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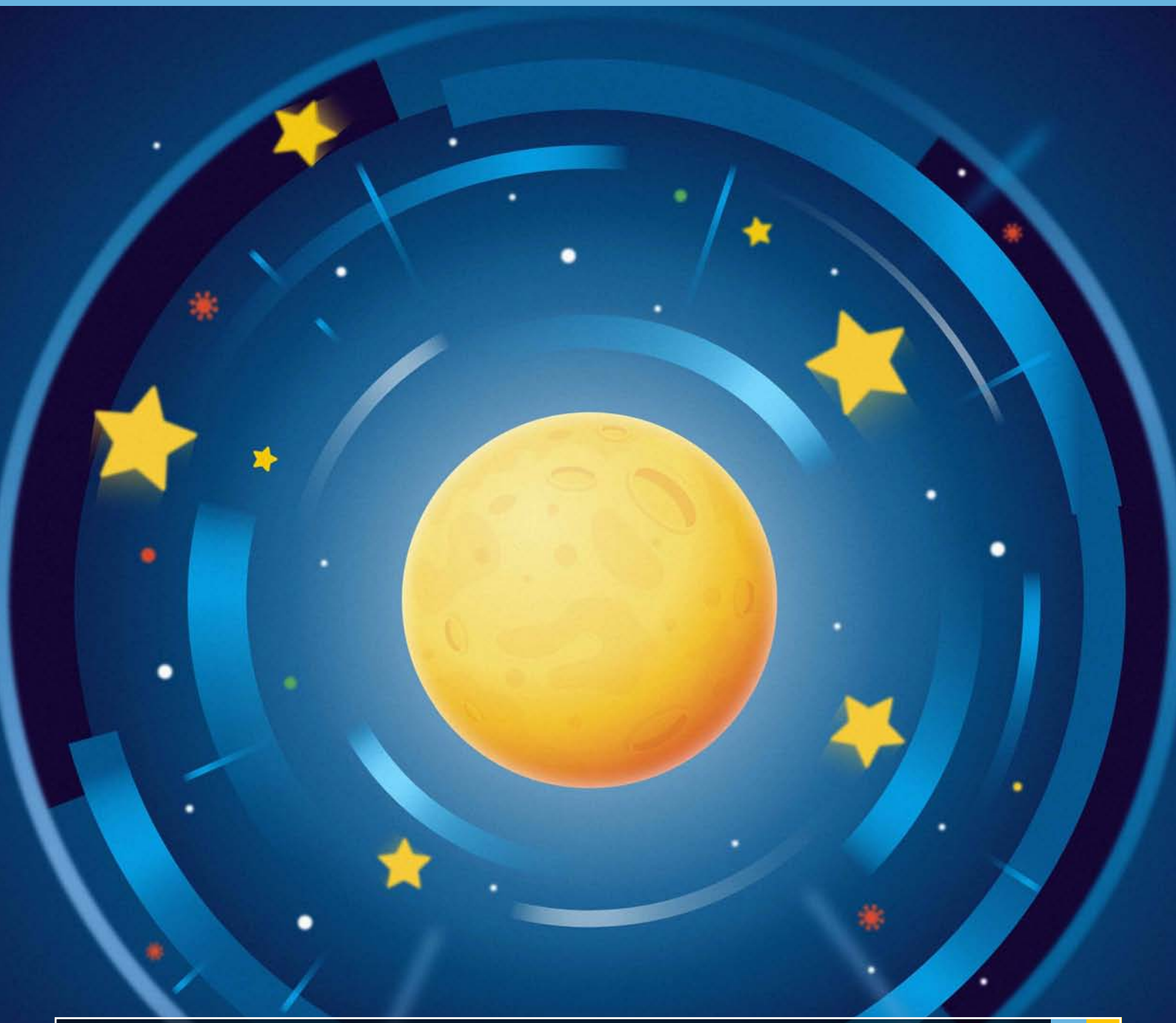
10th Special Issue: European Health Forum Gastein 2022



› A moonshot for a true European Health Union: If not now, when?

- Will the COVID-19 crisis make the European Health Union?
- The road towards developing a European Health Union
- Universal Health Coverage in the EU
- Building a true labour market for health workers
- Creating European public goods in health
- Supporting countries with implementing health system reforms
- One Health through the lens of the SDGs
- Europe's role in global health

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FOREWORD

Since its inception 25 years ago, the European Health Forum Gastein has become a harbour for ideas, encouraging dialogue and planting the seeds for some of the most important European health legislation. It has welcomed and developed ideas from national authorities, health industry and think tanks along the way.

FOREWORD

By sharing ideas among visionary peers in an open space, we can witness the seeds of ideas blossom into the oaks of real, effective policy that bring real benefits to citizens – like that of our growing European Health Union.

As we emerge from the COVID-19 pandemic, the work of securing our future through a strong Health Union is under way with the building blocks steadily being put into place. Major developments have been achieved in the last 12 months alone.

The mandates of the European Medicines Agency (EMA) and the European Centre for Disease Prevention and Control (ECDC) have been expanded. This will see them both play a stronger role in supporting the EU and its Member States in the prevention and control of communicable disease threats. They are now joined by the Health Emergency and Response Authority (HERA) whose sole mission is to prepare for, and deal with, future health emergencies. These agencies, on the front lines of our defences, will be supported by a new Cross-Border Health Threats Regulation that will further bolster the health framework to ensure that we can be ready and able to face any future health emergency head-on.

Measures such as these will enhance the upcoming Global Health Strategy which will strengthen our ability to prepare and respond to major health threats that affect us all. We may not be able to see what lies ahead but by preparing now, we give ourselves the best chances to overcome the health challenges of today – and tomorrow. As we move from the COVID-19 crisis, we turn towards the next serious threat of antimicrobial resistance, the silent pandemic.

Our Pharmaceutical Strategy, for its part, will add further resilience to this Health Union with its ambitious goal to give all Europeans equal access to affordable, safe and effective medicines and treatments by promoting stronger global supply chains and diversifying supply.

We are also adapting to the realities of our digital 21st century with yet another proposal: a European Health Data Space that will equip and empower the individual to digitally access and control their personal health data.

We are investing in our greatest asset: our health and a sustainable future. And the EU4Health programme allows for this through an injection of €5.3 billion in health promotion, diagnosis and treatment, and care in the coming years.

This investment in our Health Union is already bearing fruit in the shape of Europe's Beating Cancer Plan. One of the backbones of our Health Union, the plan is already yielding dividends since its launch in the midst of the pandemic by addressing the inequalities in cancer care across Europe. This is but one example of what a European Health Union can do.

We have laid the foundations, but the project is not yet complete. By working together, we can continue to grow and reap the benefits of a strong European Health Union that will protect citizens for decades to come.

Sandra Gallina, Director General for Health and Food Safety (DG SANTE), European Commission

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GUEST EDITORIAL

25 years of the EHFG – the road towards developing a true European Health Union

Twenty-five years of the European Health Forum Gastein (EHFG), of assembling all relevant stakeholders for at times controversial debates in a safe place, of informing policymaking and harvesting new ideas to help shape health policy in Europe – and ten years of publishing Gastein editions of Eurohealth. Time to celebrate, time to reflect, and time to discuss the future!

At this watershed moment for health, the EHFG 2022 sets out to discuss the urgent challenges and policy solutions needed for unified action across sectors, borders, and disciplines. Guided by the theme "A moonshot for a true European Health Union – if not now, when?", the EHFG will mark its anniversary by urging to leave "business as usual" firmly in the past to build a healthier, more equitable, and sustainable future for all. This is the window of opportunity to co-create a true European Health Union, which requires a fundamental transformation of the way our societies operate – and this can only be achieved through peace in Europe, supported by political will, collaboration, and unity.

This year we will discuss how more than ever before, stakeholders in health must reach beyond traditional spheres of health policy, based on new socio-economic models and a "One Health for One Planet" approach, which recognises the interplay of the four spheres of people, plants, animals, and their environment in shaping health and wellbeing. With the complex set of the interconnected challenges of the permacrisis we are finding ourselves in, can an encompassing One Health approach finally be put into practice?

Since 2020, the EHFG has been engaging in the European Health Union initiative*, which calls for more Europe in health and more health in Europe – a "true European Health Union". While supporting the ongoing initiatives of the European Commission to strengthen solidarity, commonly address cross-border threats, and provide security for EU citizens, the EHU Initiative goes further than these goals and looks beyond the pandemic by addressing longer-term and more comprehensive issues. Its vision is to:

- strive for the health and wellbeing of all Europeans, with no one left behind;
- strengthen solidarity within and between Member States, providing support, including universal health coverage, for all;
- ensure environmental sustainability, by adopting the European Green Deal and prioritising measures to promote One Health;
- provide security for all Europeans, protecting them from the major threats to health;
- enable everyone's voice to be heard, so that policies that affect their health are created with them and not for them.

The crises we are currently facing call for a renewed concentration on our shared core values and the commitment to create a legal basis that can empower the EU to protect and secure health across the continent. Towards a true European Health Union: ***We can – and must – do better!***

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

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

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* https://europeanhealthunion.eu/

WHERE WE ARE WITH THE EUROPEAN HEALTH UNION AND WHY IT IS NOT GOOD ENOUGH

By: Scott L Greer and Matthias Wismar

Summary: How can we make a moonshot for European Union health policy as we exit the COVID-19 pandemic and face many other threats? This article showcases what follows in this Eurohealth special issue which was produced together with the European Health Forum Gastein (EHFG) for its 25th anniversary. The first section sets the scene explaining why we need a true European Health Union. Next, the changing policies are presented and what needs to occur towards forming a European Health Union. Finally, making a true European Health Union happen may entail some legislative changes as well as improving health literacy among Europeans.

Keywords: *Public Health Policy, Cooperation, Regulation, Integration, European Health Union*

> **#EHFG2022** – Plenary 3: A moonshot for a true European Health Union?

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Background

When the COVID-19 pandemic hit, governments around Europe and the world took radical policy steps to contain the virus, manage the economic damage, and invest in treatment and vaccination. The European Union (EU), after a very brief period of confusion and national egotism, rose to the challenge in a way that few had anticipated, putting the EU at the centre of the most consequential health debates while cementing health as a preoccupation of the EU and a topic on which its citizens and Member States expect results. The result, by any possible standard of EU health policy in 2019, was dramatic: far more money, ambition, and centrality for European action in key areas such as vaccine acquisition.

But a big change by the standards of EU health policy of 2019 is not the same thing as the health policies that would make the EU an effective power for health, internally or in the world. Even if we sidestep questions of a fiscal union that would mean serious support for Member State health systems, there is much more that the EU could do – from data policy to global health policy, from better public health responses to workforce policy. The pandemic showed what the EU is capable of doing and locked in some major policy achievements; the question is what else needs doing now, as part of a "moonshot" for EU health policy as we exit the COVID-19 pandemic and face many other threats to health in the near future.

This special issue was produced together with the European Health Forum Gastein for its 25th anniversary. The editors and authors received input and active support from the editorial board of this special issue, comprised of supporters of the Manifesto for a European Health Union.[1]

This article summarises the articles in the issue, which are grouped across three strands:

– Setting the scene: Why we need a true European Health Union
– Changing the policies: towards a true European Health Union
– Making a true European Health Union happen

Setting the scene: Why we need a true European Health Union

In the following article, *Thibaud Deruelle and Scott L Greer* focus on the role of crisis in driving EU health policy. They show that COVID-19 was easily the biggest public health crisis the EU has seen and also promoted the most dramatic expansion of public health policy that the EU has seen. Perhaps predictably, it led to an expansion of existing EU instruments, such as agencies like the European Centre for Disease Prevention and Control (ECDC) and the European Medicines Agency (EMA), public health and civil protection budgets, and also the development of the Health Emergency preparedness and Response Authority (HERA). Nonetheless, and unsurprisingly in light of the history of European integration, the EU has not taken the next step towards any institutional oversight of Member State health policies – even pandemic preparedness – or development of a model for supporting health systems in a consistent way that provides public goods for the whole Union.

Next *Clemens Auer*, President of the EHFG and an experienced European and global health policymaker, opens the issue with a discussion of the progress that has been made. It is easy to explain why there will never be a European Health Union worthy of the name: the price of creating equally high-quality and accessible health care across all the Member States is just too high. It is easy to explain why such a European Health Union would be a good idea. What Auer highlights is the way that intractable issues can be broken down into tractable ones, and long journeys are made one step at a time. The last two years have, amidst a global public health disaster, led us to pick up our pace; while a sprint might not get us all the way, it is time to try.

Changing the policies: towards a true European Health Union

Compared to 2019, the change in the ambition and scale of EU health policies has been dramatic, but the rush to respond to the COVID-19 pandemic meant not all the key issues were addressed. This section identifies key issues policymakers must address to sustain, let alone improve, health and health care in Europe.

Erin Webb, Johanna Offe and Ewout van Ginneken address an issue on which many Europeans are proud, and which is enshrined in EU law: universal health coverage (UHC).[2] Most European citizens do enjoy timely access to good quality health care, but by a number of measures, from catastrophic health care costs, to lack of access for particular groups, to variations between Member States, there remains a great deal to be done. This article reviews the evidence on key indicators of UHC, identifying the areas where UHC is unattained, areas any ambitious health policy must address.

Matthias Wismar, Gemma A Williams, Tomas Zapata and Natasha Azzopardi Muscat focus on the European health workforce. They argue that the pandemic has demonstrated how valuable and at the same time vulnerable the health workforce is; being the frontline fire fighters and at the same time exposed to unprecedented physical, mental and social risks. There will be no strengthening of health systems or health systems resilience without a clear European focus on health workers. Much has been achieved in the past, but still too little. They see a clear added value of a true European Health Union focusing on developing the health workforce, improving the EU-labour market and fostering research on health workforce innovation and implementation.

Artur Olesch addresses a topic that has been important for a long time but became even more timely in the context of COVID-19 pandemic response: digitalisation of health services. The pandemic saw a considerable, if sometimes temporary, expansion of remote health care consultations and even provision, and gave additional momentum to the longstanding calls for strong and interoperable patient data record systems. He highlights proposals for a European Health Data Space within the European Health Union, with its potential to improve care as well as encourage the growth of innovative health care industries built on use of the newly available, protected, and interoperable data.

> “the change in the ambition and scale of EU health policies has been dramatic

Former Commission for Health *Vytenis Andriukaitis* and *Erin Webb* frame the basic potential and problem of a European Health Union in their discussion of public goods. Europeans have long relied on their Member States to provide public goods, but the ability of Member States to provide those goods, as the pandemic shows, are increasingly dependent on their participation in a shared European project. European citizens increasingly consistently identify health as a key goal of the Union, and the authors show how important goals, from vaccines development and acquisition to treatment of rare diseases, depend on Member States working together. The EU’s role has long been the rescue of its Member States, and health does not look like an exception – if they are to provide the public goods citizens demand, they must work together through the EU.[3]

Nicole Mauer, Dimitra Panteli and Stefan Eichwalder focus on the tools and need to support countries’ health systems. They discuss the broad range of tools available within the existing EU policy frameworks to support Member State health policies. Notably, they include discussion of the ways in which the EU fiscal governance framework, long viewed by many as a problem for health policy, can actually support Member States’ initiatives to improve health and health care through the example of Austria. European funding

has been a focus for many people in health care and public health, but its scale and potential contribution are still fully exploited by neither EU policymakers nor people in the health sector.

Martin McKee focuses on the EU's contribution to getting the United Nations Sustainable Development Goals (SDGs) back on track. The SDGs might seem like a development-speak buzzword, but they are important – not just because governments of the world are committed to them, but also because they are goals whose attainment is vital for anybody committed to human and planetary welfare. The world had, broadly, been doing well on the SDGs before the pandemic; the debate was about speed, not trajectory. The pandemic has not just slowed or set back progress in many areas; in some, there is a real risk that it has changed countries' trajectories for the worse, for good. This makes attention to the SDGs and the overwhelmingly important goals in them all the more important now, for Europe and the world. He focuses on One Health, a goal highlighted by recent reports including that of the World Health Organization Regional Office for Europe's Monti Commission and one whose importance is all the greater now that COVID-19 has shown us the scale of preventable risks from animal diseases in our increasingly hot and crowded world.

Ilona Kickbusch and Mihály Kökény address the extremely timely issue of the EU's role in global health. The EU is an important actor in overseas development assistance and global health governance, but its impact on global health goes far beyond that, and the Commission is accordingly revising the now-dated 2010 EU global health strategy. They identify ways the EU can harness the power it already wields, in areas such as trade and data governance, to improve global health and avoid the potential for unhealthy policy in areas such as intellectual property and healthcare workforce. The strategy that is prepared in 2022 can shape the EU's power over global health for years to come and needs to be a focus.

Making a true European Health Union happen

Making a true European Health Union may entail some legislative changes and more. The EU is based on a set of complex treaties, laws, and judicial decisions, and cannot always make policy without legal change. What would have to change in law to enable policies responding to these issues? Moreover, how would European's health literacy need to change?

One of the key debates in health circles has focused on what kinds of legal changes the EU would have to if it is to have a true Health Union. *Anniek de Ruijter and Eleanor Brooks* explain how in the EU's system of conferred powers, it can only do what the treaties allow it to do, and the treaties, in the case of health, are very limiting. They discuss some of the potential directions for legal change that would address key areas of health policy left untouched by recent changes, some of them far from obvious.

Elizabeth Kuiper and Mary Guy focus on the core tension in EU health policy: the tension between Member States' need to work together, and the respect for their autonomy, difference, and authority that is entrenched in the principle of subsidiarity. Citizens mirror their governments, with both a strong commitment to EU action for health and a strong commitment to Member State responsibility for health. They present the development of European Health Union proposals and how, at the time of this issue, they bespeak a "strong willingness to change the interaction between the EU and national levels."

Kristine Sørensen addresses the problem of health literacy, which is important to so many health agendas, from patient-centric care to prevention to avoiding health-related misinformation and disinformation. As her headline states, "Brussels: We have a health literacy problem," echoing the famous message from an orbiting spacecraft to ground control. As in so many areas, though, the already difficult problem of formulating policies is made more difficult by the complexity of the EU policy and political arenas and the doctrine of subsidiarity (as discussed by Kuiper and Guy), which means it takes as much creativity for Brussels, and professionals, to address that problem as it took the astronauts and ground control to land the spacecraft safely. In particular, the new resources in EU4Health can contribute to improving health literacy, which can have immediate benefits by combatting problems such as vaccine hesitancy and ensuring that health literacy is part of the important digital agenda.

Conclusion: Panic-neglect cycles and European health policy

Public health policy has a well-known and much-lamented cycle of panic and neglect: panic when a health threat grabs our attention and shows the weaknesses in our preparations; neglect later on, when wilful forgetfulness and other priorities become more powerful. The COVID-19 pandemic led to unusually forceful and ambitious action at the EU level, with a significant expansion of EU health policy action and ambition that the articles in this issue present.

But we do not have a long time before neglect sets in. The EU's slow and consensual process means that legislation and budgetary decisions remain for years – the health budget increases in the current Multiannual Financial Framework will last through 2027. That means the window for legislation might be closing, which makes issues such as data policy imperative, but it also means that health advocates will have approximately five years to build the coalitions and show the value of EU health work before the next big budget negotiations. The opportunity to launch a moonshot for a Europe that is good for health is now – and so is the opportunity to get to work and show the value of what has already been done.

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WILL THE COVID-19 CRISIS MAKE THE EUROPEAN HEALTH UNION?

By: Thibaud Deruelle and Scott L Greer

Summary: The European Union's health policy has been a history of crisis and crisis response. Each integrative step forward has been in response to a health challenge that integration exacerbated – and to which more integration was Member States' response. The COVID-19 response also saw a necessary and significant expansion of pre-existing EU public health policy initiatives. However, without a change in the treaties to 'upgrade' public health to a domain of shared competences, it falls short of a European Health Union capable of increasing resilience and better responding to future health emergencies, let alone one capable of improving health for all Europeans.

Keywords: *European Health Union, Public Health, European Integration, Crisis, COVID-19*

> **#EHFG2022** – Plenary 1: Europe in permacrisis – pandemic, climate, war

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Introduction

Crises have been catalysts of change in the European Union's health policy. The history of EU health policy can be told as a story of crisis. The so-called "mad cow" (vCJD) crisis in 1996, radically changed the landscape of food safety and livestock health control in the EU and contributed to the growth of named EU public health powers. The 2003 SARS CoV-1 pandemic led to the creation of the European Centre for Disease prevention and Control (ECDC) for epidemic intelligence gathering. In the same vein, the 2009 H1N1 influenza crisis led to institutionalisation of the Health Security Committee (HSC) for interministerial coordination and the creation of a mechanism for Joint Procurement of Medical Devices.

Crises do not guarantee integration, or lead to good policymaking, but they led to dramatic policy and institutional development in 2020, when the COVID-19 pandemic showed the insufficiency of EU public health capabilities and Member States' shared interests in response.[1–4] This has seen reinforced policy instruments for the coordination of Member States on health threats management, as well as the stated ambitions of President of the Commission, Ursula Von der Leyen, to build a stronger European Health Union.[5,6] It looks like one of the first steps in building the European Health Union is to further the institutionalisation of the current EU health threats management system.

Indeed, on 11 November 2020, the European Commission published a Communication on 'reinforcing the EU's resilience for cross-border health threats', accompanied by three legislative proposals aiming to strengthen Europe's health agencies and setting up a health task force, to be deployed quickly within the EU and in third countries. A year later, on 16 September 2021, the European Commission made a proposal for a regulation on medical countermeasures and created the Health Emergency Response Authority (HERA) to assist the production of medical countermeasures.

> demonstrates the limits of reliance on solidarity to solve shared European crises

However, while the COVID-19 crisis has led to notable institutional developments,[2] it is not – so far – leading to a Treaty change; therefore, the management of health threats remains a simple coordinating competence at EU level.

What is the European Health Union so far?

The European Health Union is dramatically more ambitious than any EU health policy existing or contemplated in 2019. The EU has already committed much more money, more ambition, and more investment in scientific and technical capacity. EU4Health, replacing a Health Programme that was actually being phased out, will receive €5.1 billion in 2021–2027. If we regard the €1.1 billion expansion of the Civil Protection budget, which Member States co-finance – RescEU – then the amount of money invested is so large as to make it look like a change in the nature of EU health policy rather than just a larger budget.

What is the European Health Union *not* yet?

The European Health Union, though, is not capable of binding Member States, even in delimited areas such as their preparedness planning or surveillance capacity. In European politics, any effort to intrude on Member States' responsibilities for their own health policies and systems faces high political and legal barriers. Efforts to set standards naturally come with price tags that not all member states can afford, and the politics of funding Member States' health systems from the EU budget are difficult. The result is that the EU has gained a far better funded and more ambitious version of its pre-2019 health policy, focused primarily on public health, but Member States still decline to let it constrain or shape their systems in the interests of better health.

Failing forward?

Scholars of European integration have noted a characteristic European approach that they call "failing forward".[7] Failing forward happens when the existing level of EU integration creates a shared, European, crisis for which responses need to be European. Member States, defending their freedom of action, take an integrative step forward- but take care to make it the smallest possible step. The result is that while they might address their present crisis, they take what look in future crises like half measures. Health, like many other policy areas in the EU, seems to show this failing forward dynamic, with unmistakable advances in the capacity and ambition of the EU in public health unmatched by all the integrative steps that would address the pandemic.[7,8]

A potential Health Union?

Evoking a "European Health Union" conveys the image of an integrated health policy in the EU, with binding effects on Member State health systems, a move not allowed under current Treaty provisions. The ambition of a fully fleshed European Health Union can hardly be satisfied by the development of its technical and scientific features alone.

> a change in the treaties to 'upgrade' public health to a domain of shared competences

However, the road to the European Health Union can still be taken. What matters now are the lessons learned from the pandemic and what policymakers will make of it. Indeed, lessons were drawn from the H1N1 pandemic,[9] but they might have impeded preparedness rather than supported it. That pandemic was not as lethal as expected, leading many to conclude that EU coordination would not be needed. Ultimately, the 2009 H1N1 pandemic had an important effect on Member States' expectations regarding pandemic risks and likely led national governments to minimise potential threats. We should not expect quite such complacency from the COVID-19 crisis, but it is a cautionary tale on what to make of lessons from crises.

The COVID-19 crisis shows that coordination is first and foremost crystallised by health threats. But even in the face of sizeable health threats, coordination is not necessarily a foregone conclusion. Indeed, while the crisis has opened the door to a 'stronger European Health Union', the sense of solidarity among Member States did not come about instantaneously. In times of crisis, coordination is time-consuming and may prevent Member States from being as reactive as when acting on their own.

Overall, the COVID-19 crisis demonstrates the limits of reliance on solidarity to solve shared European crises. Solidarity is subject to the goodwill of Member States and European Institutions. More specifically, existing EU policies do not reflect what the EU would be able to do, were it to be endowed with shared

competences rather than coordinating ones. Indeed, if 'solidarity' is the active compound that holds the Union together, the EU might just as well be a simple forum in which Member States cooperate and help each other. The internal market and associated four freedoms are built on strictly enforced legal ties. Member States act in concert because a complex legal order binds them together, enshrining solidarity in legal texts rather than because of the attractiveness of collective action. And thus, to be fully realised, the European Health Union will necessarily include a change in the treaties to 'upgrade' public health to a domain of shared competences.

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Addressing backlogs and managing waiting lists during and beyond the COVID-19 pandemic

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For more than two years, the COVID-19 pandemic has stretched health systems, restricting their ability to provide care for all people when needed. While countries in the European Region have some of the strongest health systems in the world, none was fully prepared or resilient enough to really tackle the wide-ranging impacts this emergency has brought. One major concern since the onset of the pandemic has been the extent to which countries' capacity to maintain essential health services has been negatively affected.

In order to restore services to pre-pandemic levels and catch up on care, we need to understand and act on what we have learned from the pandemic, including investing in the health workforce, increasing funding for the health infrastructure of the future, and maintaining the innovative forms of service delivery that proved useful in reaching out to key groups affected by the pandemic.

This Policy Brief is a valuable resource for policymakers seeking to understand the extent of disruption to health services caused by COVID-19, the reasons behind this, and what different countries are doing in response. Its aim is to provide options to reduce service backlogs for those who are addressing this challenge in their national contexts.

THE ROAD TOWARDS DEVELOPING A EUROPEAN HEALTH UNION: MILESTONES AND THE DEBATE OF COMMON EUROPEAN PERSPECTIVES IN GASTEIN

By: Clemens Martin Auer

OPINION PIECE

Summary: With the support of the European Health Union initiative, the European Health Forum Gastein (EHFG) has taken important steps by bringing together a group of committed experts and relevant players who promote the implementation of a European Health Union as a true European citizens' union. This goal still has a long way to be completed, the glass is only half full. Therefore over the next few years, a growing community will be convening in Gastein and beyond to consistently work towards a "true European Health Union" by putting the interests of the public at the centre, raising awareness, and testing options in dialogue.

Keywords: *European Health Union, European Health Forum Gastein, Internal Market, One Health, COVID-19*

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Background

For the last 25 years, the European Health Forum Gastein (EHFG) has been the marketplace where parameters of European health policy are discussed, measured, and tested. Nothing is left off the agenda, no matter how controversial the respective topic may be. The EHFG offers the ideal framework for arguments and counterarguments, even if the debates are not always comfortable for everyone. No wonder that such crucial initiatives as the European Cross-Border Directive,[1] the European role in global health, the European health literacy agenda, fair access to medicines or essential contents of the European eHealth policy were presented and negotiated in Gastein for the first time.

I have experienced the last 25 years of joint health policymaking in the European Union (EU) first-hand and have also actively helped to shape it as a policymaker of a Member State. This has resulted in overall mixed findings when it comes to the topic of the European Health Union. It is therefore a matter of perception whether the glass of European health policy is to be seen as half full or half empty. For someone who wants more in Europe, the glass is at any rate only half full.

Yes, on the one hand the COVID-19 pandemic has brought a quantum leap in joint action and a general heightened awareness of the importance of health policies. What has been noticeable for a European citizen is not just the joint procurement of vaccines for the residents of the 27 Member States. When it comes to such global health crises, the goal must be to never again be ill-prepared. This has been achieved at EU level with the establishment of the Health Emergency Preparedness and Response Authority (HERA[2]). There has also never been such a broad and politically intensive and informed debate as to what constitutes a European Health Union.

> “the goal must be to never again be ill-prepared

The pandemic has also made the EU a key driver of global health policy, largely unnoticed by the public. The EU and its Member States – particularly Germany – are now among the most important donors to the World Health Organization (WHO) and to multilateral aid programmes. And without the EU there would not have been a sustainable renewal of WHO funding, no significant changes in decision-making structures and no start of negotiations on new legally binding mechanisms in the event of global health disasters (**see Box 1**).

However, many of the efforts to expand common policy areas within the EU, such as digitalisation, have only been half-heartedly tackled. The captious explanation for this default tends to be that health – with the exception of cross-border defense against health threats – is in principle not part of the so-called “acquis communautairs”. Health attachés in Brussels or the lawyers in the capitals have perfected the game when it comes to insisting that health is solely a Member State responsibility, particularly when it comes to the funding of services or issues of service delivery, basic administration, or defining strategies and priorities (for reference, see ‘European health policy’ entry on the website of the German Ministry of Health[3]). With such arguments, some central concerns such as a meaningful European system of Health Technology Assessment (HTA) to jointly determine the quality and benefit of so-called innovative treatment methods, were talked to death in endless legal debates (**see Box 2** for an example).

Box 1: Developments from the World Health Assembly

In May 2022, the 75th World Health Assembly (WHA) of the WHO decided on the sustainable reorganisation of its financing: By 2030, 50% of the WHO programme budget is to come from contributions of Member States. The 151st Executive Board decided to set up a Standing Committee on Prevention, Preparedness and Response to Global Health Disasters to enable structured consultation between WHO and Member States within 24 hours. There was no such mechanism when the pandemic started in 2020. An extraordinary session of the WHA in November 2021 established an intergovernmental committee to prepare a new legally binding framework for pandemic response.

Box 2: The Bulgarian Presidency and HTA

The last Bulgarian Council Presidency legally pulled the European Commission’s proposal for a lean HTA directive, causing the topic to disappear into an endless loop. Then in the summer of 2020, at the start of the EU-wide purchase of COVID vaccines, the Bulgarian Ministry of Health questioned the legal basis for joint purchases in a detailed letter to the European Commission and the Member States.

The European internal market for health

When it comes to the European internal market in the health care sector, or big business if you will, for example in the joint market approval and safety of medicines or in the broader field of food safety, including the veterinary sector, EU citizens can feel the reality of the EU. The basic rules of the free movement of people, the common and mutually recognised training standards at universities, for example in medical studies, create a reality for the health systems in Member States. The mutual recognition of the training of employees in the nursing professions helps to support the free movement of persons within the EU. And large research programmes have been supported by joint EU funding and research programmes for years.

Where the European Health Union has remained weak so far, however, is the area of comparable access to specific health services and the quality of direct care for EU citizens. The Cross-Border Directive has recognised the “EU patient” who is theoretically free to be treated anywhere in the EU. Accordingly, this EU patient should not be denied care anywhere in the EU and not be discriminated against in any Member State. This inherently positive understanding of an EU patient is reduced in its importance due to the practices of (state) health insurances in the respective Member States. As a rule, the cost of treatment in another Member State must be approved in advance – unless it is an emergency. This protective clause of the insurances puts a brake on the Europeanisation of health care because it can prevent an insured EU patient from having a needed but more expensive treatment in a perhaps medically more advanced treatment facility. Although there are “cross-border treatments”, these are the exception and a bureaucratic hurdle for both the citizen and the practitioner. The economic status of one and the same insured person is therefore stronger than his or her medical status. Apart from other cost factors, the free choice of the place of

medical treatment is therefore difficult to realise due to bureaucratic and economic restrictions within the EU.

> health policy leadership with reform-oriented rigour is required

Equal access to high-quality or innovative treatment methods for all EU citizens does not exist. The manufacturers of such innovative products receive EU-wide market approval from the European Medicines Agency (EMA) and also receive guaranteed Europe-wide patent protection for their innovation. Yet, at the same time they are not required to offer their products in all Member States immediately after they are available on the market. As a result, patients in selected high-priced markets have access to the innovation early on while others have to wait up to several years for their availability. This represents one of the most serious unequal treatments of EU citizens within the Union and can basically be characterised as a market failure. These weak points and the bureaucratic protective mechanisms that some assertive stakeholders in the health sector bring into position against the enforcement of the interests of patients must be consistently exposed and discussed.

Current debates in health policy and beyond

These exemplary topics have been on the agenda of the EHFG for 25 years now, because it is in line with the principle of the forum to always put the perspective of EU citizens in the foreground. The EHFG also recognised very early on that all debates about modern health policy cannot focus solely on the health sector and has featured important discussions on commercial, political and social determinants of health. We are now discussing a comprehensive understanding of "One Health" and know that climate, environment, nutrition, housing and many other determinants influence health and thus health systems. This also means that stakeholders from the various sectors must be included in the discussions, who the EHFG has been inviting to the discussions for years.

A European Health Union that is formed in the interest of the citizen must guarantee the enforcement of the interests of the citizens as patients. The implementation of an European Health Union therefore requires addressing Member States' political, legal and economic reservations towards a stronger EU role in health, fearing a loss of their sovereignty regarding the range and financing of services, national administration as well as the definition of strategies and priorities.

This is the offer and the opportunity of the EHFG: With the support of the European Health Union initiative,[4] the EHFG has taken important steps by bringing together a group of committed experts who promote the implementation of an European Health Union as a true European citizens' union. With a view to the next few years, a growing community will be convening in Gastein and beyond to consistently work towards a "true European Health Union", putting the interests of the public in the centre and reaching beyond the commendable actions of the European Commission. In keeping with its long tradition, the EHFG brings together all relevant players, including policymakers from national ministries and national and (pan-) European politicians, WHO experts, national and private insurers, health professionals, representatives of various industries, relevant scientists and the broader group of civil society in one place. In that set-up, this new awareness of a European Health Union can grow and be tested in dialogue.

Aligned with the "One Health" approach, not only the traditional stakeholders should be included in such strategic debates, but also those whose determinants have an impact on people's health and well-being. Also, this needs to be a pan-European debate, as issues like investment and innovation in primary care, fairer access to medicines, the economic status of the health and care professions or such existential areas as the environment and the climate crisis cannot be solved solely within the borders of the EU.

Conclusions

Nobody should believe that this path will be an easy one: Politics, business and societies as a whole are in a permacrisis, and the window of opportunity after the pandemic, which has catapulted health to the top of political priorities, is decreasing and can quickly close again. Health policy leadership with reform-oriented rigour is required, coupled with a comprehensive understanding of well-being aligned with citizens' interests. In times of a physical war raging in Europe, no one should expect that social peace can be maintained or achieved without health and well-being.

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UNIVERSAL HEALTH COVERAGE IN THE EU: WHAT DO WE KNOW (AND NOT KNOW) ABOUT GAPS IN ACCESS?

By: Erin Webb, Johanna Offe and Ewout van Ginneken

Summary: Universal Health Coverage (UHC) is a key priority for many European Union (EU) health policymakers. Common descriptions of UHC include the dimensions of population coverage, service coverage, and cost coverage. Yet a formal entitlement to coverage does not always result in real access as individuals face barriers in accessing health services. This article describes the EU's progress towards UHC and points to several areas where we lack data to fully understand gaps in coverage and access. By improving data availability, health policymakers would be able to take more targeted policy actions, supporting the goals of both UHC and a European Health Union.

Keywords: *Universal Health Coverage, population coverage, cost-sharing, health benefits*

> **#EHFG2022** – Session 17: Delivering on health equity: a 2030 ambition

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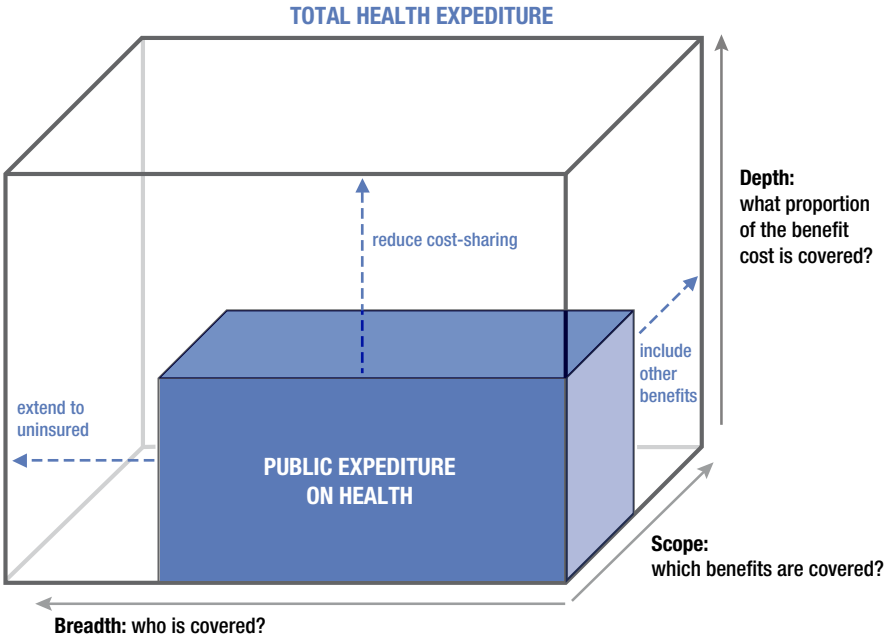
Introduction

Countries around the world seek to progress towards Universal Health Coverage (UHC), envisioned by UN Sustainable Development Goal 3.8 as, "including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".[1] The Office of the High Commissioner for Human Rights identifies health as a human right, with essential elements of availability, accessibility, acceptability, and quality.[2] Similarly, the European Union (EU) includes the principle in the European Pillar of Social Rights that everyone has the right to timely access to affordable, preventive and curative health care of good quality. However, even in the EU, gaps in coverage and access to health care persist. UHC is commonly depicted as a coverage cube with three dimensions: population coverage, service coverage, and cost coverage (**see Figure 1**). Yet, formal entitlements to coverage do not always translate into real access to health services. Adding a fourth dimension, service access, which captures whether individuals are in practice able to access the health services for which they are entitled, should be considered to help overcome this limitation.[3] A case in point is the large backlogs of care that have arisen in virtually all European countries as a result of the COVID-19 pandemic, which are mostly due to lacking access, not coverage.[4]

Figure 1: The UHC coverage cube



Coverage has three dimensions:

Breadth: the proportion of the population covered

Scope: the range of benefits covered

Depth: the proportion of the benefit cost covered

Source: [5]

While countries in Europe generally have high population coverage, certain groups such as undocumented migrants are at times excluded. Service coverage, cost coverage, and service access vary across European nations, and the lack of granular, standardized data makes cross-country comparisons difficult. This article will consider the existing gaps in coverage across the various dimensions, describe available indicators to assess coverage, and identify opportunities to increase monitoring of coverage gaps.

Population coverage in the EU is generally high, but some countries exclude certain groups

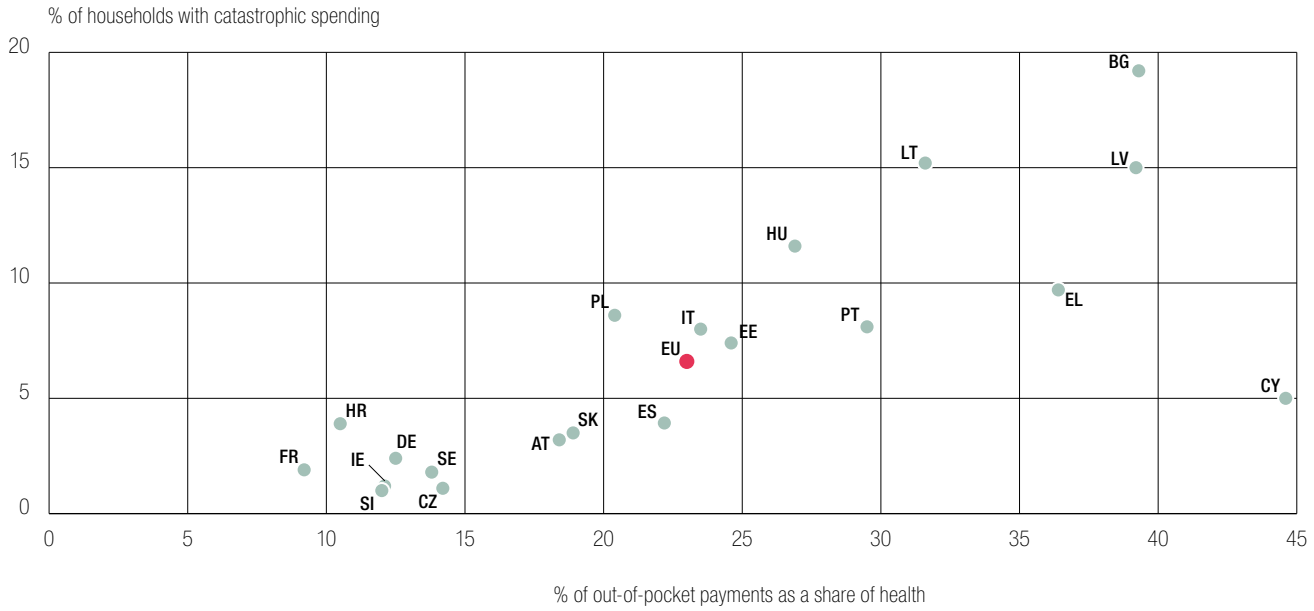
Most EU countries provide high levels of population coverage. Yet as of 2019, seven EU countries had more than 5% of their populations without statutory health coverage, including Estonia (5%), Slovakia (5.4%), Hungary (6%), Poland (6.6%), Bulgaria (10.2%, 2017), and Romania (11%, 2017), and Cyprus (17%).[6] In some cases, the relatively high percentage of uninsured may be due to reporting discrepancies (e.g., counting citizens living abroad as uninsured) or inconsistencies in the survey methodology across countries. However, in other instances, the lack of population coverage can point to excluded groups. For example, Bulgaria and Romania both require a valid identify card to register for insurance, which in practice makes it very difficult for certain population groups to obtain coverage, such as Roma individuals and homeless people.[3] More positively, a 2020 reform in Cyprus has dramatically improved population coverage, and the new General Healthcare System (GeSY) has integrated the separate public and private health systems. Cyprus now provides universal population coverage, including to refugees and asylum seekers.[7]

Several EU countries exclude some groups of migrants from statutory health coverage. In Germany, for example, EU citizens who are unable to provide for their own living costs are excluded from entering into statutory health coverage and – after four weeks of so-called "bridging services" – do not have any alternative healthcare coverage. In addition, asylum seekers, refugees and undocumented migrants in many countries are covered by a separate funding mechanism. To access these alternative schemes, many countries require undocumented migrants to apply for coverage, and some migrants fear they will be reported to the authorities.[8] In Germany, social service departments responsible for providing cost coverage for asylum seekers and undocumented migrants have the duty to immediately report undocumented migrants to the immigration department or the police. This leaves undocumented migrants *de facto* without coverage.

Cost sharing for health services is common in the EU, and in some cases leads to catastrophic spending

Most European health systems have some level of cost sharing, and several cost sharing methods exist. These include co-payments, most commonly applied for physician visits; co-insurance, most used for prescription medicines; and deductibles, a defined amount that must be paid before insurance will reimburse costs, which are prevalent in the Netherlands and Switzerland. Many countries have exemptions or caps on out-of-pocket (OOP) spending in an attempt to increase financial protection. Exemptions are most common for children, low-income individuals, and those with a chronic condition or disability. Austria and Germany set the cap for OOP spending based on household income.

Figure 2: Catastrophic spending generally increases with increased OOP payments



Note: EU averages are unweighted.

Sources: [9] [10]

Catastrophic health spending refers to health spending that exceeds a predefined percentage or threshold of a household's ability to pay for health care.[9] The WHO Regional Office for Europe has found a link between OOP payments and both catastrophic spending and unmet needs (**see Figure 2**). It therefore recommends designing coverage policy to minimize access barriers and reduce OOP payments to less than 15% of current spending on health.[9] Bulgaria (2018), Hungary (2015), Latvia (2016), and Lithuania (2016) all have more than 10% of households with catastrophic spending.

Health systems in Europe typically cover a wide range of services

A country's benefits basket describes the service coverage available to the population covered by the statutory health system. The most commonly excluded services from statutory coverage include optical treatments, dental care for adults, physiotherapy, and assistive devices.[3] In several countries, these services are commonly covered by voluntary health insurance. The coverage of novel pharmaceutical products also varies across countries, which can particularly affect cancer patients and patients with rare diseases. This has prompted some countries, such as Belgium and Latvia, to introduce exceptional reimbursement funds to pay for expensive medical treatments that are not included in the statutory system.

While a service may be considered as covered, there may be conditions (e.g., age, medical indication) for receiving the service. Further, when comparing country coverage at a more granular level, additional distinctions appear. For example, while all EU countries may cover 'reproductive services', this could mean in practice 3 or 30 doctor's visits, certain genetic screenings but not others, fertility treatments or not (or only up to a certain age), abortion services, and more. Indeed, detailed patient vignettes on stroke, depression and dental care revealed important gaps in coverage in 12 EU countries that would have stayed under the radar when only looking at available services in the benefit basket of a country. Examples are the lack of rehabilitation care and low thrombolysis and thrombectomy rates, which mean that patients in some countries do not receive recommended care even where formal coverage for such services exist.[11]

Several countries limit the scope of services for certain population groups, such as asylum seekers, refugees, undocumented migrants or citizens from other countries, often depending on the length of their stay in the country. Germany, Sweden and Belgium, for instance, limit the range of services to some extent.[12] In Germany, asylum seekers are entitled only to services for acute illness and pain, prenatal, obstetric and postnatal care as well as vaccinations during the first 18 months of their stay in the country. Other services – including for mental health or chronic illnesses – are dependent on individual case decisions. Similar restrictions exist in Sweden. Individuals in some countries also may fall behind in paying their health insurance premiums, which may limit the available scope of services (as for example in Germany) and/or lead to loss of insurance. In the Netherlands and Switzerland, new arrangements and bodies had to be put in place to administer the rising numbers of uninsured due to defaulting.[13]

Discussions about UHC must consider the service access dimension

Even when an individual has statutory health coverage, with their service covered

in the benefit basket at no cost, other access barriers are still possible. These can relate to problems of physical availability within the statutory health system (e.g., waiting times, transport cost), problems of functional capacity (e.g., inability to provide consent for care, language barriers), and problems with provider attitudes (e.g., discrimination).[3]

> formal entitlements to coverage do not always translate into real access to health services

Waiting times are most often the reason for service access issues,[14] a situation now worsened by the COVID-19 pandemic.[13,15] Service access can vary within a country, especially in the case of rural areas or islands, where health services tend to be less available. Vulnerable patient groups such as those with mental illnesses, physical disabilities or homeless people are particularly prone to service access issues. Provider discrimination is reported in the EU for the Roma population; asylum seekers; homeless individuals; patients with illnesses such as HIV/AIDS, sexually transmitted infections and mental illnesses; and undocumented residents.[3] These groups may face compounding levels of barriers to access and coverage that aggravate each other, and clinical and social vulnerability are closely linked.[16]

Cross-country indicators related to UHC and access to health care have been developed

Several international organisations collect cross-country data on indicators related to UHC and access to health care. These include the EU, which features questions on the European Union Statistics on Income and Living Conditions Survey (EU-SILC) and European Health Interview Survey (EHIS) about the prevalence and causes of unmet medical needs and which publishes Mutual Information System on Social Protection (MISSOC) tables containing detailed information on social protection (e.g. benefits); the OECD, which reports the share of services financed by public coverage systems; and the WHO, which tracks two indicators related to UHC and SDG 3.8.

The EU-SILC survey collects data from EU citizens on a wide range of indicators, including on whether they have unmet medical or dental needs. The causes for unmet needs are then categorised into several reasons, such as “too expensive”, “too far to travel”, “waiting list”, and “fear of doctor, hospital, examination or treatment”.[14] The OECD assesses the share of publicly covered services by calculating the percentage of expenditure covered by statutory health schemes. Generally, EU countries in 2018 had high statutory coverage of hospital care (88%) and outpatient medical care (74%), medium coverage of pharmaceuticals (56%), and low coverage of dental care (31%).[17]

The UN SDG 3.8 tracks two indicators, with 3.8.1 related to service coverage and 3.8.2 capturing catastrophic health spending.[18] The coverage of essential services indicator collects data on 14 tracer indicators grouped into the categories of reproductive, maternal, newborn and child health; infectious diseases; non-communicable diseases; and service capacity and access. Then, an index on a scale of 0 to 100 is calculated to assess service coverage (with 100 representing complete UHC). In 2019, the UHC service coverage index globally was 67 while in Europe it was 80.[18] According to the 3.8.2 indicator data, in 2017 6.7% of Europeans allocated more than 10% of their household income to health, compared with 13.2% around the world.[18]

Available indicators fail to capture progress towards UHC or the root cause of unmet health needs

Despite the availability of the indicators described in the previous section, all have limitations that fail to illuminate the underlying reasons for coverage gaps and therefore allow for a more targeted policy response. For example, the statistical population for the indicator “self-reported unmet need for medical care” in the EU-SILC is comprised of people living in private households above 16 years of age. This excludes people living in communal housing or in institutions (e.g. nursing homes, psychiatric hospitals or prisons), undocumented migrants and all homeless people. A report from Médecins du Monde (MdM) shows that by limiting the population base, the EU-SILC does not gauge the existing unmet need for healthcare. Data from 25,355 patients coming to the MdM clinics in seven European countries in 2019 and 2020 show that 82.3% of participants did not live in private households and 8.5% were under 16 years.[16] While actually experiencing problems in accessing healthcare, they were not represented in the EU-SILC survey and thus in the results on unmet need for medical care. Furthermore, the EU-SILC survey does not collect data on health condition or social and legal status, which would further clarify the reasons for unmet needs. Additionally, there are differences in the survey question itself across countries. Most countries ask about both a medical examination and treatment, but the Czech Republic, Slovenia and Spain only ask about a medical examination or a doctor’s consultation, resulting in lower rates of unmet needs.

With regards to financial indicators, countries often cannot disaggregate OOP spending and to determine what share is absorbed by direct payments (due to lacking population or service coverage) or cost sharing (due to lacking cost coverage). Additionally, reporting the share of cost coverage covered by public funding sources does not necessarily relate to whether a service is covered in the benefit basket. In other words, a country with relatively low population coverage but relatively high service coverage may have a lower percentage than a country with universal population coverage but relatively limited service coverage. Similarly, the category of unmet need due to financial reasons in the EU-SILC survey also does not provide insights into whether this unmet need resulted from lacking statutory coverage, service coverage, or cost coverage.

Historically, and still today with the SDG 3.8.2 tracking, the indicators used to describe catastrophic health spending are the proportion of the population with household expenditures on health greater than 10% or 25% of total household expenditure or income. However, using this method overestimates financial hardship among rich households and underestimates it among poor households. Instead, using normative spending on food, housing, and utilities is a more effective way to capture catastrophic health spending.[8]

> current indicators to measure progress towards UHC are often insufficient

Enhancing solidary and equity of health coverage in the EU requires ongoing monitoring and EU-wide coordination

European countries have come a long way in improving data availability and comparability on access and coverage in the EU. International organizations like the European Union and Eurostat have played a crucial role in this development. However, as described in the previous section, current indicators to measure progress towards UHC are often insufficient to design targeted policy responses. This is due to both the inability to capture all population groups residing in EU countries, particularly those most vulnerable, and methodological challenges. Ongoing monitoring and coordination at the EU level is needed to improve these indicators to ensure that the data available to policymakers reflects the situation on the ground and that countries can learn from each other. In fact, the European Commission's Expert Group on Health System Performance Assessment (2021) provides concrete suggestions to adapt existing tools and provide comparable data at the European level.[19] Experience from organisations such as Médecins du Monde and PICUM could be utilised to improve insights for policymakers. The existing efforts underway could coalesce around a larger EU data project to understand access and coverage in the EU, and should include governments, international organizations (including patient organizations), academia, and statistical bodies. Having the right data would be a key prerequisite to meet the goals and promises of a European Health Union.

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THE EUROPEAN HEALTH WORKFORCE: BUILDING A TRUE LABOUR MARKET FOR HEALTH WORKERS

By: Matthias Wismar, Gemma A. Williams, Tomas Zapata and Natasha Azzopardi Muscat

Summary: Strengthening the health workforce is a critical priority to improve the resilience of health systems. In this article we consider how a European Health Union can help support health workforce development. It shows that greater cooperation between the European Union (EU) and Member States within a European Health Union can help to: promote voluntary collaboration on training and life-long learning; support retention strategies; and improve health workforce planning, forecasting and monitoring. It remains important that the EU takes stock of the positive and negative effects of inter-and intra-regional health worker mobility to safeguard health workers and the performance of health systems.

Keywords: *Health Workforce, Labour Market, Human Resource For Health Data, Professional Mobility, European Health Union*

> **#EHFG2022** – Session 7: Time to place the health workforce centre stage

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Introduction

The COVID-19 pandemic has demonstrated the value of the health workforce, but also shown that it is vulnerable. Health workers were often put under extreme pressure, quickly changing working hours, deployment and skill-sets. They have been hailed as heroes. But at the same time, they were often exposed to physical and mental health risks and violence. Research suggests that 43% of frontline workers have experienced significant levels of anxiety during COVID-19,[1] while 40% of clinical staff meet the threshold for post-traumatic stress disorder.[2] Meanwhile, violence, hostility and anger against health workers has risen, often due to fear of infection transmission or by those protesting COVID-19 restrictions and reduced access to care.[3] [4]

The additional pressures of the pandemic, combined with long-standing challenges such as poor working conditions, insufficient pay, lack of flexibility in working hours, limited career opportunities and growing work pressures, are contributing to growing disaffection. In some countries, this has already translated into health workers resorting to industrial action,[5] [6] while evidence is emerging that increasing numbers are contemplating leaving the public sector or their profession entirely.[7]

Clearly, the pandemic has aggravated existing shortcomings in the European health workforce including shortages, skill-gaps, mal-distribution (medical deserts), insufficient support for physical and mental health and social protection, and the failure to implement effective retention strategies. If we are to improve the resilience of our health systems, strengthening the health workforce will be a central priority. In this article we focus on how a European Health Union could support the strengthening of the health workforce, including by improving the EU-labour market and fostering research on health workforce innovation and implementation. We first start by considering what the creation of the European Union (EU) has already contributed to health workforce development.

What has been achieved?

The EU has created a dynamic and vibrant labour market for health workers

Inter-regional health worker mobility has played a critical role in shaping the health and care workforce in the EU. This mobility has been facilitated by a regulatory regime based in the Treaties, guaranteeing the free mobility of workers and the right to reside and establish themselves. For the so-called regulated professions, which include medical doctors, nurses, midwives and pharmacists, an automatic procedure is in place that guarantees acknowledgement of qualifications obtained in another EU-countries within a three-month period. The recognition is based on a common set of minimal training hours or training standards depending on the profession. Health worker qualifications are therefore highly mobile in the EU.

This EU wide labour market has created lots of opportunities for health workers, resulting in highly diverse forms of cross-border mobility. This ranges from commuting in border regions or covering weekend shifts or seasonal work, for example during the flu season, to moving to another country permanently or seeking training abroad. Some smaller countries now rely to a great extent on foreign-trained health professionals, while some of the bigger countries with large domestic labour markets attract large numbers of foreign-trained health professionals (**see Figure 1**). The dynamic and growth of mobility has increased in the past two decades, though directions and hot-spots have changed due to geopolitical changes, like the EU accession process, or external shocks such as the economic and financial crisis, the COVID-19 pandemic and war and conflict in Ukraine, as well as domestic reforms. Overall, trends over the past two decades have seen a major outflow of health workers from EU countries in the South and East of the region to other Member States, with some countries such as Belgium, Germany and Ireland both source and destination countries.

> EU wide labour market has created lots of opportunities for health workers

The EU labour market for health workers is constantly growing, which, in theory, seems like a positive development. If we are to ask more systematically who is actually benefiting from it, the answer is less straightforward. Mobility is a complex phenomenon because it is neither wholly positive nor negative for source and destination countries; its effects change over time and are equivocal, overlapping, hard to pin down, and depend on the context and governance of mobility. Countries are faced with balancing the free mobility of health professionals in the European labour market on one hand, and the planning requirements of health systems ensuring universal health coverage on the other.

The EU-market in theory can be very efficient. If there are some countries with unemployment, health workers can move to countries where the demand is stronger. Shortages can be fixed in a fast and efficient way by becoming a destination country: instead of waiting until a new generation of health professionals is trained, cross-border recruitment works almost instantly. But source countries can also benefit from collective benefits, for example through the sending of remittances or acquiring new qualifications.

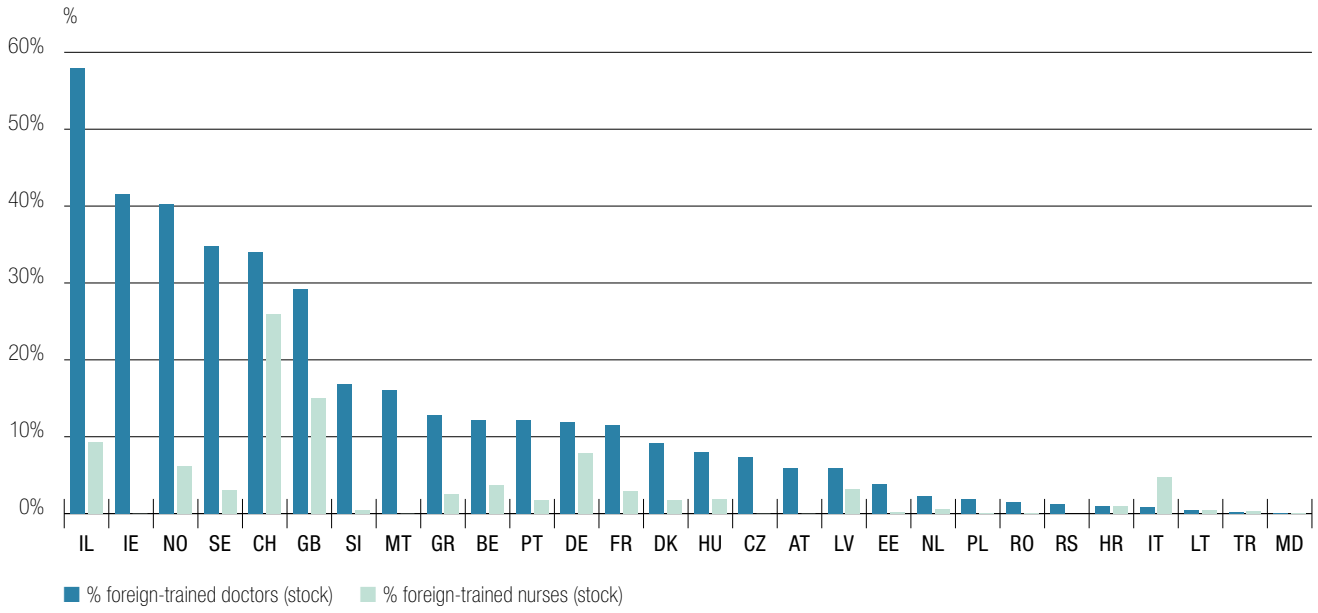
There are, however, many inefficiencies. Brain drain may affect or even undermine domestic workforce planning. If a country loses health professionals in large number, it also loses the investment in them and with it the tax-payer money spent on education, training and development. Moreover, health workers are not necessarily going where the need is the greatest but where the demand is strong. Balancing equity and efficiency to ensure all countries benefit from health worker mobility within the EU environment is therefore enormously challenging in practice.

The EU has advanced health workforce policymaking

There is no EU-health system but there is EU health policy, and these policies may sit in different and sometime surprising places: in the various Directorates-General (DG SANTE, DG MARKET, DG EMPL), the mechanism of the European semester and the social pillar. It is a great achievement to see a growing convergence around primary and integrated care, access and quality, and resilience. This convergence is not perfect, but for an intersectoral policy is arguably more consistent than the all too often implicit health workforce policies in some Member States.

Aside from this convergence, the EU has managed to bring the health workforce onto the EU-political agenda. The EU had previously invested in Agenda setting focusing on the health workforce, including under the Belgian (2010), Hungarian (2017) and Maltese (2017) council presidencies. The council conclusions coming from the Belgian presidency, for example, resulted in investment, in particular in research, as well as increased attention on developing

Figure 1: Foreign trained doctors and nurses as a share of total stock of doctors and nurses, 2018 of latest available year



Source: [8]

Notes: Foreign-trained doctors and nurses as a share of total stock of doctors and nurses, 2018 (or latest available year*). **IL**, Israel; **IE**, Ireland; **NO**, Norway; **SE**, Sweden; **CH**, Switzerland; **GB**, United Kingdom; **SI**, Slovenia; **MT**, Malta; **GR**, Greece; **BE**, Belgium; **PT**, Portugal; **DE**, Germany; **FR**, France; **DK**, Denmark; **HU**, Hungary; **CZ**, Czech Republic; **AT**, Austria; **LV**, Latvia; **EE**, Estonia; **NL**, Netherlands; **PL**, Poland; **RO**, Romania; **RS**, Serbia; **HR**, Croatia; **IT**, Italy; **LT**, Lithuania; **TR**, Türkiye; **MD**, Moldova.

Note: Countries reporting data on foreign-trained physicians but not nurses: Austria, Bulgaria, Czech Republic, Ireland, Malta, Serbia, Slovakia.

the health workforce. DG SANTE has argued that the health workforce is key to the sustainability and resilience of health systems and focused on it in its monitoring system – the country health profiles.

The EU has increasingly funded relevant health workforce research

Research and studies were funded through the programmes of DG RESEARCH and DG SANTE, helping to substantially increase knowledge on the European health workforce. Often, they focused on highly relevant topics such as the impacts of cross-border mobility, mal-distribution of workers and medical deserts, nursing quality, and digital skills (**see Box 1**). As a side effect, it's fair to say that the funding has created a health workforce research community, which finds its platform in organisations like the European Public Health Association (EUPHA) and the EU health policy platform.

How could a European Health Union support further development of the health workforce?

Despite all the achievements, a fully functioning European Health Union could further help strengthen the health workforce in the EU. We consider how Member States and the EU working more closely together within a strong health union can help improve various aspects of health workforce development, including: planning, forecasting and monitoring; building national and cross-border capacity for education, training and

Box 1: Tackling health workforce issues through different EU-instruments

EU Research Programme

- BeWell (Blueprint Alliance for a Future Health Workforce Strategy on Digital and Green Skills).

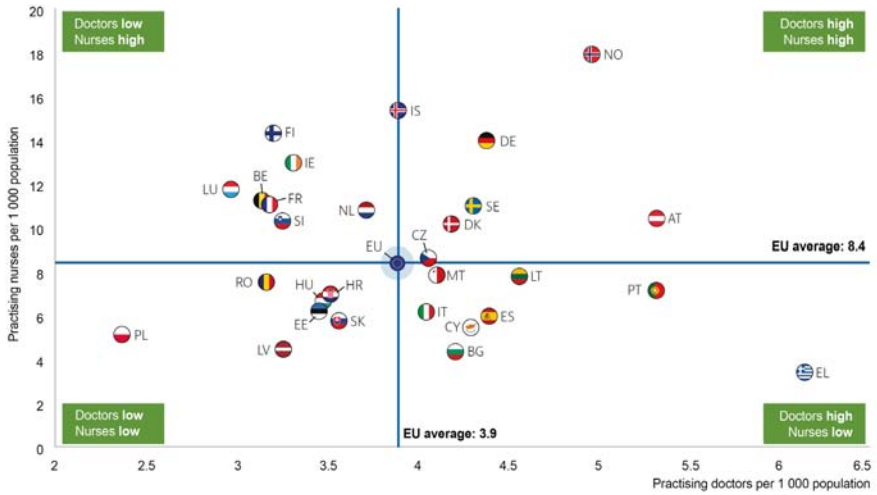
EU Health Programme

- AHEAD (Action for Health and Equity: Addressing medical Deserts)
- METEOR (Mental Health: Focus on Retention of Healthcare Workers)
- OASES (promoting evidence-based reforms on medical deserts)
- TaSHI (Empowering EU health policies on Task SHIfting)
- ROUTE-HWF (A Roadmap OUT of Medical deserts into supportive Health Workforce initiatives and policies).

Joint action

- HEROES (Health Workforce to meet Health challenges. Planning and forecasting data, tools and capacity).

Figure 2: Doctors and nurses per 1,000 population, 2019 or latest available year



Note: In Greece and Portugal, data refer to all doctors licensed to practice, resulting in an overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospitals.

Source: [9]

lifelong skills development; strengthening attraction and retention efforts; and further addressing issues pertaining to mobility.

EU health workforce monitoring needs an overhaul. **Figure 2** presents an overview of the ratios of doctors and nurses per 1,000 population. Although it looks very specific, it is at best a vague idea about the numbers of health workers operating in the EU labour market. This is because different indicators are collected in countries and reported to WHO, the OECD and EUROSTAT through the Joint Data Collection (JDC) form.

> health workforce is key to the sustainability and resilience of health systems

The EU should work with Member States on a reporting system that is accurate and timely. There are many challenges that need to be addressed to improve human resource for health (HRH) data. First, not all countries are reporting all professions. For example, nursing data, which is the largest profession by number, is missing from some countries. Secondly, comparability of data is limited. Some countries report all licensed health workers, which includes those unemployed or working in other sectors, while other countries focus only on those health workers that are actively practicing in the health sector. Further, some countries report head counts, while others report full-time equivalents. The latter indicator would be desirable as there are large variations; for instance, in the Netherlands, a large portion of the health workforce is working part time, while in Poland the majority of health workers are working full-time. This can distort comparison. Third, fragmentation of HRH data is high. For example, in many cases it is difficult to get data of health workers working in private health facilities. There are many other data shortcomings which relate to qualifications, settings of work and additional qualifications. One potential solution is for all Member States to strengthen their HRH information systems and introduce electronic health workforce registers that use common definitions of health workers and include health workers from the entire health labour market.

Health workforce planning and forecasting needs to be established and linked to other sectors. The EU needs to develop a link between national and EU planning systems. There is a need to institutionalise an EU-monitoring and forecasting system, that is linked with the forecasting and planning systems in countries. This is ambitious since the planning mechanisms across countries vary widely and some are not very effective. In fact, many countries still don't have sufficient data, tools and capacities for forecasting and planning. Linking forecasting and planning with other sectors, including education, is another challenge. Health workforce planning should include multiple ministries, such as the Ministry of Education, Ministry of Finance, Ministry of Labour, Ministry of Social Affairs and Ministry of Health among others, to cover the full spectrum of the health labour market. The fact that responsibility for certain key elements of health workforce planning and development lies with other ministries beyond health, often on the regional level, requires sophisticated governance. Undertaking Health Labour Market Analysis [10] is one approach to promote intersectoral workforce planning, investment and policy development, but will require significant efforts to strengthen HRH information systems.

Effective retention efforts are urgently needed to address demographic challenges. The health workforce in Europe is ageing rapidly. At the same time, the ageing of European societies is reducing the pool of young candidates from which to draw future health workers, while the health sector is not proving attractive enough for young students who decide to join professions in other sectors. This is raising serious concerns over replacement efforts in the coming decades. We are already observing shortages of health professionals in EU health systems. They are severe with regards to nurses, long-term and social carers and some medical specialties, such as general practitioners. This underscores the urgent need to invest in improving retention efforts to reduce attrition and early departure from the health workforce. This will require efforts to improve salaries, working conditions and efforts to protect physical and mental health. The manifesto of the European Health Union explicitly highlights the need for the EU to work together with Member States and take

action to retain and attract health workers, particularly in underserved areas, and to safeguard the rights of health workers.

Digital skills can help support retention efforts. A new generation of health workers are emerging that value working arrangements that are compatible with having a family and other life goals. Extending working hours is not an option to fix this problem, but rather to consider bringing more flexibility into working arrangements. Digital solutions for remote monitoring and teleconsultation are potential options that may play a role increasing the efficiency (as well as the accessibility and quality) of health care and reduce the bureaucratic burden on health workers. The creation of the European Health Data Space – a central component of a European Health Union – will help create a digital health service infrastructure to support and promote the use of digital health tools. Recovery and Resilience Funds meanwhile offer substantial budgets to support digitalisation, while EU's the 'Pact for Skills' initiative will play a key role in ensuring health workers can develop digital skills for the future.

Closing the skill-gaps through lifelong learning. The EU should support the development of effective life-long learning systems across its Member States. According to OECD many health workers either feel over- or under-qualified. Gaps have been reported with regards to digital skills and green skills, which are indispensable for the health sector's contribution to sustainability. Curricula adjustment is one way to address skill-gaps. It is, however, a slow and often cumbersome way to get new skills into the system. By the time the adjusted curricular becomes effective, it may already be outdated, given the rapid technological and medical developments. Often, it is not the entire health workforce that requires those skills. Life-long learning, for example in form of continuous medical education or continuous professional development, may provide better ways to strengthen the skills-profile of health workers. To this end, the EU could make life-long learning compulsory and support the establishment of Open Education Resources across the EU.

Voluntary collaboration on training and specialised care. The EU should support cross-border collaboration in the health workforce. Some EU countries are just too small or do not have the means to train all necessary specialities, though those services are included in their basket of care.[11] Taking training cycles for specialisation in another EU-Member State is possible and common thanks to the mutual recognition of diplomas. Training cycles, however, are often structured in a way that the trainee has incentives to stay in the host country or that the return to the source country is difficult. In order to avoid the unnecessary loss of highly qualified health workers, training cycles abroad should be structured in such a way that it becomes an integral part of the domestic training. Return should be incentivised or made easier. Voluntary collaboration between countries should also be expanded when it comes to patients receiving specialised treatment by doctors coming from abroad or in other countries. Examples are coming from countries like Malta, which has a cross-border collaboration with the United Kingdom giving patients with rare childhood diseases access to specialised care.[12]

> many challenges need to be addressed to improve human resource for health data

Strengthening the European Reference Networks on rare diseases. The EU should further expand the European Reference Networks (ERNs). The ERNs connecting centres of excellence and specialised institutes on rare diseases. The idea behind the ERNs is that it is not the patient traveling but rather the expertise. ERNs help to speed up the proper diagnosis and treatment of patients with rare diseases.

Sharing capacity in times of crisis. The EU should facilitate the sending of patients and health workers across borders. COVID-19 has challenged the capacity of health systems in many European countries. One strategy to confront this challenge is by using spare capacities across borders. This was the case for COVID-19 patient requiring intensive care. Examples are from France and Italy sending patients to Germany. Also, Germany has sent health professionals to Portugal, supporting the Portuguese health system in fighting against COVID-19.

It is important that the EU takes stock of the positive and negative effects that the EU-labour market for health workers has on health systems. Shortages of health workers in one country may have consequences for other countries. If the shortage occurs in a higher income country, the vacancies may attract health professionals from other Member States. If the shortage is large, which often happens in larger Member States, cross-border recruitment may affect lower income countries – particularly in the South and East – whose health workers migrate. If large numbers relative to the size of the health workforce leave, the performance of the health system may be undermined. As already noted, intra-regional mobility of health workers presents both positive and negative consequences for health systems; enhancing the benefits and reducing the harms of mobility for all parties is a considerable challenge within the EU regulatory market. The EU should work with Member States to ensure the training pipeline for health workers is transparent, to report on the production of health workers in a timely manner, and to analyse their health labour market to identify possible shortages.

The impact of recruitment efforts on the global health workforce should be addressed. Some EU countries will need to recruit health workers from low- and middle-income countries to fill vacancies in light of demographic challenges. Ensuring Member States adhere to the principles of the WHO Global Code of Practice that aims to promote ethical recruitment practices is therefore fundamental. Any EU global health

strategy must include an honest discussion about health workforce needs and form an important component of multilateral development for health. It should support strengthening of those countries most likely to be left behind and enable clear, fair and ethical recruitment pathways for young people seeking a future as part of the EU health workforce in a way that creates win-win situations.

Fostering research on health workforce innovation and implementation

Despite all the progress being made with regard to EU-funded health system research there is still a need to strengthen comparative analysis. Europe is often considered as a natural laboratory for health system research. There are not only many health systems, there are also a lot of differences and countries are implementing innovations to improve universal health coverage and health system performance. To identify what matters most, the EU-funded TO-REACH research project has identified key priority areas where European health systems can learn from each other. These areas can be clustered among four domains: [13]

(1) Person- and population-centredness

(2) Integration of services across all health sectors and traditional health system boundaries

(3) Four key sectors of care requiring reform: long-term care, hospital care, primary care and mental health care

(4) Preconditions for improved functionality of the priority areas above.

The health workforce is a key component across these four domains. This list of priority areas was compiled before the onset of the pandemic. The pandemic has underscored the importance of research with a focus on innovations and implementation. If we are to draw lessons from COVID-19, we will need to strengthen the health workforce for improved health system resilience and performance. EU-funded research will be a key component in this quest.

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DIGITALISATION: A MISSING CONNECTOR FOR HEALTH SYSTEMS IN EUROPE?

By: Artur Olesch

Summary: Many European Union (EU) Member States implement digital health strategies, while the European Commission is working to strengthen the architecture of the European Health Union, with the EU4Health programme and European Health Data Space (EHDS) at the forefront. Although there are still many disparities in digitalisation, a new infrastructure for data exchange is emerging to connect health systems and data silos towards providing better access to health services, stimulating advances in medicine and life sciences, and supporting innovative solutions. However, this transformation must accelerate if Europe wants to ensure digital health sovereignty and create a modern, accessible and equitable health system based on democratic values and social solidarity.

Keywords: *Digitisation, Digital Health, Connected Health, European Health Data Space, European Health Union*

Background

The digitalisation of European health systems is maturing too slowly in order to improve efficiency, accessibility and quality of health services. Digital health has for years been seen as a facilitator of the shift towards evidence-based, patient-oriented, prevention-focused health care. However, uptake of technologies like electronic patient records (EPRs), telecare, mobile health apps or artificial intelligence (AI) is more challenging than expected, mainly due to data interoperability and the complexity of health systems. How can we leap from digital health pilot projects and strategies to benefits for all citizens?

The pace of technology overwhelmed strategies and policies

Physicians want to make decisions based on complete patient health and well-being data, tailoring care and treatment to individual expectations and taking account of the social determinants of health. Citizens expect a better experience: easy navigation through health systems, flexible access to health services, human touch in a digital age, and continuity of care. And policymakers aim to create a cost-effective and accessible health system.

In order to meet the priorities of these three stakeholders, one ingredient is critical: data. Not just paper files turned into electronic equivalents, but interoperable data available in trusted

> **#EHFG2022** – Session 6: Data shouldn't be rocket science, Peter

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and safe health care infrastructure, easily accessible to end-users through user-friendly applications.

The digitisation of health care systems in Europe has made significant progress since it took off 30–40 years ago. In 2020, an average of 81% of doctors in EU Member States used basic functionalities of electronic health records (diagnoses, lab tests results, basic medical parameters, medical history, symptoms, clinical notes, ordered tests).[1] In some countries, such as Croatia, Denmark, Estonia, Finland, Slovenia and Sweden, this percentage reaches 100%.[2] As a result of the COVID-19 pandemic, the share of the population that has received a remote general practitioner consultation in Europe is 40%.[3] E-prescriptions, mobile health apps and wearables collecting diverse biomarkers or patient portals – among many digital health innovations – are gaining momentum.

> “Europe is still at the beginning of harnessing digital health

Widespread computerisation starting in the 1990s, followed by massive internetisation and exponential growth in the use of smartphones in the last ten years, has led to the rapid development of e-health and mobile health (mHealth) solutions. However, technologies developed mostly by the private sector were not followed by policy and system changes in health care. Common agreements on data format and structure were lacking and, as a result, electronic files could not leave the physical location where it was collected, which hampered the main benefits of digital health care. On top of that, health care and digital health remained disconnected.

But it’s changing slowly – in recent years, digital health strategies developed in the EU Member States have led to investments in data exchange infrastructure, the establishment of interoperability standards, and the design of secure data access and patient privacy initiatives. As a result of the COVID-19 pandemic, many EU countries have introduced reimbursement for virtual health services, making them more accessible to patients (**see Box 1**). And the European Commission’s Communication on the Transformation of Digital Health and Care of 2018 gave impulse to cross-border data exchange and processing.[4]

Although there are still significant differences in the speed of digitisation of EU Member States’ health systems, e-health has become a shared priority.

The right policies enable the transition from fragmented e-health solutions to cohesive health ecosystems

This scene-setting of health care transformation is essential to understanding barriers and facilitators to the uptake of novel technologies among patients and health providers. From the anarchy of different technologies and lack of integration across points of care came growing frustration among doctors, general disillusionment with digital health and confusion among politicians. The digital revolution took many by surprise. With limited benchmarking possibilities, countries experimented with technologies by launching numerous pilot projects. But without proper governance and funding, they ended up where they started: on pilots with no vision for their long-term integration into health systems.

Fortunately, we are entering the next phase of what can be called “sustainable digitalisation.” The catalyst for this incremental process was, among other factors, the COVID-19 pandemic. It has become clear that it is essential to create a new health care delivery model, harmoniously combining, and where needed upskilling, health care workers’ competencies and the possibilities of digital technologies. This is especially so, since “old, well-known” threats – rising prevalence of non-communicable diseases (NCDs), ageing population, health care worker shortages – mingled with new

Box 1: Advancing digital health: moving out of the implementation impasse

The COVID-19 pandemic has unearthed the added value of digital solutions in health, from real-time capacity monitoring of ICU beds and essential health care delivery to telemedicine, pandemic modelling, genomic surveillance, and interoperable contact tracing apps. Health systems across Europe accelerated the adoption of such technologies by breaking down existing legal and practical barriers, including enabling the reimbursement of digital tools and adapting existing regulations to facilitate their use.[5]

Prior to the pandemic, uptake of digital tools was slow and unevenly distributed across different European countries. Their role changed overnight as they shifted from promising technologies to fundamental building blocks of emergency response. The progress made over the past two years has demonstrated that organisational and systemic barriers, not technological ones, were primarily responsible for hampering the widespread adoption of such tools at the European level.[5] [6]

Going forward, the momentum generated during this global emergency must be preserved to inspire a more permanent transformation at a system level, including the establishment of adaptive legal, financial, and regulatory frameworks, investment in infrastructure and innovation pipelines, as well as multilevel initiatives to allow the uptake of digital technologies to permeate daily clinical practice.

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hazards such as pandemics, climate crisis or rising socio-economic inequalities in many countries.

Like data security and patient privacy, interoperability quickly became a fundamental challenge. EU countries are now approaching a digital-driven shift towards health care in a smarter way. Since the emergence of many policy papers and growing number of scientific publications on e-health, the know-how of decision-makers on the components determining the success of digital transformation has improved.

> designing a new health ecosystem with the patient at its centre

Digitalisation is no longer perceived as an add-on to current health systems. Instead, it has become an enabler, a facilitator in designing a new health ecosystem with the patient at its centre. Estonia, Denmark and the Netherlands – for years considered digital pioneers in the European Union (EU) – were followed by those who have belatedly elevated digitisation on the national agenda.. France, Germany, Poland, Spain and other countries have made significant progress in the last three years due to centrally coordinated actions, new legislative frameworks and strong leadership. Countries just embarking on the digital health revolution can learn from the mistakes of others. For example, France's recent roadmap for e-health prioritises governance, security and interoperability, reimbursement and funding of innovation. Today, we know that these factors are critical for a successful shift toward modern health care.[7]

Health systems have also recognised the value of digital health in achieving goals toward universal health coverage and the health-related Sustainable Development Goals. A contribution to process-based change management in health care using new technologies is 'The global strategy on digital health 2020–2025' published in 2019 by the World Health Organization (WHO).[8] It points out that digital health can improve the efficiency and cost-effectiveness of care by enabling new business models for service and process delivery. Furthermore, digital health can improve health outcomes if supported by sufficient investment in governance, institutional and workforce capacity to enable digital systems changes and training in data use, planning and management.

WHO's engagement in supporting countries to digitise their national health systems highlights how important this is for future health systems. Like many other studies and analyses, the strategy highlights the importance of the human factor. Digitisation requires governance and leadership on the one hand and strengthening digital health literacy among citizens and health care workers on the other. The assumption that digital transformation should be regarded as a critical determinant of health is also constituted in *The Lancet* and *Financial Times* Commission on governing health futures 2030: growing up in a digital world, published in 2021.[9]

Box 2: Breakthrough technologies must contribute to integration across the healthcare delivery

The implementation and up-scaling of integrated digital-enabled person-centred care services is a necessity for better patient outcomes and performance of health systems. Discrete attempts at improvement, whether it is about services, finances, education, legislation or technology aspects, are insufficient and often not successful in making health systems change.

Successful health system change requires both a bottom-up and top-down approach: i.e., addressing practical integration and improvement issues at an operational level while aligning higher system aspects like finances, regulation and authorities. The leading principle in this approach is that all actions are aimed at optimising services that anticipate people's needs.

The redesign of health and social services, as well as collaboration between relevant regional professionals and actors, should be central while implementing enabling technologies, and data should intrinsically be part of this process. Patient-centred co-creation and joint development with other users will ensure a better adaptation of technology as part of integrated health services.

Accordingly, the implementation of technology will be more successful. Although health service transformation is mainly a local and regional effort, every relevant stakeholder and authority at higher system levels should be involved in order to align policies and direct measures to create appropriate conditions for transformation and facilitate local actions.

Cross-border health care, whether provided across regions or countries, largely depends on agreement and adoption of standards for interoperability regarding services (e.g., clinical guidelines) and related information (e.g., outcome indicators) as well as data and technology. Considering the implication of these requirements, countries need a joint vision, strategy, an action plan and commitment at all levels to make the compulsory transformation for better and sustainable health care successful.

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Health care is increasingly finding its place in digital reality. During the COVID-19 pandemic, we've witnessed increased adaptation of virtual visits and remote monitoring.[3] The ecosystem of digital health startups, supported by EU-funded acceleration programs like the ones run by European Institute of Innovation and Technology (EIT) Health, is growing. Politicians are getting aware of the importance of breakthrough technologies and data. By introducing so-called Digital Health Applications (DiGAs), prescribable digital therapeutics, Germany has inspired many countries around Europe to start introducing clinically validated tools with benefits for patients.

> digital health is a tool, not a goal

Structured national health systems, with a robust data exchange infrastructure and standards for information and communication technologies, pave the way for the next chapter – exploiting the potential of digital health at the European level. However, to seize this opportunity, we will need wise governance of health futures, the creation of legal solutions firmly rooted in European values, collaboration across all stakeholders and smart approaches to secondary and primary use of data in a secure and trusted EU-wide environment.

We can have both: data privacy and safety as well as modern, equitable health care

The aforementioned Commission report on governing health futures 2030: growing up in a digital world points out that digital technologies will considerably impact our lives, including our health. The question is, what must be done to ensure this impact is positive also for future generations?

Criticised for lagging behind leaders such as China and the United States (US) in building an innovation-based economy, but also praised for its data protection and privacy policies, Europe is slowly beginning to put its own vision for digital health into action. This is becoming urgent – access to data will determine whether AI algorithms powering innovative health technology will flourish in Europe or whether we will become passive consumers of AI-based solutions. It is also a question of digital sovereignty which cannot be ignored in the context of the geopolitical implications of digital technologies.

The COVID-19 pandemic proved the value of the EU in cross-border crisis management: Pharmaceutical Strategy for Europe aims to mitigate shortages of medicines, Recovery and Resilience Plans support EU Member States in economic recovery after the pandemic, while the European Green Act addresses the climate crisis. These joint agreements between 27 different countries demonstrate the power of collective action.

A similar willingness to unite will be needed to pass the Regulation for the European Health Data Space (EHDS), one of the central elements of the European Health Union

The EHDS aims to ensure that individuals have access to and control their health data – in their home countries and in every EU Member State. The second priority is enabling the secondary use of data for research purposes, policymaking and prevention. This could also boost – along with other transformation components like the EU4Health programme – the growth of innovative companies creating new services based on AI algorithms trained on data 'generated in Europe,' accurately reflecting cohorts of citizens. Maintaining data security and patient privacy standards could additionally be the new European trademark.

A vision is not enough. Firstly, EU Member States need to secure an equal level of digitalisation of national health systems to avoid digital gaps. Secondly, the courage to shape the digital future of Europe instead of the current reactiveness to emerging technologies must be shared among all EU health leaders (**see Box 2**). Finally, what could be a better glue for the European Health Union than data exchanged across the borders – data to unfold research, connect doctors for better decision-making and care about citizens no matter where they are.

New Green Deal for digitalisation in health care

Thanks to the eHealth Digital Service Infrastructure (eHDSI), the first EU countries can already exchange e-prescriptions and Patient Summaries. Increasing interoperability to drive the flow of information is removing the last walls left in European data protection.

Nevertheless, Europe is still at the beginning of harnessing digital health. While interoperable medical health records are tangible progress, it is not yet a transformational power to reduce the impact of medical staff shortages, minimise medical errors, provide a precise diagnosis and individual treatment, and personalised health prevention.

In order to create next-generation health care, it is crucial to take a broad look at innovations in health care. We need to strategically adopt new solutions such as remote monitoring, big data analytics, smart wearables, AI and augmented/virtual reality, but to do so smartly so that patients get solutions that offer therapeutic benefits. We also need a trusted legislative framework at the national and EU level, reimagined reimbursement policies, modern digital education, and attractive conditions for innovation growth. Digitalisation of health is a cross-sectoral challenge.

Europe lacks a radical Digital Deal on the scale of the Green Deal, with leaders driving digital change that is true to European values and inspires citizens' trust. We need to combine the enormous potential of science with entrepreneurship to generate breakthrough technologies; we need local innovation hubs connected by a European data exchange infrastructure in a single digital market to thrive progress in health care.

The European Health Union should be a union of health data and innovation.

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The Politics of Healthy Ageing
Myths and realities

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Research from the European Observatory's Economics of Healthy and Active Ageing series finds overwhelmingly that population ageing is not a major problem for the sustainability of health care systems or societies. So why is it so often treated as a threat?

This brief draws on a book presenting and synthesising the international evidence on this question. It first identifies and discusses three myths that are widely influential in debates about ageing. It then reviews evidence on the possibility of 'win–win' politics that produce good outcomes for people of all ages. In terms of policy design, this means focusing on life-course policies. Life-course approaches have extensive implications for policy because they suggest ways to make policies that invest for the future at every stage of people's lives. They also have distinctive politics because they ask for political leaders, interests and advocates to form coalitions among different groups that mutually benefit from the same policies. The brief concludes with lessons on ways to develop political coalitions in support of life-course policies.

RETURNING TO THE ORIGINAL DESIGNS OF EUROPEAN INTEGRATION: **CREATING EUROPEAN PUBLIC GOODS IN HEALTH**

By: Vytenis Povilas Andriukaitis and Erin Webb

Summary: At the EU's foundation, joint development and management of public goods was a fundamental element of European integration. Yet the past few decades have moved away from this original vision and towards Member State management of public goods. Now, especially in the context of COVID-19 and the war in Ukraine, the EU community is placing renewed attention on public goods, especially in health. Positive experiences at the EU level provide tangible examples of what works for European public goods in health. This article provides a framework and emphasises the need to capitalise on political opportunities for policy action.

Keywords: *Public Goods, Cooperation, Regulation, Integration, European Health Union*

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Public goods in health have local, regional, national, European Union (EU), and global dimensions. In practice in the EU, most actions in health require governance at the national level by Member States (MS). The EU may make decisions and take action when the objective cannot be sufficiently achieved by MS due to the scale and effects of the proposed action. Shared competences between the EU and MS provide an opportunity to enhance the health of Europeans by targeting policies MS struggle to perform alone.

This article will consider the historical context of considering public goods – defined as goods that have a societal benefit, which people cannot be stopped from accessing and where use or enjoyment by one person does not reduce availability to another – at the EU level, with the governance tensions between the EU and MS levels. It will then describe some more recent incentives for action in this area, and identify where this has worked well in the past few years. Last, the article will present a framework for potential policy action and emphasise the importance of capitalising on political opportunities for action.

The European project started from the development of public goods, but public goods continue to be mostly managed at the MS level

The management of public goods was core to the foundation of the EU, and early European priorities focused on the protection and provision of public goods. As was stressed by Fuest and Pisani-Ferry in 2019, "Early priorities – defence, until the rejection of the European Defence Community in 1954, food self-sufficiency, which was a major objective of the Common agricultural policy (CAP), and energy autonomy, with the Euratom treaty of 1957, focused more on integration through the provision of European public goods".[1] The emphasis of EU policy on the benefits from integrated markets for goods, services, capital and labour prevailed in policy-making at the European level until the economic recession of 2008–2009 and the austerity policies that followed. This shifted the centre of attention away from public goods towards economic concerns.

> "the management of public goods was core to the foundation of the EU

In practice, the provision of public goods in Europe is primarily a task of the national governments or subnational entities even when the EU shares areas of competences with the MS. This includes Article 4 of the Treaty for the European Union, which relates to security, public health, safety, and environmental protection. Human health, culture, and education are outside of the EU's scope of responsibilities. Further, the EU budget is relatively small, and is fixed at approximately 1% of GDP for MS.[2] Of this, very little money goes to financing pan-European public goods.

Box 1: Market failures in treatments for tuberculosis and Hepatitis C

Multi-drug-resistant tuberculosis (MDR-TB) accounts for 600,000 TB cases and is responsible for 240,000 deaths globally per year. Technologies for proper treatment are not properly developed. Markets lack interest to develop new drugs for TB treatment, and the first new treatment in 40 years to treat MDR-TB, bedaquiline, was approved in 2012. The high cost of second-line medications used for treatment of MDR-TB often precludes those who cannot afford therapy.

About 60 million people globally are infected by Hepatitis C virus (HCV). Despite the availability of an effective treatment, WHO estimated that in 2019 HCV was responsible for approximately 290,000 deaths globally.[4] Pan-genotypic direct-acting antivirals (DAAs) can cure most persons with HCV infection, and treatment duration is short (usually 12 to 24 weeks). However, the cost of treatment is around €50,000 making universal coverage unaffordable even for many affluent countries.

Innovative medicines to treat MDR-TB and Hepatitis C are candidates for future European or even global public goods. MDR-TB is widespread in Africa, South Asia, as well as European countries (for example, Ukraine) and some EU MS (Baltic states, Romania). The transformation of DAAs from a private to a public good is an opportunity to save lives through social innovation. It has to be stressed that if growth of DDA demand is stronger in comparison to reduction of prices, the transformation may result in neutral or even positive profits for the pharmaceutical industry.

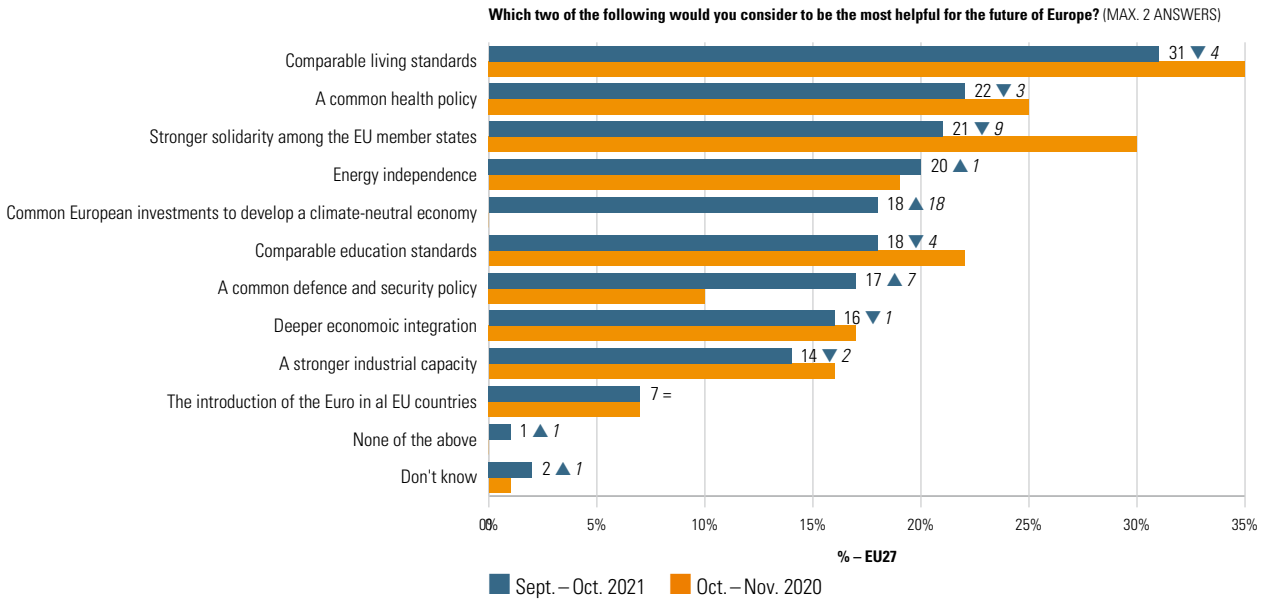
Thus, stakeholders involved with public goods should look to integrate the EU, MS and private resources.

A paradigm shift towards shared responsibility of public goods between MS and the EU is gaining momentum, especially in health

According to the tradition of decision making, European institutions often interpret subsidiarity as a reason not to take pan-European action in health. However, successful recent trends are changing this perspective, especially the European cooperation seen during the COVID-19 pandemic. Other trends even outside of health are prompting a re-evaluation of the EU role of managing public goods. These include the conflict in Ukraine, which has reminded the world that defence and security should not be disregarded as priority areas of European policy. In addition, technological breakthroughs in the US and China in digital, aerospace, and medical technologies are suggesting a greater role for the EU in regulating, sponsoring, and funding innovative initiatives. Climate change is also acknowledged as a global threat that requires coordinated action, especially when viewed through its related One Health dimension (see the article by McKee in this issue).

Another contributing factor in the shifting perspective of public goods in Europe relates to the role of MS in the world and the convergence of MS. Increasingly, individual European countries are losing their dominance in international politics and development cooperation, and the EU has the potential to play a larger role in these areas. At the same time, the convergence of MS is increasing, and the countries that joined the EU since 2004 are catching up economically with the EU15. This convergence narrows the national differences in development objectives, and thus strengthens preconditions for creating European public goods. Further, MS are becoming more integrated. After Brexit, the United Kingdom, one of the strongest proponents of an internal market and therefore sceptic of international development of public goods, is no longer in the EU. The converging global and European trends described in this section suggest that Europe is ready to return to its roots of integration through the provision of European public goods.

Figure 1: Priorities of Europeans in 2020–2021



Source: [3]

European citizens are placing health at the top of policy priorities for the EU

In addition to the macro trends just described, individual European citizens are also demanding more national and European public goods as opposed to market liberalisation. According to recent Eurobarometer surveys, European citizens consistently rank health among the top priorities of pan-European actions (**see Figure 1**).

> “Europe is ready to return to its roots of integration

Market failures provide a rationale for European public goods, and successes from the COVID-19 response support this

It is well known that markets fail to effectively manage public goods. Two global examples of market failures relating to public goods include the development of treatment for multi-drug-resistant tuberculosis and the availability of Hepatitis C treatment (**see Box 1**).

At the same time, before moving towards European management of public goods, there must be a demonstration of added value — that the net benefits of European action exceed the net benefits of a MS acting alone. Two experiences from COVID-19 provide this evidence: COVID-19 vaccines and the EU Digital COVID Certificate.

In the case of COVID-19 vaccines, the EU prefinanced research and development (R&D) and jointly procured COVID-19 vaccines through an Advanced Purchasing Agreement. The pooling of European public resources for the vaccines appears to be more efficient in comparison to market-driven R&D and competitive bidding for vaccines by MS. The EU Digital COVID Certificate pooled European digital and administrative resources to develop a gateway through which all covid certificates issued by national authorities could be verified across the EU.[5] The novel public health tool was instrumental in restoring free movement of people across the EU and beyond.

Promising health areas for the development of European public goods

Several areas for action in the area of European public goods in health have emerged, and are introduced in this section. These include R&D for orphan drugs and personalised medicines, the management of rare diseases, the regulation of health technologies and public health, and the management of communicable diseases and health emergencies.

Investing in research and development for orphan drugs and personalised medicines

In general, European research financing is comparatively low. The Commission proposes spending almost €100 billion over seven years on Horizon Europe, plus about €20 billion on the other research programmes, most of which are not related to health.[6] In comparison, the US annually spends almost $40 billion ($280 billion or approximately €250 billion over seven years) just for the National Institutes of Health.[7]

The rationale for developing orphan drugs and personalised medicines as public goods is based on European solidarity and economies of scale. By definition, an orphan drug is a pharmaceutical agent developed to treat medical conditions which, because they are so rare, would not be profitable to produce without government assistance. Typically, the development of a new orphan drug is very expensive (up to €1 billion), while the production is relatively inexpensive. Therefore, expanding the demand across the EU could lead to decreased costs per patient and higher international competitiveness of Europe's manufacturing.

Managing access to treatments for rare diseases

Up to 30 million patients in the EU are suffering from rare diseases.[8] MS struggle to provide diagnostics and care, and there are obstacles that are difficult to overcome without strong European cooperation. These include on the one hand inappropriate infrastructure to diagnose and to treat these diseases in many small and medium sized MS, and on the other hand many national tertiary hospitals that have the capacity to treat rare diseases, but are working at a fraction of their capacity, in larger MS. This unevenness across Europe limits accessibility to available treatments and leads to high marginal costs of services. **Box 2** presents a new pan-European patient pathway for a child with a rare disease, as proposed by Helmut Brand.

Agreements to manage development of treatments for rare diseases as a European public good would provide an opportunity to increase accessibility, decrease unit costs of services, and grow the competitiveness of Europe's health science, service provision, and manufacturing. The effort towards universal coverage of patients suffering from rare diseases started with the development of European Reference Networks (ERNs). However, the voluntary participation of MS and the absence of regulations about how to finance the provision of services undermines the progress of innovation.

Box 2: A vision of health cooperation in the EU

According to Helmut Brand, a citizen of the EU expects that health care services are organised in a European cooperation that delivers good health. The ideal would look like:

"A child is born with a rare disease in one of the Baltic Countries of the EU. Since the population in this country is small, there is no focal clinic for this disease here. However, since one exists in Madrid, parents and child travel to Spain after making an appointment. There, they can stay with their child during the evaluation of the findings. Translation services are available to take the medical history and explain findings, diagnoses and therapy to the child and parents. Initial therapy takes place in Madrid, as high-tech equipment must be used that is not available in the child's home country. After treatment is completed, the child and parents travel back with a doctor's letter translated into their local language. A follow-up examination is conducted via videoconference with translation service, during which an electronic prescription is issued by the Spanish doctor for further drug treatment, which the parents can redeem at their home".

Source: [9]

Expanding pan-European regulation of industrial health technologies

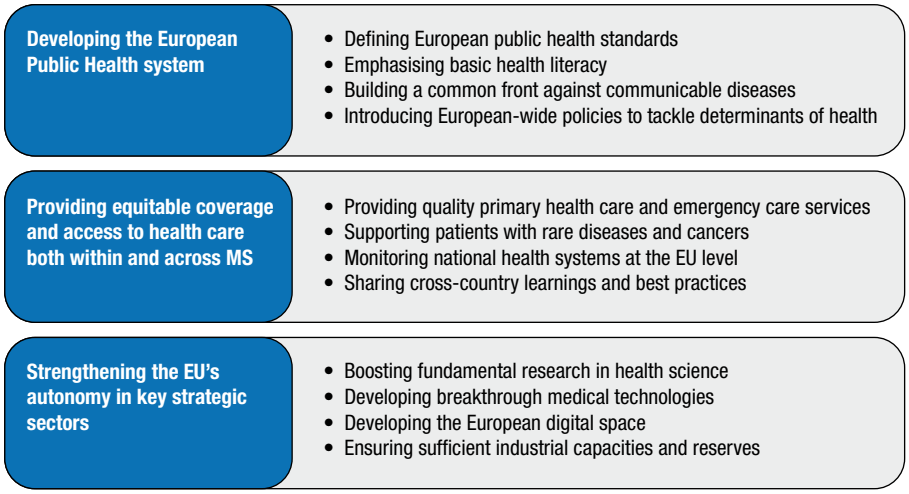
The European Medicines Agency (EMA) carries out the authorisation of medicines in the EU on behalf of MS. While pan-European management of medicine authorisation is not perfect, it does offer 'strong European added value and that this is widely recognised by MS and other stakeholders including businesses'.[10] The centralisation of certain functions at the level of EU Agencies has certain advantages, including mitigating the risk for patients that companies decide not to sell products and services in small countries due to their market size, providing expertise and information of higher quality in comparison to that developed by national sources (especially for small MS), and producing industry savings on certification of products and services through a single EU agency rather than in a number of countries. Additionally, the EMA helps maintain the EU's position in global discussions about regulations. The existence of a well-respected certification process has made it easier for European pharmaceutical companies to obtain certifications in third countries.

While medicines are authorised at the EU level, health technology assessments (HTAs) are still conducted in individual MS. Centralising HTA processes could reduce the time that patients are waiting for public reimbursement of innovative treatments with proven medical efficacy, increase the quality and transparency of decision making across the Union, and save public and industrial financial resources allocated for HTA and decisions on public remuneration of innovative products. Discussions about centralising HTA processes at the EU level are currently underway.[11]

Developing European regulatory tools in public health and provision of essential health services

European regulations are strong and efficient with regards to food safety. In addition, Europe has achieved clear progress in controlling production, distribution and consumption of tobacco. The success has the potential to be mirrored by pan-European policies to tackle social determinants of health leading to obesity, diseases related to overconsumption of alcohol, diabetes, and more. Further, the provision of essential health services, such as immunisation, emergency care, and primary health care have the opportunity for strengthening. Monitoring national health systems at the EU level and sharing evidence-based advice across countries is growing. These activities should be expanded, as they have the potential to provide insights and

Figure 2: A potential structure for European public goods in health proposals



Source: Authors' illustration.

improve assessments that could be used for cross-country learning on effective public health and service delivery approaches.

Managing communicable diseases and other health emergencies

The likelihood of a new health crisis caused by, for example, antimicrobial resistance has not disappeared from the radar of the public health community. The development of medical technologies to mitigate risks related to antimicrobial resistance has a priority on the list of potential European public goods.

Responding to health emergencies, including improved planning and development of health-related reserves, is needed across Europe. EU regulations should define minimum requirements for reserves of medical products, reserve capacities to produce extra medical goods and health services obligatory to MS, and introduce algorithms for cooperation of MS in normal and emergency times. Regular trainings are needed to assure that reserves, overseen by the European Commission, are fit to mitigate health emergencies.

Opportunities for decision making in health policy can draw on hot issues in European politics

Since the Autumn of 2020, a European Health Union as an EU policy has been an important step towards European regulatory action for health. The Conference on the Future of Europe (May 2021– May 2022) [12] was a huge step towards strengthening European health policy and developing European public goods in health. The conference discussed proposals related to the development of European actions in health, with speakers from the three main EU institutions (Council, Parliament, Commission) considering a treaty change during the closing event. While a treaty change is realistic just in the long term, a stronger narrative about the EU's role in public goods has emerged, and practical bold steps towards more European public goods in health are very likely.

Advocates of an increased EU role in the management of public goods should strategically take opportunities for political impact. These could include the presidencies of the European Council, which could concentrate on debating what European public goods are of priority for the EU and what is the most appropriate management of these social innovations. They could be European elections, which should be on the radar of the health community as an opportunity to engage with voters, especially given their high prioritisation of health. They could also relate to the multi-annual financial framework. Awareness campaigns to present the most promising European public goods along with the resources needed for development of European public goods in health is of critical importance. Enhanced investment into key public goods in health such as those presented in **Figure 2** should be advocated by academia, professionals and patient groups. In particular, stronger pan-European cooperation is needed to train, retain and allocate the health care workforce for the provision of equitable coverage and access to health care.

> "new era of pan-European collaboration to improve health and prevent deaths

Looking forward

The years 2020 and 2021 will be remembered in the context of COVID-19, while 2022 marks the return of war in Europe. For the second time during a three-year period, the lives of people (not GDP per capita) became the main criteria for progress in Europe. Joint action in developing COVID-19 vaccines and the notion of a European Health Union introduce a new era of pan-European collaboration to improve health and prevent deaths. COVID-19 has made it crystal clear that cooperation in health should not be limited by national borders of MS, and unified action for peace is a European answer to the humanitarian crisis caused by the military action. Peace in Europe, thus saving human lives, was at the centre of the EU project from its very beginning. Peace is undoubtfully a public good with a health benefit, because people cannot be stopped from accessing it and the use or enjoyment of it by one person does not reduce the availability to another.

A united response and joint actions for health and peace are prerequisites for medical masks disappearing from European streets and tanks from wheat

fields of Ukraine. The successful mitigation of these currently most urgent emergencies will contribute to the development of strong fundamentals for efficient pan-European cooperation in health for the years to come.

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How can skill-mix innovations support the implementation of integrated care for people with chronic conditions and multimorbidity?

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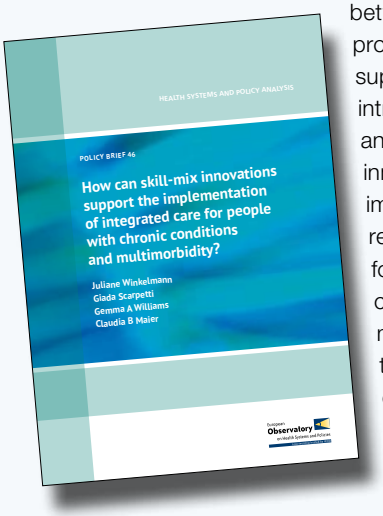
Skill mix innovations are changes to the roles, tasks, and skills of health professionals that are new and disruptive within their specific contexts. Broadly, they involve re-allocation of tasks between (at least) two professions; introduction of supplementary roles; or introduction of teamwork and collaboration. Skill-mix innovations are an important part of the reorganisation of care for people with chronic conditions and multimorbidity. With their focus on improving coordination and patient-centeredness they are at the core of many integrated care models and health professionals involved in the new roles, tasks and modes of working are often seen as the true 'integrators' of care.



This Policy Brief identifies six skill-mix innovations which enable the management of chronic conditions and multimorbidity.

INVESTMENT IN HEALTH: SUPPORTING COUNTRIES WITH IMPLEMENTING HEALTH SYSTEM REFORMS

By: Nicole Mauer, Dimitra Panteli and Stefan Eichwalder

Summary: Mobilising financing for health systems can prove challenging for most health policymakers. The difficulty of persuading finance ministers of the positive social and economic returns of health system funding and investment is accompanied by the tension of allocating limited resources effectively, particularly in times of crisis. There is a broad range of EU mechanisms and instruments which can support health policymakers navigate change processes in health systems, including securing appropriate financing and obtaining tailored technical support when managing reform. Moving towards a European Health Union will require strengthening these instruments and wielding them for the specific needs of different Member States and their health systems.

Keywords: *Health System Investment, EU Support, Financing, Technical Support, European Health Union*

> **#EHFG2022** – Session 11: Money fuels the health system moonshot

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Introduction

While health expenditure continues to rise in most European countries, investment in health systems has been stagnant. This imbalance, accompanied by projected falls in revenues over the coming years, has heightened the challenge of allocating limited resources effectively.[1,2] Health ministers especially are faced with the difficulty of advocating for health systems to finance ministers and of showing how health financing can support overall economic growth and fiscal sustainability.[3] It is typically more challenging to secure long-term funding for health systems, although the need for urgent responses may call for exceptional spending under certain circumstances. As exemplified by the COVID-19 pandemic, a steep rise in health expenditure is not always related to structural reforms and, although more money is spent, this may not be accompanied by demonstrable positive returns in the short- or long-term.

While funding is limited, the demands from health systems are manifold and addressing them is not straightforward. Garnering insights on securing sustainable funding for health systems from settings where such issues have been tackled

successfully and drawing on innovative solutions which have worked elsewhere can support these decision-making processes. Beyond engaging with other health systems and presenting convincing evidence to build a case for health financing, setting a reform in motion and maximising its outcomes may also require reaching beyond the technical and financial instruments that are available at national level.

> health system reform required substantial proactive engagement

The European Union (EU) provides an increasingly shared context for health systems and for safeguarding the health of Europeans today, which is reflected in the recent COVID-19 response and the mobilisation of numerous EU instruments and investment tools to support the recovery from this health system shock.[4] Given that the organisation and provision of health services is a Member State competence, EU health policy largely takes coordinative and complementary roles (see Article 168 on "Public Health" of the Treaty on the Functioning of the European Union (TFEU)). However, EU policy impacting health extends to other areas that are perhaps less intuitive, including the EU's fiscal policy, environmental and agricultural action, and the internal market. Paradoxically, some of these can be more effective at driving change within national health systems than the EU instruments that are dedicated to health as delineated in TFEU. This is because they are frequently linked to harder powers and regulatory mechanisms.[5] Over time, the EU has developed a wide range of support mechanisms for Member States, which create potential for health system improvement even if they do not necessarily seem relevant to health at first sight.[6] Their fragmented nature combined with their frequently elusive relevance for health systems can make them challenging to navigate and coordinate.

What is currently available to Member States? A short overview

The sole instrument at EU level exclusively dedicated to health is the Health Programme (currently EU4Health). Initiatives funded under EU4Health aim at generating evidence through the development of joint models and frameworks, cross-country data comparison and the pooling of good practices, which can facilitate benchmarking and enhance cooperation between EU countries, although not being directly applicable for investment in health systems. In the area of research and development (supported by the EU's overall research programme, currently Horizon Europe), EU funding has long focused on promoting research projects that answer biomedical and technological questions, with fewer research dedicated to health systems, services, and organisational change within health systems.

Conversely, there are other instruments outside the health sphere that are suitable for funding some elements of health care reform at national level. They have mostly focused on funding large health infrastructure projects such as hospitals, as well as training programmes and the development of professional skills. Financial instruments amenable to health-related projects include the Cohesion Policy funding instruments (formerly known as the European Structural and Investment Funds InvestEU, Digital Europe and the Connecting Europe Facility, as well as a diverse set of other instruments provided through the European Investment Bank (EIB), including loans and guarantees. A unique tool is represented by the Technical Support Instrument (TSI), which provides expert support to Member States along every stage of the reform planning, testing and implementation phases. Anchored within the European Commission's Directorate-General for Structural Reform Support, it consists of tailored services involving the recruitment of experts and hands-on support on the ground. The TSI can and is being used to support health care-related reform efforts.

In recent years, the European Semester, a cyclical governance framework primarily dedicated to coordinating and monitoring Member States' fiscal and economic policies, has gained importance for EU health policy due to the rise in domestic health expenditure experienced by most countries. The European Semester is the only EU instrument which allows the European Commission to make explicit reform recommendations for health systems, which Member States have to acknowledge and whose progress they are required to monitor over time. The European Semester has included several recommendations for health system reform in its last iterations, raising health system investment on some Member States' national policy agendas. In response to the COVID-19 pandemic, the EU has designated over €700 billion to a recovery instrument called Recovery and Resilience Facility (RRF) which features investment in health as part of its six priority pillars. Every Member State has devised a national recovery plan which outlines how the allocated funds will be used to propel the economic and societal recovery from the pandemic through public investment and reforms. All plans have been approved by the Commission and are closely linked to the European Semester mechanisms for monitoring and country-specific recommendations. The disbursement of funds is triggered progressively as milestones are reached over the coming years. Several Member States have opted to allocate RRF financing towards their health systems, with some investing several billion euros to support the digitalisation and modernisation processes of hospitals and health care facilities. The TSI can be used in combination with the RRF to ensure reforms planned as part of the national recovery plans are implemented effectively.

For a comprehensive overview of EU instruments relevant for health and care systems, please refer to the European Observatory's Policy Brief on EU support for health and care system.[7] This article will pick out some of these instruments

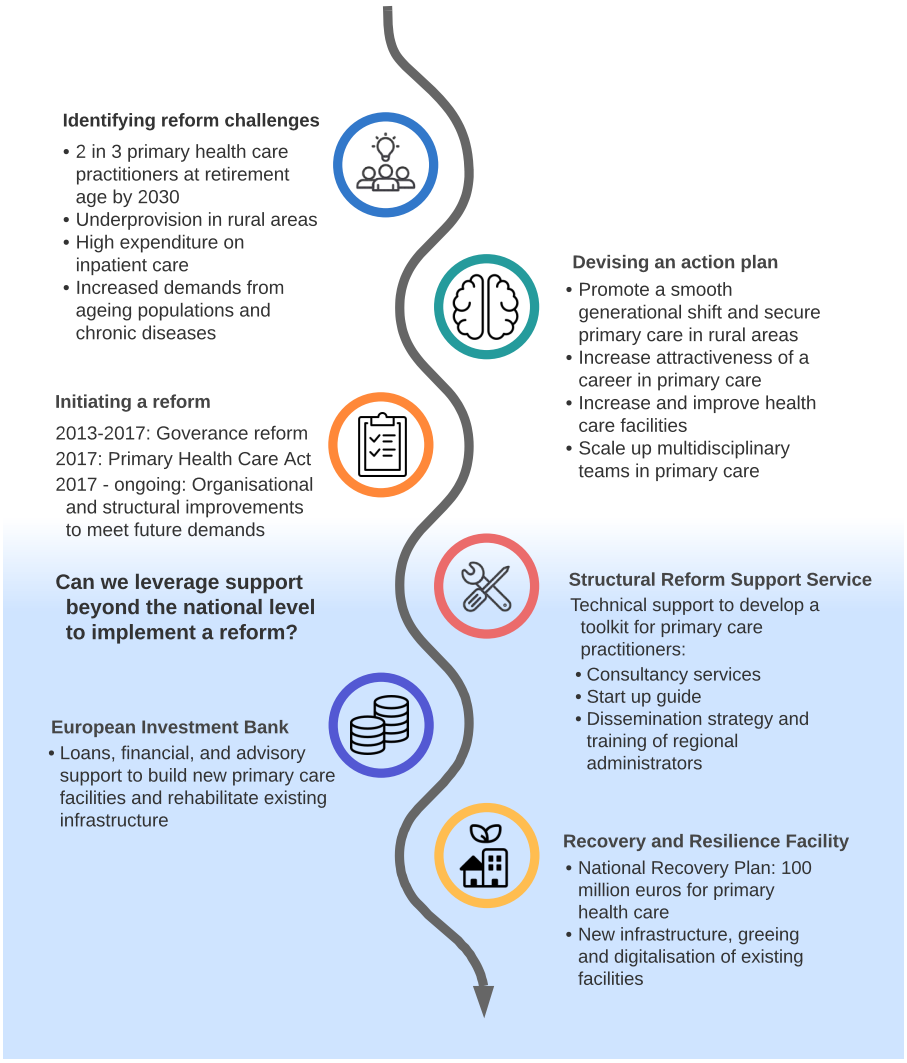
to highlight how they may support the various stages of change processes in health systems, including securing appropriate financing, and how they can be helpful to Member States when navigating a reform process.

How effective are EU tools at supporting health system change? An insight from the Austrian Primary Health Care Reform

Although the range of support tools is broad, identifying what is useful to address specific reform priorities and how to unlock this potential entails careful planning, dedicated resources, and continued commitment. Every instrument is characterised by unique governance mechanisms and is typically managed along a different EU policy arm, usually within different Directorates-General of the European Commission or the European Investment Bank. Combining multiple tools requires knowledge and understanding of each tool's operational and bureaucratic idiosyncrasies, as well as proficiency in application processes and the appropriate technical language. Furthermore, the compatibility and timing of different instruments must be aligned effectively, which can be a time-consuming and burdensome process.

Despite these challenges, the Austrian government has been able to utilise and combine several of the above-mentioned EU instruments to support the implementation of a primary health care reform (**see Figure 1**). Like many EU countries, Austria's health system is having to adapt and change to meet a series of challenges including a growing burden of non-communicable diseases and an ageing population. Two in three primary health care physicians are projected to reach retirement age within this decade. Concurrently, few young doctors have been taking up a career as primary health care physicians in recent years, hampering a smooth generational transition. Particularly rural regions are struggling to attract primary care physicians. Overall, the system is affected by an overabundance of specialists, a high number of avoidable hospitalisations for conditions amenable to primary care and high public expenditure for specialist and inpatient care. After having implemented a structural governance reform between 2013 and 2017 which laid the groundwork for organisational and structural changes at health system level, the Austrian government has leveraged three different types of EU support to advance the implementation of its reform:[7,8]

Figure 1: Roadmap of the Austrian experience: challenges, changes and utilised EU tools



Source: Authors' illustration.

1. Technical support from the Structural Reform Support Service. The SRSS, now known as the Technical Support Instrument under the new Multiannual Financial Framework (see above), has supported Austrian policymakers with creating tailored start up services to encourage health professionals, especially young doctors, to establish their own primary care practice. The support provided since 2018 entails hands-on consultancy services to develop a business plan and tackle the legal hurdles of going into business, a start-up guide summarising useful information, a dissemination strategy to attract professionals who may be interested and training sessions for regional administrators to promote available support at local level.[9]

2. Loans and financial advisory services from the European Investment Bank. By pooling financial support from the EIB and other partner banks in Austria, the government was able to initiate millions in bank financing to enable the establishment of new primary health care units across

Austria. However, these funds have largely remained untapped due to low market interest in recent years.[10] [11]

3. Funding for primary health care from financial instruments, including the Recovery and Resilience Facility and the European Agricultural Fund for Rural Development (EAFRD). Austria has recently pledged €100 million towards its primary health care reform in its national recovery plan. The allocated funds will continue to support the establishment of new infrastructure, as well as placing a strong focus on promoting the digitalisation and improving the environmental sustainability of existing facilities.[12] In previous years, the EAFRD, which is primarily dedicated to spurring the development of rural regions, was eligible for and has been utilised by Austria for projects supporting the expansion of ambulatory health services and infrastructure (with a focus on primary care) in rural areas.[13]

Box 1: Making the case for investing in health systems: Evidence that finance policymakers cannot ignore

- Focus on the most tangible economic benefits of health spending: *Beyond the direct impact of better health outcomes on overall productivity and participation in labour markets, health systems are major employers in most countries, while also creating an international market for the cross-border movement of health care students and the workforce. At the same time, they drive several rapidly growing scientific industries (e.g., pharmaceuticals and medical devices).*
- Demonstrate commitment to efficiency and responsible spending: *Tracing how metrics of health care variation and efficiency improve with increased financing strengthens health policymakers' accountability, while also reducing wasteful spending and negative health outcomes.*
- Highlight the importance of investing in health systems now to ensure future fiscal sustainability: *Fiscal sustainability depends on tax revenues and how stable these are over time. With ageing populations, maximising the time spent in good health is essential to increase tax revenues and active participation in the labour force. Beyond this, healthy ageing ensures fewer disability, health care and social care claims, consequently curbing public expenditure in the long run.*

Adapted from: [3]

> there is room for better monitoring the implementation and results

Going forward: What is needed?

Most of the support instruments mobilised for the Austrian reform were not inherently geared towards supporting projects in the health and health system sphere. Consequently, identifying, applying for, and combining these tools for a health system reform required substantial proactive engagement from Austrian policymakers. The Austrian success currently represents an exception to the rule. National ministries, regional, and local authorities generally lack the resources, capacity, and expertise to initiate and navigate the process of assembling multiple different EU tools effectively. Beyond the practical complexities of accessing these programmes, health ministries may not be directly involved in budgetary decisions and may lack the tools to corroborate the socioeconomic returns of using EU instruments for health system investment with the necessary evidence to persuade their governments accordingly. Traditionally, health expenditure has grown due to a rise in the running costs of health systems, for which EU instruments cannot directly be used at their current state. In contrast, their potential primarily lies in researching and financing innovative ways of reducing these costs, including by decreasing the ecological footprint of health infrastructure, by supporting the health workforce with adequate training or by making sure patients access preventive services proven to be effective in EU-funded research projects before needing expensive hospital care.

Beyond making the process of identifying tools more intuitive and supporting Member States with the required expertise to apply for and combine them, there is a need for strengthening our understanding of how these tools are best used and the generated health system outcomes. Specifically, there is room for better monitoring the implementation and results of EU-supported projects and reforms by means of adequate performance indicators and evaluation processes, including how they help health systems achieve efficiency objectives or reduce variations in care (**see Box 1**).

Better keeping track of outcomes would enable Member States to pick out the instruments most suited to their specific objectives and to build a case for investing in health systems to their governments by highlighting the positive socioeconomic returns of health investments which, when combined with EU support, only require partial national financing. Further, systematically evaluating the process of accessing EU support could facilitate the improvement of and synergies between available instruments. More broadly, tracing outcomes over time would safeguard the results of those EU projects whose duration is limited to a few years, but which have the potential to inform other projects and policymaking at both national and EU level.

Many of the challenges faced by European health systems require changing the status quo. Beyond investing in the early stages of change processes, such

as developing frameworks for concerted action or pooling expert knowledge on biomedical issues, EU support tools should be legitimised to cater towards the later stages of change and towards implementing reforms. Technical support, such as is currently provided by the TSI, must be bolstered, and tailored specifically towards propelling health investments. Actively pursuing cross-country learning opportunities and fostering the adequate platforms for best practice exchange is an additional element of finding what works in practice and successfully transferring this across different local, regional, and national settings.

> health financing can support overall economic growth and fiscal sustainability

Shaping future objectives

The European Commission's proposals for building a European Health Union have shone a light on the need to strengthen the Union's pandemic preparedness and response capacity.[14] However, the EU has the potential to support Member States and their health systems on a much broader range of issues. Some actions are slowly taking shape, including a revision of the European strategy and legislation on pharmaceuticals to ensure better access to innovative medicines, joint health technology assessment (HTA) processes to reduce the duplication of work across national agencies, the establishment of an EU Health Data Space to empower patients and foster the use of clinical data for research (see the article by Olesch in this issue) and most recently, the announcement of a new Global Health strategy which is likely to pave the way for stronger EU health policy both internally and externally (see the article by Kickbusch and Kökény in this issue). While these developments are promising, propelling investment in health systems will require more EU support geared specifically towards health systems and the implementation stage of reforms. At the same time, strengthening health policymakers' capacity to advocate for investment and to complement this by accessing the right EU instruments to support their reform processes will be equally crucial steps to strengthen European health systems and to move towards a stronger European Health Union.

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ONE HEALTH THROUGH THE LENS OF THE SUSTAINABLE DEVELOPMENT GOALS

By: Martin McKee

Summary: In 2015, world leaders committed to the Sustainable Development Goals (SDGs). These goals are highly interdependent – achievement of one helps progress in others. Going forward, we need to re-learn one of the key lessons of the pandemic, the importance of One Health, the issues that lie at the interface between human, animal, and environmental health. Yet this will not be easy. There are many obstacles, of different types. Fortunately, the commitment to create a European Health Union offers an opportunity but, to succeed, One Health must be at the top of the European Union's priorities.

Keywords: *One Health Sustainable Development Goals, Animal Health, Environment, European Health Union*

The SDGs are interconnected

In 2015, world leaders agreed an agenda to respond to the challenges facing our planet, committing to 17 Sustainable Development Goals (SDGs), to be achieved by 2030.[1] Collectively and individually, these goals set out what needs to be done to end poverty, improve health and education, reduce inequality, and support economic growth while tackling climate change and preserving the health of our natural environment.

Health is the focus of one of them, SDG 3, which commits our governments "to ensure healthy lives and promote wellbeing for all, at all ages". However, we will only achieve this by action in the areas covered by other SDGs, such as ending poverty (SDG 1) and hunger (SDG 2), ensuring inclusive and equitable quality education (SDG 4) and availability of water and sanitation (SDG 6), among many others. Similarly, we can only hope to achieve many of the other SDGs by improving health. Poor health is a major contributor to inequalities (SDG 10) and undermines economic growth (SDG 8). Falling ill makes it more difficult to learn a living and risks incurring catastrophic health expenditure.[2] Our increasing appreciation of the interconnections among the SDGs, and the policies needed to achieve them, has encouraged us to look to what are termed co-benefits, whereby effective and equitable policies in one area brings benefits to another, creating virtuous cycles that become self-sustaining.[3]

One Health looks at the interface between human, animal, and environmental health

All of these connections should be obvious. But it is important that we do not stop there. One thing that we should have learnt from the COVID-19 pandemic, or rather, we should say,

> **#EHFG2022** – Plenary 2: One Health – what does it mean for people?

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re-learnt, is the importance of looking beyond human health and, specifically, to what is termed One Health, or the interrelationships between human, animal, and environmental health, and the policies needed to respond to the challenges that emerge at this interface.[4]

SARS-CoV-2, with its origins in bats, is only one of the more recent microorganisms to transfer from animals to humans, in technical terms zoonoses. It has already been joined by monkeypox, so named because it was first isolated in laboratory primates, although commonly spread by rodents.[5] These diseases, along with very many others, from measles to HIV, have emerged as threats to human health when we have acted in ways that change our relationship with the animal world and the natural environment.[6,7] This may be through the sale of wild animals for food in poorly regulated markets, the encroachment of human settlements on environments that are home to wild animals and their accompanying microorganisms, or the intensification of animal husbandry, among other activities.

And there are other One Health issues that give rise to concern. Antimicrobial resistance, now recognised as an existential threat to health, is a direct consequence of human activity, such as the inappropriate use of antimicrobials in health care or in food production.[8] The damage that we are doing to our natural environment, for example, through deforestation, is threatening the biodiversity on which we depend.[9] Loss of pollinators, as a result of careless use of pesticides, is a serious risk to global food production.[10] The importance of policies that bring together the many actors, each currently with responsibility for only a small part of this complex nexus, is clear. Yet the obstacles to doing so are great.

We first need to be clear about what we mean by One Health. A review of literature on the response to coronaviruses (SARS, MERS, and COVID-19) identified three ways in which the term was used.[11] The first referred to *institutional collaboration*, involving a structured means by which organisations can work together to solve complex health challenges. The second involved *coordinated actions*, such as creating a system for surveillance of potential health threats. The third, which was the least frequently observed, comprised a *comprehensive approach* which emphasised the complex nature of the relationships and how they are embedded within broader social and environmental frameworks. This last approach might ask, for example, about the social, cultural, legal, and economic factors that give rise to hazardous forms of food production and distribution.

> “requires collaboration between researchers from many different disciplines

This holistic approach is obviously what is needed, but it is challenging, for several reasons. Understanding the issues and identifying solutions requires collaboration between researchers from many different disciplines, in the biological, social, and political sciences as well as the humanities. Existing academic structures and funding streams rarely encourage transdisciplinary work. Actions and policies require collaborations between different ministries within governments and, in many countries, between different tiers of government, which in some cases may be led by different political parties. In the competitive political environment in which successes have many parents but failures are orphans, ministerial collaboration requires a degree of altruism that is all too infrequent. Yet failure to develop a One Health approach to health and sustainable development is not an option. Indeed, our survival as a species will depend on it.

Facing a challenge and an opportunity

We now know what we need to do. The Pan European Commission on Health and Sustainable Development, endorsed by the 53 Member States of the World Health Organization (WHO) European Region, includes a call to operationalise the concept of One Health at all levels.[12] Specifically, it calls on governments to:

- establish structures, incentives, and a supportive environment to develop coherent cross-government One Health strategies, building on the concept of Health in All Policies and the SDGs;
- strengthen mechanisms for coordination and collaboration between relevant international agencies, such as WHO, the Food and Agriculture Organization of the United Nations (FAO), the World Organisation for Animal Health (OIE) and the United Nations Environment Programme (UNEP), in order to support efforts towards a shared understanding, common terminologies, and an appropriate international architecture for establishing priorities, agreeing areas of responsibility and identifying the scope for joint work to promote the health of humans, animals and the natural environment;
- take coordinated action at all levels to reduce environmental risks to health, including biodiversity- and climate-related risks, and to enhance One Health reporting systems.

We also have an opportunity to make this a reality. Since the 1950s a growing number of European countries have been pursuing the goal of an ever-closer union. At first, health was marginal in the then European Economic Community, only coming to the fore in the 1992 Treaty of Maastricht.[13] Yet, even then the principle of subsidiarity ensured that any role for what was by then the European Union would be limited, with responsibilities lying within Member States. The role of the European Union was limited mainly to coordination and sharing of information. Over time the European dimension has expanded, most notably with the creation of the European Centre for Disease Prevention and Control (ECDC), in 2004. Yet, when the COVID-19 pandemic struck, it was apparent that there were problems.[14] Distribution of essential equipment, border closures, and data sharing all struggled to overcome practical barriers resulting from poor coordination. Although many of the initial difficulties were largely resolved, this had been a salutary lesson of the need for greater collaboration. The result was a commitment to create a European Health Union.

This has several strands, including expanding the role of ECDC, but it is the creation of a Health Emergency Preparedness and Response Authority (HERA) that has attracted most attention.[15] With an initial budget of €6 billion for 2022–2027, it will conduct threat assessments, support research and innovation, boost capacity to produce medical countermeasures, including vaccines, and stockpile essential supplies.

> look again at what the European institutions are seeking to achieve

There are, however, risks. HERA is entering an already crowded field. Besides ECDC, it must work alongside the European Medicines Agency, the European Food Safety Authority, and the European Civil Protection Mechanism. Within the European Commission itself, there are not just DG SANTE, responsible for health and food safety, but DG AGRI, responsible for agriculture and rural development, and DG ENV, responsible for the environment, as well as several others than can lay claim to some aspects of One Health.

We can all agree that these bodies should talk to one another, but we cannot ignore the transaction costs involved. How do we balance the benefits of collaboration with the costs of interminable meeting? There are examples that we can learn from, both positive and negative. The so-called Quadripartite Alliance, which brings together WHO, OIE (the World Organisation for Animal Health), FAO (the Food and Agriculture Organisation) and, most recently, the UN Environment Programme, has made important contributions in areas such as antimicrobial infections and rabies elimination.[16] Also there are other things that could be done, such as extending the scope of the Codex Alimentarius to cover the entire food chain or the Convention on International Trade in Endangered Species to all trade in wildlife. But none of these will be easy.

One of the greatest challenges is how to advance a One Health agenda when some of the actors that could play a role are pursuing their own agendas. Is the health community strong enough to withstand the lavishly funded and highly effective lobbying of the food and agrichemical industries?[17] A thorough understanding of the growing literature on the commercial determinants of health will be essential but, given the need for HERA to work closely with the life sciences industry, it is to be expected that there could be substantial cultural challenges, as well as difficulties in ensuring that cautionary voices are heard.

Making One Health a reality

So what is the answer? I believe that we need to look again at what the European institutions are seeking to achieve. This means going back to the SDGs. They recognise the importance of economic growth, but not at any cost. So we need to look at our existing measures, including those used to measure progress towards the SDGs, and balance the current prioritisation of economic indicators in policy discourse with others that capture the health and wellbeing of not only humans but also animals and the environment. This will require a paradigm shift in thinking by us and, perhaps more importantly our political leaders (who, we should not forget, owe their positions to us through the ballot box).

If we are serious about creating a European Health Union, then we must also ensure that we have robust systems to measure progress towards it and, through the Council of Ministers and the European Parliament, to hold those responsible to account. Without them, we risk what Greta Thunberg described, in a memorable speech at the 2021 Youth4Climate summit, as simply more "blah blah blah".[18]

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EUROPE'S ROLE IN GLOBAL HEALTH: WHAT TO EXPECT FROM A NEW STRATEGY?

By: Ilona Kickbusch and Mihály Kökény

Summary: The timeliness of the initiative for a new European Union (EU) global health strategy is justified by the radically changed geopolitical circumstances and emerging public health challenges, as well as the lessons learned from the COVID-19 pandemic. It is expected that the new strategy will also reflect the evolution of the European Health Union, a gradually broadening common health policy framework. In an interconnected global political environment, particular attention should be paid to the smart choice of priorities, consistency with UN and WHO objectives, coherence with Member States' existing national global health strategies and the involvement of non-governmental actors. But the strategy must also be ambitious and address the big transformations impacting on health, especially where the EU has already shown leadership, such as digitalisation.

Keywords: *Global Health, European Health Union, COVID-19, Global Public Goods, Multilateralism*

> **#EHFG2022** – Session 19: Designing tomorrow's EU Global Health Strategy

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Introduction

At the G7 meeting of health and development ministers on 19 May 2022, EU Commissioners Stella Kyriakides and Jutta Urpilainen announced the launch of the process to develop a new EU Global Health Strategy. Their short statement predicts the main areas to be covered including: improving health systems' ability to prevent and respond to global health treats, infectious and noncommunicable diseases (NCDs); addressing inequalities; advancing universal health coverage (UHC); strengthening strategic health partnerships; reinforcing local health manufacturing capacities; and upholding the One Health approach.[1] The announcement followed on several years of advocacy by consecutive presidencies, Member States, civil society and academia.

The partnership between health and development policies will be critical. For example, the EU's Global Gateway will aim to mobilise up to €300 billion in investments between 2021 and 2027 "to underpin a lasting global recovery, taking into account our partners' needs and own interests."[2] A wide-ranging consultation process under the guidance of the relevant directorates-general of the European Commission, namely SANTE (Health and Food Safety) and

INTPA (International Partnerships) is already underway – the strategy is to be adopted in November 2022. Given the new importance assigned to global health, the involvement of the EC President's cabinet and of the European External Action Service will also be critical.

Background

The EC's document "Together for Health – A Strategic Approach for the EU, 2008–2013" (published in 2007) was the first paper to establish a broad cross-policy framework to respond to a wide range of health challenges in a comprehensive way and reflected the need for the EU to play a global role in health.[3]

> "the principles set in 2010 have matured for redesign"

The 2010 EU Commission Communication and the EU Council Conclusions on "The EU Role in Global Health" still lay the basis for today's actions of the Union in this field. At the time of its release, the policy was considered a fresh and innovative tool, placing the EU in the context of the existing structures and frameworks of global health governance, and suggesting ways in which the EU's actions could be better coordinated across different policy areas. Among others, the Council Conclusion stated that "the EU has a central role to play in accelerating progress on global health challenges, including the health Millennium Development Goals and NCDs, through its commitment to protect and promote the right of everyone to enjoy the highest attainable standard of physical and mental health."[4]

These guidelines laid the groundwork for the EU's involvement in planning The Agenda 2030 with the Sustainable Development Goals (SDGs)[5] and advocating for the World Health Organization (WHO), when the organisation was heavily criticised for its response to the 2014 Ebola outbreak. Angela Merkel, the then German Chancellor, set the direction at the 68th World Health Assembly with the decisions of the G7 summit and the prestige of the EU behind her: "WHO is the only international organisation that enjoys universal political legitimacy on global health matters."[6]

While the 2010 guideline helped to clarify the EU's approach, principles and priorities for global health, it has not led to the necessary internal and external policy reorientation to ensure programming coherence and consistency. Nevertheless, it is also important to note that under EU law, the European Union can act outside the EU only in matters and to the extent that it has a mandate and authorisation within its borders.[7] This does apply to a range of public health matters – note the EC's role in the adoption of the Framework Convention on Tobacco Control[8] – and became critical during the outbreak of the COVID-19 pandemic. Applying its commitment to multilateralism, the EU stood by the WHO during the unjustified attacks on the organisation by the Trump administration in 2020, proposing a new global pandemic treaty[9] and took on significant financial obligations. The EU has also become one of the biggest contributors to COVAX, a WHO-led partnership for the development and equitable distribution of COVID-19 vaccines and will contribute significantly to the new pandemic financing instrument that has been proposed by the G20.

Therefore, the principles set in 2010 have matured and are in need of redesign. Several studies have detailed the reasons for this and made recommendations for the content of a new concept.[10] As part of the project launched during Finland's Presidency of the Council of the EU in the second half of 2019, a working paper, which includes input from the newly established "Informal Expert Group on the EU's role in global health" suggested a synergistic strategy for global health.[11] Just months after the start of the pandemic, NGOs prepared a so-called shadow global health strategy stimulating EU decision-makers to come up with new initiatives.[12]

The context of the new global health strategy

In the grip of the pandemic, the need for a new EU global health direction became increasingly clear, not least because of the growing geopolitical dimensions of global health. New challenges emerged around vaccine nationalism, vaccine and mask diplomacy, access to supply chains and intellectual property waivers. As the pandemic progressed, health moved from a "soft power" agenda to a critical economic and security issue and took up large parts of the deliberations of the G20 and the G7 and most recently at the World Trade Organisation (WTO). It continues to be embroiled in geopolitical positioning and interests.

During the pandemic, health moved from being a lesser consideration of the Union – as its members have jealously guarded their own competence – to one of its essential functions that required joint and cross-border action. COVID-19 marked an explosive paradigm shift making it clear that EU mechanisms were slow in public health crises, and the current coordination, advisory and recommendation powers remained insufficient. This led to the accelerated elaboration of the concept and components of the European Health Union in the governing bodies. The Future of Europe conference series[13] also called for a treaty change in relation to the health competencies.

This internal/external nexus of a growing recognition that strengthening community competencies in health and the display of health in external activities will require the expansion of health provisions in EU treaties.[14] This is all the more desirable because financial instruments for the EU's global role, as well as health programmes, have grown significantly in the EU budget of 202–2027. Appropriations for the latter area are more than 12 times larger than the funds provided in the previous cycle, while coverage for external actions increased by 10%.

In May 2021 the EC and Italy, as chair of the G20 group, co-hosted a Global Health Summit which adopted the Rome Declaration, committing to common principles to overcome COVID-19 and to prevent and prepare for future

pandemics.[15] As a follow up, the Commission has introduced the Global Health Policy Forum*, most recently held in June 2022.

Increasingly the EU – Team Europe – is speaking with one voice at various negotiating tables, in particular in WHO. This has been experienced most recently at the 75th World Health Assembly, where EU Member States have made a constructive proposal to support the long overdue strengthening of the International Health Regulations and to increase membership fees for sustainable funding of the WHO. Both proposals were adopted.[16] [17]

> Increasingly the EU – Team Europe – is speaking with one voice at various negotiating tables

Key issues to be addressed

The approach to an EU strategy on global health should not be disease based – and it must be a global strategy that includes but goes beyond aid for development. Indeed, as one of the largest donors, the EU could use its financial negotiating power to reshape development policies towards true partnerships and to support global public goods (see the article by Andriukaitis and Webb in this issue). The starting point must be to think towards the future and how to shape the big transformations – for example the digital transformation – towards a more equitable world within the EU and beyond. This includes significant investment in research and innovation, joint technology development, support to infrastructure and production sites.

The growing challenges as well as health technology industry world-wide will require a policy response both within and beyond the EU. The EU is a leading regulator in the data space and must show leadership for the responsible cross-border use of health data, using a public value and global public goods approach. Connectivity is rapidly becoming one of the key features of health inequalities and a crucial determinant to build digitally based health systems in low- and middle-income countries (LMIC). Such considerations need to be part of an innovative new UHC agenda, as the EU supports the establishment of sustainable infrastructures such as primary health care and public health centres, making best use of digital approaches and ensuring commitment from LMIC for national investments.

As the world's largest trading block, recognising the commercial determinants of health [18] and acting responsibly is particularly important because frequently the regulatory systems of low-income countries are unprepared to restrict the health-damaging impact of multinational companies. This is a key factor in the explosion in the prevalence of NCDs worldwide. The climate agenda is part of this challenging complexity, both in terms of its direct impact on health especially in LMIC and its consequences, for example on food systems.

The economic weight of health care in the EU is on the rise: currently, almost 10% of the GDP generated in the 27 Member States is spent on the sector. Some 10% of EU workforce is employed in health care, yet there is a significant shortage of health and care workers, a highly worrying perspective in view of the demographic challenge Europe faces. The mobility of health workers between regions will likely play a key role in tackling this issue, making it a truly cross-border and global health challenge that a European global health strategy must address. At the same time, the global strategy is an opportunity to show the EU's commitment to gender equity, with women comprising the majority of the health and social care workforce worldwide.

Such a multifaceted interpretation and focus on health should be a driver for the EU's regulatory power to make its health policy commitments on the global stage a real gamechanger. The architecture of a European Health Union is not complete without a global component. More precisely, the European Health Union and the global health strategy represent two sides of the same coin. The former is an internal dimension with a strong grounding in the social pillar, the latter is the external one that should reflect European values such as solidarity, equity and more. But at the same time, a global health strategy also falls within the remit of many political forcefields of the EU: trade, environment, technology, research, pharmaceutical, digital and security agendas. This too is a challenge: how to address the health in all policies dimensions and ensure an equity oriented internal/external nexus that uses the "Brussels effect" for greater wellbeing on a global scale. A value-oriented, multi-stakeholder framework with appropriate financial and internal legal background can allow for EU leadership.

Next steps for the EU to lead in global health

The EU's role in global health is continuously emerging with the pandemic serving as an impetus to strengthen its responsibility in global health sustainably. It has certainly pushed the EU out of "its comfort zone" by the cautious expansion of the community health competence (European Health Union) and the development of a global health strategy in parallel. The two issues are organically linked. If the EU has an ambition to lead in global health, the power of the example holds and a strong EU health competence is unavoidable – this can justify the amendments of the Treaties, as is presently being discussed.

In the short run, this also means a clear ramping up of the EU's global health diplomacy. WHO negotiations have shown what a difference a joint approach can make, now is the time to consider

* For more information see: https://eudevdays.eu/community/sessions/6446/global-health-policy-forum

where strong EU representation is needed in relation to other health relevant organisations, important diplomatic hubs, and other key global health players such as the United States, China and the African Union. Health now is an integral part of geopolitics.

> A value-oriented, multi-stakeholder framework with appropriate financial and internal legal background

Challenges in developing the strategy

However, priority setting remains a key challenge and the strategy will require a limited number of flagship initiatives. Health strategies have a tendency towards "Christmas tree" approaches as interest groups fight for "their" issue or disease. We have outlined broader strategy priorities that we consider critical at this point in time. Obviously, actions emerging from the pandemic that will ensure pandemic prevention, preparedness and control will need to constitute part of the agenda – but the strategy must be driven by wider concerns. Economic, food, and energy crises stemming from the pandemic and the war in Ukraine have called into question whether the health-related SDGs can be achieved. The 3 billion targets of WHO can provide guidance on the content of the strategy related to the shared objectives of achieving UHC, addressing health emergencies, and promoting healthier lives.[19] Yet there are also gaps in the SDGs – such as very little consideration given to the digital transformation – that must be addressed in a European Strategy.

The harmonisation with other EU policies which directly and indirectly impact health – such as the European Green Deal – should be addressed and the global role of EU institutions should receive consideration, for example on how the capacity and intelligence of the European Centre for Disease Prevention and Control (ECDC) interacts with partners globally. Harmonisation can also be considered in relation to national-global health strategies which some Member States (for example Germany, France and Sweden) have already developed as well as supporting other EU members – for example through a Joint Action Programme – to develop their global health capacities as well as increasing coordination between EU countries on global health. As the strategy develops, the key challenge will be first about ambition, then about implementation.

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THE EUROPEAN HEALTH UNION: STRENGTHENING THE EU'S HEALTH POWERS?

By: Anniek de Ruijter and Eleanor Brooks

Summary: This article takes stock of the role of law in the development of the European Health Union. It reviews the limited legal basis for European Union (EU) action on health, and assesses the significance of the European Health Union given that, to date, its constituent elements have done little to strengthen EU health powers. It argues that, in the short term, the European Health Union has a political role in underpinning union-building and providing a framework for more ambitious health action. In the longer term, its significance will stem from its contribution to strengthening of the coherence and legitimacy of EU health governance.

Keywords: *EU Health, Legal Basis, Competence, Treaty Change, European Health Union*

Introduction

The 25th anniversary of the Gastein Forum takes place against a backdrop of unprecedented threat and opportunity for health in the European Union (EU). Though slipping down the political agenda, in the case of COVID-19, and eliciting slow responses from governments, in the case of Monkeypox, communicable diseases remain a real and present danger to health in the EU and beyond. At the same time, and in partial response to this threat, the EU has committed to the development of a European Health Union. In this article we ask – what will this European Health Union mean for health in Europe and what is the role of law in determining its significance?

The European Health Union: strengthening the EU's health powers?

The existing legal basis for health in the EU is constrained. Constitutionally, the Union is based on a system of 'conferred powers.' This means that the EU may act "only within the limits of the competences conferred upon it by the Member States in the Treaties to attain the objectives set out therein" (Art 5(2) TEU). In health, the powers that Member States have conferred are limited; the EU has no power to harmonise national public health laws (Art 168(5) TFEU) nor can it adopt or harmonise laws that regulate the organisation of health care (Art 168(7) TFEU). There are, nonetheless, a few areas where the EU enjoys competence. It has stronger powers in the fields of pharmaceuticals and medical devices, substances of human origin, and veterinary and phytosanitary measures.

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It also has coordinating and incentive powers regarding cross border health threats – but its legal mandate in health is narrow and tightly delimited.

> Health policy made without health representatives is unlikely to account for the core rights and values of European health systems

The newly adopted laws that form the initial building blocks of the European Health Union do not confer any strong new legal power to the EU. The legislation proposed and adopted to date is mostly related to the bureaucratic structuring of Member States' coordination. It strengthens the mandates of existing agencies, including the European Centre for Disease Prevention and Control (ECDC) and the European Medicines Agency (EMA); in the area of procurement and cooperation some new EU internal institutional structures are created; and there are stronger information exchange obligations created together with soft monitoring that might take place from the EU side.[1] Beyond these initiatives, however, no expansion of the EU health mandate is being proposed, and certainly no change to the treaties looks likely for the foreseeable future.

More fundamentally, the current provisions of the European Health Union do not tighten the bonds – as the term 'Union' might suggest – of solidarity and risk-sharing between Member States, nor between citizens of the Member States. Furthermore, they do not strengthen the core of EU health law and policy with regard to the deepening of its relationship to the foundational legal principles that underlie national health care systems and health governance more generally, such equality, equity, a respect for solidarity and human dignity.[2] In sum, the current incarnation of the European Health Union does relatively little to change the legal status of health in the EU.

In the absence of legal power: the symbolic and political importance of the European Health Union

What then is the European Health Union's significance? For the moment, at least, its power is primarily symbolic and political. Language is important and the term 'Union' has particular connotation in European law and policy. Historically, union-building has underpinned integration; in 1968, when the European Customs Union was created, the use of the word 'Union' signposted that within the European project a special policy space was to be created, where a deepening of integration and joining of communal interests would take place. Similarly, the establishment of a 'political union' in 1992, as part of the Maastricht Treaty, indicated that the European Economic Community would be more than an economic organisation. Though the European Health Union does not pursue the same intensity of integration as, for instance, the European Energy Union or the Economic and Monetary Union,[3] there is considerable symbolic and political significance to the framing of the European Health Union. In the future, its significance may well be more concrete. Observers have noted its potential to strengthen global health and the EU's role within it,[4] contribute to tackling health inequalities and improving health status within the EU [5] and, perhaps most importantly, reduce the fragmentation of EU health law and policy.[6] The latter point is core to the European Health Union's significance because the weakness of current EU health law and policy lies in its patchwork construction. Though EU policies that affect health are wide-ranging, they are often based on non-health legal bases. As a result, the primary objectives of EU policies that affect health are often not health.[7] If the European Health Union can offer coherence, by bringing the existing building blocks and their scattered legal bases together, it would mark a fundamental step forward in health integration.

In the meantime, EU law and policy will continue to develop, as it has historically, across multiple legal bases and via soft policy instruments. As has been outlined elsewhere, the constraints on the EU legal basis imposed by Member States have largely failed to stop the development of a significant body of EU health law and policy.[7] This is because EU law, like all law, has dynamic potential; far from being static, it is open to interpretation, subject to contextualisation and amenable to political deployment. When utilised creatively, the Union's legal powers in health domains can be used to improve human health in the EU.[2] Using its powers in the internal market sphere, the EU has adopted regulations on (health care) professional qualifications, medicines, tobacco manufacturing and advertising, and cross-border health care provision. Other powers, for instance in occupational health and safety, environmental protection and competition regulation, have been used to adopt legislation that governs the working conditions of doctors, ambient air quality and the financing of health service delivery. Moreover, where the limits of legal creativity have been reached, the EU has adopted an expansive range of soft initiatives, programmes and cooperation that give the EU influence over virtually every aspect of health and health policy. None of these developments were foreseen by the drafters of Article 168(7) TFEU.

Long term significance: Creating coherence and legitimacy

Given the successes of EU health policy in the absence of a comprehensive legal basis, and the unexplored potential of the existing treaty provisions, we might ask whether there is any need for a European Health Union that seeks to strengthen or amend the EU's health powers. Why should we not continue in the same vein? In addition to the difficulties with coherence noted above, the core reason for supporting the continued development of the European Health Union's legal underpinning is related to legitimacy;

'… when the dynamic potential for health law and policymaking is fully exploited without a sense for the constitutional stakes at play […] using indirect legislation constrains the consideration of the full spectrum of rights and values that are involved in health law and policy generally at the Member State level'.[2] To take a common example from the history of EU health policy development: improving health by adopting legislation using the internal market base is dependent upon ensuring that the actors involved, who are unlikely to have expertise in the complexities of health and health policy, have understood and accounted for health rights and values, both at EU and national level. The difficulties involved here are evident from myriad experiences, not least that of the European Semester and the EU's wider fiscal governance framework, where health actors have fought to protect health systems from provisions that were not sensitive to the organisation and financing of national health systems.[8]

> the slow progress of the European Health Union may be frustrating for the health community

This challenge to legitimacy exists because the EU's limited health competence undermines the power of national health departments within the executive, vis-a-vis their counterparts. When in the EU laws are adopted based on other functional legislative bases, such as the internal market, environment or agriculture, political representation is usually led by institutional actors in that particular field of policy. In health there is no separate Council of Ministers formation, despite a ministerial representation that is specifically responsible for health being a feature of all EU Member State governments. This means that, though national health departments might be confronted with the task of implementing EU health laws, the adoption of the particular law or policy at EU level has most likely taken place without these ministerial departments' involvement. Health policy made without health representatives is unlikely to account for the core rights and values of European health systems. It is thus here that a stronger legal basis for health, necessitated by the European Health Union, stands to have greatest significance.

Building the European Health Union: A slow road to strengthening EU health law and policy

The slow progress of the European Health Union may be frustrating for the health community. Yet it reflects the historical development of EU health policy, conditioned by the national political and social significance of health as part of the welfare state and an area of political sensitivity vis-à-vis transfer of power.[9] [10] Such an incremental, uncertain path is also common to union-building projects. When the EU was proposed, no one knew exactly what it would eventually entail – and we could argue that this is still unclear – but an integrative force was created, spurring piecemeal deepening of cooperation. The European Health Union has the potential to generate this same force. For now, it is doing so symbolically and politically; in the future, it may yet do so legally and concretely, with implications for the coherence and legitimacy of EU action for health.

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FORGING A EUROPEAN HEALTH UNION: BETWEEN SUBSIDIARITY AND SOVEREIGNTY?

By: Elizabeth Kuiper and Mary Guy

Summary: Developing a European Health Union necessarily involves re-examining European Union (EU) and national level interaction. While this is currently framed around limited legal competence, its political identity is notable: the EU's role is restricted because health is a Member State competence. Although this has not precluded more subtle EU-level involvement via, for example, internal market rules and fiscal policies such as the European Semester, the explicit development of a European Health Union is more contentious and political by nature. We consider here how the principle of subsidiarity and concerns about national sovereignty may help – or hinder – the shaping of a true European Health Union.

Keywords: *European Health Union, Subsidiarity, Sovereignty, Solidarity, COVID-19*

Introduction

The development of a "European Health Union" was announced by Commission President von der Leyen in September 2020 as a response to the COVID-19 pandemic. Although the leadership of the Commission was welcomed initially in the context of the global pandemic, it inevitably invites longer-term questions of how the EU and national levels will interact within this Union, and how the relationship between Commission and Member States constrains or facilitates its development. Thus far, there has been limited explicit EU-level competence: health is seen fundamentally as a national competence, circumscribed by the principle of subsidiarity. However, the effect of EU-level involvement has evolved over time and (public) health goes far beyond the treaty competence (Article 168 Treaty on the Functioning of the European Union (TFEU)) to include the effects of internal market rules and fiscal policy.[1] The reluctance of Member States to give more power to the EU level over health can be linked to various concerns, which are often political in nature. However, linkages between perceptions of the EU and the sovereignty of national governments (and by implication health care systems) can be at once misleading yet extraordinarily politically salient. This has been evidenced by the knee-jerk reaction of national governments to close their borders at the start of the COVID-19 pandemic, as well as the Vote Leave campaign's bus promising more money for the National Health Service in the 2016 United Kingdom referendum on EU membership. While this latter may suggest an extreme example, it

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nevertheless highlights how concerns about national sovereignty in health care can be fragmented within the perma-crisis and could easily hold back, if not derail, the development of a true European Health Union.

> EU-level activity in health is largely confined to incentive measures

Subsidiarity and sovereignty in health around COVID-19

Insofar as initial EU-level responses to the COVID-19 pandemic were found wanting, this was attributed to the clear demarcation of health as a national competence – this outcome emerged because "Member States wanted it so".[2] If the Maastricht Treaty is notable in part for introducing the first public health competence, then other notable aspects can be seen in the identifying of "incentive measures" to underscore EU-level competence to coordinate and support national measures, and in the linking of the principle of subsidiarity with health care. The initial formulation of the public health competence provided at least two key responses: to those who recognise that (at least some) health policy issues and certainly health crises warrant action beyond the national level; and to those concerned about "competence creep" by the EU institutions regarding health. These tensions – which reflect the importance attached to sovereignty regarding health care – remain constant and find reflection in responses to the construction of a European Health Union.

EU-level activity in health is largely confined to incentive measures (Article 168(5) TFEU) – whether forming the legal basis for successive health programmes, or being referenced in connection with the Joint Procurement Agreement, developed in the context of the H1N1 pandemic, but also a key aspect of the COVID-19 response.[3] The benefits to incentive measures are clear – they allow scope for a greater EU role while still respecting national sovereignty of health care.

The demarcation of Member State competence regarding health care system organisation provided by the "subsidiarity clause" for health care (Article 168(7) TFEU) appears to encompass a curious mix of political and legal force: on the one hand, it might be considered to "shut down" discussion of varying degrees of EU-level activity in health; but on the other hand, it clearly fails to prevent perceptions of EU-level "incursion" into national health care associated with fiscal policy. This, for example, is the case for the Country-Specific Recommendations issued by the Commission in the context of the European Semester economic assessment cycle. Another illustration of EU health legislation that goes beyond pure public health concerns is the Health Technology Assessment (HTA) Regulation, which explicitly sets out that "HTA can (…) assist Member States in creating and maintaining sustainable health care systems and stimulate innovation that delivers better outcomes for patients."

However, perhaps the most notable "threat" to national sovereignty regarding health care systems has been with the steps taken to facilitate access to cross-border health care – with the legal basis for this coming from internal market rules, like the above mentioned HTA Regulation that has its legal basis both in Articles 114 and 168 TFEU.

Two visions of a European Health Union – crisis response, and beyond …?

Calls for a European Health Union can be traced back to around May 2020, at EU level by the Socialists and Democrats as well as in France following calls by French President Macron to construct "une Europe de la santé".[4] These calls gained significant momentum with reiteration by Commission President von der Leyen in her inaugural State of the Union address in September 2020. At that stage, questions of the Member States' role within the Union, and the expansion of EU-level competence, appeared open to negotiation – with suggestions that Treaty change was both feasible (by Commission Vice-President Schinas)[5] and necessary (by former German Chancellor Angela Merkel).[6]

The initial elaboration of how a European Health Union should be constructed was published by the Commission in November 2020, and clarified the legal basis as Article 168(5) TFEU, concluding with the pithy remark: "The European Health Union will be as strong as its Member States' commitment to it".[7]

> whether the momentum and political will remain to construct a true European Health Union

Developments of a European Health Union saw this take on two conceptualisations: one as fundamentally a crisis response, and the second relating to wider concerns about continuity and resilience of health care systems. Over time, it has become clear that the Commission's position lies somewhere between the two, albeit with an arguable emphasis on the former. This can be seen by the focus in von der Leyen's 2021 State of the Union address shifting to HERA, with less mention of the European Health Union.

The distinction between the two visions of a European Health Union is helpful for indicating where questions of subsidiarity and sovereignty may prove contentious: with calls for "more Union" being clearer in the direct response to the pandemic. The question is whether the momentum

and political will remain to construct a true European Health Union, now that the worst of the pandemic seems behind us, and the agenda of the Heads of States has been taken over by other priorities.

Forging a true European Health Union: solidarity, not just subsidiarity and sovereignty?

As outlined elsewhere in this Special Issue, a true European Health Union will strengthen our health systems beyond crisis preparedness and response. This is needed to face not just COVID-19 as a single event, but the perma-crisis including economic, climate and refugee crises. For this, health systems will be needed to be strengthened with a view to prioritising Universal Health Coverage and improving health system performance, and (investment in) health needs to be seen as a prerequisite for a well-functioning society.

Tackling the potential barriers posed by subsidiarity and sovereignty in this endeavour will be a challenge. But the nature of this challenge needs further elaboration – is it legal, or political? Or both?

The possibility for revisiting the Treaties to build a European Health Union had been reserved to consideration by the Conference on the Future of Europe (CoFoE). Those dubious about what this event could achieve regarding changing EU-level competence in health may have found their scepticism justified by Health Commissioner Kyriakides' clarification in September 2021 that "[a] strong European Health Union is not about redrawing the competences of Member States".[8]

Nevertheless, at the time of writing in June 2022, the CoFoE proposals have been published, indicating a strong willingness to change the interaction between the EU and national levels to a "shared competence". This would require amendment of Art.4 TFEU – something which has already been picked up by the European Parliament. It might be anticipated that aspects of Article 168 may also benefit from amendment – although Article 168(7) TFEU can be seen to offer a range of flexibility which is often overlooked.[9] Nevertheless, a conscious effort should be made in parallel to reflect on the discussions and suggestions of the CoFoE regarding the potential need for an expanded EU role in health policy.[10]

> strengthen our health systems beyond crisis preparedness and response

In view of the fact that any legislative change will require significant and sustained political will of EU Member States, it remains the case that policy framings may help the development of a true European Health Union. By shifting the focus of sovereignty to the EU level – arguably by referencing the value of solidarity – it may become possible to leverage a sense of "European sovereignty" in tackling the perma-crisis, an identity which distinguishes less between EU and national levels, and more between Europe and other global actors.

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"BRUSSELS – WE HAVE A HEALTH LITERACY PROBLEM"

By: Kristine Sørensen

Summary: Health literacy is a public health challenge that should not be neglected in the efforts to accomplish the moonshot project such as the European Health Union. Health literacy encompasses peoples' knowledge and competencies to manage health and navigate health systems. However, many face difficulties in finding, understanding, judging, and using information to maintain and improve their health and well-being which in turn impacts health costs, outcomes, and equal access to services. A European Health Union depends on a health literate union. This can be achieved through a European strategy and joint action focusing on building health literacy system's capacity. Bridging the health literacy gap is imperative to make the vision of the European Health Union come true.

Keywords: *Health Literacy, European Health Union, Wellbeing, People-centred Health*

Introduction

Consider *the European Health Union*, a modern moonshot project; the alarm is buzzing as it did in Apollo 13 when the astronauts alerted the mission control. ***"Brussels, we have a problem"*** – in this case a health literacy problem!

According to NASA, the original alert from Apollo 13 – ***"Okay, Houston, I believe we've had a problem here."*** [1] – came from the astronauts orbiting in space more than fifty years ago. They faced a challenge which needed intensive, collective efforts by the crew and the ground staff to succeed. The Apollo 13 mission was part of the ambitious project initiated by John F. Kennedy in 1961 requiring an immense wave of human exertion to land a manned spacecraft on the moon; an effort that was later referred to as a *moonshot project* – an innovation that was previously thought impossible.

The health literacy alarm is buzzing because European health literacy surveys published in 2011 [2] and 2021 [3] revealed that health literacy remains a public health challenge which should not be neglected. Despite years of improving welfare societies in Europe; there is still a substantial gap in health literacy across and between countries in the European region. A gap that causes health and social inequalities which are nonetheless preventable with intensive, combined efforts at local, national, and regional level. The social and economic return on investments is prominent from a short term and long-term perspective. Apart from improving health outcomes of individuals, the United Health Group in the United States, for instance, estimates that health literacy would help avoid one million unnecessary hospital visits a year and save over $25 billion annually.[4]

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What is health literacy and why is it important?

Health literacy encompasses people's knowledge, motivation, and competencies to access, understand, appraise, and apply information in everyday life concerning health care, disease prevention and health promotion to maintain and promote quality of life across the life course.[5] People's health literacy depends on the health literacy support within the environments where they live and the services provided which means that health literacy is not the sole responsibility of the individual. In turn, organisations' health literacy responsiveness is crucial to meeting people's needs for timely, relevant, and trustworthy information and services.

Yet, there is still a leap to go. Health literacy is hampered due to systemic barriers and personal challenges. For example, the recent Health Literacy Survey (HLS_{19})[3] measuring health literacy in 17 European countries indicated a range of health literacy tasks where people often struggle. These include: judging different treatment options; protecting oneself from illness; using information from the mass media; and finding information on how to handle mental health issues. With regards to navigating health systems, challenges were related to understanding health care reforms, judging the suitability of health services, finding out about patients' rights, and judging the extent of health insurance coverage. In terms of health communication, obstacles were found in relation to getting enough time from physicians and expressing personal views and preferences. Barriers to digital health literacy concern judging the reliability of information, judging whether information is offered with commercial interests, and using information to help solve a health problem. Furthermore, vaccination literacy was hampered with regards to judging which vaccinations one needs and finding information on recommended vaccinations.

The HLS_{19} -survey[3] showed a social gradient as well where people in vulnerable situations are at increased risk of limited health literacy. The risk is strongly predicted by financial deprivation and self-perceived social status in society along with poor self-perceived health and low levels of education. These findings suggest the need for understanding and responding to health Literacy as a social determinant of health.[6]

During the COVID-19 pandemic it became clear that the impact of people's health literacy limitations was under-estimated.[7] Linguistic, and cultural barriers in healthcare settings may have led to poor patient experiences preventing people from accessing essential public health information and limiting their ability to keep themselves, their families, and their communities safe, if they did not speak or read the language in which it was published. Moreover, the complexity of the pandemic itself dealing with a new virus and disease was a challenge for many to comprehend and take appropriate action.

> "health literacy is essential for accomplishing the mission of the European Health Union.

The European Health Union requires a Health Literate Union

Health literacy is essential for accomplishing the vision of the European Health Union.[9] Brought to the European agenda by the public health community, the value of health literacy was defined in the European Union (EU) strategy *Together for Health 2008–2013* and the first European survey highlighted the health literacy gap which is still apparent today. Moreover, the World Health Organization Regional Office for Europe published a report on *Health Literacy: the Solid Facts*[8] with a call to action, and the European Health Forum Gastein proved to be instrumental as a forum for discussing solutions among decision-makers from policy, research, practice, industry, and the civic society. The European Commission has also funded several projects on health literacy to gain deeper insights on its impact and importance with regards to e.g., diabetes, digital literacy, and self-care.

Some European countries have adopted national health literacy goals, strategies, and action plans to support health literacy policy, research, and practice such as Germany, Norway, Portugal, and Scotland. These countries experienced a ripple effect where health literacy is targeted through general health literacy strategies as well as through specific measurements, for example in national cancer control plans.[10]

A European strategy and joint action to develop health literate systems

A successful European Health Union depends on becoming a European Health Literate Union. By developing a European strategy and joint action to improve health literacy; the European community can build on lessons learned while at the same time accelerate the creation and implementation of innovations that may be presently unthinkable. For instance, governments may develop health literacy system capacity by investing in the following eight areas of concern.[11]

1. Health literate workforces;
2. Health literate organisations;
3. Health literacy data governance;
4. People-centred services and environments based on user engagement;
5. Health literacy-focused leadership;
6. Health literacy funding;
7. Health literacy-informed technology and innovation; and
8. Health literacy-oriented partnerships and inter-sectoral collaboration.

The aim will be to generate a health literate system that can be multiplied and sustained over time, rather than relying on organisational and individual behavioural change alone.[11]

Concluding remarks

Bridging the health literacy gap is imperative to making the vision of the European Health Union come true. Being content- and context-specific health literacy spans the whole continuum of health from protection, care, and prevention to promotion of health and well-being, thereby contributing to the much-needed paradigm shift from disease-oriented systems to health-oriented systems. For the European Health Union to be truly successful no one should be left behind. Health literacy enhances people-centred services through informed and shared decision-making that balances and respects the individual as well as societal concerns. Identifying communities, counties and countries faced with health literacy challenges will help decision-makers to target and tailor resources and programmes to improve health literacy and thereby increase health outcomes significantly in the EU. Subsequently, targeted investments will help contribute to health literacy as an asset for sustainable development by implementing health literacy as a quality indicator for better health services. All types of stakeholders are needed to accomplish the mission of improving health literacy – policy, academia, industry, health providers, and civic society. Health literacy is everyone's business – only with interdisciplinary, collective efforts it will be possible to accomplish the mission of enhancing health literacy for all.

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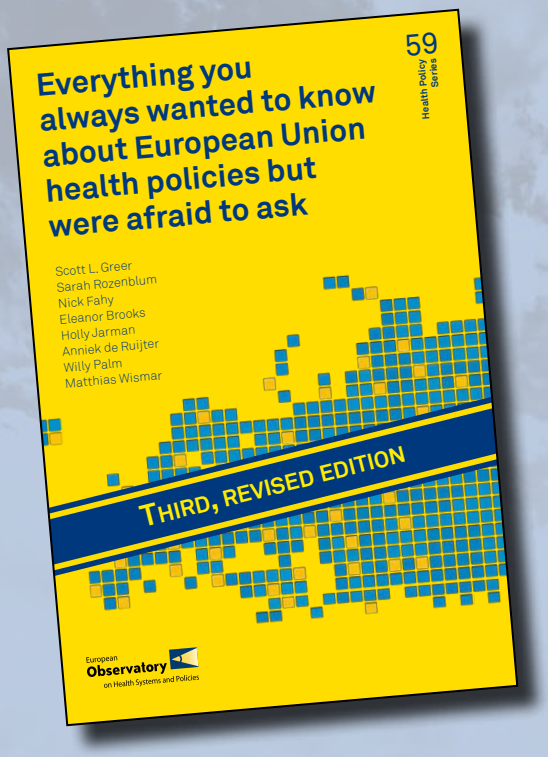

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