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European Health Forum Gastein 2019



➤ A healthy dose of disruption? Transformative change for health and societal well-being

- Changing the DNA of health care in the age of Artificial Intelligence
- Health innovation: from organisation disruption to outcomes value
- Facts. Figures! Fiction?
- Transforming financial markets for the good of all
- Co-creating policies to tackle obesity
- Empowering communities to reduce health inequalities
- The global climate crisis: a public health emergency
- Interview with the European Commissioner for Health

:: Special Issue ::

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Quarterly of the
European Observatory on Health Systems and Policies
Eurostation (Office 07C020)
Place Victor Horta/Victor Hortaplein, 40/10
1060 Brussels, Belgium
T: +32 2 524 9240
F: +32 2 525 0936
Email: contact@obs.who.int
<http://www.healthobservatory.eu>

SENIOR EDITORIAL TEAM

Sherry Merkur: +44 20 7955 6194 s.m.merkur@lse.ac.uk
David McDaid: +44 20 7955 6381 d.mcdaid@lse.ac.uk
Gemma Williams: +44 20 7107 5304 g.williams@lse.ac.uk

EDITORIAL ADVISOR

Willy Palm: palmw@obs.who.int

FOUNDING EDITOR

Elias Mossialos: e.a.mossialos@lse.ac.uk

LSE Health, London School of Economics
and Political Science
Houghton Street, London WC2A 2AE, United Kingdom
T: +44 20 7955 6840
F: +44 20 7955 6803
[http://www2.lse.ac.uk/LSEHealthAndSocialCare/
aboutUs/LSEHealth/home.aspx](http://www2.lse.ac.uk/LSEHealthAndSocialCare/aboutUs/LSEHealth/home.aspx)

EDITORIAL ADVISORY BOARD

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Julian Le Grand, Willy Palm, Suszy Lessof, Martin McKee,
Elias Mossialos, Richard B. Saltman, Sarah Thomson

DESIGN EDITOR

Steve Still: steve.still@gmail.com

PRODUCTION MANAGER

Jonathan North: northj@obs.who.int

SUBSCRIPTIONS MANAGER

Caroline White: caroline.white@lshtm.ac.uk

Article Submission Guidelines

Available at: <http://tinyurl.com/eurohealth>

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List of Contributors

- Vytis Andriukaitis** • DG Sante, European Commission, Belgium
- Clemens Martin Auer** • European Health Forum Gastein, Austria
- Sherria Ayuandini** • University of Amsterdam, the Netherlands
- Ben Barr** • Institute of Population Health Sciences, University of Liverpool, United Kingdom
- Jan-Philipp Beck** • EIT Health, Germany
- Chris Brown** • World Health Organization European Office for Investment for Health and Development, Italy
- Jonathan Cylus** • European Observatory on Health Systems and Policies, United Kingdom
- Stefan Eichwalder** • Federal Ministry of Labour, Social Affairs, Health and Consumer Protection, Austria
- Tamás Evetovits** • World Health Organization Barcelona Office, Spain
- Josep Figueras** • European Observatory on Health Systems and Policies, Belgium
- Scott L. Greer** • Department of Health Management and Policy, School of Public Health, University of Michigan, United States of America
- Johanna Hanefeld** • London School of Hygiene & Tropical Medicine, United Kingdom
- Noora Heinonen** • Ministry of Finance, Finland
- Dorli Kahr-Gottlieb** • European Health Forum Gastein, Austria
- Stephen K. Klasko** • Thomas Jefferson University and Jefferson Health, United States of America
- Knut-Inge Klepp** • Norwegian Institute of Public Health, Norway
- Pasi Korhonen** • Permanent Representation of Finland to the EU, Belgium
- Robert Madelin** • Fipra International, Belgium; Royal College of Physicians of London and University of Oxford, United Kingdom
- Martin McKee** • London School of Hygiene & Tropical Medicine and European Observatory on Health Systems and Policies, United Kingdom
- Rachel Melsom** • Tobacco Free Portfolios and Worthing Hospital, United Kingdom
- Pasi Mustonen** • Permanent Representation of Finland to the EU, Belgium
- Margot Neveux** • World Obesity Federation, United Kingdom
- Willy Palm** • European Observatory on Health Systems and Policies, Belgium
- Clare Payne** • The University of Melbourne and Tobacco Free Portfolios, Australia
- Aaron Reeves** • Department of Social Policy and Intervention, University of Oxford, United Kingdom
- Tanith Rose** • Institute of Population Health Sciences, University of Liverpool, United Kingdom
- Rachel Stancliffe** • The Centre for Sustainable Healthcare
- David Stuckler** • Department of Social and Political Science and Dondena Research Centre, Bocconi University, Italy
- Aleksandra Torbica** • Department of Social and Political Science, Bocconi University, Italy
- Sarah Thomson** • World Health Organization Barcelona Office, Spain
- Liisa-Maria Voipio-Pulkki** • Ministry of Social Affairs and Health, Finland
- Yuxi Wang** • Department of Social and Political Science, Bocconi University, Italy
- Matthias Wismar** • European Observatory on Health Systems and Policies, Belgium
- Lin Yang** • World Health Organization, United States of America

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True change happens outside the comfort zone

Our European Health Forum Gastein (EHFG) 2019 conference on “A healthy dose of disruption? Transformative change for health and societal well-being” aims to raise questions which may be uncomfortable to ask, yet need to be addressed if we truly want to counter deadlocks in health systems and move forward.

On the road towards 2030, with the Sustainable Development Goals shining a guiding light, we are at a stalemate in many respects. The EHFG 2019 sessions and related articles in this year’s Special Eurohealth Gastein edition highlight different examples of transformative change, some more and some less disruptive. We invite you to explore key themes related to system change and innovation: what is disruption? And what can disruption look like beyond the field of technology and the concept of digitalisation? How do we make sure that in an area as vital as health, the human touch is not lost in a swirl of efficiency and innovation? What can we learn from climate change movements like Fridays for Future or Extinction Rebellion, and what part does the health sector play when addressing the climate crisis?

At the EHFG, we are used to lively discussions around the annual main theme in the run up to each conference. This year, however, we were intrigued about just how much room for debate there was, both on the terminology and the moral uncertainties surrounding our theme of disruption. The ambivalent concept of disruption has a promising note to it for some and inspires apprehension and fear in others. It has by no means a universally accepted definition, or agreement on whether and in what context it is desirable. There is equally no consensus on whether the more tech-oriented approaches we know from other sectors are transferable to health—an area where the general rules of market economies do not and should not hold.

In many areas, the health of Europeans has stagnated, positive trends are reversing, and stalemates are hardening.¹ Decision-makers and citizens alike are

exasperated when it comes to issues such as vaccine hesitancy, the nursing crisis or medicine shortages, to name but a few examples. While the current system might not be broken, it features some severe cracks and is failing to address many of the most pressing issues of our time, with severe implications for health and societal well-being. Clearly, transformative change is needed. Now, change comes in many forms and with many labels attached. It can come from within or outside a system, be gradual or abrupt, be wanted or unasked for. In all cases, the process of systems change is complex and challenging. To get us thinking about how complex systems change may be cultivated and supported, we will explore the concept of the Two Loops model at the EHFG, which helps to illustrate why old systems may decline and new systems emerge (see overleaf, Box 1).² An opening opinion piece in this issue ‘*Changing the DNA of Health Care in the Age of Artificial Intelligence*’ by our keynote speaker Stephen Klasko gets us to further reflect on how disruptive and transformative change may occur in health systems specifically.

We then invite you to dive deeper and explore the four different EHFG 2019 topic tracks. Clayton M. Christensen, Professor at the Harvard Business School, has famously coined the term “disruptive innovation”.³ He maintains that disruption is a process, not a product, and uses the analogy of the automobile to make his point clear: the invention of the car was not disruptive, because it was a mere luxury good not able to destroy the market for horse-drawn vehicles. However, when Ford introduced assembly line production and made the car affordable to many, this had a disruptive impact, destroying an old market

¹ OECD/EU. Health at a Glance: Europe 2018: State of Health in the EU Cycle. Paris: OECD Publishing, 2018. Available at: https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf

² Wheatley M, Frieze D. Using Emergence to Take Social Innovation to Scale. The Berkana Institute, 2006. Available at: <https://margaretwheatley.com/articles/using-emergence.pdf>

³ Christensen Institute. Disruptive innovations web page. Available at: <https://www.christenseninstitute.org/disruptive-innovations/>

and creating a new one.⁴ Are we witnessing this kind of disruption in health? Should we promote it? The first track on **“Disrupting innovation”** spans topics related to the digital future of health care, including Artificial Intelligence (AI), the use and safety of (Big) Data, and new health care technologies such as cell or gene therapies. A scene setter for this track and touching on many of the relevant concerns, from data quality to pushing the reset button on traditional professional profiles, is the article by Jan-Philipp Beck, *‘Are we ready for AI? Why innovation in tech needs to be matched by investment in people’*.

This leads us straight to the next thematic block of the EHFG 2019, **“Systems for change”**, which addresses the oft-bemoaned slowness of health care systems and the attached institutional and political machinery. What could a more agile system look like, and how much is cautious diligence required to ensure prudent decisions? Topics gathered in this track discuss themes ranging from the optimisation of health system governance to cross-national disease preparedness, including the challenges posed by shortages of medicines or misinformation. The article on fake news – *‘Facts. Figures! Fiction?’* – by McKee et al., offers a great read on the latter topic.

The third track aims to reflect the spirit of a new era for European policymaking in health and beyond, with the appointment of a new EU Commission and new leadership in the World Health Organization Regional Office for Europe. Under the heading of **“Future formulas”**, sessions will be run on a multitude of topics, be it the changing power relations between global industrial players and public actors, or policy design for the advancement of societal well-being. In this track, we challenge you to reflect on what needs to be done and what we want to fight for. A good example of one of the opportunities available to us can be found in an article by Melsom and Payne on *‘Transforming financial markets for the good of all’*.

Finally, we want to discuss **“Transforming societies”**. As professionals working on health topics, our conference participants and Eurohealth readers will be acutely aware of just how much health is determined by what happens outside the health sector. This is the reason for the final EHFG 2019 track that aspires to shed light on the societal aspects of health, with our closing plenary focusing on the climate crisis. From topics like alcohol policies to HIV responses and health literacy, we hope that you will join us in looking at both the structural aspects as well as the personal experiences that make all the difference between simply being and well-being. The important issue of financial hardship incurred by health care is discussed in an article by Thomson et al., asking us to reflect honestly: *‘Can people afford to pay for health care?’*

With this agenda, we do not aim to answer the question of what “true” disruption is. We rather invite you to reflect with us on the discussions and questions we encountered during the formation and refinement of the EHFG 2019. Can we, as part of the same system, be true disruptors, or does disruption always come from an external source? If so, how do we open the door to usher in a healthy dose of disruption? We hope to provide you with a lens through which we, as individuals, patients and professionals, as family members and representatives of institutions, can look at change and rethink the status quo.

The final **Eurohealth Monitoring** section of this issue reflects on recent European Health Policy. Here, Scott L Greer likens Article 168 of the Treaty on the Functioning of the European Union to a gate with no fence that may appear to provide obstacles to the development of EU health policy, but can instead be ‘opened’ when Member States choose. **We are delighted to conclude with a farewell interview with Health Commissioner Andriukaitis who reflects on his mandate as European Health and Food Safety Commissioner and provides his thoughts on the future.** Enjoy reading about this and much more in the 7th Gastein edition of Eurohealth!



Clemens Martin Auer,
President,
European Health Forum Gastein



Dorli Kahr-Gottlieb,
Secretary General,
European Health Forum Gastein

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⁴ The Encyclopedia of Human-Computer Interaction, 2nd Ed. Disruptive innovation web page. Available at: <https://www.interaction-design.org/literature/book/the-encyclopedia-of-human-computer-interaction-2nd-ed/disruptive-innovation>

Box 1: The Two Loops theory of systems change

It can be difficult to have the bigger picture in mind when making decisions, and systems change is the poster child for just how complex life can get. There have been many attempts to illustrate systems change in a way that is accessible to our minds, hearts and business ideas, and which grasps the essence of how transformation happens and how it can be cultivated and nurtured. Among these theories we find the Two Loops model, as developed by Margaret Wheatley, Deborah Frieze and others, during their time together at The Berkana Institute.

The very basis for the Two Loops model is the idea that when a previously dominant system goes into decline, it leaves room for an alternative system to develop. This alternative system is not purposefully constructed but emerges from a growing network of pioneers – proponents of the alternative approach – that become aware of each other and connect. These local and yet isolated hotspots of change spring up while the dominant system is still in its prime, and only gain momentum when combined. The process of transition from one system to the next is rocky and unsettling, for while the new system has not yet reached stability, the old one is no longer able to fulfil its purpose and a gap emerges that needs to be filled.

Graphic illustrating the Two loops theory

Accordingly, if we want to ease the way for change and help alternatives prosper from within a community, Wheatley and Frieze identified four components as crucial:

1. “Name” – recognise pioneers with experiences that are of value to others
2. “Connect” – make these proponents of the alternative solution aware of each other
3. “Nourish” – create the conditions for these individual agents of change to exchange knowledge, learnings and practices
4. “Illuminate” – make the network visible to itself, going beyond the act of connecting autonomous pioneers, and instead inviting in a broader community.

From these actions, a new system may emerge, featuring capabilities and capacities that were never found in its component parts. In the field of health and healthcare, have we witnessed developments in line with the theory proposed above? What will the next big systems change be? These issues and more will be discussed at the EHFG 2019.

HOW CHANGE HAPPENS



EMERGENCE OF THE NEW

COURTESY OF DEBORAH FRIEZE, BOSTON IMPACT INITIATIVE

IS THERE AN AVATAR IN THE HOUSE? CHANGING THE DNA OF HEALTH CARE IN THE AGE OF ARTIFICIAL INTELLIGENCE

By: Stephen K. Klasko

OPINION PIECE

Summary: Health care is going through a once-in-a-lifetime change that presents an opportunity to make it friendly, equitable and focused on health assurance – if the industry and its leaders embrace transformation. With his extensive experience in medical education, universities and hospital system management, Stephen Klasko has written about change as a good thing for the consumers of care. Transformation can bring “understanding,” not just transparency – understanding both potential costs, and potential outcomes. The author argues that inequities in care apply across numerous nations, where access to care remains difficult despite national differences in payment systems.

Keywords: *Artificial Intelligence, Disruption, Health Disparities, Social Determinants of Health, Patient Experience*

Background

In 1978, when I was a senior medical student, I was asked to lead a panel about what concerned me regarding the future of medicine, as someone who was just starting my career. There were three issues that I highlighted through my oblivious, naïve, and idealistic lens, but remember, this was 1978:

1) There seems to be a huge issue with health inequities globally, whether that is by zip code in Philadelphia, or between socioeconomic classes in Asia or southern Africa. Why can't we address them?

- 2) Doctors seem to not do well with change and often seem to “want to leave the status quo as it is.” How do we get physicians to be more optimistic about the future?
- 3) My bank just got an ATM. Why can't health care do cool consumer things like that?

Forty-one years later, after delivering over 2000 babies and countless numbers of surgeries, and having been the dean of two different medical schools and now leading one of the fastest growing academic medical centres in the United States, I am sad to say that on the panels I am asked to serve, the same questions come up when

> #EHFG2019 – Opening Plenary:
A healthy dose of disruption?

Stephen K. Klasko is President and CEO, Thomas Jefferson University and Jefferson Health, Philadelphia, United States of America. Email: Stephen.klasko@jefferson.edu

I'm asked: As a CEO, what concerns you about the future of health? I am sadder to say that these would be my three answers:

- 1) There seems to be a huge issue with health inequities globally, whether that is by zip code in Philadelphia, or between socioeconomic classes in Asia or southern Africa. Why can't we address them?
- 2) Doctors seem to not do well with change and burnout is a huge issue globally as physicians feel "incapable" of doing the work they set out to do. How do we get physicians to be more optimistic about the future?
- 3) Why can I do my holiday shopping in my pyjamas binge-watching Netflix, but if I have a stomach ache I still have to get on the phone and listen to 11 options to get an appointment three days from now?

The reason we haven't solved any of these three concerns may not be as elusive as you think. One of my mentors when I was receiving my MBA at the Wharton School was William Kissick, MD, DrPH. He wrote a book 25 years ago that spelled it out. The book was called *Medicine's Dilemmas: Infinite Needs, Finite Resources*.¹ My interpretation of his book is summed up by his view of the "iron triangle" of access, quality and cost. If you remember your ninth-grade geometry classes, you can only increase one angle if you decrease another. So, if you want to increase access, you have to increase cost or decrease quality, etc. You can change the geometry only if you are willing to disrupt the system, and disruption is painful. He once told me, "if anyone says they are going to expand access to all and it's not going to be disruptive or painful, they are advertently or inadvertently skirting the truth." So, in my country, the landmark Affordable Care Act (ACA) bill, was heralded with this quote, "We are going to increase access for all, increase quality and decrease cost ... and it's not going to be painful."²

Our current President has promised that his alternative plan will provide "health care for everyone and take care of everybody much better than they're taken care of now; it will be a beautiful

picture"³ and again it won't be painful. And this is not just an American problem. I was honoured to serve as the American representative for the Centre for Progressive Policy evaluating the current and future state of the National Health Service in the United Kingdom. Some of the same geometric limitations were exhibited there: Access is guaranteed, but quality, cost, social determinants and patient experience are in need of a healthy dose of disruption.

Is this an insolvable problem? Is health care doomed to be the global exception to the consumer revolution? I don't think so, and I believe that we can look to other industries to chart a global path.

Look to other industries to chart a global path

Disruption in practice

The answer became clearer to me as I presided over my last commencement where John Sculley, former CEO of Apple, received an honorary degree from Thomas Jefferson University. He talked about the "business plan" that Steve Jobs set for Apple at a time when the computer industry was stagnating. While Sculley was expecting a consultant-driven, glossy 60 page strategic and financial plan, the entire three-year blueprint for strategic action was on a single page ... actually half a page:

Year 1: We change

Year 2: We change the industry

Year 3: We change the world

Steve Jobs recognised that the consumer computer world was going through a once in a lifetime change from a desktop/laptop industry to a digital lifestyle industry. He disrupted how the company selected, paid and motivated their employees (we change), he diverted dollars from development of PowerBooks and desktop

computers to iPods and digital instruments (we change the industry) and, with the iPhone and iTunes store, he started the global mobile revolution (we change the world).

Not everyone understood the strategy both within and outside the company. Much has been written about Gateway (missing the digital computer revolution), Blockbuster (missing the streaming revolution even though they initiated it), Kodak (missing the digital camera revolution because they wanted to sell film), or traditional retail megastores underestimating the Amazon revolution.

Which brings us to health care. I believe we are going through a once in a lifetime disruption from a business-to-business model to a business-to-consumer model. From physician and administrator as the boss to the person-patient as the boss. In other words, a radically new kind of health experience that actually works as simply and easily as most of our other consumer experiences. And this new model is so different from the old one, we can't even call it health care. That label is too tied to the past, and isn't even correct in the first place. Anyone in the health care industry will tell you that we're really in a "sick care" industry designed primarily to take care of people only after they develop health problems.

I propose a new term that captures the spirit of what's developing: health assurance. It is being developed further in a book I am writing with Hemant Taneja, one of the leading entrepreneurs in Silicon Valley, who had previously written a book called "Unscaled."⁴ That book highlighted companies that disrupted otherwise stale industries: AirBNB, Stripe and Livongo. In our new book we reference easy access to services and technology aimed at ensuring we stay well, so we need as little "sick care" as possible.

In my role at Jefferson Health, which now encompasses more than 30,000 colleagues, 14 hospitals, multiple urgent care centres, 100,000 virtual patient visits, we have a simple mission: We improve lives. Our vision calls for us to meet the needs of patients to consume their health care in the flexible manner in which they

Figure 1: The patient diamond**THE PATIENT DIAMOND OF HEALTHCARE**

Ability to thrive and not have health get in the way

Ability to connect and have human relationships

Ability to easily navigate on their own terms

Ability to understand what they need to do

Source: authors' own

consume every other consumer good, and to redefine Jefferson Health based on our care and caring rather than our location.

So how do we get from here to there ... and yes it will be disruptive ... and it may be painful (for some). Or to put it another way "What would Steve Jobs do?" in an industry where technology has advanced light years for individual patients, but health care delivery, patient experience and social determinants are still in the pre-computer age. Well let's go back to his simple business plan.

“we are going through a once in a lifetime disruption”

YEAR 1: WE CHANGE

Technology, AI and genomics will fundamentally transform how and where health care is provided. I believe that by 2020, it will be commonplace to provide real time genomic-based decision support at the time of prescription writing. I further believe that by 2022, 20% of the population with chronic conditions will be relying solely or in large part on virtual health assistants for wellness and management. By 2025, 40% of all health care will be delivered virtually, and by 2027, for the first time, the majority of

health care interactions will be at home or remote, involving AI or machine cognition applications.

The iron triangle of cost, access and quality (hospital/physician centric) will be replaced by a patient diamond of health assurance: namely an ability to thrive and not have health get in the way, to connect and have human health relationships when needed, to easily navigate one's own health care on their own terms, and the ability to understand options, cost and outcomes (see Figure 1).

What about the human health care provider in the middle of all this? Just as Steve Jobs recognised he could not rebuild Apple with IBM designers, we cannot continue to select medical students based on science GPA (Grade Point Average) scores, multiple choice tests and organic chemistry grades and "hope" that physicians will become more empathetic, communicative and creative. The ability to choose students based on self-awareness, empathy, cultural competence and communication skills is the only way to ensure that the "human in the middle" (provider) is providing value to the "human at the centre" of their health care, the person/patient. It also means we need to fundamentally transform the medical school experience with a heavy dose of humanities, population health, quality improvement, communication skills, collaborative negotiations and social determinants becoming a much larger part of the curriculum.

At Jefferson, we are moving from a two-tiered system (basic and clinical science) to a four-tiered curriculum (basic science, clinical science, health systems/population health science and innovation/creativity). Also, we have to recognise that even though it took us many years to think about interprofessional education between doctors and nurses, soon we will need to develop "inter-sentient education" models between humans and non-sentient AI robots!

YEAR 2: WE CHANGE THE INDUSTRY

It's fair to assume that in the next few years, the "Category Five" disruption leading to these changes will be the ever-rising global cost of health care, the

unsustainability of health care inequities and policies that do not address those issues, and the ageing of the millennial generation. Why millennials? Because there is little chance that in the one-click world in which they were born and grew up, that they will accept the archaic service we provide in health care. There is even less chance they will deal with long waits in the waiting room, non-transparent costs and outcomes and the inability to track and manage their own health in the way they have taken over their own shopping, travel and every other aspect of their consumer life. That consumer driven disruption will accelerate the pace of change in how health is delivered globally to the point where our current hospital centric construct will seem as archaic as having to get money by going to a bank. The result of this revolution was highlighted in my 2018 book, *Bless This Mess: A Picture Story of Healthcare*.⁵

"Changing the industry" starts to look like this: Jefferson will offer a subscription service to a technology-plus-human combo package that becomes a new first layer of health care, a kind of pre-primary care. You sign up with Jefferson's service and give it access to your data, both static data (DNA) and real-time data (heart rate from your Apple Watch, sleep patterns from an app, etc.). The AI gets a baseline of your health and then watches and learns from your patterns. The technology is running in the background, constantly keeping an eye on your health. If the AI spots something unusual, you're not sleeping, your heart rate is up, or some other combination of events, it might send a text asking some basic questions. Your answers at first go to an AI bot, and perhaps you figure out that not much is wrong, you're just stressed about a big decision at work. But if the AI suspects something more, it sends the dialogue to a human doctor at Jefferson, a doctor who has enough time to talk to you because the AI is taking over some of the low-level work that used to suck up the doctor's day. The doctor can then get on a video call and do a deeper exploration.

What that means to us in the health care ecosystem is as big a change as moving from being a computer engineer to creating digital solutions to complex problems. For one, payment models will

reflect these disruptions. The writer Upton Sinclair once said, “It’s hard to get someone to understand something when their salary depends upon them not understanding it.”¹ In this very near future, we will be paid based on quality, cost, patient experience and outcomes; hospital stays will be commoditised; our doctors and nurses will coexist (hopefully cooperate) with deep learning, machine cognition entities; we will select and educate humans to be better humans than the robots, not better robots than the robots; and population health, predictive analytics and social determinants will move to the mainstream of medical education and clinical care.

And it will not be one technology. We have to stop talking about “telehealth,” for example. We don’t get up in the morning and say “I think I’m going to telebank!” It’s just that banking has moved from 90% being in the bank to 90% happening at home. At Jefferson, we call this disruption, “health care with no address.”

YEAR 3: WE CHANGE THE WORLD

This is the most important part of the strategic plan and the one that will require the most innovation and discussion. I was incredibly encouraged as a participant in the World Economic Forum at Davos this year by how much attention is being paid to technology as a solution for the social and economic determinants of health. It is unacceptable, based on our understanding of social determinants, that all the money we spend on medical care only accounts for 20% of a person’s health outcomes.² Food, education, housing, prevention of chronic conditions, climate change ARE health care! They were only an academic exercise in our former “sick-care” model where the centre of the universe was the hospital. In the new “health assurance model” they become THE most important determinant for the team, patients and providers. Health care policy, health care incentives and salaries are tied to creating an environment that works to prevent chronic conditions starting at home.

This will be the real test for AI engineers, technology entrepreneurs and the health care ecosystem. Can we marshal the trillions of dollars spent in health care not

just to develop the new MRI or robotic surgical arm, but to understand what populations need to prevent childhood obesity, eradicate smoking, prevent drug abuse and overuse of opioids, create a clean environment and in essence take a no limits approach to noncommunicable diseases? It is a future where health policy, population health and personalised medicine converge, a future I wrote about in my 2017 book, *We CAN Fix Healthcare, the Future Is Now!*³

The answer is difficult but not impossible. Take food deserts for example. In the past, in low socioeconomic areas in many countries, food choice meant a market within walking distance, which often offered highly processed, high sodium, unhealthy products. But today, with drone shipping technology and healthy food being farmed and cultivated, a combination of forward-thinking health policy and mega-company philanthropy could change that. What if those in government assistance food programs could receive significantly more dollars if they agreed to serve their family healthy food? What if the big tech companies pooled their philanthropic efforts for those programs to provide free or near-free delivery? The return on investment from the decrease of noncommunicable diseases alone could easily eclipse the initial cost and would lead to population health moving from an academic exercise to a health policy reality.

The future is bright and limitless

As an obstetrician, every baby I deliver should have unlimited potential. That hope depends on a revolution, not from health care reform to health care transformation, but to non-incremental health care disruption. When the ACA was becoming law in the US, I had an opportunity to meet with one of its architects. He asked me what I thought about health care reform in America. I answered the way I answer any expectant mother that asks me what to expect in labour and the birth of their baby. I say, “It’s going to be long, it’s going to be painful ... and you probably really won’t know how well you did for about 21 years.”⁴ What is true, in both cases, is the result is game-changing and the future is bright and limitless! In order

to spark this revolution, we need a call to action, not dissimilar to that of climate change. The future demands that we take a no-limits approach to ensuring that every individual on the planet has an opportunity to enjoy a healthy life. And those of us choosing health care as a profession need a new Hippocratic oath that our role is to work with each individual and population as a team to ensure a healthy life for all.

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ARE WE READY FOR AI? WHY INNOVATION IN TECH NEEDS TO BE MATCHED BY INVESTMENT IN PEOPLE

By: Jan-Philipp Beck

Summary: Artificial Intelligence (AI) promises to deliver transformative impact on health care settings over the next decade. But the health sector faces significant organisational challenges in keeping pace with this fast-moving technology. This article explores some of the very human factors in the implementation of AI and the role of policy in translating improved data into improved care.

Keywords: Artificial Intelligence, Digital Literacy, Health Care Professionals

Introduction

AI is perhaps the most divisive issue in health care today. To some, it heralds a shimmering, data-driven future – one in which decisions are made with ever-increasing confidence, and health care is made ever more accessible. For others, AI highlights deep-seated concerns about the erosion of traditional roles, its implications for data storage, and clinical accountability.¹ These understandable anxieties are rooted in a complex mix of ethics, public trust or simply a very human fear of being out of a job. Ultimately, however, these concerns add up to a simple practical question: is health care ready for AI?

In many networks, as in EIT Health¹, we see the breakneck pace of innovation in AI first-hand (**see Box 1**). But what about the human half of the equation? What

changes will need to be made to our systems, operations and infrastructure to keep pace? After all, this technology is entirely dependent on human expertise if it is to realise its potential in health care. We may be witnessing exponential growth in AI, but let's not forget that *human* intelligence is also a major growth area; in the context of an ageing population and ever greater demands on health care systems, McKinsey expects to see continued, sustained growth in health care employment.³

This growing group of professionals will not be made up of AI 'users'. Instead, these people will be gatekeepers, evaluating emerging technology, making sense of its findings and translating them into real-world benefits for patients.² A new, data-literate clinician will not emerge overnight, however. We need investment in people and processes to match investment in the technology itself. This technology will require significant changes to the way

> #EHFG2019 – Forum 11:
AI: It's not (just) about the technology!

Jan-Philipp Beck is CEO, EIT Health, Munich, Germany. Email: jan-philipp.beck@eithealth.eu

¹ EIT Health is a network that brings together the brightest minds from the worlds of business, research and education to answer some of our biggest health challenges. EIT Health is supported by the EIT, a body of the European Union.

people are organised, trained and perhaps even the way they identify themselves as professionals.

A culture playing catch-up?

We have witnessed a sea change in digital technology in recent years. Advances in cloud computing, processing power and increasingly sophisticated algorithms have accelerated human decision-making in health care.³ And yet, just as data legislation in the wider world lags behind its use in social media, there is a danger that we in health care will remain on the back foot. A major concern from the health care community is that the regulatory environment – particularly in terms of information governance – is simply not yet ready for these advances.

A data-literate clinician will not emerge overnight

Meanwhile, inconsistent quality of data means the machines are primed and hungry for information, but we may not know how to feed them.³ Perhaps most importantly, these technologies require a shift in mindset on the part of clinicians. A recent opinion piece published by the American Medical Association describes the ‘black box’ nature of a technology that generates insights via non-traditional, unobservable methods – which in itself may be a barrier for uptake by health care professionals.⁴ There’s also a perception that AI will only add to the surfeit of information and cognitive burden for already overloaded professionals.

Dr Umar Naeem Ahmad is ideally placed to comment on these challenges, being both a clinician and AI pioneer. He developed a platform which uses AI and big data to transform antibiotic prescription on an individual basis with the aim of tackling the ever growing threat of antimicrobial resistance. It provides a real-time nudge to clinicians so that they become aware of unwarranted variation

in care. Health care professionals are able to access individualised feedback, drawn from metrics from across a health system – which can improve care while reducing costs.

Dr Ahmad is optimistic about overcoming some of the infrastructural barriers to adoption. “The conventional wisdom is that our hospitals are burdened with legacy systems, and that our resource-constrained public health care will lag behind other industries, but I disagree,” he explains. “I see that both frontline practitioners and national policymakers are now seeing innovation as a necessity rather than a luxury. If the top and bottom are on board, it may take a little longer for management structures to roll out aspects like data sharing agreements, payment structures for AI related services and open, interoperable systems – but things are changing.”²

He believes the pitch to concerned professionals should hinge on Dr Eric Topol’s³ assertion that automation gives doctors back the ‘gift of time’, and in an evidenced common-sense presentation of the benefits of these technologies. The rate-limiting step, however, sits beyond any individual clinician or setting, Dr Ahmad believes. “If Europe wishes to continue to keep up in this race, we need to come to an agreement on sharing data at scale, safely but quickly,” he says. “It’s time to turn the policy and plans into pilots and partnerships on the ground.”

An intelligent approach to training

The overwhelming consensus is that only significant and holistic training will adequately prepare clinicians (and by extension the environments in which they work) for these technologies.

Earlier this year, the Academy of Medical Royal Colleges in the United Kingdom published The Artificial Intelligence in Healthcare paper, commissioned by NHS Digital.⁴ Amongst its seven recommendations for politicians, policymakers and service providers was a

suggestion about how the clinicians of the future are trained. The Academy debunked claims that the presence of AI in retinal scans and targeted radiotherapy would reduce the need for medical specialists. Chair of the academy, Professor Carrie MacEwan, remarked that – if anything – the opposite is true, and that AI makes the case “for training more doctors in data science as well as medicine”.⁴

As the director of policy at the European Medical Students’ Association (EMSA), Lina Mosch sees a clear appetite for exactly this kind of training in the clinicians of tomorrow. A recent EMSA survey⁴ found that more than half of medical students consider their eHealth literacy either ‘very poor’, ‘poor’ or ‘acceptable’. Moreover, 85% would like to see more eHealth content in the medical curriculum. “We identified a huge gap, or lag between the lack of awareness of these technologies and the willingness of future health care professionals to be key players in the digitalisation of health care,” Ms Mosch explains. “And it’s also a generational question – health care professional organisations on a European level are not really dealing with this topic in-depth. But without a holistic approach, it’s not possible to cope with the disruptive potential of AI.” She notes that only two European medical associations have published policies on digital health or education. It’s a gap that not only stands in contrast to students’ appetite for greater knowledge, but also to a broader structural need for a reshaping of clinical roles.

Health care professionals will likely become more patient-centric and relationship-focused as AI absorbs more of the routine work.⁴ What’s more, clinicians will need to operate as gatekeepers⁴ able to bring critical thinking to bear on emerging technology throughout a lengthy career – just as they do with new medicines today. This new job description requires no small degree of training – training that sits above the practical operation of the technology (which would be vulnerable to obsolescence as technology changes). EMSA believes this

2 Ahmad, Umar Naeem. Telephone interview on behalf of EIT Health, August 2019.

3 Founder and Director of the Scripps Research Translational Institute.

4 Mosch, Lina. Telephone interview on behalf of EIT Health, August 2019.

Box 1: AI is already transforming infrastructure and outcomes

Advanced diagnostics platforms are already shaping the patient pathway in therapy areas such as oncology. Products are being developed to address the infrastructural problem of bottlenecks in diagnosis.

For prostate cancer diagnosis specifically, a shortage of uropathologists and insufficient use of available data led to the development of a platform that combines big data, AI and cloud-based tech to achieve a number of advances: i) faster, better and more cost-efficient image analysis of prostate biopsies; and ii) new analytical tools for precision medicine, leading to faster treatment and accelerated drug implementation.

This platform is being trialled in hospitals, but these technologies can also facilitate larger structural shifts, such as the much longed-for move to more patients receiving home care.

The benefits of psychological and physical rehabilitation in the home setting are self-evident, yet we know provision is patchy in many countries. Another new platform aims to pick up where the clinician leaves off and operates as an AI companion to mitigate against feelings of loneliness in people living with chronic disease.^{7 8}

training should include the fundamentals of data analytics, ethical considerations and communications skills.

The inherent difficulty, of course, lies in the competing interests over curricula, as Ms Mosch identifies: “The speed of digital transformation in industry and start-ups is very quick – while in health care there are a lot of steps to take and lots of opinions. Old professions want to keep their subjects in an already-packed programme.” The solution – at least according to EMSA⁹ – is to develop a framework for implementation comprised of different

stakeholders, with medical faculties directly involved in its drafting to avoid it being seen as a ‘top-down’ approach. Furthermore, this kind of initiative will only achieve so much at a national level. Cross-border, European-level collaboration is required to ensure we’re learning from our collective successes and failures.

“Machines are primed and hungry for information but we may not know how to feed them

Conclusion

EIT Health’s great hope for the coordinated approach identified by EMSA and others must be to create a generation of health care professionals who are not simply ‘comfortable using AI’. We need professionals who are far more than end users. They must be actively involved in the design of AI-enabled technologies, along with the ethics that surround them.

Quite rightly, they also need to be satisfied that data is rigorously regulated, and excited by the opportunities afforded by the ‘gift of time’ in building stronger relationships with patients. Part of this time will be spent ensuring that patients themselves are comfortable and confident with this new technology.

Clinicians will also need to be critical evaluators of this new technology as it emerges, ready to adopt the innovations that will have a lasting impact on patient outcomes.

Clearly, no single innovation will bring about major structural shifts towards increased self-care or home care. But these types of innovations are examples of a

groundswell of efforts whose cumulative effect will be transformative over the coming decade.

Policy will be made in an environment of enormous possibility – but getting there will require significant time and effort. It’s a tall order – and one we need to get started on right now.

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HEALTH INNOVATION: FROM ORGANISATION DISRUPTION TO OUTCOMES VALUE

By: Robert Madelin

OPINION PIECE

Summary: Innovation is always a challenge to human conservatism. Innovation is not always truly ‘disruptive’. Nor is innovation always technological in nature: it can be organisational, society-wide or behavioural in a professional class. We need to adopt an innovative mindset if we are to make the most of innovation opportunities for better health, more resilient health systems and better patient outcomes. We must see health as a value system, where all positive outcomes, however created, are sought and welcomed. We also need to ensure that we are resourceful in nudging our systems towards the changes needed, and thoughtful in providing health actors with the support necessary to accelerate the adoption of any innovation as the new normal.

Keywords: Innovation, Mind-set, Nudge, Openness

Medicine since before Hippocrates is a risk-taking and innovative endeavour

Introduction

Not all innovation is ‘disruptive’.¹ Arguably, the risk-taking attitudes behind ‘do no harm’ get forgotten from time to time. For a century or so, from Nightingale to Crick, via the creation of state-funded universal health services, innovation ‘helped doctors do better’, with some spectacular step-jumps in outcomes. But it did so without creating too directly a challenge to the self-belief of health elites or the empowerment of the patient population.

Twenty-first century medicine is arguably ever more innovative, notably with the move towards using genetic tools and

personalised treatments. And it faces unprecedented disruption, as accelerating demographic ageing and increasing population movement combine to create less stable health needs, while fiscal limitations promise a moment of truth for health systems. We fear pressures that will likely require change and even threaten the abandonment or sell-out of the European model of state provision. Patients, their families and health professionals all feel disrupted, and not in a good way. Those concerned look back to better times, feeling disenabled and at risk.

In uncharted waters and severe weather, the roads thus far travelled are no reliable point of reference. In health, as elsewhere in life, there is no return, and no forward grand innovation strategy to be had.

Robert Madelin is an Honorary Fellow of the Royal College of Physicians of London, United Kingdom. He is a former Director General of Health at the European Commission. He is currently both a visiting research fellow on technology and global affairs at the University of Oxford, United Kingdom and chairman of public affairs advisers Fipra International in Brussels, Belgium.
Email: robert@madelin.one

What health in Europe needs is rather an innovation attitude.² While plans may founder, an innovative attitude and small-scale tools and trials will create a pro-innovation system in health, and drive value for all concerned.

“Patients, their families and health professionals all feel disrupted

The whole literature around disruptive innovation is new, extensive and fast-growing. It is not summarised here. Instead, this short text uses four themes to illustrate this approach:

1. Open Minds – Grandmother’s Footsteps
2. Innovation inside – Nudging for the Homeless
3. Appropriating technology – Reorganising for genetics
4. A new mindset – Welcoming challenge.

Grandmother’s footsteps

I shall start with a heresy, dressed up as a childhood memory. As national reimbursement of homeopathy in parts of Europe hit the news this year, I thought of my grandmother.

She was a modest herbal and bone-setting and birthing “healer”, in an age and a society where even general practice medicine was beyond the pockets of 90% of her neighbours. For her, the experience of moving to the big town came with a (male, elite, informal but imperious) medical and religious instruction to stop doing what she did: Wales no longer burned witches in the 1900s, but it did not like reminders of the past at a time of universal exhibitions and the triumph of science. Modest working people did not revolt. Grandmother dialled down her work, which was not in any case a paid occupation, and went on quietly doing the bare minimum for difficult births in

the neighbourhood. The experience did not affect her luminous quietness. But, in the health “value network”³ of a Welsh mining town, that was a net loss.

Europe is more tolerant of this practice today. Reimbursement is different. But we do need to invest some research effort in the synergies between Western Medicine on the one hand and on the other the assembled wisdoms of Traditional Chinese Medicine (TCM), Ayurvedic Medicine, and other non-allopathic practice. To its credit, the European Union has a modest programme doing just this for TCM.⁴ At the global level meanwhile, the WHO has developed a Traditional Medicine Strategy (2014–2023) outlining how traditional medicine of proven ‘quality, safety and efficacy’ can act as a complement to mainstay health care delivery and help improve access to care.⁵

More open minds needed? If Hamlet could warn his friends that their philosophies might not cover all that is to be had in heaven and earth,⁶ how much more open must we be in the Age of Innovation. Not to swallow blindfold every assertion, but to seek more evidence to inform others’ ideas of ‘what works’.

Innovation inside – nudging for the homeless

Much innovation is not ‘new technology’. But creating an innovation dynamic inside established organisations is far from easy. In the United Kingdom, the National Health Service (NHS) offers “start-up grants” to test new ideas. For £34,000 (about €38,000), one such experiment (the creation of a single homeless officer in a big hospital, with 40 hours a week and a smartphone) was enough to shift the attitudes and practice of his fellow health workers. Instead of largely ignoring the high costs, low effectiveness and poor humanity of patching up the homeless and sending them back into the streets, the hospital in question (both emergency and acute medical) saw a shift of 20% towards engaging with the need to find accommodation and a future perspective for each homeless patient, and was able to do so without creating longer stay times in the establishment itself.⁷

The experiment was small, cheap and fast. The intervention was largely a social nudge,⁸ showing hard-pressed individuals that more was possible, that it produced more health value and that it eased their burden rather than the reverse. Making a more effective choice an easy choice requires imagination and a willingness to try things.

Appropriating technology – Reorganising for genetics

When cutting edge technology creates new potential, innovation refers NOT to the technology, but to its appropriation by the health system in ways that accelerate and maximise the creation of value outcomes for people.

Genomics is a crucial case for Europe today.⁹ And there is a lot to do.

First, to accept the ‘miracles’ of genetic testing more readily than is so far the case. None of us notices that we consent to the blood tests our doctor prescribes. And we need to rather quickly get to the same sense of normality for genetic testing. Here, the innovation mindset of health professionals is trammelled by all too much red tape. We need a greater sense of political and policy leadership to encourage us all to accept genetic tests as the new normal. Of course, while encouraging greater adoption of genetic testing, the many ethical and legal questions surrounding its use must be answered and addressed. For instance, society must ensure that I do not lose protection and solidarity (whether state or insurance-funded) just because my genome is better known, and my privacy rights must keep pace with medical advances.

Second, to engage while understanding that this IS still new. So the results of a battery of tests may require more careful risk-risk analysis than patients and doctors find easy. Not all BRCA2 variants are yet confidently classified as threats of breast cancer or likely benign – in uncertain cases, where a patient faces an option of preventive (“risk-reducing”) bilateral mastectomy, the patient may decide to

do the operation, and then learn that the variant is no longer uncertain but definitely benign.

Third, to be patient and yet engaged for the long term. There are happily increasing numbers of cases where a patient 5 or even 20 years ago could not get a clear genetic diagnosis and yet today has had a diagnosis that enables clear treatment to be defined, and can in some cases open the path to preventive screening tests for family members. We are all guinea pigs.

“creating an innovation dynamic inside established organisations is far from easy”

To shape the existing health value system for all, these genetic opportunities is no mean task. Centres of expertise need to be established across the continent, with accessible paths to funded access, so that (as with the European Reference Networks¹) all health professionals can easily get the advice they need for specific cases. This sort of network must also help whole systems to accumulate and use (including with Artificial Intelligence and Machine Learning) the data generated in exponentially increasing quantity by genomic mapping. Health is a data business, and the fastest progress to new value outcomes for patients will come (in genomics, and elsewhere) from novel partnerships between clinics, innovators and data experts¹.

A new mindset – welcoming challenge

How long will it be before all doctors turn towards the patient the computer screen with the patient's data on it? How long before doctors and hospitals pay for their inclusion in the crowd-sourced benchmarking offered by the likes of

IWANTGREATCARE.com, instead of grumbling at the unethical nature of the resulting transparency?

Much of this desirable pressure and insight will be digitally intermediated.

Doctors are increasingly willing to use Google themselves to explain to patients what is going on. Hospitals are increasingly alert to online soft signals of even ward-specific dissatisfaction or overload.

Even in the hyper-sensitive field of the second opinion, digitally-enabled systems can enable an individual to acquire alternative views of treatment options, in days not months and without travelling to distant teaching hospitals².

Properly embraced, such innovations can bring added value into the system, cut the costs of repeated improvable treatments, and improve patient outcomes.

Conclusion – Only Connect!

History, if not ethics, seemed in the last century to be on the side of the priests and doctors who assured my grandmother's charges that a state-funded health service would be along shortly.

In the current phase of our human health journey, things are less clear. With unprecedented technological disruption, fiscal uncertainty and our demographic transformation into a grey continent, the health value system needs to be more open to outside knowledge and pressure.

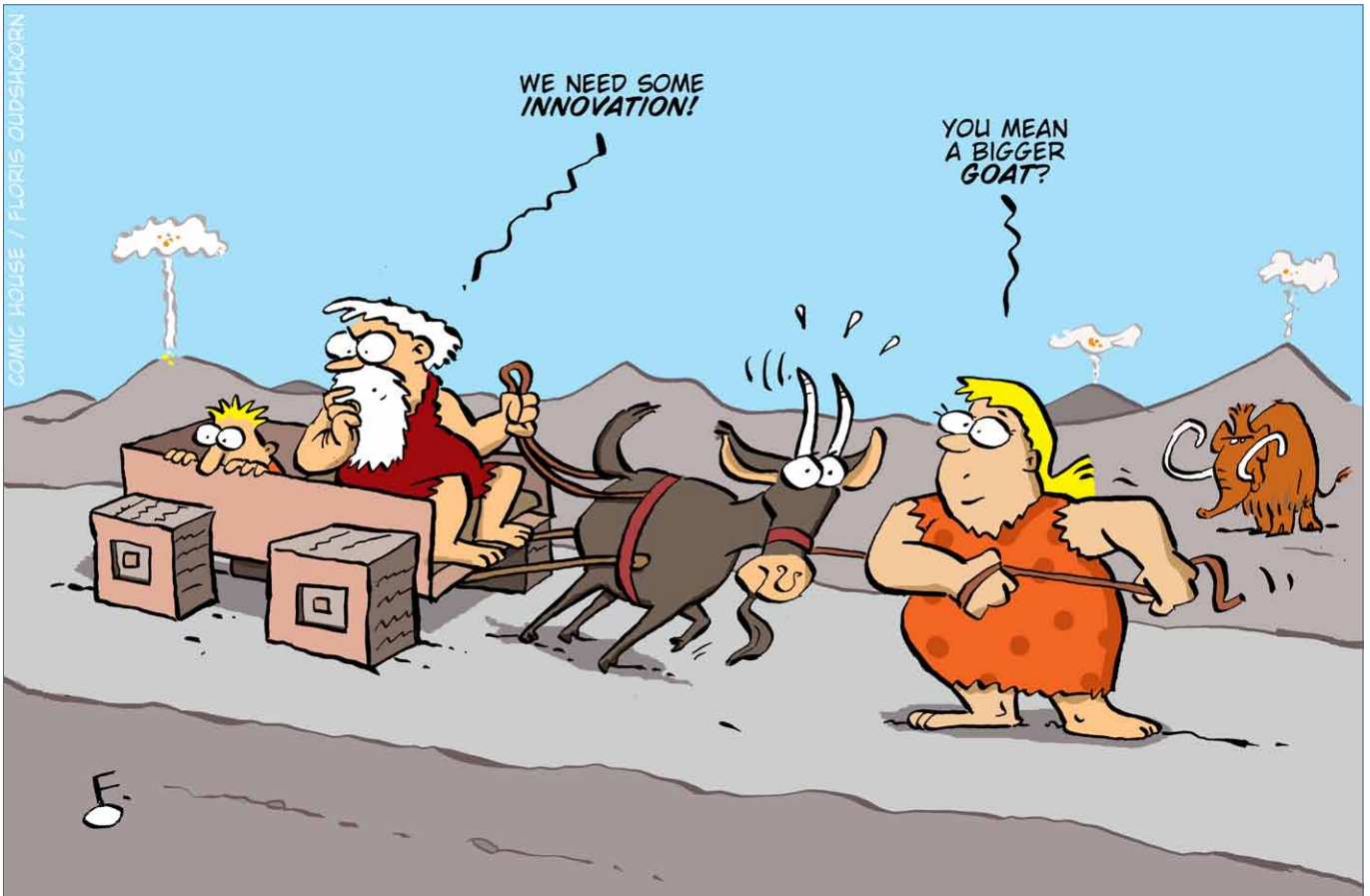
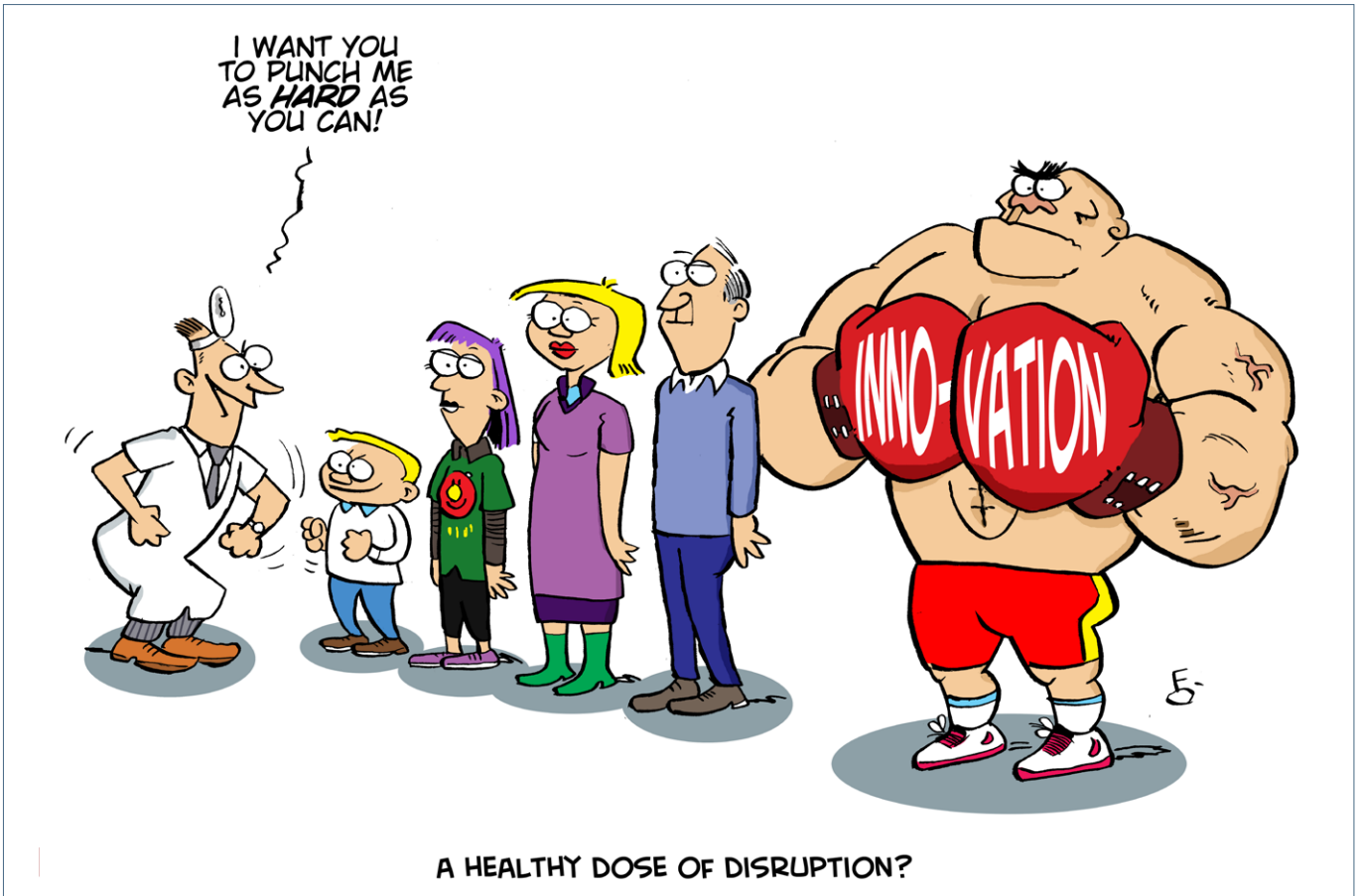
The tools of such openness are themselves largely data-driven and digital. BUT they will not be incorporated in a system of health innovation without a positive and pervasive change in the health community's mindset. The biggest new step today could just be to teach “disruption” to first-year medics and hospital managers. So that young leaders with innovation mindsets pull into the health value system all the great potential that is at present “out there”. Health needs innovation inside.

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STEER DON'T ROW? BUT HOW TO MOVE THE BOAT TOWARDS THE HARBOUR?

The TAPIC governance framework

By: Scott L. Greer, Matthias Wismar, Stefan Eichwalder and Josep Figueras

Summary: Governance is important but hard to understand or do right. We use the TAPIC framework to shed light on governance's contribution to policy success and failure via the Transparency, Accountability, Participation, Integrity and Capacity dimensions of governance. Looking at governance this way puts the old "steering versus rowing" debate in a fresh light. Elaborate separations of policy and management or complex public private-private partnerships can overtax governance and choke off valuable information, whether by making decisions opaque, diminishing accountability, or increasing demands on integrity and capacity. Simpler mechanisms can work better. As in boating, to steer is often to row.

Keywords: Governance, Steering, Health Services, TAPIC

> #EHFG2019 – Workshop 1:

Steering, not rowing!

Scott L. Greer is Senior Expert Advisor on Health Governance to the European Observatory on Health Systems and Policies, Brussels, Belgium, and Professor of Health Management and Policy, Global Public Health and Political Science at the University of Michigan, Ann Arbor, USA. **Matthias Wismar** is Senior Health Policy Analyst and **Josep Figueras** is Director, European Observatory on Health Systems and Policies, Brussels, Belgium. **Stefan Eichwalder** is Advisor, Federal Ministry of Labour, Social Affairs, Health and Consumer Protection, Vienna, Austria. Email: slgreer@umich.edu

Introduction

The debate on the advantages of 'steering against rowing' has become ubiquitous in health policy circles since the early 1990's when many governments looked at the application of New Public Management techniques including an increased role of the private sector, to health care services. The metaphor implies that some are responsible for keeping the course while others are charged with moving the boat. Together, they make progress towards defined goals. The premise is that the public sector should be less in the business of 'rowing', i.e. delivering health services, and more on to 'steering', i.e. providing and ensuring strategic guidance and direction. Without going into the thorny issue of the theoretical

differences (or lack of) between steering versus stewardship versus governance, we argue here that this debate is essentially about how to strengthen health sector governance from the public sector perspective.

While most commentators, regardless of their political positioning, would agree about the importance of governance; there is far less consensus about 'how to go about it' let alone about its definition 'what is meant by governance' itself. This article tackles this challenge by proposing TAPIC, an effective framework to assess and strengthen public sector governance, so governments can be as good at steering as they (hopefully) are in rowing.

What is governance?

Governance is often a much-abused term, one that can obscure as often as reveal or help. It has been widely used in the literature to mean very different concepts, ideas or strategies.

At the broadest level, governance can be defined as the ways in which societies make and implement decisions. But beyond this basic understanding of governance there is an impressive degree of confusion as different authors and organisations put forward very different propositions. A review of the literature shows that governance has been defined by a list of sometimes disparate attributes including democracy, rule of law, accountability, transparency, quality, control of corruption or formulating policy among many others.

Our approach to governance aims to avoid, first, treating governance as a shopping list of desirable things that may not be immediately relevant or applicable to the practical operational needs of health decision makers; and second endorsing a theory of governance that incorporates too many assumptions about how organisations and systems work.

We conducted a review of governance frameworks, synthesising key dimensions common to the many different frameworks that exist, and then tested with a series of case studies in health services,¹ including areas such as primary care reform, health technology assessment and public-private partnerships, and broader public health² including homelessness,³ trade,⁴ climate change and pollution,⁵ child health,⁶ care integration⁷ and the regulation of new technologies.⁸ The basic framework can be found in a variety of places.^{9 10 11}

In this process we developed a framework for understanding the important domains of governance where problems and opportunities for improvement can lie. There are five of them (see Box 1).

The TAPIC Framework

Put together, these five domains comprise the core of the “TAPIC framework.” The framework is diagnostic and prospective, designed to be used in identifying the

ways in governance might endanger a current or possible policy. The *first step* of the process is to identify whether the problem is one of governance, as opposed to something else (e.g. lack of resources or a fundamentally flawed policy idea). If the problem is in the ways that decisions are made and implemented (“process”) then it is probably a governance issue.

“Identify the concrete policy ideas that can address the problem”

The *second step* is then to ask what kind of governance issue it is. Which of the TAPIC components is the problem? Is it, for example, policies that fall afoul of legal challenges because a lack of policy capacity meant they lacked the necessary evidence base and process management?¹² That would call for a policy capacity investment. But if the problem is a lack of trust within the system due to capricious and poorly explained central decisions, then the problem is more likely to be transparency and perhaps participation mechanisms.

The *third step* is to identify the concrete policy ideas that can address the problem: for example, developing the participatory mechanisms that build trust and bring better information, or building policy capacity in order to better anticipate problems. There are long lists of such mechanisms¹³ and not all mechanisms are equally feasible or useful in every case.

The *fourth step* is to see what can be learned from the experience in order to avoid the problem recurring.

In each case, the question is not how to have “good governance” in some abstract sense but how governance can empower civil society and improve health.^{14 15}

Box 1: TAPIC Framework

Transparency is the extent to which decisions and the grounds on which they are made are clear and known.

Accountability is the extent to which actors must account for their actions to principals in a clear and productive way.

Participation is the extent to which affected parties are consulted in decisions relevant to them.

Integrity is the extent to which organisations have clear rules, procedures, and missions, including anti-corruption and rule of law measures to clear mandates and organisational goals.

Capacity is the extent to which the system has policy capacity to understand the system and the legal, economic, political, social and other challenges in policies.

Conclusions

This brings us back to our initial postulate; this short piece further endorses the need for clarity when ‘steering’ rather than ‘rowing’ is needed and when ‘rowing’ is essential to retain capacity and clout for steering: rowboats and even some galleys combine both rowing and steering indispensably, while other vessels separate them.

Yet it also shows the massive complexities and difficulties in practice, particularly in the face of the perennial scarcity in Capacity (the last of our TAPIC dimensions) in many public administrations. We refer here not only about capacity in terms of human skills and resources; but also, to the technical, information, legal and political resources to steer effectively. When this is not the case some government health administrations may be better off going back to the business of rowing to avoid the failures and negative impact of incompetent steering.

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Strengthening health systems through nursing: Evidence from 14 European countries

Edited by: AM Rafferty, R Busse, B Zander-Jentsch, W Sermeus, L Bruyneel

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‘Who is a nurse?’ and ‘What is nursing?’ seem to be simple questions yet the answers are strangely elusive. This book explores the variations in structure and organisation of the nursing workforce across the different countries of Europe. This diversity, and the reasons for it, are of more than academic interest. The work of nurses has always had a critical impact on patient outcomes. As health systems shift radically in response to rising demand, the role of nurses becomes even more important.

This book (Part 1 of 2) provides a series of national case studies drawn from 12 countries which were chosen as the subject of a large EU-funded study of nursing (RN4Cast) along

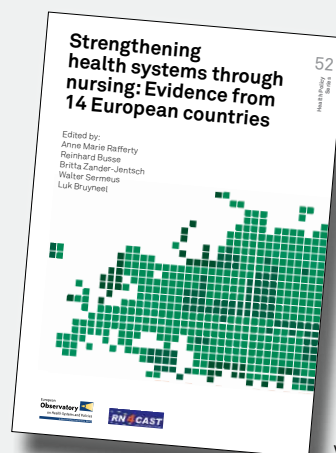
with Lithuania and Slovenia which were added to provide broader geographical and policy reach. Part 2, to be published later in 2019, will provide thematic analysis of important policy issues such as quality of care, workforce planning,

education and training, regulation and migration.

The lessons learned from comparative case-study analysis demonstrate wide variation in every dimension of the workforce. It examines what a nurse is; nurse-to-doctor and nurse-to-population ratios; the education, regulation and issuing of credentials to nurses; and the planning of the workforce. While comparative analysis across countries

brings these differences into sharp relief, it also reveals how the EU functions as an important ‘binding agent’, drawing these diverse elements together into a more coherent whole.

Contents: Foreword; Author affiliations; List of figures and tables; List of abbreviations; Acknowledgements; Introduction; Belgium; England; Finland; Germany; Greece; Ireland; Lithuania; the Netherlands; Norway; Poland; Slovenia; Spain; Sweden and Switzerland.



FACTS. FIGURES! FICTION?

By: Martin McKee, Yuxi Wang, Aleksandra Torbica and David Stuckler

Summary: Disinformation, or as we now say fake news, is not new, but the advent of social media now allows it to travel with unprecedented speed to ever larger audiences. It has enormous implications for public health. Some groups pursuing political goals have weaponised issues like vaccine safety. Others have discovered that by tapping into these concerns they can make large amounts of money, using them as clickbait. Health professionals need to understand this changing information environment, understanding the cognitive biases that favour the spread of fake news, proactively tackling its sources, and framing their messages in ways that reduce its impact.

Keywords: Disinformation, Fake News, Anti-vaccination, Backfire Effect, Public Health

The evolution of fake news

In early 2018 former US President Barack Obama appeared in a video to warn about the dangers of what are termed “deepfakes”.¹ Originally developed to manufacture images of celebrities in pornographic acts, deepfakes use artificial intelligence to make it look and sound as if someone is doing or saying something they are not. In that particular video, it cut away to show that Obama’s words were being spoken by movie director and actor Jordan Peele, who has worked with the CEO of BuzzFeed Jonah Peretti to create what was extremely convincing imagery. The message was clear. You cannot trust anything anymore.

The creation of disinformation is not new. History has always been written by the victors, or at least by scholars and dramatists seeking to flatter them. Shakespeare’s plays contain many examples, made more obvious as his plays span the transition between two royal dynasties in England.² Yet his messages were confined to a relatively small,

even if politically important, section of the population. What changed was the technology to distribute disinformation to the masses. The first technological revolution was the printing press. By the 18th century this was being exploited by pamphleteers such as those who spread salacious stories about the alleged sexual adventures of Marie Antoinette.³ Based in England, their objective was blackmail and they succeeded in extracting money from Louis XVI. But they also had a political impact, encouraging the actions of revolutionaries who would change the course of history.

Today, we are in the midst of a series of technological revolutions, many affecting what we see, hear, and read. And these have profound consequences for health. They include the artificial intelligence application that made possible the fake video of Obama but also the social media outlets that allowed it to be disseminated rapidly. Collectively, they have given us the term, “fake news”.

> #EHFG2019 – Lunch Workshop 1:
Facts. Figures! Fiction?

Martin McKee is Professor of European Public Health at the London School of Hygiene and Tropical Medicine and Co-Director of the European Observatory on Health Systems and Policies, London, United Kingdom;

Yuxi Wang is PhD candidate and **Aleksandra Torbica** is Associate Professor at the Centre for Research on Health and Social Care, Department of Social and Political Science, Bocconi University, Italy; **David Stuckler** is Professor at the Department of Social and Political Science and Donde Research Centre, Bocconi University, Italy. Email: martin.mckee@lshtm.ac.uk

Although this term was first used as long ago as 1925, in a Canadian magazine,⁸ it has only become widely used in the past few years. In Europe, the term took off at the time of the European Union (EU) referendum in the United Kingdom when the Leave campaign engaged in a series of illegal activities.⁹ One element of their strategy involved harvesting data on the interests and concerns of individuals to target them with misleading messages,⁹ many drawn from the very large number of what have been termed Euromyths, now collected on a website by the European Commission.⁹ A similar process took place in the United States, where many millions of unique and mostly misleading advertisements were aimed at individuals during Donald Trump's election campaign.⁹ Bizarrely, Trump has now taken ownership of the term, using it as a means to attack the mainstream media as they seek to hold him to account.

What are fake news, misinformation and disinformation?

So what is fake news? A recent Parliamentary enquiry in the United Kingdom concluded that the term is often used with no clear idea of what it means.⁹ The term has taken on a variety of meanings, including a description of any statement that is not liked or agreed with by the reader. The Members of Parliament (MPs) recommended that the term fake news should be rejected and replaced with agreed definitions of the words misinformation and disinformation.

Misinformation is where false or misleading information is provided but there is no intent to deceive. Disinformation is where information is purposely created to deceive people. In practice, however, it is often quite difficult to differentiate them because of the difficulty in ascertaining intent. For example, some of those spreading anti-vaccination messages genuinely do believe what they are saying, even if they are completely wrong, but there are others who are using it as an opportunity to undermine trust in democratic governments.

Disinformation takes many forms. The most widely used taxonomy was

developed by Claire Wardle, and goes from satire and parody, where there is no intention to cause harm but some people are still fooled, to fabricated content that is completely false and is designed to deceive and to do harm.¹⁰

“Familiarity with false information or, fake news, increases the likelihood that it will be believed”

Many aspects of health have been subject to disinformation but vaccines stand out as one of the most frequent targets. Italy has been one of the countries in Europe most severely affected by the anti-vaccine movement.¹¹ An analysis of videos on YouTube aimed at Italians found a striking increase in the number of videos, but especially among those attacking vaccination.¹² It also provided a graphic demonstration of what is termed confirmation bias,¹³ with videos criticising vaccination more likely to be liked and to be viewed than those providing an objective assessment of the benefits of vaccination.

A recent paper from the United States examined in detail where these messages are coming from.¹⁴ The authors identified three main sources that were tweeting misleading information on vaccines. The first was a group of accounts that had previously been linked to the Russian government. They were disseminating messages that were both pro- and anti-vaccine. The apparent intention was to create divisions and polarise opinion, as well as creating confusion. This is a well-known tactic used in accounts from this source. For example, they have been extremely active in spreading messages in the United States that are both for and against the #BlackLivesMatter movement and gun control.¹⁵ The second category

involves a number of sophisticated bots, mostly run by anti-vaccine groups, but with many different motives. Some are from those who genuinely believe that vaccines cause harm. Others are from conspiracy theorists and others who simply oppose any form of government action. Some of these accounts combine automated messaging with human activity, making them difficult to detect but there are now quite sophisticated tools using artificial intelligence that can identify bots with a high degree of certainty. The third category includes content polluters, again with a variety of motives. Some are used to spread malware, knowing that anti-vaccine messages are likely to be disseminated widely. Others attract traffic to sites that have been monetarized, such as those with advertisements.

Understanding and changing people's views

The question then arises as to what can be done about this problem. Just as we differentiate misinformation from disinformation, it is important to separate out the two reasons why people have incorrect beliefs. They can be uninformed or they can be misinformed. If they are uninformed, then providing the correct information may be effective. There is much evidence of the need for misconceptions to be corrected. Surveys repeatedly show that members of the public are wrong on many contemporary issues.

Unfortunately, it is often not enough to tell people the truth. In one study, when individuals were presented with information reporting myths and facts about influenza vaccination, they could separate the two quite easily if asked immediately afterwards. Yet, only 30 minutes later, most were unable to do so.¹⁶

The real problem is that many people are not so much uninformed but misinformed. They hold views that are shaped not by a lack of knowledge but by fundamental biases. To understand this, it is necessary to use theories of motivated reasoning. When people try to find out about something, they are motivated by two goals. The first is to find the truth, where they look for and consider carefully all

of the evidence, so as to reach the best conclusion. The second are partisan, where they look for evidence that will fit their prior beliefs. In practice, everyone pursues both of these goals to some extent. The question is why some people place so much emphasis on the partisan goals at the expense of the accuracy ones.

One of the classic studies in this area involved asking subjects to synthesise evidence that would allow them to explain an issue to someone else.¹⁷ The two issues selected were both known to evoke strong feelings: gun-control and affirmative action. In both cases, the prior positions of the subjects were noted. The computer tracked the information that they searched and the time that they spent reading different arguments, with the material being clearly labelled as to where it came from.

The researchers found evidence of a series of different biases. Subjects regarded evidence that they agreed with as being stronger and more relevant than anything they disagreed with. They actively denigrated evidence they disagreed with while accepting evidence they agreed with at face value. When they were given control over the sources that they looked at, they actively sought out anything that would support their views and avoided anything that would challenge them. Even when people were presented with exactly the same evidence, they could take completely different messages from it.

The same can be seen with vaccines. In one study, while many people were willing to accept evidence of the effectiveness of human papilloma virus vaccine, some went to considerable lengths to undermine it.¹⁸ These were people who had particular views on individual responsibility, traditional gender norms, or who believed that this particular vaccine condoned sexual activity.

Recognising the backfire effect

But surely there is something we can do. For those of us who live in what we believe to be a rational, evidence informed world, isn't it possible to engage in a dialogue where we challenge false beliefs? For example, if someone has been given

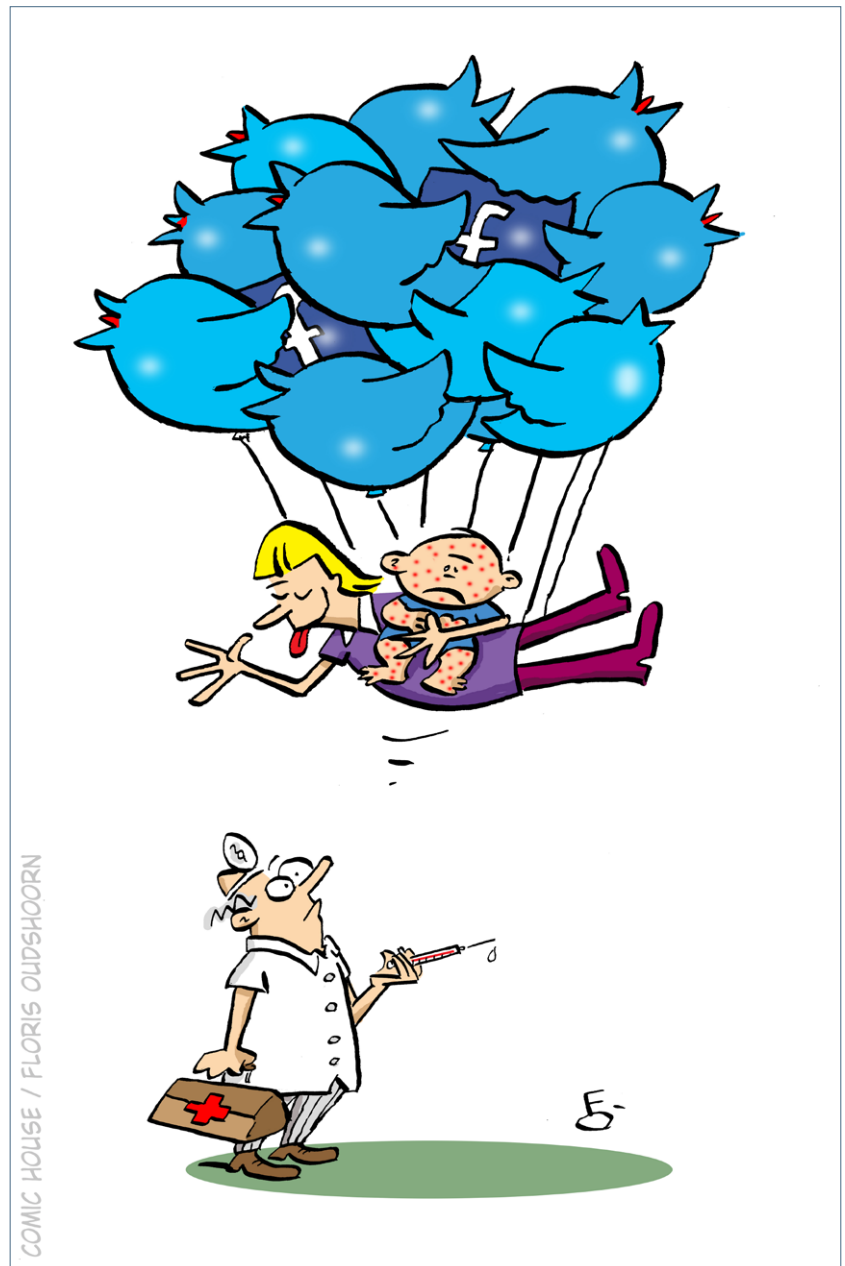
incorrect information, surely it would be possible to provide correction from an authoritative source? Not necessarily.

In one study, parents were presented with information from the US Centres for Disease Control.¹⁸ This challenged the widespread myth that the MMR (measles, mumps and rubella) vaccine causes autism. Overall, it did reduce the extent to which the false claims were believed, but those who were already opposed to vaccination said that they were even less likely to have the child vaccinated.

Observations such as this are manifestations of what has been called the backfire effect.¹⁶ It takes several forms.

Familiarity with false information or, fake news, increases the likelihood that it will be believed. Quite simply, if a lie is repeated often enough, many people will believe that it is true. This is even the case when repeating it simply to challenge it.

Overkill occurs whenever many different reasons are given as to why it is wrong. People like simple explanations and multiple counterarguments simply cause confusion.



COMIC HOUSE / FLORIS OUDSHOORN

Polarised attitudes are important. When people are given information that is contrary to their beliefs, they selectively recall any evidence or arguments that oppose it. In this way, they reinforce the pre-existing beliefs, no matter how wrong they are.

Finally, messages that cause fear can be counter-productive, either because they're simply not believed or because the activity in question appeals to people who are attracted to risk-taking.

How to best communicate the facts in support of public health

So what can be done? Many proposed solutions respond to the evidence of backfire effects. For example, one can state the facts, and then introduce the myth, rather than the other way round and then can debunk the myth, ending with the scientific fact. A common recommendation is to avoid repeating myths. Above all, messages should be kept simple. Trying to wear people down by multiple counterarguments simply confuses them. In some cases, it may be better to avoid the facts altogether and simply appeal to people's values and norms. And it is important to avoid implying that activities that are very rare are actually common. Appeals to fear can work, but they need to be used selectively and with care.

If disinformation is a threat to public health, what can be done more generally? First, the health community must challenge politicians who lie. Too often we have been reluctant to do so for fear of being seen as political. Yet the political determinants of health have been clear at least since Virchow called for action against the aristocracy, and the church that supported them, when he investigated a typhus epidemic in Silesia in the 19th century.¹⁹ If we believe in evidence, surely it is a natural consequence that we will confront those who lie so blatantly, no matter what their position? Second, it is essential to tackle the threat that disinformation poses to the democratic process. At the very least, the public should know who pays for political advertising and the authorities should be able to respond to it in real time. Finally,

it is important to engage seriously with technology companies themselves. They already can decide what is seen and what is not seen. It is already possible to install software that will link messages to fact checking sites. Should this not be the default setting? It is also possible to deny advertising revenues to those distributing hate messages. And even if governments fail to act, we should call for action, such as boycotts of companies that advertise on websites that peddle lies designed to create hatred and division.

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THE QUEST FOR MORE BALANCED POLICY AND DECISION MAKING – THE ECONOMY OF WELLBEING

By: Liisa-Maria Voipio-Pulkki, Noora Heinonen, Pasi Korhonen and Pasi Mustonen

Summary: The European Union owes its legitimacy to and earns prestige from its commitment to democracy, the rule of law and human rights, environmental sustainability and a strong social dimension. These values are pursued for their own account but they are also a source of economic strength, contributing to Europe's success as a globally competitive and attractive yet socially and environmentally responsible market economy. Finland's Presidency of the Council of the European Union is introducing the Economy of Wellbeing as an approach to policy and decision making to address the political, economic and societal challenges of the 2020s.

Keywords: Wellbeing, Economy, Policy making, EU Presidency, Finland

Background

Since the 1950s, the European Union (EU) has pursued sustainable peace, improved quality of life and advanced social protection. It has increased the wellbeing of EU citizens by developing the internal market and promoting macroeconomic stability. The *raison d'être* of the EU, as enshrined in the *EU Treaties*¹ and in the *European Union Charter of Fundamental*

Rights, is to ensure respect for human dignity and to promote the wellbeing of its people. People's wellbeing is therefore the responsibility of the EU and its Member States.

The Economy of Wellbeing is a policy orientation and a governance tool with the objective to put people and their wellbeing at the centre of policy and decision making. While people's wellbeing is a value in itself, the Economy of Wellbeing underlines the mutually reinforcing nature of wellbeing and economic growth. Taking wellbeing into account in all policies is vitally important to the EU's economic growth, productivity and fiscal sustainability, as well as to societal stability, democracy and the rule of law.

¹ Respect for human dignity is a central value of the Union (Art. 2 TEU) while promoting the wellbeing of its people is a central aim of the Union (Art. 3 TEU). In all its activities, the Union shall aim to eliminate inequalities, and to promote equality between men and women (Art. 8 TFEU). In defining and implementing its policies and actions, the Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health (Art. 9 TFEU).

> #EHFG2019 – Forum 4:
Towards the Economy of Wellbeing

Liisa-Maria Voipio-Pulkki is Director General, Ministry of Social Affairs and Health, Finland; Noora Heinonen is Ministerial Adviser, Ministry of Finance, Finland; Pasi Korhonen is Counsellor for Social Policy and Pasi Mustonen is Counsellor for Health policy, Permanent Representation of Finland to the EU, Brussels, Belgium. Email: noora.heinonen@vm.fi

*The European Pillar of Social Rights*² (hereinafter the Pillar) provides a compass for renewed upward convergence towards better working and living conditions in the EU. The Pillar has been an important milestone in raising the social dimension higher on the EU's policy agenda and linking the economic and social dimensions together more closely. Delivering on the Pillar is a shared political commitment and responsibility of the core EU actors and necessitates continuous developments and profound actions at both EU level and in the Member States.

Improved health status contributes to increased economic growth

The Economy of Wellbeing contributes to the aims and implementation of the Pillar in line with the new *EU Strategic Agenda 2019–2024*. The Economy of Wellbeing is also at the heart of the global *2030 Agenda for Sustainable Development*, a joint commitment and action plan by all governments for people, planet and prosperity, contributing to integrated and transformative action and to the fulfilment of agreed targets.³

How can we pursue the Economy of Wellbeing?

A horizontal approach, overcoming silos by cross-sectoral collaboration, is elementary to the realisation of the Economy of Wellbeing. As a multisectoral approach the Economy of Wellbeing touches upon social, gender, health, employment, education and environmental issues and their relation to economic growth. The necessity to engage with cross-sectoral action is embedded in requirements enacted in the Treaty on the Functioning of the EU and in the *European Social Charter*, and has been brought up as part of *Health in All Policies approach* in the 2006 Council Conclusions.²

The core of the Economy of Wellbeing concept is to improve the prospects for a good life based on better cross-sectoral cooperation. It is a horizontal approach, which:

- increases our understanding of how investing in wellbeing enhances productivity, generates economic growth, increases employment, and thus holds promise to reduce public expenditure in the long term;
- highlights the importance of wellbeing impact assessments, designed to evaluate how legislative and policy measures affect the wellbeing of people; and
- underlines wellbeing as a value in itself and as a source of societal resilience and stability that also benefits business and investment.

Public spending on wellbeing, namely social, health, education and employment expenditure, constitutes a major part of national budgets. Often the dominating tendency in reforms is to cut these expenditures in order to attain fiscal consolidation in the short-term. On the other hand, major challenges and opportunities loom on Europe's horizon linked to the changes driven by climate change, new forms of work, ageing of the population and changes driven by technological development such as digitalisation, artificial intelligence and robotics. Resilience and the capacity to

adapt have never been more important as the EU Member States are constantly challenged to preserve trust and stability.

Social cohesion is vital to economic progress

In order to better respond to these developments and to strive for the objective of the EU becoming the world's most competitive and socially inclusive low-carbon economy, we need to intensify our efforts in promoting *the European Social Model* empowering all people by promoting upward social and economic convergence. Sustainable and inclusive economic growth and resilience can function as enablers for the wellbeing of people, societies and the planet.

The balance between economic progress and social cohesion is at the core of European integration, but it also distinguishes the EU globally. It is about understanding the importance of social, gender equality, health, employment, education and environmental policy aims in relation to economic growth, as well as the stability of the economy and societies.⁴ The recent *World Bank Human Capital index*, released in October 2018 provides results supporting this thinking.⁵

Let us take examples. Should women increase their paid working hours so that gender gaps, in both participation and working hours, disappear completely by 2040? This would boost the economy by an additional 15–30% Gross Domestic Product (GDP) per capita growth in the Nordic countries – an estimation made by the OECD.⁶ Overall, the cost of the lower employment rate of women in the EU is estimated to be around 2.8% of the EU's GDP.⁷ Improving gender equality would lead to an increase in the EU's GDP by 6.1% to 9.6% by 2050.⁸ Another example is the perspective of the ageing population. Longevity is one of the successes of national policies in Europe, which is strongly and increasingly shaping our societies and economies. Ageing of the population has a strong impact on economic growth, productivity, public finances and the financial sector, as well as wealth and income distribution.

² See the Interinstitutional Proclamation on the European Pillar of Social Rights (OJ C 428, 13.12.2017, p. 10) Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32017C1213%2801%29>

³ It has particular relevance to the following sustainable development goals: (1) End poverty in all its forms everywhere, (2) End hunger, achieve food security and improved nutrition and promote sustainable agriculture, (3) Ensure healthy lives and promote well-being for all at all ages, (4) Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all, (5) Achieve gender equality and empower all women and girls, (8) Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all, and (10) Reduce inequality within and among countries. Available at: <https://www.un.org/sustainabledevelopment/development-agenda/>

Health is an intrinsic value and a prerequisite

Health is a fundamental human right and key factor contributing to wellbeing. Improved health status contributes to increased economic growth through greater educational attainment, improved labour market participation and higher savings.

On the other hand, ill health imposes a significant economic burden on society and public finances, in addition to its human toll. For instance, mental health is fast becoming one of the defining global health challenges of the 21st century. The total costs of mental ill health are estimated at more than 4% of GDP – or over €600 billion – across the 28 EU Member States. Around 550,000 people of working age die prematurely every year across the EU due to non-communicable diseases, amounting to 3.4 million life-years and €115 billion in economic potential lost annually.⁹

The dual pursuits of population wellbeing and sustainable economic growth

Population wellbeing and sustainable economic growth are not contradictory goals. The Economy of Wellbeing is based on a sound economic policy. It highlights the importance of investing in effective and efficient policy measures and structures ensuring access to all to public services including health services, promotion of health and preventive measures, social protection, and education and training. It emphasises employment, active labour market policy and occupational safety and health as measures to guarantee wellbeing at work. It stands for equal opportunity, gender equality and social inclusion.

Assessment and monitoring of the long-term consequences of budgetary policies on both wellbeing and macroeconomic development are crucial for the implementation of the Economy of Wellbeing concept. In the EU, it is vital to understand how wellbeing can benefit from and contribute to the internal market. Climate change will have an impact on the lives of all people, and the transition to a climate-neutral economy

should be implemented in a fair manner. It is essential to achieve sustainable growth through measures that benefit both population wellbeing and the environment, but never at their expense.

empowering
all people by
promoting
upward social
and economic
convergence

Knowledge-based policy making requires the use of a broad set of indicators and comprehensive impact assessments and evaluation of the cost-effectiveness of different policies and actions. It is widely accepted that GDP alone does not provide a comprehensive picture of people's wellbeing as stated already by *the Stiglitz-Sen-Fitoussi Commission*.¹⁰ Therefore, further collaborative efforts across sectors are required to improve existing instruments, to better use them and to build on them for the development of a common approach to measuring the different dimensions of the Economy of Wellbeing.

Inclusive growth is a priority

Finally, we need to recognise that the economic growth during past decades has not brought benefits to all people in Europe. Though the majority of people in the EU are wealthier, healthier and more educated than ever before, the number of people at risk of exclusion and vulnerable groups remains high. Paying attention to inclusive growth is, therefore, of utmost importance.

The Economy of Wellbeing approach aims at ensuring that no one is left behind in our rapidly changing world and that all people in the EU live in prosperity. Finland's Presidency aims to incorporate the Economy of Wellbeing approach into

the core of the EU's future strategies as the next step towards a socially, economically and ecologically sustainable EU.

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TRANSFORMING FINANCIAL MARKETS FOR THE GOOD OF ALL

By: Rachel Melsom and Clare Payne

Summary: For the last 50 years, tobacco has been a key investment for many pension funds, insurers, investors and banks. However, investments are no longer viewed solely on financial return and the framework for review is being re-examined in a rapidly changing and transforming investment world. The negative impact of tobacco on health, human rights, environment, corporate governance, reputation, and the clear negative impact on the achievement of the Sustainable Development Goals (SDGs), has been highlighted through the increasing adoption of a framework driven approach, accelerating decisions to divest across the globe.

Keywords: Tobacco, Sustainable, Responsible, Framework, Investment

Introduction

In the world of global business, the word disruption is usually associated with technology companies, maverick Chief Executive Officers (CEOs) and ‘unicorns’ (privately held start-ups valued at over \$1 billion/€0.8 billion). There are well known examples of new businesses with leaders who think differently, encouraging us to ride in the cars of strangers (Uber), sleep in their houses at night (Airbnb) and watch a whole season of your favourite show in one sitting (Netflix). Each of these ‘disruptive’ businesses have flourished in a world where finance is available to new ideas. Large investments of capital flow to businesses set to ‘transform’ our lives whilst providing a handsome return on investment along the way. But, why is it that so little innovative practice seems to flow to public health? The good news is that this is set to change and financial markets are transforming, for good.

Questioning the status quo

Tobacco is one of the biggest issues of our time, something well understood by the global health community, but less so in the world of finance. This lack of understanding and the commonly held view that tobacco is an individual health choice issue rather than a global financial drain, has seen tobacco promotion and investment continue, facilitating product uptake at alarming rates in emerging nations.

The current reality, the status quo, is that many of us are ‘owners’ of tobacco companies through our investment portfolios, most commonly through compulsory or corporate pension structures. The largest tobacco companies have been considered a reliable investment, hence they are routinely included in default investment options, meaning that if someone does not explicitly ask for an exclusion, they

#EHFG2019 – Forum 1:

Public stewardship & economic globalisation

Rachel Melsom is Director UK and Europe, Tobacco Free Portfolios, London, United Kingdom and a Doctor at Worthing Hospital, West Sussex, United Kingdom; **Clare Payne** is Honorary Fellow, The University of Melbourne, Australia and Director of Communications, Tobacco Free Portfolios, Sydney, Australia.
Email: rm@tobaccofreeportfolios.org

Box 1: The three questions

1. Can the product that the company makes be used safely?

With respect to tobacco, the answer is an unequivocal 'no'. The only safe amount of tobacco for human consumption is zero. Even smoking an average of less than one cigarette per day increases the risk of death from lung cancer nine-fold compared to non-smokers.¹² When used precisely as intended, tobacco will result in the early death of two out of three smokers.¹³ The evidence demonstrating the categorical and unconditional danger of smoking tobacco is irrefutable.

2. Is there a UN Treaty regarding the issue?

For tobacco, the answer is 'yes'. There is the UN Tobacco Control Treaty, the WHO FCTC.¹⁴

3. Can investors use engagement with the company as a tool to effect change?

As it pertains to tobacco, the answer is 'no'.

are likely to have tobacco stock in their investment portfolio. Countries have found themselves invested through Sovereign Wealth Funds, even when signed to the United Nations (UN) Tobacco Treaty (WHO Framework Convention on Tobacco Control, FCTC) that contains a provision prohibiting investment in tobacco companies.¹⁵

The global finance community has largely discouraged divestment (the removal) of any stocks, instead favouring a 'diversified' (i.e. all stocks) portfolio to minimise and spread financial risk. Due to this attitude towards divestment, even the use of the word divestment can meet resistance from the finance sector. Removing tobacco stocks has therefore required the introduction of a new thought process and framework for investment.

The rise of responsible investment combined with the increased pressure on businesses to reduce the negative impact of their products on society has accelerated us towards a transformation of financial markets. The new framework for investment that is emerging in global financial markets is seeing people's health prioritised like never before. There is still a long way to go; however, the case of tobacco gives hope that we may yet be able to address some of the biggest public health issues of our time.

Challenging existing practices to develop a new framework for our time

Existing practices and rationales have had to be challenged in order to introduce a framework for investment that prioritises people's health alongside financial criteria.

1. An exception to the practice of 'engaging for change'

The concept of 'engagement', where investment professionals encourage companies to improve their practices (usually around environmental, social and governance matters) is now commonplace across the finance sector. Engagement is considered the preferred practice, allowing investors to influence companies to effect positive change. In the case of tobacco companies, however, engagement is futile, as the core product is the problem, and the only acceptable outcome is the cessation of the primary business – tobacco production.

Dr Vera Da Costa e Silva, Head of Secretariat of UN Tobacco Control Treaty, has stated, "*Engagement with the tobacco industry is contrary to the United Nations' systems, objectives, fundamental principles and values.*"¹⁶ With no levers for change through positive influence, the case for divestment is strengthened.

2. Understanding all the facts

It is over 50 years since the United States (US) Surgeon General announced the unequivocal link between poor health outcomes and tobacco use and yet the true extent of the devastation of tobacco is not well understood by the finance sector. The facts, the sheer numbers, tend to startle: seven million people will die prematurely this year¹⁷ and one billion people this

century because of tobacco use.¹⁸ This story and the implications beyond the share price must be told and understood by the finance sector in order for a new framework for investment to emerge.

3. Challenging the accepted business model

Tobacco is a business, with health implications and associated human, societal and financial costs. The profitability of tobacco, however, is the outcome of a business model that internalises profits and externalises costs. This business model has allowed these companies to thrive in financial markets.

However, recent successful litigation has challenged the business model where the costs of tobacco are borne by society. The Court of Appeal of Quebec upheld the ruling for three large tobacco companies to pay C\$15.5 billion (€10.6 billion) in damages¹⁹ – the largest award in Canada's history. The plaintiffs were Quebec smokers who argued that the companies did not properly warn their customers and failed in their general duty "not to cause injury to another person."²⁰ In May 2019, Brazil launched a case against two of the largest tobacco companies to recover the cost of treating tobacco related illnesses.²¹ Cases such as these could see significant shifts in the valuations of tobacco companies and ultimately a questioning of the once accepted business model.

4. Fiduciary duty beyond profit alone

A fiduciary duty is underpinned by a fiduciary relationship, which can be defined as a person having full trust and confidence in another to act in their interests rather than out of self-interest. Many financial services providers are subject to a statutory obligation to act in the 'best interests' of their clients. The term 'best interests' is one of continuing inquiry as trustees, directors and fiduciaries attempt to determine the extent of their responsibilities and whether 'best interests' implies more than the pursuit of purely financial benefit. According to the *Fiduciary Duty in the 21st Century Report*, which was published by the UN-backed organisation Principles for Responsible

Investment (PRI), “Fiduciary duty is not an obstacle to action on environmental, social and governance (ESG) factors”.⁷

The European Parliament and European Union (EU) Member States agreed in March 2019 on new rules on disclosure requirements related to sustainable investments and sustainability risks.⁸ The UN Environment Programme Finance Initiative (UNEPFI) outlines that the new regulation will provide consistency across EU Member States by clarifying that duties require investors to consider financially material ESG factors in their investment decision-making. It also sets out how financial actors should inform beneficiaries about their compliance with the integration of ESG risks and opportunities. This will apply to private and occupational pension funds, insurance funds, portfolio management and investment advisors. This includes requirements to disclose the adverse impact of ESG matters. This would be the first regulatory-backed disclosure framework for sustainability impact of investment activity.⁹

This evolution of fiduciary duty has effectively removed a barrier to the divestment of tobacco stock from investment portfolios, allowing for a new investment framework to emerge.

5. Addressing tobacco to achieve a sustainable future

The Sustainable Development Goals (SDGs) were formally adopted by the UN General Assembly in September 2015, they officially came into force on 1 January 2016 and are increasingly adopted by the finance sector to guide and measure their activities. The SDGs have provided a valuable, constructive platform on which to base dialogue regarding tobacco-free investment.

While it is easy to appreciate the importance of tobacco control in pursuit of SDG 3, ‘Good Health and Well-Being’, many in the finance sector are becoming aware that dramatic improvements in comprehensive tobacco control are vital for achievement of 13 of the 17 SDGs. One of the most recent high-profile decisions has been the European

Parliament vote in March 2019 paving the way for a ban on single use plastic, to reduce pollution in the oceans and to come into force by 2021, per SDG 14 ‘Life below water’.⁹ What is less well known is that cigarette butts are the biggest manmade contaminant of the ocean and can take over a decade to decompose.¹⁰

SDG 17 calls for ‘Partnerships for the Goals’, which most clearly articulates the importance of cross-sector collaboration when addressing major global issues and is the philosophy that underpins the new investment framework.

An investment framework specific to tobacco

With the preceding factors understood, a review framework of three questions provides a robust investment critique¹¹ for all products including tobacco (see Box 1):

When these questions and answers are considered collectively, a clear framework emerges. As such, applying an exclusion to investment in tobacco companies can be viewed as both a rational and pragmatic option for investment professionals.

Viewing this in conjunction with the financial impact of increased litigation, regulation, health awareness and decreasing social acceptability, it is clear that tobacco cannot be considered a sustainable investment.

Financial markets are transforming, becoming an ally in the fight against tobacco

In the United States in 2019, one in four US dollars is invested under a socially responsible mandate,¹² and BlackRock’s CEO, Larry Fink, who manages one of the biggest investment management companies in the world, is calling for more.¹³

The removal of tobacco stocks from investment portfolios is an indication of financial markets that are transforming for health and societal well-being.

Momentum around tobacco-free investment has grown steadily in the last five years. In January 2018, ABP, the

world’s fifth largest pension fund, based in the Netherlands, announced a new policy excluding investment in tobacco¹⁴ based on the framework detailed above. It was a signal of the year ahead with the Tobacco-Free Finance Pledge¹⁵ led by Tobacco Free Portfolios and launched at the UN in New York during the General Assembly in September 2018.

tobacco cannot
be considered a
sustainable
investment

The initiative was sponsored by the French and Australian governments and supported in person by Dr Tedros Ghebreyesus, Director-General of the WHO, Dr Vera Luiza da Costa e Silva, Head of the Secretariat UN Tobacco Control Treaty, French and Dutch health ministers, and global finance leaders from across Europe, the US, Australia and Canada, all stood side-by-side in a public demonstration of the finance sector’s desire to play their part in helping to solve a global health issue of monumental proportions.¹⁶

Finance leaders are increasingly willing to use their power to contribute to addressing some of the most pressing issues of our time. Translating these issues into financial reality will be the key. If this transformation of financial markets continues, public health will be the beneficiary, at last.

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Health, the economy & the G20

By: National authors, in collaboration with/support from the European Observatory on Health Systems and Policies, 2019

Freely available to download: <https://www.hspm.org/g20/>

Governments of the world recognise health as a driver of economic and societal progress in the 2030 Agenda for Sustainable Development (SDG 3). In reality, health systems may face difficulties securing the necessary funding to deliver on their governments' commitments to move towards Universal Health Coverage. There are a number of reasons health systems do not always receive the funding they need, including legitimate concerns about efficiency and value for money in health care. It is also clear that health is not the only sector that matters when it comes to sustainable progress. Acknowledging all of this, it is equally as important to recognise the growing evidence that shows that health is a major contributor and key driver of strong economies and societal well-being.

This new series of country assessments (fiches), authored by national experts with the support of the Observatory, explores the significant part health systems play in the broader economy. The series draws on cross-country comparable data and country-specific analysis to explore how well the health

sector contributes to the economy in the G20 Member States and in the invited guest countries for 2019.

The series aims to make the contribution of health systems to the economy better understood, supporting both health ministers in their negotiations with their finance colleagues and other health advocates so that health systems receive a fair hearing. A compendium of the country assessments will be officially launched at the G20 Health Ministers' meeting in Japan in October 2019.



YOU(TH) MATTERS – CO-CREATING POLICIES TO TACKLE OBESITY

By: Margot Neveux, Sherria Ayuandini and Knut-Inge Klepp

Summary: In the past two decades, the prevalence of childhood obesity has risen dramatically, and no country has successfully reversed this trend. Current approaches to address the obesity epidemic have focused on influencing individual choices. However, children and adolescents are particularly vulnerable to the influence of the social, physical and economic environments we live in. Given the failure of traditional approaches to provide meaningful results, new innovative ideas are urgently needed. Through CO-CREATE, we will show the value of a participatory approach and co-creation with youth in the establishment of health policy priorities and ultimately in the formulation of policy proposals.

#EHFG2019 – Forum 8:

Obesity in Europe – time for a new approach?

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Margot Neveux is Policy & Projects Coordinator, World Obesity Federation, London, United Kingdom; **Sherria Ayuandini** is Youth Engagement and Participatory Research Specialist, University of Amsterdam, Netherlands; **Knut-Inge Klepp** is Executive Director, the Norwegian Institute of Public Health, Oslo, Norway and coordinator of the CO-CREATE project. Email: mneveux@worldobesity.org

Keywords: Obesity, Youth, Participatory, Policy, Co-creation

Introduction

The prevalence of overweight and obesity is increasing globally and in 2016, it was estimated that overweight (including obesity) was affecting 340 million school-age children.¹ Europe is no exception: in 2013, 4.5 million children between the ages of five and 18 years were living with obesity in European Union (EU) Member States.² Recently, the World Health Organization (WHO) has flagged childhood obesity as “one of the most serious public health challenges of the 21st century.”³ As yet, no country has been successful in reversing this trend, and by 2025, the number of children aged five to 18 years living with obesity is projected to reach 4.8 million in the EU.²

Overweight and obesity in youth and adolescents aged 13 to 18 years is a strong predictor of adulthood obesity and leads

to an increased risk of developing a wide range of diseases, including type-2 diabetes, hypertension, heart disease, psychosocial morbidity and certain types of cancer. Individual-level treatments of overweight and obesity, such as bariatric surgery or weight loss programmes, have been shown to be either hard to tolerate or ineffective in sustaining weight loss over time.⁴ To promote the sustainability of healthy weight, prevention should be the prioritised strategy and a strong focus should be placed on adolescents.

Current approaches to address the obesity epidemic have focused on influencing individual choices, but today's social, physical and economic environments are rather complex and impact on individual decisions in unconscious ways. Obesity is driven by several factors, and we need to move towards comprehensive policies

to address the food, physical activity systems and environments surrounding us and reshape the context to make healthy choices the easiest and most widely preferred ones.

“ Young people are the stimulus for change

In 2019, young people represent the largest part of the population globally. Increasingly around the world, we are seeing a desire for young people to have their voices heard, and the recent youth strikes on climate change have shown the potential impact of engaged youth. Producing long-lasting effects to positively impact youth health, including reducing overweight and obesity, will not only need to include young people's input, perspective and suggestions: the initiative and leadership of young people themselves should be part of the answer. The Horizon 2020 project “Confronting obesity: Co-creating policy with youth” (CO-CREATE) aims to have young people involved and even leading the process in the development of health policies.

Co-creating policy with youth

Led by 14 research organisations, CO-CREATE (www.co-create.eu)⁵ is the result of a large effort by the EU to curb the childhood obesity epidemic. Structured in ten work packages (WPs), CO-CREATE engages regional and international partners from different policy contexts in Europe (Norway, Netherlands, United Kingdom, Portugal, Belgium and Poland), Australia, South Africa and the United States.

With a focus on equity, CO-CREATE addresses the current gaps in obesity research by placing adolescents, their perspectives and the factors that shape their health, at the centre of the project. The main aim of CO-CREATE is to prevent overweight and obesity in adolescents in Europe and the rest of

the world by providing the necessary tools, knowledge and infrastructure to adolescents on policies to support making the healthiest choices the preferred ones. By politicising the issue of obesity, the project focuses on fostering multi-stakeholder involvement, including academics, policymakers, civil society organisations, relevant industry and market actors, and, most importantly, adolescents.

Ultimately, CO-CREATE will demonstrate a new model to identify, generate, test and support the implementation of obesity and energy balance related behaviour (EBRB) policies at national, regional and city level. Concretely, CO-CREATE will develop a model on how to involve young people in the development of policies and priorities for obesity prevention and in the range of relevant stakeholders by providing specific obesity-related policy proposals, and by designing and testing advocacy tools and strategies for implementation and evaluation. It builds movement towards further youth involvement in policymaking in the future, looking beyond obesity to other health issues and has the ambitious goal of involving youth as much as possible in the various activities and phases of the project. The focus on adolescents as the specific target group aims to show the value of harnessing passion from youth in health policy development. They are also at an age where they gain more autonomy in their behavioural choices and longer-term behavioural habits are established. It is therefore no surprise that the empowerment and investment in adolescents as European citizens is the core vision of the EU Strategy for Youth.⁶ It drives the co-creation of apprioritised set of policy objectives to tackle the obesity epidemic using a range of novel tools, and existing approaches adapted and enhanced for this purpose.

CO-CREATE uses an innovative systems approach

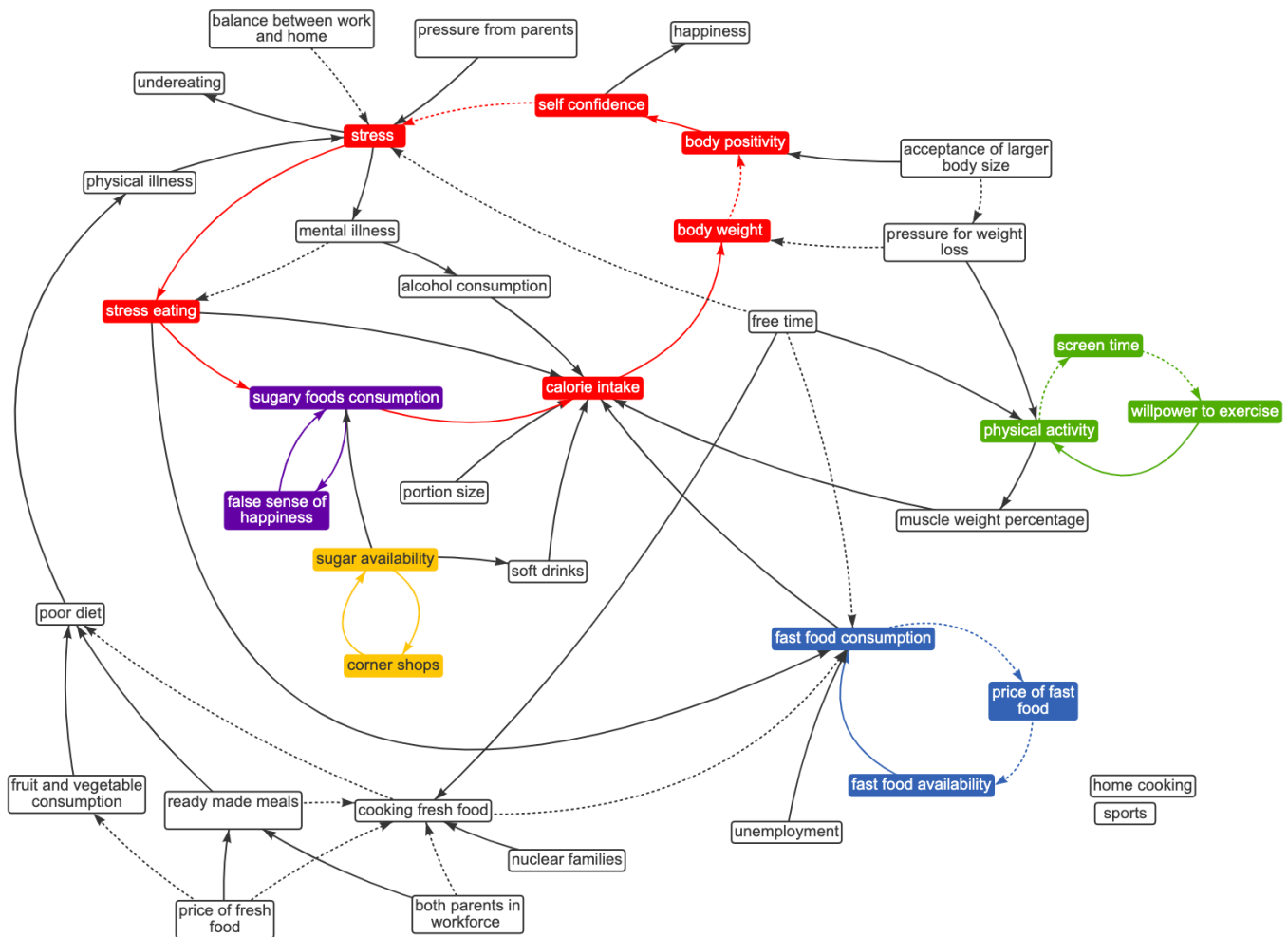
Changing the obesogenic system for – and more importantly, in collaboration *with* – adolescents across Europe, appears to be a key strategy to reduce obesity prevalence and the related burden of

disease. In CO-CREATE, adolescents are not merely the object of an intervention designed by researchers, but are themselves agents for change, able to identify required actions and collaborate to help achieve them. A core concept underpinning the project is the need to move away from single intervention towards the development and investigation of systems-based, evidence-informed, stakeholder-involved, comprehensive policy interventions. This reinforces the need to move away from a primary focus on the ‘downstream’ individual-level, autonomous and rational choice-based determinants of nutrition and physical activity behaviours and subsequent obesity risk, towards the more ‘upstream’ drivers or determinants of these behaviours. A key element of CO-CREATE will be the use of a societal systems approach to understand how different societal factors, stakeholders and institutions associated with obesity interact at various levels, and the implications these have on policy and young people.

“ It builds movement towards further youth involvement in policymaking

This complex systems approach underpins CO-CREATE's activities and seeks to highlight the ways different contextual and environmental factors are interlinked, consequently leading to systems that work in a dynamic, uncertain and non-linear way. This novel approach encourages relevant stakeholders to consider other factors in the development of these policies, and to look at the process in synergy rather than in isolation, through techniques such as group model building to create ‘causal loop diagrams’ (see Figure 1). For these reasons, CO-CREATE adopted a systems approach to tackling adolescent obesity, looking at the bigger picture to deliberately explore the

Figure 1: A causal loop diagram created using the systems approach. This one was generated by CO-CREATE participants in the UK



Source: ⁷

complex, ‘messy’ influences on diet and physical activity that must be considered to generate effective public health and other policies.

Youth Alliances for Overweight Prevention Policies will be created

In line with the community-based system dynamics approach of CO-CREATE, the project engages adolescents to collaborate in system relevant research. In Norway, the United Kingdom, the Netherlands, Poland and Portugal, CO-CREATE aims to empower adolescents by developing sustainable and transferable Youth Alliances for Overweight Prevention Policies. The alliances will bring adolescents together, train and co-create with them the most suitable organisational form for Alliances for Overweight

Prevention Policy. Based on participatory action research principles, the activities conducted in the alliances “involve young people constructing knowledge by identifying, researching, and addressing social problems through youth-adult partnerships.”⁸

Through regular meetings, the youth will design the core activities to support their goal of creating novel policy ideas in areas influencing obesity. Young people themselves will oversee the organisation and agenda of their meetings, as well as communication and interaction methods. Each of the countries’ alliances consist of a group of young people between 16 and 18 years old recruited through schools, existing youth organisations or other community outlets. They will be

facilitated by a CO-CREATE local country staff member and a local youth representative (co-facilitator).

In the alliances, young people will learn about the systemic factors affecting health-related lifestyles and receive capacity building training to support their information collection activities and enable them to refine their policy ideas. The activities in which young people engage are built on the principles of youth-led participatory action research during which young people are actively involved throughout the entire process. While CO-CREATE serves as a starting point and offers activities for young people to engage in, ultimately, the young people themselves decide which activities they would like to pursue and how the alliances are to be run. The direct involvement of

adolescents as project partners will take a complex system's approach to enhance our understanding of how the broad range of factors at different policy and contextual levels impacts adolescents' diet, physical activity and weight, and identify relevant policy responses.

The process of building the youth alliances and their activities will be carefully monitored and evaluated throughout the project. The policy ideas generated will be shared and discussed with relevant community stakeholders, including policy makers, non-governmental organisations and private sector representatives in a series of dialogue forums. The potential impact of the proposed policy agenda will be predicted applying system dynamics modelling.

All tools, methodologies and prototypes developed as part of the project will be made publicly available and disseminated widely along with the results from the study.

Conclusions

If we are to be successful at curbing the obesity epidemic, we need to move away from a focus on traditional health

education-oriented interventions that presume rational decision-making, and high levels of individual autonomy. Rather, we need to move *towards* comprehensive policies addressing the food and physical activity systems and environments within which children and adolescents live, in order to make healthy choices the easiest and most widely accepted choices.

The CO-CREATE project is a platform aiming to build consensus on the importance of youth-led co-creation in policymaking among all stakeholders. It involves and empowers adolescents and youth organisations to foster a participatory process of identifying and formulating relevant policies, deliberating such options with other private and public actors, thus promoting relevant policy agendas, tools and strategies for implementation.

Young people are the stimulus for change, both as the inheritors of obesogenic environments and as the democratic representatives of the future. It is important that we understand the potential role of youth in developing health policies and as disruptors of the status quo for positive change.

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Sustainable health financing with an ageing population: implications of different revenue raising mechanisms and policy options

By: J Cylus, T Roubal, P Ong and S Barber

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Freely available for download: <http://www.euro.who.int/en/about-us/partners/observatory/publications/policy-briefs-and-summaries>

This brief looks at how health and long-term care systems are financed and reports on the potential effects of population ageing on countries' ability to generate sufficient and stable revenues for health from common funding sources (i.e. income taxes, consumption taxes, property taxes and social contributions) in the future.

The analyses find that for countries where the population is comprised of a large share of relatively younger people who are likely to be active in the labour market, population ageing can have a positive impact on revenue generation from all funding sources. This leads to the challenge in many country contexts of strengthening tax collection mechanisms to take



advantage of this opportunity. However, in countries with a large (and growing) older population, relying in particular on social contributions generated from the labour market to raise revenues for health is expected to result in fewer revenues per person over the coming decades.

The authors consider a number of policy options to address potential revenue shortcomings as a result of population ageing. This brief was produced jointly with the WHO Centre for Health Development, Kobe, Japan.

EMPOWERING COMMUNITIES TO REDUCE **HEALTH INEQUALITIES** IN EUROPE

By: Johanna Hanefeld, Aaron Reeves, Lin Yang, Ben Barr, Tanith Rose and Chris Brown

Summary: The political determinants of health are vital to understanding where we are in addressing health inequities in the European Region. Politics and policies are a product of their environment and context, the way in which political institutions and the distribution of power shape the political process. This includes important questions on who participates, whether processes and decision-makers are accountable and transparent, and if people and communities are genuinely empowered to have voice. These factors all drive the wider processes that determine whether we can make meaningful progress on health equity.

Keywords: *Health Inequalities, Political Determinants, Political Voice, Community Empowerment, Accountability*

> #EHFG2019 – Forum 2:

Changing the game on health inequalities

Johanna Hanefeld is Associate Professor, London School of Hygiene and Tropical Medicine, United Kingdom, and a Member of the Scientific Advisory Group for the European Health Equity Status Report; **Aaron Reeves** is Associate Professor, Department of Social Policy and Intervention, University of Oxford, United Kingdom; **Lin Yang** is Consultant, World Health Organization, New York, USA; **Ben Barr** is Senior Clinical Lecturer and **Tanith Rose** is Research Associate, Institute of Population Health Sciences, University of Liverpool, United Kingdom; **Chris Brown** is Head of the WHO European Office for Investment for Health and Development, Venice, Italy. Email: johanna.hanefeld@lshtm.ac.uk

Introduction

Closing the gap in health inequities within countries has been slower than many had hoped,¹ especially since we know the policy conditions which can facilitate progress towards achieving health equity.² The World Health Organization's (WHO) recent European Health Equity Status Report Initiative (HESRI) has outlined five sets of policies that are an essential part of this agenda: 1) access to health services; 2) income security and social protection; 3) safe living conditions; 4) social and human capital; and 5) employment and working conditions.³ However, establishing health improving policies across all of these areas is not straightforward and countries have often struggled to put these policies in place. Moreover, this failure is set against a backdrop of widespread agreement

that health inequalities represent social injustices, threaten social stability and represent an unnecessary waste of lives and human potential. It is clear that health inequities should be curbed and, encouragingly, all of the five policy areas so essential for addressing health inequity are modifiable by policy decisions, which are ostensibly within the control of politicians. The puzzle, then, is not why health inequalities are so pervasive, but rather why there has been such slow progress in reducing them and, by implication, how can we accelerate action on health equity?

Again, the WHO's European Health Equity Status Report provides invaluable insight. Politicians are not simply free to remake societies once they come into

power because they are constrained both by the past and by the institutional and societal conditions that make some decisions easier to implement than others. This is because politics and policies are a product of their environment and context, and the way in which political institutions and the distribution of power shape the political process. The HESRi stresses the centrality of understanding the political determinants of health if countries are to address health inequities in the European Region.⁵

The job of political institutions is to translate the interests of individuals and groups into policies which, in turn, affect life chances. Political institutions influence population health because they make politicians more or less responsive to the preferences of citizens and this can influence policy decisions (such as whether countries implement Universal Health Coverage–UHC) that impact health and well-being. In practice, these processes are not straightforward because whether policies are responsive depends on who participates, whether processes and decision-makers are accountable and transparent, and if people and communities are genuinely empowered to have voice; these factors all drive the wider processes that determine whether we can make meaningful progress on health equity. Just because a country is a democracy does not mean their politicians will implement policies which reduce health inequalities if those with the worst health are also disenfranchised (either formally or informally) from decision-making processes. In short, the HESRi suggests that to scale up action on health equity, action needs to be taken on underlying factors driving health equity and this includes the political determinants of health.

Who has voice?

Political institutions, laws and regulations, together with institutional practices (that is, ways of doing politics, which in turn are shaped by context and history) govern who has voice (or who has the right to speak) in decision-making processes. These rules affect policy choices because politicians are not compelled to heed the voices of those who do not participate

in decision-making processes.⁶ When political institutions systematically exclude some groups from decision-making, their health is likely to suffer because their interests may be overlooked.⁶ Put simply, inclusive political institutions incentivise politicians to implement UHC, expand social protection, allow the least well-off to capture a greater share of economic growth, or other policies that could improve well-being.

“Political institutions influence population health”

Lack of political voice frequently follows a clear social gradient. Across the region, people with fewer years of education feel less able to influence politics than those with more education.⁶ This sense of lacking political voice has direct health implications because, as shown in data from the Health Equity Status Report too, health inequalities were wider in countries with higher inequalities between those who felt able to influence politics.⁶ One reason is that actual political participation tends to be lower among those who believe they have little or no influence on politics. That is, feeling powerless makes you less likely to exercise what little power you do have. Indeed health inequalities are wider in countries with greater inequalities in voting, a crucial aspect of political decision-making.⁶ When some groups do not participate in electoral processes or other forms of deliberative democracy, their values are too often discounted.

Equally, the quality of participation matters. Where involvement in the policy process signals genuine participation in decision-making, people take ownership of policy decisions and participation translates into shared power and responsibility with greater accountability. This differs from the kind of participation in political processes which is ultimately consultative and which rarely alters the status quo of power relations. Unfortunately, those with more resources

tend to have higher quality participation and thereby have a greater influence on policy processes.⁷

Empowering communities

Political institutions can also play a role in how communities get to participate in decision-making processes. Many people clearly feel disconnected from policy decisions which affect their lives and subsequently experience a lack of control. Moreover, there are inequalities here too, because such feelings are far more common among those with little or no education.⁸ A lack of control is 11 percentage points higher among men with low levels of education than men with high levels of education.

Experiencing lack of control is not just about education, however. Women are more likely to experience low levels of empowerment, and this is true of highly educated women too. In four of the countries surveyed over 40% of women with the highest level of education reported lacking freedom and having little control over their own lives.⁸ Feelings of empowerment intersect with education, social class, gender, and race and ethnicity, but they are rooted in political institutions which shape who has autonomy.

Empowering communities relies on trust because collective action and cooperation are almost impossible in situations where trust is absent. Given this backdrop, it is unsurprising that lack of trust is one of the primary drivers of health inequities across Europe, accounting for 28% of health inequities in social and human capital.⁹ Trust, of course, may have a direct effect on health through engendering social support but it is also likely to work through more political mechanisms too, such as making collective action possible.⁹

Empowering communities is also concerned with fostering social participation, which reflects the degree to which a population is involved in the decisions that affect their health. Of course, participation goes beyond that too, it is also concerned with who gets to define the problem and then how it is defined. Empowering communities entails creating governance mechanisms that

raise awareness and recognition of the rights of those groups with the greatest health disadvantage, transforming them from being ‘vulnerable’ into being agents of change for their own interests and the interests of their community. Once again, it is political institutions that determine whether communities are empowered or not.

Are policymakers accountable?

While horizontal trust (between citizens themselves) is a necessary condition for a well-functioning democracy, it is not sufficient. Effective political systems need vertical trust (between citizens and policymakers) too. One of the mechanisms for ensuring vertical trust between citizens and policymakers is transparency and accountability, and these are also some of the underlying drivers of action of health inequalities. When politicians are seen to be unaccountable and able to act in their own interests, people become disenfranchised even if they are formally allowed to participate. Indeed voter turnout tends to be lower when trust in politicians is lower too.⁸

Freedom of speech is one way citizens ensure accountability. Civil society organisations and the media play a crucial role in holding political leaders to account and when governments curtail the freedoms of these organisations it weakens their ability to work on behalf of the communities they serve. Freedom of the press, however, has faced a number of set-backs across the world in recent years and this has coincided with increasing levels of distrust of mainstream press organisations.⁹

Corruption is often high when accountability is weak and there is evidence of corruption across the European region. In the health sector, informal payments, ‘kickbacks’ from selling access to medical devices, or payments from pharmaceutical companies to physicians are all too common.¹⁰ Beyond health, corruption continues to influence politics, with some think tanks selling access to politicians for funding.¹¹ This lack of accountability

and transparency will only serve to weaken trust and slow progress toward health equity.

Commercial determinants – a spanner in the works?

The creation of political institutions that foster ‘responsive, inclusive, participatory and representative decision-making at all levels’¹² of our societies is opposed by countervailing forces that do not want to deepen democracy. These powerful, organised vested interests may work against giving voice to deprived communities and oppose efforts to increase accountability. Commercial entities are one set of actors that have, at times, tried to shape public health policy according to their own priorities, and in doing so represent the commercial determinants of health.

Clearly not all corporations actively seek to influence public health policy, and many have the potential to be an active partner in improving population health, but public health researchers have uncovered numerous examples where corporations and other vested interests have acted to the detriment of population health.¹³ Their strategies are diverse, sometimes they seek to frame the policy agenda (by shaping what policies are up for debate) while at others they try to directly influence legislation (by opposing policy change). The challenge has always been detecting precisely when and how this influence works, largely because those who deploy such power want to obscure it.

Commercial determinants play an important role in shaping population health but the outsized influence of these vested interests could be curtailed by increasing accountability, empowering communities, and giving people more voice in political decision-making.

Conclusion

‘Politics [is] nothing but medicine at a larger scale’¹⁴ and public health efforts to address health inequalities will require not just better interventions but more inclusive political systems. Addressing health inequities rests on changing political and economic systems to create

governance structures where communities can become empowered to address their own needs. Paying lip-service to notions of co-production and participation will not be enough. Instead we must value the knowledge of individual and community experiences, maximise the potential of empowering spaces, such as civic centres and citizens’ assemblies, and explicitly move away from stigmatising narratives of disadvantage. Making this move will not come easily to the health community, and it will mean creating new partners, finding new ways of working and taking on new challenges. In short, we need a step change in how we build the coalitions that put power into the hands of those who are most deeply affected by health inequity.

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THE GLOBAL CLIMATE CRISIS: A PUBLIC HEALTH EMERGENCY

By: Rachel Stancliffe

Summary: The climate crisis, the collapse of biodiversity and the widespread pollution of air, water and soil are no longer merely environmental health concerns. They are the biggest public health threats humankind has ever faced. Public health understanding and solutions, not technological fixes, are needed to guide us. Public Health has the skills and tools in research, practice and policy to help the public and government to understand the urgency of the situation and the options for dealing with it. We must now rapidly take that responsibility and work to ensure transformative change is taken to avoid climate catastrophe.

Keywords: *Climate, Environment, Emergency, Sustainability, Carbon*

Introduction

Climate breakdown now poses an immediate threat to human health and survival. This is a public health priority. This disruption is not available in a healthy dose. This disruption is an emergency happening with what will be a lethal dose for vast numbers of people. We need transformative change to avoid climate catastrophe. If we do not achieve rapid transformation, we will see increasing death tolls within our lifetimes. However, if we do, we could witness the emergence of much healthier and happier societies.

Is society at last waking up? The last year or so has seen increased awareness of the impact of humans on the ecosystem upon which they depend for survival. Over 60% of vertebrates have been lost from our

planet in less than 50 years, and humans have accelerated extinction rates up to 1000-fold. The prevalence and impacts of plastic pollution have hit the headlines.

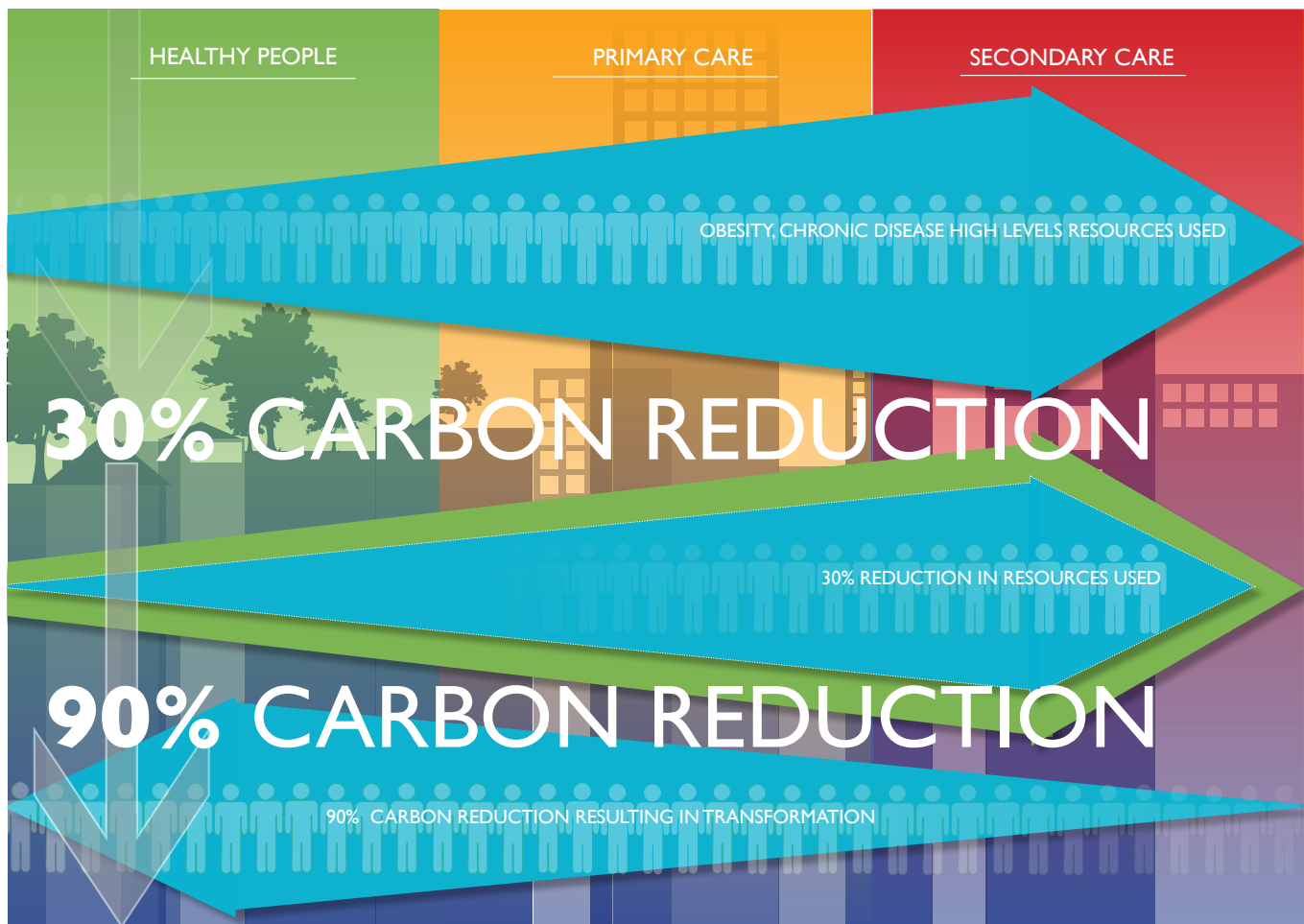
Extinction Rebellion, Greta Thunberg and others have successfully reminded us of the climate crisis, and the lack of action to address it: despite the political ‘hot air’, global greenhouse gas emissions have more than doubled in less than 40 years, and have been rising at an accelerating rate in the last three years.¹⁵ They remind us that we face a public health emergency: just as for outbreaks of communicable disease, the epidemic has already taken hold, and we must work together to limit further spread and find cures. They remind our leaders that they have a duty of care to us all.

> #EHFG2019 – Closing plenary:

The global climate crisis:
a public health emergency

Rachel Stancliffe is Director, The Centre for Sustainable Healthcare, Oxford, United Kingdom.
Email: rachel.stancliffe@sustainablehealthcare.org.uk

Figure 1: Moving towards transformation



Source: ⁹

It was, at least partly, the success of public health interventions which helped to facilitate the rapid increase in the global population and longevity, which, together with consumerism, support conditions for the current climate crisis. It is public health that will suffer the most if we do not transform urgently. Yet it is also the principles and experience of public health that are best placed to help us to understand how to re-focus health and health care to prioritise how we use our precious resources for maximum health.

Is there a climate emergency?

Over the last 100 years our consumption of our planet's resources has grown exponentially and the rate at which we are impacting our natural environment continues to accelerate. Despite over 40 years of warnings, CO₂ levels in the atmosphere have continued to rise, passing 415ppm for the first time in 2019.¹⁰

“we have
no time left for
inaction”

Earlier models suggested that global heating up to two degrees above pre-industrial times might be manageable. However, the 2018 report of the Intergovernmental Panel on Climate Change (IPCC) spells out the stark impacts of even a 1.5 degrees increase.¹¹ Historic emissions alone will drive a 1–1.2 degree ‘fever’ for our planet and heating beyond 1.5°C will cause drought, crop failure, mass starvation and the collapse of many urban civilisations. Beyond this we are likely to move through a series of tipping points which break down the stability of the climate as we know it. At the current trajectory, the planet is due

to pass the 1.5°C mark in 2030. We have just 11 years to avert ecological, social and public health disaster.

The IPCC reports that avoiding catastrophic climate change requires “rapid, far-reaching and unprecedented changes in all aspects of society”: transition to 100% renewable energy, upgrading housing stock, investment in sustainable transport infrastructure and a largely vegetarian diet. These changes, designed to protect human health in the future, will also bring substantial public health benefits now.

These changes are still – just – achievable, but only with a huge mobilisation of political will.

Dr Hugh Montgomery offers a summary of the situation in his presentation available on YouTube. He jokes that

‘homo sapiens’ is a disease that is making the earth sick, but the disease of ‘homo sapiens’ is self-limiting.

Why is the climate emergency also a public health emergency?

Humans are exploiting resources at a rate which cannot be sustained: we have drained fossil aquifers and ground water, and will soon have destroyed all the topsoil on which we can grow crops.⁵ We are destroying the ecosystems upon which the very survival of our species depends.⁶ Climate change acts as a force multiplier on such impacts and their health consequences, whilst increasing bacterial growth rates, vector borne diseases, oceanic algal blooms and ground level ozone concentrations. It drives rising sea levels and more (and more extreme) weather events: heatwaves, wildfires and flooding. Such consequences drive direct (e.g. water and air pollution) and indirect (such as famine, conflict and migration) health impacts. These are not impacts which are amenable to ‘simple fixes’.

The World Bank predicts that by 2030 the changing climate will already have reversed global public health gains of the past 50 years, throwing 100 million people back into poverty and causing at least an additional 250,000 deaths annually.⁷ These may be a very significant underestimation of the scale of mortality, given that we do not understand climate tipping points, nor the social and political factors entwined with these. The scale of the 2019 fires in the Amazon, an increase on 2018 by 84%,⁸ very clearly illustrates this. Increases in heatwaves, flooding, infectious diseases, air pollution and declining food and water security may be manageable now, but as they increase dramatically over the next decade, the social, political and financial ability to deal with them – even in rich countries – will decline.

The Lancet has supported excellent work to analyse, interpret, and publicise the connections between health and climate change, as reported in The Lancet Countdown 2018 Report.

What can public health do?

The core principle of public health—organising and using resources for the best health for all people—should guide us now. What resources are available in this crucial decade to come, and how must they be deployed? How does this relate to every domain—transport, agriculture, energy generation and more? How can policymakers support the most vulnerable, who have contributed least to the problem? How can carbon taxes on fossil fuels (such as those introduced by French President Emmanuel Macron) be made equitable and palatable to the voting populace?

How must the health service transform? Will we need to prioritise prevention over cure, at least in the short term.

And what is the role for the public health community in tracking climate change impacts (e.g. disease surveillance) and in adapting to such impacts? We may not yet know the answers to these questions. But we have no time left for inaction. We must do our best, and now.

Identifying emissions hotspots and improving surveillance of related diseases will help to detect and prevent some of the burden of disease. However, public health practitioners have a much bigger role to play. Our skills in systems thinking, bio-social relationships, equity and management must be deployed to help policymakers in every country design equitable transformations to a post-carbon world.

What can all health professionals do?

Health professionals dedicate their working lives to serve individuals and populations. Despite the efforts during the last decade of organisations including the Global Climate and Health Alliance (climateandhealthalliance.org), Medact (www.medact.org), Healthcare Without Harm (<https://noharm.org>) and my own organisation, The Centre for Sustainable Healthcare (www.sustainablehealthcare.org.uk), the commitment of health professionals to this issue has been far too timid. Health professionals, policymakers and their organisations must support and learn from the recent schoolchildren’s strikes, finding more effective ways to

help people and politicians understand the scale of the crisis. They must also transform their systems to be fit for the future.

“the
biggest known
public health
threats
humankind has
ever faced

1. Speak out

Health professionals are widely respected in our society. Use your voice to call for political and institutional action on climate breakdown. Consider supporting the work of climate change organisations and movements such as Extinction Rebellion (<https://rebellion.earth>) and the calls for declarations of climate emergency (<https://climateemergencydeclaration.org/>).

2. Develop environmentally sustainable health care systems

Sustainable health care provides health care for patients today without compromising health and care provision in the future. That seems obvious and simple. Yet we know that our lifestyles are making us ill, and our health care practices are using up natural resources far too rapidly, leaving more pollution and waste than planetary systems can handle, without consideration for the health care needs of tomorrow’s patients.

So, how do we know what is sustainable? The environmental and social sustainability of health care delivery is as important as the financial viability of services. These three elements together are often referred to as the ‘triple bottom line’. Analysing in detail the full resource use, or triple bottom line, of all that we are doing is essential in understanding what we should prioritise – we could think of it as: what gives us the most health for our triple bottom buck?

The Centre for Sustainable Healthcare's four principles of sustainable clinical practice⁸ are:

- prevention
- patient empowerment and self-care
- lean systems
- low carbon alternatives

These principles help us to prioritise resource use within health care, and direct us toward upstream spending, including preventative care and low carbon interventions.

Sustainable health requires more than a lower carbon version of today's health care. It requires transformative investment of resources to keep people healthy, rather than addressing their illnesses once they are sick (see Figure 1).

3. Connect with others

It is important to develop contacts with like-minded individuals to support you and to share ideas with. The Centre for Sustainable Healthcare (CSH) offers a range of free networks⁹ that you are welcome to join as do many of our partner organisations. Become active on social media.

4. Support the fossil fuel divestment campaign

Whether as organisations, or as individuals, how we spend our money and where we keep our money is important. Switching to renewables starts with our own energy suppliers and then we must look at where our bank and our pension funds are invested. Medact have been instrumental in driving a campaign to persuade health care organisations such as the United Kingdom Royal Colleges to divest from fossil fuels.¹⁰

Don't panic...

Above all, let us not be paralysed simply because we do not have all the answers. Policymakers must work collaboratively with researchers and practitioners to study the evidence for the best models worldwide on options for optimising use of resources for public health. We must put aside competition – there is really no

time for that – and focus all our efforts on working together to save the future of our species.

Read more, speak to everyone you know, be humble but brave and generous; begin to act.

Greta Thunberg, the Swedish student who is raising global awareness about the risks posed by climate change, speaks bluntly: “Why should I be studying for a future that soon will be no more, when no one is doing anything to save that future? ... We must change almost everything in our current societies ... Adults keep saying: ‘We owe it to the young people to give them hope.’ But I don’t want your hope. I don’t want you to be hopeful. I want you to panic ... If you have a child that is standing in the middle of the road, and cars are coming at full speed, you don’t look away because it is too hard to see, you run out and get that child away from there.”¹¹

The disruption is certainly there. We certainly need transformative change, of our health systems and of our whole societies, and more quickly than many of us can comprehend.

OK, now PANIC!

The climate crisis, the collapse of biodiversity and the widespread pollution of air, water and soil are no longer merely environmental health concerns. They are the biggest known public health threats humankind has ever faced. As professionals who understand the evidence and its implications, we owe it to our children to panic.

The time for Public Health to shine

Public health interventions have supported the population increase and rises in life expectancy over the past 150 years. Public health understanding and solutions, not technological fixes, are now needed to help respond to the climate emergency. Public Health has the skills and tools in research, practice and policy to help the public and government understand the urgency of the situation and the options for dealing with it. We must now rapidly take that responsibility and work hard by all means

available to ensure that transformative change is achieved to avoid a climate, and public health catastrophe.

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CAN PEOPLE AFFORD TO PAY FOR HEALTH CARE? NEW EVIDENCE ON FINANCIAL PROTECTION IN EUROPE

By: Sarah Thomson, Jonathan Cylus and Tamás Evetovits

Summary: New analysis shows that out-of-pocket payments lead to financial hardship for people using health services, even in high-income countries that cover the whole population. To strengthen financial protection, countries need to focus on the design of health coverage, paying attention to policy on co-payments for outpatient prescriptions – a key determinant of financial hardship, especially in countries where the scope of the publicly financed benefits package is adequate. Learning from a wealth of good practice in Europe, countries can improve co-payment policy by introducing exemptions for poor people, applying annual caps to all co-payments and replacing percentage co-payments with low fixed co-payments.

Keywords: Access, Affordability, Co-payments, Financial Protection, Universal Health Coverage

Out-of-pocket payments undermine universal health coverage in Europe

New evidence from the World Health Organization (WHO) Regional Office for Europe finds that when people have to pay out of pocket for health care, some of them face barriers to access and forego treatment due to the cost involved; some pay and suffer financial hardship; and some experience both unmet need and financial hardship. ¹

The new WHO study draws on contributions from national experts in 24 countries in Europe, involving analysis of microdata from household

budget surveys and analysis of national policy developments. It reveals that:

- between 1% and 9% of households are pushed into poverty, or further into poverty, as a result of out-of-pocket payments;
- between 1% and 17% of households experience catastrophic health spending, which may mean they can no longer afford to meet other basic needs such as food, housing and heating;
- catastrophic health spending is consistently concentrated among the poorest 20% of the population;
- it is mainly driven by out-of-pocket payments for outpatient medicines; and

> #EHFG2019 – Forum 7:
Can people afford to pay for health care?

Sarah Thomson is Senior Health Financing Specialist and **Tamás Evetovits** is Head, World Health Organization Barcelona Office for Health Systems Strengthening, Barcelona, Spain; **Jonathan Cylus** is Economist and London Hub Coordinator, European Observatory on Health Systems and Policies, London, United Kingdom.
Email: thomsons@who.int

- the share of people foregoing needed health services, including prescribed medicines, is high in countries where financial protection is weak.

“Financial protection is a core dimension of health system performance

Ensuring everyone can use quality health services without experiencing financial hardship – universal health coverage – is a Sustainable Development Goal (SDG targets 3.8.1 and 3.8.2) all countries have

committed to reach by 2030,² and a priority for WHO (see Box 1). This new study is the first systematic attempt to monitor financial protection in Europe.³

Out-of-pocket payments push people into poverty or make them even poorer

There is wide variation in the incidence of impoverishing health spending among European Union (EU) countries and among non-EU countries (see Figure 1).

The poorest households are most likely to experience financial hardship

The incidence of catastrophic health spending varies widely among EU countries (see Figure 2). Among non-EU countries, the incidence is generally high

(over 12%). Across Europe, people in the poorest quintile are consistently most at risk of catastrophic health spending.

Outpatient medicines are the main driver of financial hardship

Out-of-pocket payments incurred by households with catastrophic health spending are mainly due to outpatient medicines, followed by inpatient care and dental care. The share of catastrophic health spending due to outpatient medicines is consistently higher than average in the poorest quintile (see Figure 3).

Unmet need must be part of the analysis

Financial protection indicators capture financial hardship arising from the use

Box 1: What is financial protection, why does it matter and how is it measured?

Financial protection is a core dimension of health system performance and central to universal health coverage.¹

People experience financial hardship when out-of-pocket payments are large in relation to their ability to pay for health care. Small out-of-pocket payments can cause financial hardship for poor households or those who have to pay for long-term treatment. Large out-of-pocket payments can lead to financial hardship for rich households as well as poor households.

Where health systems fail to provide financial protection, some people may be forced to choose between using health services and meeting other basic needs such as food, housing and heating; some may forego health care, resulting in unmet need. Lack of financial protection can therefore reduce access to health care, undermine health status, deepen poverty and exacerbate health and socioeconomic inequalities.

Because all health systems involve some out-of-pocket payment, financial hardship linked to the use of health services can be a problem in any country.

Financial protection is measured using two indicators:

- Impoverishing health spending provides information on the impact of out-of-pocket payments on poverty. A household is impoverished if its consumption is above the poverty line before spending out of pocket and below it after spending out of pocket (it is no longer able to afford to meet basic needs). A household can also experience impoverishing health spending if its consumption before spending out of

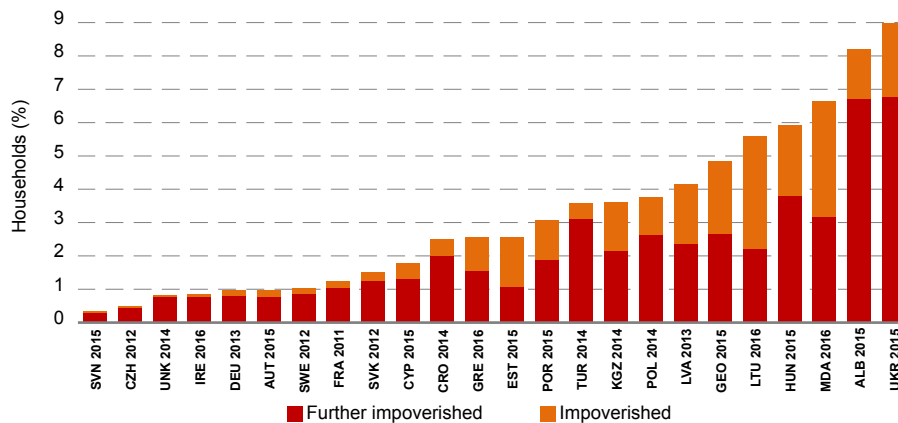
pocket was already below the poverty line (it was already unable to meet basic needs); it is further impoverished after spending out of pocket.

- Catastrophic health spending occurs when the amount a household pays out of pocket exceeds a predefined share of its ability to pay for health care. This may mean the household can no longer afford to meet other basic needs.

Financial protection indicators can be calculated in different ways, using a range of metrics.^{5 6} The WHO Regional Office for Europe has developed new metrics to measure financial protection in response to concerns that the method used to measure financial protection in the SDGs (SDG target 3.8.2), and other global approaches, pose a challenge for equity and have limited relevance for Europe.¹ Building on established methods, the metrics used in the new WHO study are less likely to underestimate financial hardship among poorer people than the SDG metrics because they account for differences in household capacity to pay for health care.^{5 6} The aim is to measure financial protection in a way that is relevant to all countries in Europe, produces actionable evidence for policy and promotes policies to break the link between ill health and poverty.

All financial protection metrics draw on similar sources of data, typically household budget surveys; define out-of-pocket payments in the same internationally standard way as formal and informal payments made at the time of using any health care good or service provided by any type of provider; and measure financial protection at the level of the health system, not at the level of different types of health care, diseases or patient groups.

Figure 1: Share of households with impoverishing health spending, latest year available



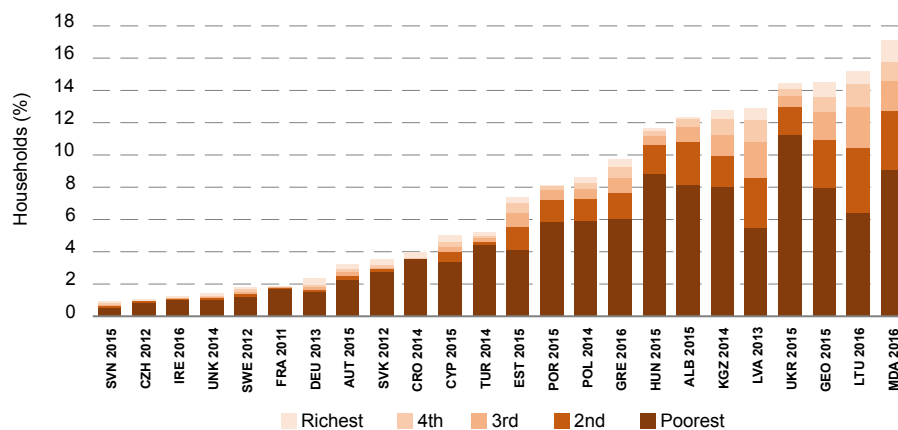
Note: ALB: Albania; AUT: Austria; CRO: Croatia; CYP: Cyprus; CZH: Czechia; DEU: Germany; EST: Estonia; FRA: France; IRE: Ireland; GEO: Georgia; GRE: Greece; HUN: Hungary; KGZ: Kyrgyzstan; LTU: Lithuania; LVA: Latvia; MDA: Republic of Moldova; POL: Poland; POR: Portugal; SWE: Sweden; SVK: Slovakia; SVN: Slovenia; TUR: Turkey; UKR: Ukraine; UNK: United Kingdom.

Source:

of health services, but do not indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need. Bringing together data on financial hardship and unmet need reveals the following findings.

In countries where the incidence of catastrophic health spending is very low, unmet need also tends to be low and without significant income inequality.¹⁴ The incidence of catastrophic health spending and levels of unmet need are both relatively high in many countries, and income inequality in unmet need is also significant, indicating that health services in these countries are not affordable, especially for poorer households.

Figure 2: Share of households with catastrophic health spending by consumption quintile, latest year available



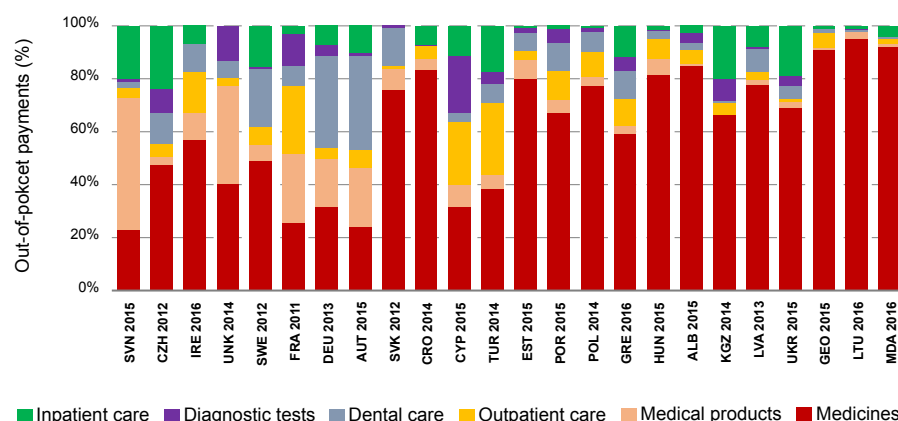
Notes: consumption quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales. The first quintile is labelled "poorest" and the fifth quintile "richest".

Source:

Some health services – notably dental care – are a much greater source of financial hardship for richer households than poorer households. This reflects higher levels of unmet need for dental care among poorer households than richer households in most countries.¹⁵

Unmet need for prescribed medicines is generally higher in countries with a higher incidence of catastrophic health spending, which indicates that out-of-pocket payments for medicines lead to both financial hardship and unmet need for poorer people.¹⁶

Figure 3: Breakdown of out-of-pocket payments by health service among households with catastrophic health spending in the poorest consumption quintile



Note: countries ranked by incidence of catastrophic health spending from lowest to highest.

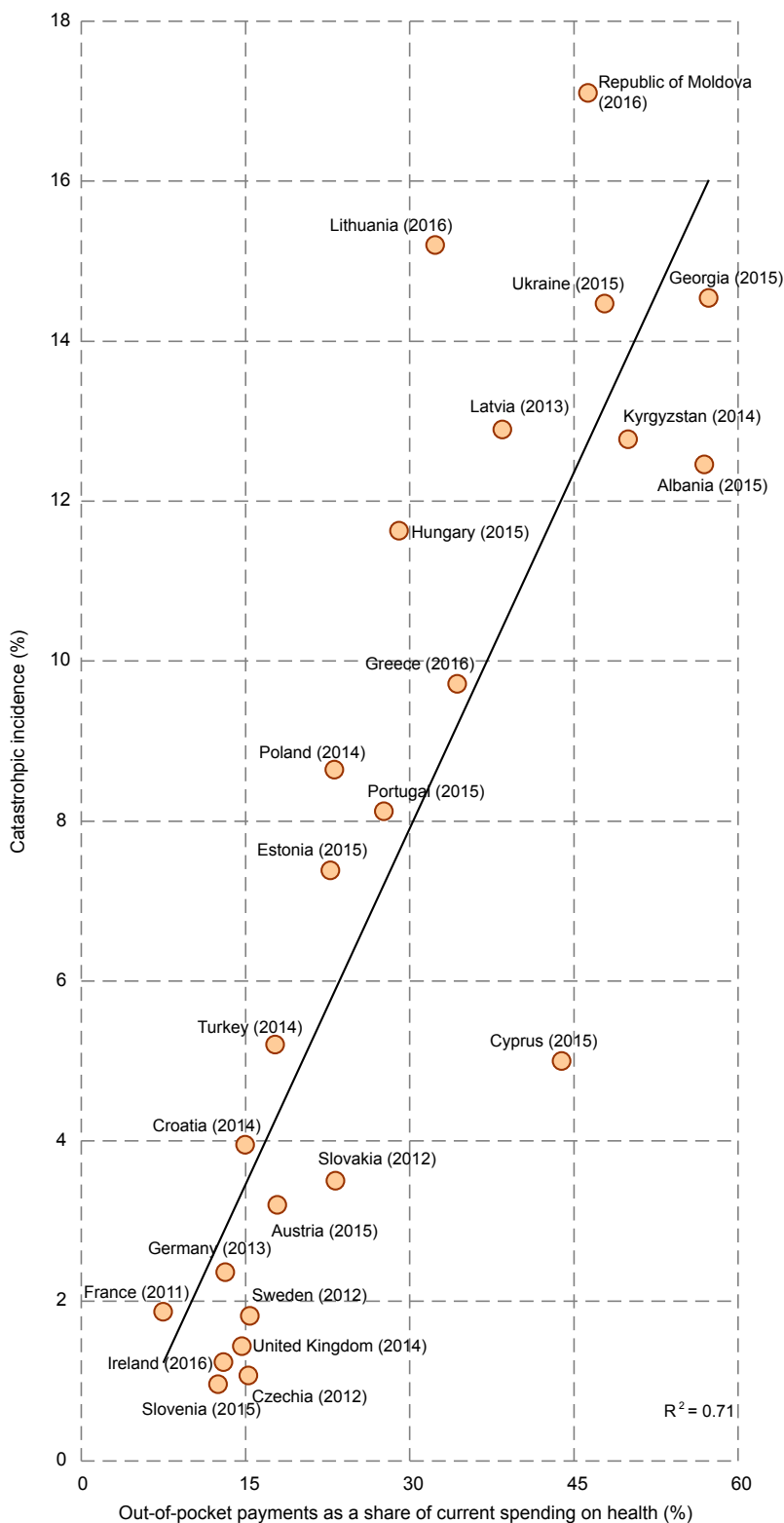
Source:

Factors that strengthen financial protection

Health systems with strong financial protection and low levels of unmet need share the following features:

- there are no major gaps in health coverage;
- coverage policy – the way in which coverage is implemented and governed – is carefully designed to minimise access barriers and out-of-pocket payments, particularly for poor people and regular users of health services;
- public spending on health is high enough to ensure relatively timely access to a broad range of health services without informal payments; and, as a result

Figure 4: Incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health, latest year available



Notes: R^2 : coefficient of determination. Data on out-of-pocket payments are for the same year as data on catastrophic incidence. The association between catastrophic incidence and the out-of-pocket payment share excluding out-of-pocket payments for long-term care is almost identical ($R^2 = 0.70$).

Source: ¹

- out-of-pocket payments are low, accounting for less than or close to 15% of current spending on health.

The strong association between the incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health (see Figure 4) suggests that the out-of-pocket payment share can be used as a proxy indicator for financial protection when data on financial protection are lacking.

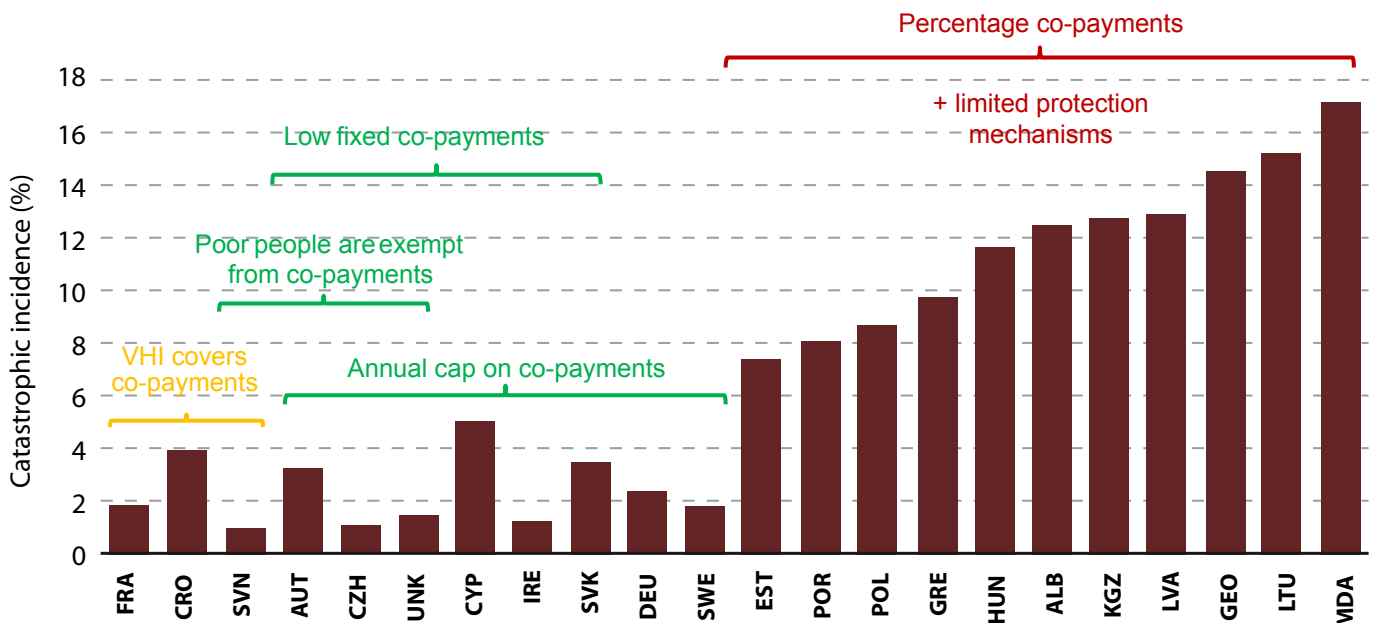
“Better co-payment policy plays an important role in reducing financial hardship”

Addressing gaps in coverage to reduce financial hardship

Across countries, public spending on health is shown to be much more effective in reducing out-of-pocket payments than voluntary health insurance.¹ Increases in public spending on health or reductions in out-of-pocket payments are not enough to improve financial protection in all contexts, however. Coverage policies play a key role in determining financial hardship, not just patterns of spending on health.

Gaps in coverage arise from weaknesses in the design of three policy areas:

- the basis for population entitlement leaves some people without access to publicly financed health services;
- the range of services that is publicly financed – the benefits package – is narrow, or there are issues relating to the availability, quality and timeliness of these services; and
- there are user charges (co-payments) in place for services in the benefits package.

Figure 5: Catastrophic health spending and the design of co-payments for outpatient prescribed medicinesSource: ¹

Weaknesses in coverage policy undermine equity and efficiency by creating financial barriers to access. They also shift the financial burden of paying for health care on to those who can least afford it – poor people and regular users of health services – and encourage inefficient patterns of use.

Acting on the evidence: better co-payment policy is key

The first step to strengthening financial protection is to identify gaps in coverage in a given context. The next step is to find ways of addressing them through a careful redesign of coverage policy.

Co-payment policy is a key determinant of financial protection in European health systems (see Figure 5). It is the most important factor in countries where financial hardship is driven by outpatient medicines and the scope of the publicly financed benefits package is adequate.

Countries can improve co-payment policy by introducing exemptions for poor people, applying annual caps to all co-payments and replacing percentage co-payments with low fixed co-payments.

There is a wealth of good practice in Europe. Lessons can be learned from

countries with strong financial protection and countries where financial protection is weak overall but steps have been taken to protect poor people.¹

Acting on the evidence: progressive universalism ensures no one is left behind

Better co-payment policy plays an important role in reducing financial hardship because it allows the health system to target the people most in need of protection. Taking steps to benefit the most disadvantaged first – an approach known as progressive universalism² – is vital in contexts where public resources are severely limited. It also offers advantages in countries that do not face a severe budget constraint, enabling them to meet the challenge of leaving no one behind by ensuring that poor people gain at least as much as those who are better off at every step on the path to universal health coverage.

Progressive universalism rests on the ability to identify the health services most likely to lead to financial hardship, the people most likely to be affected and the root causes of gaps in coverage. This, in turn, requires indicators and metrics amenable to equity analysis, like those developed and used by WHO in Europe.^{1 5}

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Can people afford to pay for health care? New evidence on financial protection in Europe

By: WHO Regional Office for Europe

Copenhagen: WHO Regional Office for Europe, 2019

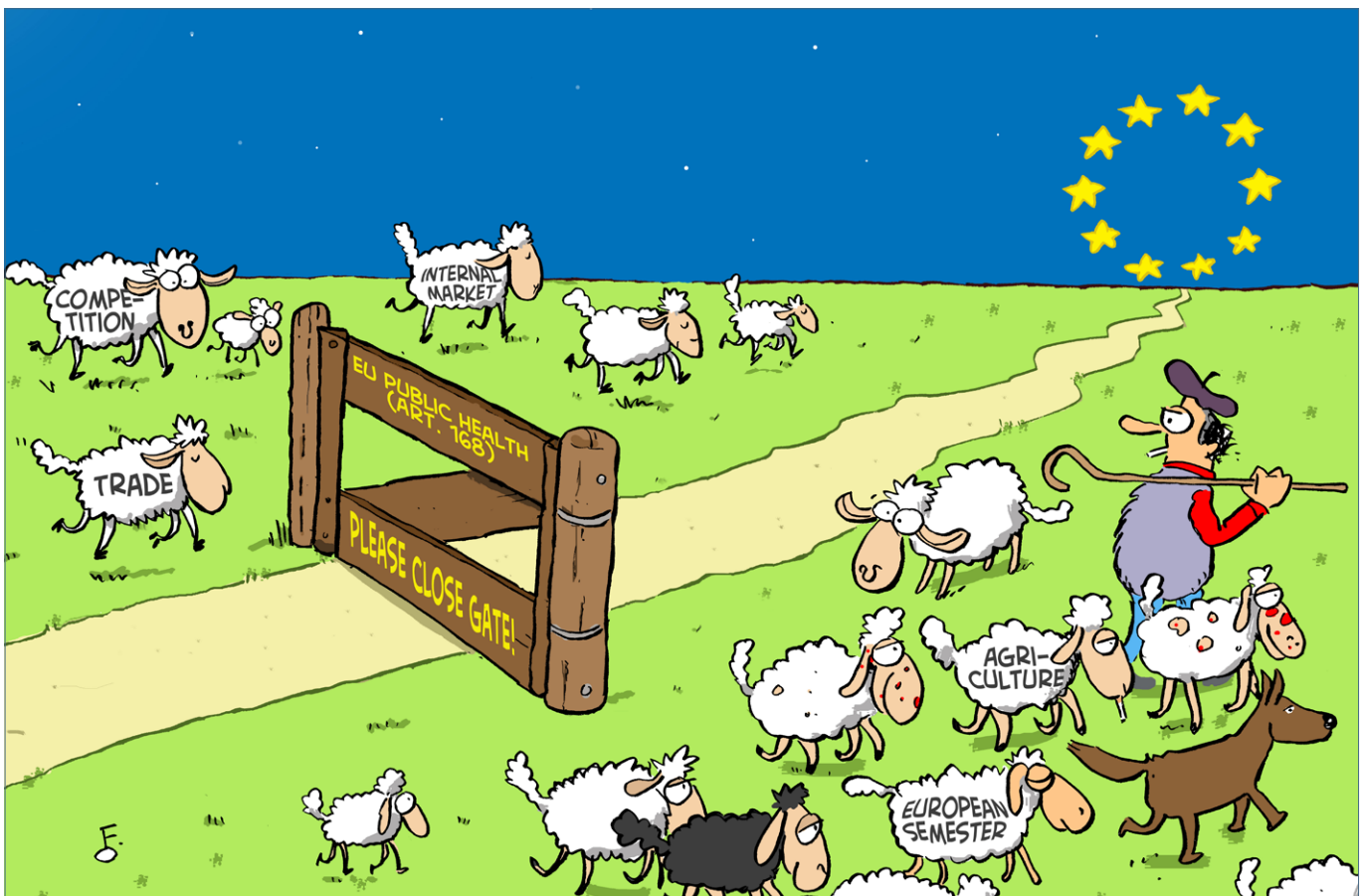
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Freely available for download: <http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2019/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-europe-2019>

This new study brings together for the first time data on unmet need and financial hardship to assess whether people living in Europe can afford to pay for health care.

Drawing on contributions from national experts in 24 countries, the study shows that financial hardship varies widely in Europe, and that there is room for improvement even in high-income countries.

Through analysis of microdata from household budget surveys and analysis of national policy developments, the study identifies practical steps countries can take to reduce unmet need and financial hardship. It also highlights actions that should be avoided.



EUROPEAN UNION HEALTH POLICY: THE GATE WITH NO FENCE

By: Scott L. Greer

Summary: As the European Union (EU) institutions are gearing up to start a new legislative term, with new Commissioners, new European Parliamentarians and even some new governments, it is perhaps a good moment to remind us how EU health policy is developed and what the scope and constraints are of the health mandate that Member States have attributed to the EU level. This is exactly the idea behind a new publication – or rather a revised edition of a previous “best seller” – called *Everything you always wanted to know about European Union health policy but were afraid to ask*.

Keywords: Regulation, Internal Market, Fiscal Governance, Public Health, European Semester

Introduction

Picture this: a freestanding gate in a field with no fence on either side. It might be good gate: solid, well-oiled, easy to open and sturdy when closed. But if there is no fencing on either side, people and animals can just go around it.

A gate with no fence on either side is an apt description of Article 168 of the Treaty on the Functioning of the European Union (TFEU) that lays out the European Union’s (EU) public health powers, as we argue in our new, completely revised edition of *Everything you wanted to know about European Union health policy but were afraid to ask*.¹ Make no mistake, Article 168 is a gate that Member States intend to keep closed most of the time. The Article is a virtual lexicon of cautious phrases and exclusions that constrain, rather than foster, EU action in this field (see Box 1).

With such a legal base, it might almost seem miraculous that a considerable body of EU health policy has been developed

over time. But all of these limiting phrases do not add up to a fence that keeps out EU public health action. Rather, they constitute a sturdy gate that can be opened when Member State governments choose. And they have on several occasions decided to open the sturdy gate, over time, with actions including the creation of the European Centre for Disease Prevention and Control and invocation of Article 168 in a variety of important pieces of legislation such as the General Food Law of 2002 (Regulation 178/2002) and the directive on cross-border patient mobility (Directive 2011/24).

But the gate of Article 168 that Member States so laboriously constructed stands alone in a field with no fence, and so other dimensions of EU health policy and integration can simply go around it.

Walking around the gate with internal market regulation

On one side, there is no fence keeping out the massive amount of internal

Scott L. Greer is Senior Expert Advisor on Health Governance to the European Observatory on Health Systems and Policies, Brussels, Belgium, and Professor of Health Management and Policy, Global Public Health and Political Science at the University of Michigan, Ann Arbor, USA.
Email: slgreer@umich.edu

Box 1: Article 168 of the Treaty on the Functioning of the European Union

“Union action, ... **shall complement national policies...** The Union **shall complement the Member States’ action...** The Union **shall encourage cooperation** ... and, if necessary, **lend support ... improve the complementarity** of their health services in cross-border areas...**Member States shall**, in liaison with the Commission, ... **coordinate among themselves** their policies and programmes ... **The Commission may**, in close contact with the Member States, **take any useful initiative to promote such coordination ... adopt incentive measures** designed to protect and improve human health ... **excluding any harmonisation of the laws and regulations of the Member States...** and adopt **recommendations** ... Union action... shall **respect the responsibilities of the Member States** for the definition of their health policy and for the organisation and delivery of health services and medical care. The **responsibilities of the Member States** shall **include the management of health services and medical care and the allocation of the resources** assigned to them”.

Source: Selected excerpts from Article 168(2); boldface added for emphasis.

market regulation that is the traditional core of the EU. This is the legislation and policy involved in the ongoing EU project of unification through the market, promoting deregulation in Member States by removing policy that discriminates on the basis of Member State origin, and replacing it with regulatory floors at the EU level. The internal market is the basis of most EU law, and it certainly is in the case of health.

Consider the Directive on the application of patients’ rights in cross-border health care, a case of the EU simply walking around the gate on one side. The substantive policy impact involved was and remains minor, since people who are willing to pay out-of-pocket for health care services abroad and then claim reimbursement are not very numerous. For most cases, EU social security coordination rules, which organise the exportation of social security rights, including the European Health Insurance Card (EHIC), are able to solve the key problems of patient mobility. The whole issue of patient mobility is less consequential in substantive terms than the issue of health professionals’ mobility.⁶ None of that really matters, though, given that the issue of patient mobility in EU law and politics referred to the assimilation, by the European courts, of health care to internal market law starting with the 1998

Kohll and Decker decisions and the fallout from those cases.⁷ Over two decades, the European Court of Justice has learned more about health care, health care actors have learned more about operating in the EU, and the EU has passed legislation which accepts that health care is a service and regulates it as such. That legislation, the 2011 directive,⁸ uses internal market law as a jumping off point for cross-border health systems improvements, such as better interoperability of health information technology systems and a stronger EU role in health technology assessment (with internal market law now the basis for a proposed Regulation further enhancing it). The case of patient mobility showcases it all:⁹

- how court rulings applying internal market law simply bypassed the careful constricting language of Article 168
- how the solution was to accept an EU role grounded in the internal market build better legislation on internal market treaty bases, and
- how the policies over time actually came to contain potentially valuable and supportive health systems policy.

Sidestepping the gate with fiscal governance

Next consider fiscal governance, a case of the EU walking around the gate on

the other side. Fiscal governance refers to the rules binding Member States, especially Eurozone Member States, to avoid profligacy that might endanger the Euro. It was substantially strengthened in the aftermath of the 2008 financial crisis, which manifested in Europe as a series of sovereign debt crises starting at the end of 2009 and some highly controversial bailouts. The logic of fiscal governance is to both punish Member States that run excessive deficits or macroeconomic imbalances and to preemptively monitor and shape their policies in order to prevent such bad behaviour. There is an elaborate coercive set of mechanisms in EU law now, backed up by an intergovernmental treaty.¹⁰ There is also a complex mechanism designed to promote good policy and prevent bad policy, justified by fiscal governance legal bases, called the “European Semester.”¹¹

“turn these policies and legal bases to ends that promote health

The European Semester is a year-long process of budgetary surveillance, with complex relationships between EU institutions’ evaluations of Member States and Member States’ contribution to broad EU goals. From its inception, the Semester took an interest in health simply because it is big, expensive and publicly funded, and it would be very strange for a procedure focused on preventing excessive deficits to ignore such a big and expensive public sector. This is irrespective of what Article 168 might say about Union action respecting the “responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care” (point 7). The result was a large number of recommendations about health services, not always with a coherent basis in good data or understanding of health policy, such as the puzzling 2015 recommendation

that France should reconsider the *numerus clausus* (limiting the number of students) for health professional education.¹³ But again, over time and as with previous EU governance initiatives, the goals began to expand beyond simple budgetary control and to include an understanding of health as desirable in its own right and as a social investment. The number of Country-Specific Recommendations about health produced by the Semester increased, but also became more nuanced, sensitive, and potentially helpful for health. This reflected, in large part, health ministries, experts, Commission officials and advocates who engaged with the Semester and made clear the benefits of health, showing that it was not just a cost, and argued for subtler and more complex policy recommendations.

Using market regulation and fiscal policy to promote health

In the cases of both market regulation and fiscal governance, the opportunity for health advocates, as well as the most effective defensive posture, has been to turn these policies and legal bases to ends that promote health. In the case of the internal market, much has been done to promote health on internal market bases. In the case of fiscal governance, what began as an often crude and austerity-minded intervention has increasingly become supportive of more egalitarian, higher quality, and even better funded health systems. The gate did not keep the EU out, but the entrance of the EU could be turned into something harmless or valuable to health.

That situation is even clearer when we remember that Article 168 is not even the only Treaty article that *explicitly* presents health as an EU goal. The Treaty chapters on Consumer Protection (Art. 169 TFEU), Environment (Art. 191 TFEU), and Social Policy (Arts. 151, 163, 156 TFEU) all call for health as a key goal, above and beyond the general call in Article 9 of TFEU for the EU to pursue a “high level of protection of human health.” It is almost certain that laws made under these legal bases have saved more lives than laws justified by Article 168. Workplace safety, work-life balance, and the control of potentially existential environmental risks,

such as climate change, are all clearly contributors to health where the EU has often taken a leadership role.

The EU has, further, partially resiled from the austerity and economic focus that it adopted immediately after the debt crisis that focus had led to the explicit and effective devaluation of health in many EU policy areas (such as alcohol, diet, physical activity, and nutrition). The European Pillar of Social Rights enumerated 20 rights, including a right to health care and social care as well as rights with obvious health dimensions such as a right to adequate housing. The Commission adopted the United Nations’ Sustainable Development Goals as its own programme, bringing priorities such as health, climate change, and equalities into the Semester and other processes as EU goals. EU Presidencies have argued for a focus on well-being as an explicit goal. These initiatives and declarations mark a shift from the near-exclusive focus on markets and fiscal rigor of a decade ago. They reflect the work of advocates for a broader and healthier EU, and further empower them.

Conclusions

Article 168 might be a beautifully constructed gate, but without a fence on either side, its well-oiled hinges and solid bars have failed to give Member States control over their health care systems or isolate them from EU policy and law. On one side, internal market legal bases underpin EU regulation of health care services as well as EU policies that affect health in many ways, often for the better. On the other side, fiscal governance mechanisms born in 2012–13 were by 2015 producing detailed recommendations about Member States’ health systems, and by 2019 were being mobilised to support good health policies in Member States. Given that the Juncker Commission did not prioritise health as a goal or a policy area, we might be impressed by the number of good things for health that happened even in years when the gate was rarely opened.

When we see a gate in a field with no fence, it usually means that somebody will come along and build the rest of the

fence. There are good practical reasons for a farmer to build the gate before the fence. But the history of EU health policy tells us: there will be no fence. The challenge for everybody in health is to pay less attention to that beautiful, sturdy, defensive gate, and to pay more attention to the whole field and everything in it. There is much EU policy affecting health. The question is whether there will be EU policy for health.

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Everything you always wanted to know about European Union health policies but were afraid to ask (Second, revised edition)

By: SL Greer, N Fahy, S Rozenblum, H Jarman, W Palm, HA Elliott and M Wismar

Copenhagen: World Health Organization (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies), 2019

Freely available for download: <http://www.euro.who.int/en/about-us/partners/observatory/publications/studies>

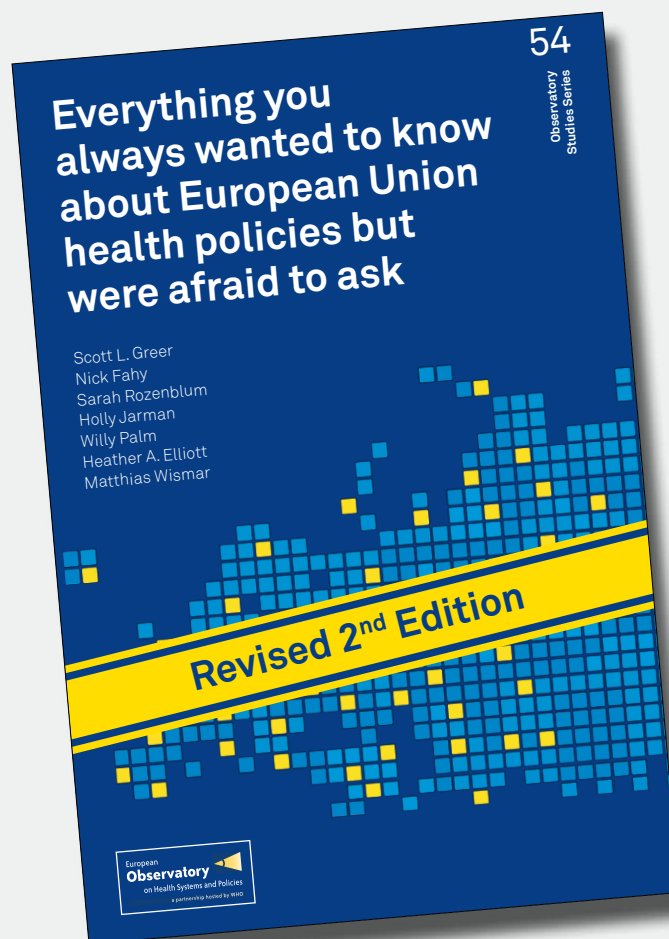
What does the European Union mean for health? What can it mean for health?

This comprehensively revised second edition answers these questions. It provides a comprehensive review and analysis of European Union (EU) public health policies to mid-2019. It covers the three faces of EU health policy. After explaining the basic politics of European integration and European policymaking in health, including the basic question of how the EU came to have a health policy and what it can do, it moves on to the three faces of EU health policy.

The first face is explicit health policy, both public health policy and policies to strengthen health services and systems in areas such as cancer, and communicable diseases. The second face is internal market building policies, which are often more consequential for health services but are not made with health as a core objective. These include professional and patient mobility, regulation of insurers and health care providers, competition in health care. They also include some of the policies through which the EU has had dramatic and positive health effects, namely environmental regulation, consumer protection and labor law. The third face is fiscal governance, in which the EU institutions police Member State decisions including health. Each face has different politics, law, policy, and health effects.

The book provides a synthesis with sources of the different faces and the different ways in which they have been used to strengthen or weaken public health and health systems in Europe. It shows the many ways that the EU has worked for health, often unappreciated, as well as the opportunities to further strengthen the EU's positive impact on health. This book is aimed at policymakers and students of health systems in the EU who look to understand how the influence of the EU on health policy affects those systems and their patients. To ensure that the EU's impact on health is wholly positive, the wider health community must understand and engage with the EU in the future -something this book aims to encourage.

Contents: Introduction; The EU: institutions, processes and powers; EU action for health; The EU market shaping health; Fiscal governance of health; Conclusion; Appendices.



**This publication is launched
at the European Health
Forum Gastein 2019**

I AM THE EUROPEAN COMMISSIONER FOR HEALTH, NOT FOR DISEASE!

Farewell interview with Health Commissioner Andriukaitis

Interview by Willy Palm, Senior Adviser, European Observatory on Health Systems and Policies, Brussels, Belgium. Email: palmw@obs.who.int

With less than two months to go, Vytenis Andriukaitis from his office in Brussels looks back at his mandate as European Health and Food Safety Commissioner and shares his wishes for the future.

Q Commissioner, thank you for taking the time to reflect on your experience of the last four years. What was your ambition when you took office in 2014 and how do you assess the state of health in the EU now that your term is nearing its end?

During these past four years my compass has been the definition of health as enshrined in the World Health Organization Constitution, health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. For me these are not idle words. The prevention and cure of diseases and the fight against their risk factors is only part of the game. We need to start thinking differently about health. We cannot just limit ourselves to only talk about healthy food and more exercise. We need to expand our perspective to “healthiness” and promoting healthy environments: families, schools, work places and cities. Otherwise healthy lifestyle becomes a narrow concept.

Healthiness implies broadening our tools for keeping people healthy, both physically and mentally, during the whole life-course. It requires systematically monitoring the health and well-being of newborns, children, adolescents, adults and older people with a new set of parameters. If we want to be really serious about healthy ageing, a change of paradigm is needed, moving away from a single disease or risk

factor approach, empowering our citizens to monitor their health, also using new digital technologies and devices.

I’m very happy that Finland for its current EU Presidency decided to focus on health as part of well-being. This is a big step forward and this broader approach aligns with the concept of Health in All Policies, which was the focus of the Finnish EU Presidency back in 2006.

I see a lot of opportunities. Last year we established the EU Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases. This group will help to work out new instruments and concrete proposals to address the different determinants related to health, not only disease.

Q Looking back, what are you most proud of in terms of successes and achievements?

I think we did a lot so it is difficult to limit myself to only a few.

Perhaps I am most proud of the State of Health in the EU, the two-year cycle that we put in place to describe and monitor the status of health and health systems in the EU. From the start of my mandate



I asked DG SANTE (the Directorate-General for Health and Food Safety) to improve our knowledge and capacity to assess the status of health and health reforms in Member States. With the help of the OECD and the European Observatory on Health Systems and Policies we managed this and it gave a real impetus to EU health policy. It allowed us to develop constructive recommendations for the European Semester process that can help to improve access to care and prevention, but also to draw the attention of other DGs to the importance of health for the wider economy.

Together with the progress that we made on developing sound methodologies for assessing the performance of health systems and the linkage with the financial instruments, we now have a robust set of tools and instruments to help Member States in reforming their health systems and achieve better outcomes.

But it is only just the beginning. So far, the State of Health in the EU cycle has been mainly looking at public health and health care. Again, we will have to broaden our perspective and look at the health dimension in other sectors, including education, transport and environmental protection. All ministers need to take responsibility for health and well-being of the populations they serve.

In the field of health care, I am particularly proud of the European Reference Networks, which were launched during my mandate, and enable the exchange of all the available knowledge and expertise on rare diseases. This is an absolute miracle and a clear example of how the EU can be beneficial to its citizens. This is also true for other areas like eHealth and the digitalization of health care, where the Commission's work on advanced therapies, big data and the one million genome project is helping to build a new ecosystem for the use of artificial intelligence in health care.

In the area of pharmaceuticals, we have managed to put the issue of access high on the political agenda. Our proposal on health technology assessment received the support of the European Parliament. Now it is up to the Council to finalise the work.

We were also very vocal on the importance of vaccination and provided tools and strategies for Member States to improve vaccination coverage rates. Similarly, we pushed the beacons on fighting against Antimicrobial Resistance, with a new One Health action plan based on three pillars – agriculture, environment and health care – and a close collaboration between the three agencies,

the European Centre for Disease Prevention and Control (ECDC), the European Food Safety Authority (EFSA) and the European Medicines Agency (EMA).

During my mandate, we have shown that by working together, between services in the Commission but also hand in hand with Member States, we can solve common problems and overcome international crises. This is what we did with Ebola at the beginning of my term. This is also what we did in the midst of the migration crisis, providing concrete solutions and coordinating support, such as creating temporary health records for migrants, monitoring their health and ensuring access for them to primary care services.

Q ■ It probably hasn't always been an easy ride. You encountered set-backs and push-backs. What has been your biggest disappointment?

Probably I'm mostly disappointed by the fact that there is still much misunderstanding about the EU's role in health, not only at Member State level but even within the European institutions.

What people often fail to see is that the Lisbon Treaty gives a clear and strong mandate for the EU to act on health. While they keep on referring to the principle of subsidiarity, this only relates to the organisation of health services, which clearly is a Member State responsibility where the EU can only coordinate, cooperate and facilitate, like we do in the field of cross-border care. But, when it comes to the concept of Health in All Policies, this is completely enshrined in the Lisbon Treaty and the protection of human health is a responsibility for every single Commissioner.

The Tartu Call for a Healthy Lifestyle made this very clear. Together with my fellow Commissioners, Tibor Navracsics (Education, Culture, Youth and Sport) and Phil Hogan (Agriculture and Rural Development), I signed 15 commitments to promote healthy lifestyles through sport, food, innovation or research. This is also why I am so proud of the joint commitment that the Commission has demonstrated in the implementation of the Sustainable Development Goals (SDGs). Of all 17 SDGs, 14 are related to health. An expert team recently concluded that the most progress has been made on SDG 3 (Ensure healthy lives and promote wellbeing for all at all ages).

We did a lot to act upon the health determinants and reduce premature death of EU citizens, like in the field of tobacco. Yet, there is so much more that the EU can do: through taxation or regulating marketing practices for instance. Look at our supermarkets and

how easy it is for people, including children, to get unhealthy and harmful products, like sugary drinks and alcohol. Excise duties haven't changed since 1992 because you need unanimity in the Council of Finance Ministers.

Lack of action and political will cost lives. I often felt alone when calling for bolder action on health promotion, prevention and protection. Our policies to fight against diseases like cancer, diabetes and obesity are weakened by the lack of action on the root causes. I am Commissioner for health, not for disease! You get a lot of support for using the EU's financial instruments to invest in health care infrastructure or diseases, but less when you want to use them for investing in the development of "healthiness valleys" where all people can enjoy good health.

Q ■ During your mandate the EU went through some politically challenging times. How do you see the future of the European integration project?

I hope the next Commission will continue the work in the same spirit. In my Mission Letter from Jean-Claude Juncker in 2014 when taking office, he concluded with the words: "We live in a Union with a 29th state of unemployed people, many of them young people who feel side-lined. Until this situation has changed, this 29th state must be our number one concern, and we have to be very determined and very responsible in carrying out our work as Members of this Commission."

Today, 100 million EU citizens still live in poor or very difficult conditions. Certain regions in the EU are abandoned. Progress on closing gaps within and between Member States is too slow. Fifteen years after ten Central-European countries joined the EU, people don't see the convergence between richest and poorest parts. The financial crisis has made a great part of the European population feel insecure about the future, especially the younger generation. This feeling has been abused by populist movements and politicians to bedazzle them with simplistic and fake solutions.

For me it's clear, the only sustainable solution can come from more European solidarity and cooperation. We need to organise a new debate on strengthening the social component of the EU, and translate the pillar of social rights into reality for all citizens. Only a strong social Europe can help us overcome our other challenges, including climate change. Only through more European integration and concrete cooperation with actors on the ground—in regions, in cities and local communities—can we help solve national and local problems, break the Brussels bubble and

convince people of the added value of the EU. But let's not fool ourselves, with an EU budget of 1% of Member States' GDP this is not going to be enough.

Q ■ To conclude, what are your thoughts on the European Health Forum Gastein, which you always faithfully attended?

Unfortunately, last year I couldn't attend. But I have always been a big fan of the Gastein Health Forum. Next to health promotion, prevention and protection, I am also convinced of the importance of health participation, the involvement of citizens and civil society. Gastein is a great place to discuss all these issues with the wider health community and to join forces in fighting fake news and misinformation in health and distrust in science.

“the only sustainable solution can come from more European solidarity and cooperation”

I wish it could become as big as the World Economic Forum in Davos, showing another and more sustainable approach to creating health and well-being for all citizens in Europe.

Let me also tell you, I am grateful for all the support I received. I feel I'm part of a broad international team. Together we started changing the narrative on health. Let's continue our work.

Thank you, Commissioner! What are your plans for the future?

First, I want to finish my mandate and pass the ball to my successor in the best possible way. After that I will return to Lithuania. I have no concrete plans yet, but I will definitely continue to advocate for health as a normal and committed European citizen.



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