues regarding the collection of data also from a bottom-up perspective.

How do we make sure the patient's information is protected if his data is being collected? How do we establish trust between providers of data and the data collectors? How do we make sure we don't overburden the collectors of data with additional administrative work considering they already have a long list of papers they have to process? And how do we stop thinking about health information purely from a medical perspective and expand it to be more interdisciplinary?

Both the speakers and audience addressed the importance of accurate, harmonised and relevant health data across countries. After all we should not let doctors use their time and energy registering data that are not relevant. In addition, there was consensus that we lack health information for vulnerable patient groups, or in the words of Sir Michael Marmot:

***To address inequalities in health in Europe, our first step must be to address the inequalities in health information.***

***All too commonly where health is poorest, health information tends to be poorest. Health information is absent or incomplete just where we need it most.***

***Health Information is crucial in all countries.***

Michael Marmot, University College London

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Written by KHALID LAFKIRI

**WORKSHOP 6**

CHRISTOPHER FEARNE, MP, Minister of Health, Malta  
CLAUDIA STEIN, Director, Division of Information, Evidence,  
Research and Innovation, WHO Regional Office for Europe  
NIEK KLAZINGA, OECD Health Division, Head of the Health  
Care Quality Indicators (HCQI) Project  
ANNA KOROTKOVA, Deputy Director, Federal Research  
Institute of Health Care Organization, Moscow, Russian  
Federation  
CAROLINE COSTONGS, Managing Director at  
EuroHealthNet

**FURTHER READ/USEFUL LINKS**

Cultural contexts of health & well-being  
The European health statistics app  
Panorama journal  
WHO Europe Networks: Small countries initiative  
Evidence-informed Policy Network (EVIPNet)  
CARINFONET (Central Asian Republics Health Informa-  
tion Network)  
European Health Information Initiative (EHII)  
WHO Europe Networks: Building capacity and exchang-  
ing findings regarding the burden of disease in the  
Region

**ORGANISED BY**

World Health Organization Regional Office for Europe



# Sustainable & equitable cancer care

## Tomorrow's reality or science fiction?

WORKSHOP 2

The session, chaired by Vivek Muthu of The Economist Intelligence Unit Healthcare, discussed cancer and cancer care access in Europe by looking at some of the main issues arising at several points in the chain of healthcare research, delivery and receiving. To explore potential measures for improvement the workshop dealt with questions such as what determines access and sustainability? How can we ensure sustainable and equitable cancer care against the background of constraint (financial) resources?

The session started out with the clinician's perspective. Richard Greil, University Hospital Salzburg, shared his views on what can and should be changed to optimise the efficiency and quality of cancer care and improve clinical outcomes.

The incidence of cancer is expected to rise from 12 million (2016) to 26 million (2050) globally, and accounts not only for an enormous amount of annual life years lost, but also for a bigger productivity loss than any other disease. We can gain at least part of this loss back by improving on care. While considerable treatment advances have been made regarding long-term survival, there is a rising range and number of unmet needs in survivors that healthcare systems must accommodate for. Where and how can we improve? Access to cancer care depends on several factors such as socioeconomic status, but also on how the healthcare system is organised – Greil highlighted the importance of centralised care in this context, but also referred to parameters like speed of uptake of new drugs, which varies highly both across and within countries. Steps towards economising better and becoming more efficient can be identified across the healthcare sector, not only in relation to cancer, and includes e.g. delegating certain kinds of tasks to nurses or reducing over-utilisation of

surgery. Greil's conclusion: when looking at total numbers of healthcare spending in e.g. Austria, we see that cancer care is affordable now and in future. "There is no reason for pessimism, but only for action".

Bengt Jonsson from the Stockholm School of Economics began his presentation with observing that, even though European countries spend roughly the same on healthcare, the economic conditions do differ. This diversity is part of the challenge of ensuring equitable cancer care, just like population ageing and the increasing number of multimorbid patients. The share of healthcare expenditure allocated to cancer is generally low when compared to the burden of disease, and has been relatively stable, even though its composition has changed. Despite this relative stability in spending there have been significant improvements e.g. on breast cancer survival rates that are due to innovation in several fields such as diagnostics, treatment, and general care delivery. However, Jonsson argued that to further take advantage of scientific advances, we may need to reallocate resources; while there are opportunities to do better with the resources we have now, this may not be enough when aiming for further improvements. Summing up: We see that the content of expenditure has changed; innovation challenges existing patterns of care and the more alternatives we have the more difficult it is to use these options for the best.

Not to be omitted in the picture was of course the patient perspective, provided by Alfonso Aguarón, Project Manager, Myeloma Patients Europe. His message was clear: patient participation is needed in HTA processes, from choice of research methods to outcome definition. Patients can, with appropriate training, and should help

guide research, particularly since there is now a need to go beyond clinical endpoints. With long-term survival increasing and ever more sophisticated drugs, quality of life is of growing importance.

Turning towards the topic of equitable access, Aguarón introduced his organisation's work on compiling "The European Atlas of Access to Myeloma Treatment", which summarises patient's views on barriers and aims to help countries to devise national action plans. Access issues are not only complex, but also country specific. Aguarón concluded: Since advocacy so far has failed to solve these problems, we need to join forces and work towards better empirical evidence to properly understand the issues underpinning access.

Emmanuel Blin, Chief Strategy Officer, Bristol-Myers Squibb, asked a rather fundamental question: Is affordability the real issue? Are we spending enough on cancer? Today, one in five national Cancer Control Plans lack sufficient funds for their implementation. According to Blin, from an efficiency / effectiveness perspective at both society and economy level there is a real argument to invest more. The reason for why this has not been done yet, Blin argued, is that the positive impacts of investing and the negative impacts of not investing have been largely overlooked. He reminded us that 60% of the economic burden of cancer is non-healthcare related, but due to indirect implications such as productivity loss – a trend that is growing further because of ageing. However, with set budgets spending more on cancer requires tough reallocation decisions within healthcare. Blin also suggested ways in which we could "spend better", e.g. by ensuring the appropriate use of generics and bio-similars, working towards improved adherence, or improving ambulatory care. To become more efficient systems need to find ways to enable the rapid disinvestment in drug interventions that are outdated. A related problem is the failure to agree on what matters in terms of outcome – only then can we assess the added value of new interventions and decide on what to fund. Blin finished his presentation by saying that industry needs to partner with patients to understand unmet needs. All stakeholders, from care provider to payer, need to shape cancer policies.

The last presentation given in the session was from a policy perspective. Lieve Wierinck, Member of the European Parliament (ALDE, Belgium), referred to the title of the session and stated that sustainable cancer care is certainly not science fiction. A prerequisite for making it a reality



Emmanuel Blin.

is sharing of both good scientific and care practice. She asked how it is possible to make cancer plans affordable without asking the overall budget to increase. Firstly, investments need to be evidence-based. Secondly, we need to think in the long-term; sustainability means that today's decisions work for future generations. Thirdly, "waste is a toxicity in the system" – we do not only need to improve screening practices, but eliminate inefficiencies by providing good reporting systems for patients, minimum standards and connectedness for good practices in all European countries.

Following on from the Cancon joint action and its harmonisation efforts in European cancer control practices, Wierinck called for bringing patient-centredness to the forefront. While no single formula can be applied to all Member States, we can aim at some shared principles of sustainability. Since benefit can only be assessed after implementation, best practice sharing is crucial, and the European Semester may also help.

Like Blin Wierinck mentioned that part of the problem is the continued funding of obsolete practices, "we can do better, and we must do better. Patient outcomes can be delivered within a current financial framework."

One of the key themes running throughout the session was efficiency, and when asked the audience preferred to firstly reduce inefficiencies rather than to increase resource allocation. In this context, Greil pointed out that we are running the danger of wrongly concentrating on the cost of medicines. While here, efficiency and efficacy is under scrutiny, a lot of wastage goes unobserved e.g. in the fields of diagnostics and surgery. And: the biggest increase in cost has been due to bureaucracy (e.g. in relation to clinical trials) and long-term care.

Both panel members and audience agreed that a crucial factor for ensuring sustainability and equity in cancer care is reliable data and their adequate translation.

The particular challenge: in the context of innovation we have to make decisions about things we cannot know yet – we do not know what outcomes e.g. an investment in personalised medicine will yield later on. This issue plays a crucial role in pricing and reimbursement of (innovative) drugs, where an often-lamented evidence-gap seems omnipresent.

mHealth and eHealth sparked a vivid discussion when going deeper into the data topic. It became clear that harnessing data is anything but easy. While our ability to collect data is increasing, our ability to process it is not – and the value of information depends largely on what we can do with it.

When asked about adaptive licensing and real world evidence, Blin said that it would be of immense value for cancer patients if research and development could be conducted in a more focused, informed way, by having more patient level information earlier on to design trials that better fit patients' characteristics. Most countries however lack the infrastructure to measure this kind of data, and where it is done it is often unreliable and of poor quality.

Once the situation improves, industry, is "ready to move into a space where pricing and remuneration is based on the outcomes truly delivered", Blin stated.

Policy requirements were also addressed. There can be no debate about sustainability without getting decision-makers from other policy areas involved. Wierinck reminded us that while there is some will to put streamlining healthcare sustainability on the table on a EU level, the European Semester is largely directed towards finance minister. Since health remains a national competence, it will be a difficult task to convince Member States of the importance of streamlining. Blin pointed towards some private sector efforts, e.g. in relation to data collection, and to national cross border talks on how to evolve laws and regulations on HTA, pricing and access to new medicines.

A number of other important issues were touched upon, such as transparency, and the call for open discussions of risk-sharing models between pharma and other stakeholders, leaving a lot of open question and food for thought. As Muthu put it: "There is a rallying cry here about being able to identify, articulate, and bring stakeholders together around the inefficiencies, and opportunities for improving quality within current cancer care resource envelopes, notwithstanding those envelopes may not be enough."

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Written by LISA BORNSCHEUER

**WORKSHOP 2**

LIEVE WIERINCK, Member of the European Parliament  
(ALDE, Belgium)

EMMANUEL BLIN, Chief Strategy Officer, Bristol-Myers  
Squibb

BENGT JONSSON, Associate Professor of  
Economics, Stockholm School of Economics

ALFONSO AGUARÓN, Project Manager, Myeloma Patients  
Europe

RICHARD GREIL, Professor, University of Salzburg

Chaired by VIVEK MUTHU, Chair, The Economist Intelligence  
Unit Healthcare

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Bristol-Myers Squibb



# Hear today – Here tomorrow

## WORKSHOP 5

In this workshop, the associations of age-related disability with co-morbid conditions and the options for prevention and increase of healthy life expectancy were explored by using the example of hearing loss.

Hélène Amieva from the University of Bordeaux presented the current evidence and the newest research from her team on the topic of hearing loss and cognitive decline using self-reported data of the PAQUID study.

Generally, research on this topic shows that hearing loss is associated with e.g. increased social exclusion, higher frequency of falls, tiredness and diabetes. In their most recent study they followed up almost 3700 older individuals over the course of 25 years for cognitive decline, of which approximately 35% reported to have some level of hearing loss. The results showed that hearing loss is associated with greater cognitive decline, independent of age, sex and education. This association could however be eliminated by the use of innovative hearing aids as similar associations were not seen in participants who used these devices. Hearing aids are not yet frequently used due to stigma, low political and societal awareness and the lack of high quality research in this field.

David Sinclair from the International Longevity Centre, London, gave further context to hearing loss as a public health challenge.

He stressed the economic impact of hearing loss by presenting evidence from the UK: 1 in 5 people in the UK will be faced with hearing loss at some point in their life, and one third of these people do not have or do not use their hearing aids. The employment rate among people with hearing loss is much lower than in fully hearing people, indicating that the economic and public health impact of

this and associated health conditions could be reduced by awareness raising in the population and especially among employers, thereby reducing stigma. Furthermore, there are examples from other countries where the rate of non-users of hearing aids is much lower, i.e. in Switzerland with approximately 3%, which is likely related to better screening and referral systems in place to detect and manage hearing loss early and appropriately. As the age-related loss of hearing is a slow process, it can take up to 10 years to recognise a hearing problem, which may then be too late to prevent social exclusion and associated conditions.

Patrick D'Haese, Corporate Director of Awareness and Public Affairs at MED-EL, provided insight from the industry perspective.

To overcome hearing loss as a barrier to communication and quality of life he presented the 'Hearing Loss Journey': It starts with awareness of the problem, followed by its identification, referral and professional counselling, the fitting of an appropriate hearing aid or implant as well as potential rehabilitation, and finally leads to the ongoing maintenance of the hearing aid. As hearing aids technically enhance the conventional way of hearing, early identification of hearing loss is essential for the user to get accustomed to the device. Therefore, early identification and professional and ongoing support could improve device usage. If needed, hearing implants could be fitted for individuals for which hearing aids are not appropriate.

In a short video message by Roberta Metsola of the European Parliament, the key solutions to the challenge of hearing loss were summed up from the EU level perspective. The EU could support the social inclusion of individuals with hearing loss by encouraging Member States

to raise awareness, combat ageism on the employment market, invest in technology and improve accessibility of hearing aids and putting the need for sign language interpreters and use of subtitles in the media on the agenda. Thus, even small investments could help increase quality of life for make people with hearing loss.

## Conclusions

In this workshop session, further key solutions were found: An important intervention would be the prevention of noise-induced hearing loss, especially among working-age adults.

Similarly important are screening procedures to improve early detection and referral to professionals to fit a hearing aid early in the 'hearing loss journey'. Part of this process would be the training of GPs and nurses and accessibility for every affected individual. Once hearing loss is on the health promotion agenda and recognised as a part of 'active ageing', stigma and social exclusion will become less of a problem.

Further high-quality research could be done to learn more about this topic and hearing loss could be addressed in coherence with similar public health challenges of ageing, such as cognitive decline, low physical activity, social exclusion, frailty and decrease of overall well-being.

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Written by **KATRIN BERKEMEYER**

### WORKSHOP 5

PATRICK D'HAESE, Corporate Director of Awareness and Public Affairs, MED-EL

HELENE AMIEVA, University of Bordeaux

DAVID SINCLAIR, International Longevity Centre, UK and AGE Europe

ROBERTA METSOLA, Member of the European Parliament (EPP, Malta) (video message)

Moderated by PETER O'DONNELL, Contributing Editor, POLITICO

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### ORGANISED BY

MED-EL Medical Electronics

**MED<sup>EL</sup>**

# EU Action on Pancreatic Cancer

WORKSHOP 8

Pancreatic cancer can be placed at the interface between rare and common diseases; its incidence is increasing due to factors including demographic change.

The main topic covered in the session was the increased research and the changing regulatory environment around new drugs for pancreatic cancer, and how to bring this orphan disease to the top of the political agenda.

The panel was composed of international experts, researchers and policymakers: Nuria Malats, CNIO Madrid, Ricardo Baptista Leite, Member of Parliament, Portugal, Matthias Reumann, IBM Research, Lada Leyens, Swissmedic, and Angela Brand, EUPAncreas WG4 Coordinator, Maastricht University.

The session was chaired by Elke Anklam, Director, Joint Research Centre, European Commission.

## What can be done – From research to policy

Regarding regulatory mechanisms, it has been suggested to have shorter trials and to grant exceptions for new orphan drugs once the additional added benefit is evident. One option here could be the concept of adaptive pathways. Adaptive pathways aim to improve timely access for patients to new medicines. It is a scientific concept for medicine development and data generation which allows for early and progressive patient access to a medicine. The approach makes use of the existing European Union (EU) regulatory framework for medicines.

Research still misses evidence on the causes of pancreatic cancer, and there are no validated bio-markers to support early diagnostics. Without bio-markers, early diagnosis is challenging as patient symptoms can have several different causes. This leads to late diagnosis, which furthermore leads to a small survival rate mid- to long-term, and poor prognosis (6,5 months from diagnosis to death).

Problems with research studies are: low incidence (need big data); high level of misdiagnosed cases; patients are too sick to participate in studies; only some patients undergo surgery, sampling difficulties and underfunded research work amongst others.

Once there are appropriate bio-markers it has been suggested to screen high-risk groups, although in discussions it was also argued that bio-markers are expensive and we should rather work on developing better primary prevention measures for pancreatic cancer.

Research shows that the mutation journey from a healthy cell to pancreatic cancer cell can take up to 17 years, so early diagnosis could prevent the disease, or lead to better treatment results. Countries should make the data they collect publicly available and collaborate in a way that researchers can use that data. Big Data can be useful if it is made actionable; data actions need to be transparent, standardised and holistic.

We need to characterise the problem first, and look at how pancreatic cancer is managed in different countries – from diagnosis to treatment, what are the differences and what are the problems.

An innovative way could be to use bio-markers and research evidence from other orphan diseases for pancreatic cancer (spill-over-effect). Looking at different kinds of cancers could be beneficial for pancreatic cancer diagnostics. Pharma companies should work together on “umbrella trials”, to achieve more effective results.

It was also suggested to invest in Public-Private Partnerships (PPPs), using shared patent-schemes, to bring pharma, research and policymakers together to collaborate and foster data-sharing. This topic was controversial during the discussion with the audience, and ethical concerns were raised.

PPPs should have a common ethical background, and be transparent. This is a clear example of an unmet need, and we can learn from Norway's recent example of creating a consortium for unmet vaccination needs following the recent outbreaks of Zika and Ebola with the WHO, WEF and Bill and Melinda Gates Foundation: other diseases could also benefit from this approach.

As pancreatic cancer is an orphan disease which naturally has a low chance to achieve a critical mass for trials, it was suggested to enable cross-border clinical trials. Besides, reimbursement schemes should be included in the discussions on HTA, and different stakeholders need to be involved.

For the future, personalised medicine could be an answer. Personalised medicine is a medical procedure that separates patients into different groups - with medical decisions, practices, interventions and/or products being tailored to the individual patient based on their predicted response or risk of disease.

Partnerships should also centre on what patients and families are concerned about, rather than just looking at numbers i.e. survival rates. This is critical if we want to move towards a value based society. What do patients and their families expect and want?

## Conclusion

Death rates for pancreatic cancer are increasing despite the general decrease in death rates for all cancers across Europe. As pancreatic cancer is a silent disease, it is of utmost importance to raise awareness among health professionals, patients and relatives, but also among the wider public and policymakers.

Researchers, health professionals, policymakers, donors and other stakeholders should all work together in a multi-disciplinary way, “from cell to society”, to achieve better health outcomes for the individual patient. This could be in the form of PPPs and policy-research networks such as the European Cooperation in Science and Technology (COST), with action EU Pancreas (BM1204) aiming to unite pancreatic cancer research groups across Europe and providing an innovative and unique platform for collaborating and sharing information, ideas and experience.

The “Pancreatic Cancer White Paper 2015” is a direct appeal to policymakers, legislators, regulators and stakeholders for collaboration, to raise awareness, and work on prevention and treatment of pancreatic cancer. Delegates agreed that such approaches are essential to make a stand together to fight the increasing burden of pancreatic cancer.

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Written by **DIANA KOERNA & STEFANIE PRAXMARER**

**WORKSHOP 8**

NURIA MALATS, CNIO Madrid, Spain  
RICARDO BAPTISTA LEITE, Member of Parliament, Portugal  
MATTHIAS REUMANN, IBM Research  
LADA LEYENS, Swissmedic, Switzerland  
ANGELA BRAND, EUPancreas WG4 Coordinator, Maastricht University

Chaired by ELKE ANKLAM, Director, DG Joint Research Centre, European Commission

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**ORGANISED BY**

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