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European Health Forum Gastein 2017

› Health in All Politics: a better future for Europe

- The quest for authentic well-being
- Investing in healthier cities
- Inclusive workplaces to avoid social exclusion
- Harnessing the 2030 Agenda for health & well-being
- Considering the future of health systems
- Improving access to health care for underserved groups
- Co-creating health to meet local needs
- Pathways to better and affordable medicines
- Efficiency in cancer care through novel partnerships

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CONTENTS

Gastein Special Issue

Health in All Policies

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Health Systems

Access to Medicines

Innovation, Big Data & ICT

Eurohealth Monitor

GUEST EDITORIAL

The fifth special Gastein edition of *Eurohealth* marks an important milestone – 20 years of the European Health Forum Gastein (EHFG). The name stands for two decades of facilitating debates and best practice exchange on European health policy.

It stands for the first Forum of its kind, with a look at health policy not solely from a national but from a European perspective. And it stands for a seminal emphasis on the importance of multi-stakeholder collaboration to work towards better health for all Europeans.

To celebrate its anniversary, the EHFG 2017 will look back upon health policy developments of the last 20 years, to focus on what has been achieved, put today's challenges into perspective – and turn with confidence towards the future. We have chosen this year's main theme of "Health in All Politics – a better future for Europe" because we believe that Europe can do even better. It is time to work towards making Health in All Policies a political reality.

Looking back

For the founding fathers of the EHFG, the initial motivation behind the Forum was to fill a gap. A European forum focusing on the exchange of health policy and best practice was perceived as lacking, even though there was already a shared understanding that health was a common goal and that cooperation beyond borders was needed. It is therefore no coincidence that the cross-border health care discussions took momentum in Gastein and helped shape the content of the 2011 Directive. Another important health policy issue kick-started in Gastein – which will again be on the agenda of this year's closing plenary with Germany representing the G-20 Presidency – was global health under the leadership of Ilona Kickbusch. In addition, the health literacy debate was propelled forward here, and has been in the programme many times – and will be on the agenda again this year.

Why Gastein, why not Brussels or Vienna? Why do we bring together over 500 participants from more than 40 countries in a remote Alpine village? Again, no coincidence – but rather a success factor not to be neglected. The unique location frees the mind and offers an unrivalled platform for formal and informal discussions and exchange.

Looking into the Future

Taking its 20th anniversary as an incentive to look ahead, the EHFG has engaged in an elaborate scenario building process. "The EHFG Health Futures Project" imagines what health and health care for Europeans might look like in another 20 years' time, taking into consideration the complex factors that influence health and well-being. The scenarios, developed in collaboration with approximately 60 experts with diverse backgrounds from the health arena and beyond, are designed to help us consider policy choices in preparation for how the future could unfold and what it might mean for different stakeholder groups. Neither predictions nor recommendations, neither utopian nor dystopian, our visions for 2037 aim to inform our policy actions today, and help set up future-proof health systems that are equipped to deal with whichever reality will be the next to come. All this bearing in mind that "the future is not some place we are going, but one we are creating".*

Look out for the EHFG session in the programme focusing on the post truth world many say we live in today – lacking trust in authorities and across society, disconnected from policy and evidence in an ever-increasing ubiquity of (filtered) social media. We look forward to the official launch of our three alternative "health futures" already in the Opening Plenary. Discuss with us from your stakeholder and personal perspective how to move on towards a healthy future in 2037.

Last but not least, it is time to extend a warm thank you to all the policy makers, civil society advocates, industry representatives, health researchers and more who have made the EHFG what it is today. Time to celebrate 20 years, time to move on and keep learning.

Clemens Martin Auer,
President EHFG

Dorli Kahr-Gottlieb,
Secretary General EHFG

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* John H. Schaar

POSTCARDS FROM THE FUTURE: THE QUEST FOR AUTHENTIC WELL-BEING

By: Anne Lise Kjaer

Summary: Based on a keynote delivered in July 2017, as part of the EHFG Health Futures Project, this article explores ways in which we could assess and measure true progress in a 21st-century context to deliver a cohesive society for the future. It proposes the inclusive 4P prosperity model, which balances profit with purpose, placing the well-being of people and our planet at the centre of everything we do. Visionary leadership is needed to achieve sustainable goals for both society and business – a vision in which we create value by cultivating values.

Keywords: *Social Cohesion, Lifelong Learning, Creative Leadership, No-Age Society, Public Policy*

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Past and present hold keys to the future

Philosopher Marshall McLuhan said: "We march backwards into the future", and this resonates with anyone involved in planning ahead, since we can only get a glimpse of what tomorrow's world might look like by considering the landscape and tools we know. Try for a moment to imagine Europe in twenty years' time in a context of greater well-being for everyone? What would that vision look like and how might we make it happen?

To take the long view, we have reflected on past development, while considering the relevance and potential impact of current events. The result is a Trend Management Toolkit[1] to anticipate the future, and a global Trend Atlas to monitor and filter the interconnected layers of society. These include the socio-economics drivers of PESTEL – politics, economics, societal, technology, environment and legislation – alongside more values-based and emotional dimensions.

As a society, we are currently facing a spectrum of global and local challenges, from climate change and terrorism to migration and social exclusion. To reduce the potential impact of such volatile forces, together we must cultivate a culture of positive change. New digital tools give us access to more information than ever – allowing individuals to make informed choices from work and play to health and well-being – but dissonance is fuelled by the quantity and quality of information.

We are still in the early days of the Networked Society, but already it is offering new awareness of where we might target energy and resources in the future to improve outcomes for our children and grandchildren. In effect, the ability to

shape better lives for many more people will be enabled by our increasingly all-seeing networks, and by the realisation that everything is interconnected. Technological progress offers a step change and the tools to better understand weak signals in order to develop relevant and timely approaches. Big data already means we can access information on a vast scale so that we can, for instance, target resources better.

> how do we measure prosperity and well-being?

The Trend Atlas is an indicator of what's happening in a current context, the outcome of these drivers is never set in stone. People, organisations and societies don't just land in the future; they create it through their choices and actions. This means that today we have the freedom to explore our options by considering multiple future scenarios.

A bold forecast by economist John Maynard Keynes in 1929 envisaged that, by 2030, growth in the developed world would have slowed down and that a 15-hour week would be the norm because, as he saw it: "people will have enough to lead the good life." A 15-hour working week is very unlikely within the next two decades, although Sweden's recent test of a 30-hour week found that people's happiness and health improved along with their productivity.[2] With the full potential of artificial intelligence (AI) and robotic welfare technology yet to be understood, Keynes's prediction might not be as far-fetched as it sounds today. However, it is the other part of his prediction that is worthy of closer examination: the belief that by 2030 we would reach a point where we would have "enough". This is a pressing issue for policymakers to explore; who decides what's 'enough', and how do we measure prosperity and well-being to set realistic goals for the 'good life' in tomorrow's Europe?

Fostering creativity in a complex society

Keeping pace is one of our biggest challenges in today's society. In 2012, IBM interviewed 1,500 CEOs across the globe. There was a broad consensus that complexity is escalating and that most organisations are not equipped to cope. The leaders interviewed agreed that creativity is the single most important leadership quality for the 21st-century. If creative thinking is the essential skill then how do we foster a society in which it is activated to solve real-world problems and achieve sustainable progress?

There is certainly evidence to suggest that it is time businesses put their creative hats on in order to reassess their role in society, since today only one-in-five brands is considered to have a positive impact on people's well-being. If 80% of companies are judged to make no meaningful difference to our lives, it would suggest that the leaders of all organisations need to re-examine their purpose beyond making a profit. One potential solution for navigating this minefield of complexity is a 4P prosperity approach – of *people, planet, purpose and performance*. When organisations have a positive impact on both people and the planet, and a deeper purpose underpinning all their activities, then they enrich their environment rather than merely feeding off it – creating sustainable value in a much wider context.

People and the quest for authentic well-being

Increasingly, people want to get more out of their lives. Forward-thinking organisations are already tapping into the potential for growing people, not just gross domestic product (GDP). According to WEF's Future of Jobs Study,[3] emotional intelligence is now one of the most desirable skills and will be critical in an era of automation. In Sweden, the creative business academy, Hyper Island, assists people in building the skills and confidence needed to lead the future. In the US, Stanford University's Design Your Future programme – created by Silicon Valley design innovators, Bill Burnett and Dave Evans, and now open to all – teaches skills such as cross-cultural working, problem solving, entrepreneurship, creativity and design. In London, The School of Life, founded by philosopher Alain de Botton and a group of writers, artists and educators, are devoted to lifelong learning and run courses on emotional intelligence. The pursuit of happiness, fulfilment and human flourishing is the future of business, says de Botton.

Organisations of every type, and not just policymakers, are crucial players in assisting people to flourish as individuals and become engaged, happy citizens – because when people thrive so do businesses and society. In this context, we need to rethink the term 'going to work' by looking at the best models of lifelong learning and co-creation. Already, learning through play, scenario creation and ideation are useful approaches for inspiring people and to build the 'out of the box thinking' tools required to solve 21st-century issues. This rings true on many levels in a greying society, where self-diagnostic tools and eHealth solutions will redefine the role of health care – taking us from a prescriptive model to a more collaborative preventive one of self-monitoring and actively building our own health capital.

Planet and collaborative communities in an age of no retirement

While people look to improve their own future, they also want to participate in making the world a better place by being part of something bigger than themselves. There are already several collaborative communities and innovation labs around the world cultivating the thinking needed to tackle pressing challenges. For instance, IKEA's Space 10 in Copenhagen gives total creative freedom to a global network of contributors, enabling them to explore 21st-century themes such as food security, urbanisation and well-being.

In an ageing society, we could potentially face a future of no retirement. To prepare for much longer working lives, we must adopt a 'no-age' mindset, so we can harness the skills of every generation. The Age of No Retirement is a movement for inter-generational action to create a future where our age doesn't define us. Also, in the UK, Age of Creativity is a

collaborative network of professionals spanning health and social care, academia and the arts using creative activities to help older people maintain quality of life. A cornerstone of its work is inspiring people – whatever their age – to play an active role in shaping their own quality of life.

Even though age discrimination undeniably exists, it's also inspiring a new generation of successful 'olderpreneurs' driven a movement of start-ups by older people. The *Financial Times* commented recently that, while older workers are in short supply in the City of London, the over-64 workforce has doubled in the UK in the past decade alone.[4] What might the no-age generation of policymakers and entrepreneurs do to develop propositions and platforms that help us remain productive and fulfilled citizens throughout our lives?

Building purpose through 'betterness'

Redefining our goals for prosperity is the key to developing a sense of purpose. The Austrian-American management guru Peter Drucker noted that: "management is doing things right; leadership is doing the right things". While this quote is often cited in a business context, it has equal relevance to policymakers – expressing the urgent need to have a clear 'betterness' goal in both legislation and public health guidance.

There are some striking examples from the Nordic countries of how the 4P prosperity model can be used in public policy to shift society in a positive-values direction. In Denmark, paternity leave has become compulsory – a clear message that parenthood (not only motherhood) is critical to family futures. The Norwegian Public Roads Administration – tasked with keeping Norway's roads and transport infrastructure running smoothly – offered employees who biked or walked to work an extra week's holiday as a reward for not only relieving the strain on the nation's roads, but also improving their own health and well-being. Both examples show that simple initiatives can have a far-reaching impact in changing behaviours for both individual and the common good.

Inspiring people to take control of their lives puts the human perspective back into economics. A good example is UBS' Why Health Matters campaign. In a sector notorious for its long working hours, this campaign invited workers to think about their work/life balance to put themselves and family first. A further UBS initiative, known as 'take two', has offered investment bankers at least two hours a week of personal time.[5]

Fostering better performance in a smart society

In our data-led economy, valuable new tools are evolving, enabling policymakers to collaborate with citizens and businesses to drive a culture of positive change. While automation and urbanisation are often perceived as a threat to society, the World Bank has noted that the growth of cities may actually be a positive force in building a sustainable society.[6] Since 80% of GDP is generated by cities, good management of urban areas through networked information and automation can build prosperity, improve public health outcomes and foster innovation and strategic alliances.

Smart cities require a collaborative, open-source system, rather than a top-down approach. New York City has successfully capitalised on using real-time big data in to solve complex urban problems – pooling diverse information to identify trouble spots and target everything from landlord-tenant issues to breaches in food-safety regulations. E-government – already successful in Scandinavia – makes it much easier for citizens to feel part of civic life by breaking down traditional barriers between the electorate and legislators/local government. For instance, Denmark's MindLab is a cross-ministry innovation lab using design thinking to facilitate new public-sector solutions. Notably, it encourages the active involvement of individuals and businesses in finding these solutions.

In public health, big data can deliver real-time information, in even the most rural areas. Canada's OSCAR (open source clinical application and resource) is a McMaster University-developed programme for primary care clinics that has expanded into a multi-disciplinary resource for health professionals. It enables everything from accurate patient record keeping to electronic referrals. The potential for eHealth to revolutionise the way we deliver care by 'joining the dots', is enormous and offers a route to manage resources more efficiently while delivering targeted care and better health outcomes.

'The Good Life' in tomorrow's society

To return to John Maynard Keynes' prediction of life in 2030 and beyond, we may never achieve a 15-hour working week in our lifetime but policymakers and businesses can address the question of how more of us will achieve a better work/life balance and come closer to 'the good life'. A 4P approach – *people, planet and purpose for better performance* – offers a route to a more cohesive and positive leadership style focused around a society that works for all of us. One could envision a future scenario where leaders say: "I don't want to be the best in the world – I want to be the best for the world". This is surely the society we all aspire to for our children and grandchildren.

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HEALTH IN ALL POLITICS – A BETTER FUTURE FOR EUROPE

Voices from Europe

Compiled by: Willy Palm

Vytenis Andriukaitis: EU Commissioner for Health and Food Safety

Zsuzsanna Jakab: Regional Director, World Health Organization Regional Office for Europe (WHO/Europe)

Pamela Rendi-Wagner: Federal Minister of Health and Women's Affairs, Austria

Nicoline Tamsma: President, EuroHealthNet

Usman Khan: Interim Director, European Health Management Association (EHMA)

Nathalie Moll: Director General of the European Federation of Pharmaceutical Industries and Associations (EFPIA)

As in previous years we asked a panel of prominent 'voices' from the European health policy scene to reflect upon the topics to be discussed at the European Health Forum Gastein 2017.* These individuals represent the key stakeholders attending the EHFG: international and national policy makers, academic researchers, industry and civil society.

Keywords: *Health in all Policies, Health Systems, Medicines, Innovation, Future*

Health: a political choice?

People attach a high importance to health. In all surveys that determine satisfaction in life good health ranks in the top three factors. Not surprisingly, health is also an important political issue. There are many examples – not least some very recent ones – where health issues played a central role in electoral campaigns or political processes. However, moving from "politics" to "policies" it may seem more difficult to keep the overall focus on health and convince politicians and political leaders that health should be high on the agenda in all policy areas.

In the past 20 years of the European Health Forum Gastein it has been repeatedly said that "Health is a political choice". This is perhaps even more true in these politically and economically unstable and unpredictable times. But how can we make sure that politicians are making the right choice for health?

For WHO Regional Director **Zsuzsanna Jakab** health is not just a political choice but a political must because only a healthy society can bring prosperity. "Good health allows children to learn and adults to earn. It helps people to escape from poverty and provides the basis for long-term economic development." She is joined by European Health Commissioner **Vytenis Andriukaitis**: "To achieve citizens' welfare and economic growth we need a healthy population and this requires the involvement of all political sectors. Take the most obvious example of non-communicable diseases: we all know that tobacco kills and that we have to exercise to live longer as well as

* The statements were selected from written contributions received from the various panel members to questions submitted to them, and re-organised by the Eurohealth editors.

healthier lives. But not all ways to achieve this are in the hands of health ministers, such as tax on tobacco, biking lanes or the limitation of sugary drinks in vending machines in schools. As citizens, parents and society we need to encourage our policy makers in all sectors and at all levels to act." Austrian health minister **Pamela Rendi-Wagner** agrees: "If we want a healthy, fair society, we have to see health as a fundamental part of every political strategy. Our health is influenced by various factors, including working and living conditions, access to education, traffic, communal life and leisure time. We also know that there is a growing gap between poor and rich as well as a connection between sickness and poverty". EuroHealthNet President **Nicoline Tamsma** shares this concern. "It is often the most vulnerable members of society that suffer the negative effects of ongoing changes, and disadvantages tend to accumulate over the life-course. The non-communicable disease burden continues to rise, and health inequalities persist across and within countries. If we want to make a difference we urgently need to improve and level up healthy life expectancy." EFPIA Director General **Nathalie Moll** also feels that Europe needs to address the unprecedented health and social care challenges that an ageing population and increased prevalence of chronic disease will bring. "Whilst recognising the importance of other political issues, such as security and immigration, Europe's future depends on our ability to find collaborative solutions making health and social care affordable now and sustainable in the future".

> What we need is a Paris agreement for heallth

Our panel notice some positive signs. Increasingly, European finance ministers and organisations like the OECD acknowledge the importance of health for wealth and make the case for investment in health and health promotion. For **Zsuzsanna Jakab** the global commitment to the Sustainable Development Goals (SDGs) offers a unique opportunity in this respect. "To me, health is not merely one of the SDGs – it underpins every single one of them and should therefore be placed at the centre of the global development agenda. If the current rates of smoking, alcohol consumption and obesity do not decline substantially and if we do not address the social, economic, environmental and cultural determinants, gains in life expectancy could be lost again. This also requires equity, gender and human rights approaches to be mainstreamed into all policies." **Nicoline Tamsma** argues: "What we need is a 'Paris agreement' for health, a firm commitment across all policy levels to walk the talk of health in all policies and to fulfil the Agenda 2030 pledge to leave no-one behind. This requires politicians who adopt a longer term perspective, understand the impact of socioeconomic determinants, and are not afraid to take bold steps that will help reverse the current trend of increasing health inequalities". EHMA Director **Usman Khan** sees it as "our" role as a health community to convince politicians to buy into the ambition of building an economic, social and environmental platform that enables individuals and communities to make the positive life choices. "Health is a political choice but it is also a personal one. Only when these two realities align are we likely to see the very real prospect of '80 great years and 20 good ones' turning from an exception being enjoyed by more than just a small proportion of the world's population to the norm within reach for all".

Challenges ahead

This year's Forum has chosen four thematic tracks for its discussions: Health in All Policies, Health systems, Access to medicines and Innovation, and Big Data & ICT. Each one of these areas will face important challenges over in the next decades that will determine the health of our populations and will require careful political attention and interventions from other policy areas. How does our panel see this future and how will their respective organisations contribute to help meet these challenges?

Health Minister **Rendi-Wagner** sees multiple challenges: "The way we live and work is changing, society is changing, people are getting older and there are more chronic diseases. All policies have to work together to face these challenges successfully. The Ministry of Health and Women's Affairs plays an important part in this process. This year we celebrated the fifth anniversary of our ten Health Goals – a project which involves over 50 partners and experts from different fields. They cooperate to improve the health of all people in Austria and above all to grant a fair and equal access to health care." Common engagement and cooperation is also central in Regional Director **Jakab's** vision. "All of us – national government leaders, members of civil society, partners, the private sector, health workers, patients, their families and community leaders – have a critical role to play in driving progress. Working together with many sectors, including architecture, food, energy, transport, environment and social affairs, as well as others; mobilising communities and individuals, and building consensus, this is what we need to address the multiple determinants of health demand. This is a fundamental tenet of Health 2020, the European health policy framework that the 53 countries in the WHO European Region have been implementing since 2012."

This integrated approach needs to be translated into our health systems. Nicoline **Tamsma**: "We need to embrace whole system, innovative approaches that empower and enable people. Health systems can only be sustainable if they integrate health promoting principles and create synergies, not silos. EuroHealthNet is very committed to this, and to ensuring that health systems are equitable. This will also be reflected in our contribution to new EU Joint Actions on chronic diseases and health inequalities." Also for Usman **Khan** the notion of bringing together aspects of prevention, treatment and care is to be supported. "However, the challenge over the next 20 years will be even greater. At EHMA we are working with our partners to provide facilitative rather than directive health care, flipping the health system more than just filling it. Such

an approach is radical as primary power and responsibility for designing, managing and delivering sustainable health returns to the individual and the communities in which they live. In my view, this is the only means to deliver 21st century health systems that are fit for purpose." Health system transformation is also key to Health Commissioner **Andriukaitis**. "Health systems have to adapt as they are confronted by the ageing of population and the rise of chronic diseases. The principles the Commission set in 2014 – resilience, effectiveness and accessibility – are to remain the core components in the coming decades. The EU can encourage and support policy reforms by providing knowledge and comparability as well as tools and processes for increased networking, knowledge sharing and cooperation between Member States. The European Reference Networks, which will facilitate the access of patients with rare and low prevalence complex diseases to highly specialised health care, are an excellent example of EU cooperation."

However, it is also clear that financial sustainability will remain an important challenge, which risks jeopardising access to health care, in particular to innovative medicines and treatments. **Nathalie Moll** acknowledges the affordability challenges faced by health care systems, under pressure from rising demand. "Introducing transformative treatments can be problematic in the short-term with constrained, time-limited budgets, while the impact of new treatments is often delivered over the course of the patient's lifetime. EFPIA is addressing these issues by working with governments to develop more flexible pricing models such as outcomes-based reimbursement and investing in health care data infrastructure to support more efficient care. We are supporting the development of pan-European Relative Efficacy Assessment, part of the health technology assessment process to increase efficiency and streamline decision-making. And critically, we are working with health systems to look at more effective horizon scanning of new technologies and treatments to better plan for their introduction."

20 years of health policy exchange

This year the European Health Forum Gastein celebrates its 20th anniversary. In the view of our distinguished panel, what has been its contribution to the health policy debate in Europe and what would be their wish for its future?

Vytenis Andriukaitis: "First of all, my warmest congratulations to EHFG. The contribution has been great and I am grateful for your input to the debate on health. Now, you are 20, I wish you to grow and expand, involve a larger audience of participants – finance and economy ministers to advocate for taxation that benefits health, mayors to showcase their healthy cities or chefs to present the change they can make in school or staff canteens."

Zsuzsanna Jakab: "Over the past 20 years, the EHFG has provided a collaborative, informative space, bringing a broad range of stakeholders together to strengthen the focus on public health. In so doing, the Forum has anticipated the multisectoral, multilevel approach to implementing the SDGs. Nurturing the Young Forum Gastein Initiative, and thereby strengthening public health knowledge exchange across generations, will provide a lasting legacy."

Pamela Rendi-Wagner: "The EHFG has taken a leading role in facilitating exchange between a wide range of stakeholders within the health sector. The fact that all pillars of the sector – including policy makers, experts, patient groups and health care professionals – are represented in Gastein makes for a striking mix of ideas and opinions that ensures high quality workshops and discussions and a platform to share best practice experiences. Many ideas initially discussed in Gastein have since been implemented into policy practice throughout Europe. I wish Gastein to maintain their impact on European health policies by successfully enhancing dialogue and exchange among key stakeholders."

Nicoline Tamsma: "I have been fortunate enough to attend most of the EHFG meetings and to serve on its Advisory Committee of Experts. The Forum is unique in the way it offers a warm and welcoming place for open dialogue. 'Gastein' is built on exploring different viewpoints and interests. Debates can be heated sometimes but when we go home after three intense days we all feel part of the European health community. It is a place to make new friends and join forces across stakeholder positions and professional hierarchies. Policy relevance is another key EHFG asset. Over the past 20 years the Gastein valley has provided the backdrop to timely analyses of major EU and WHO initiatives, not only increasing understanding of their policy impact but also helping to further shape the agenda. If the Forum wants to keep its special place under the European health policy sun it seems essential to keep this focus, yet maybe further broaden the perspective to allow for more cross-sectoral links, also in light of the UN Agenda 2030."

Usman Khan: "Ensuring that health is given a similar priority at European level to that it generally receives at national level has always been a challenge. On this basis, the very fact that I know Gastein by reputation alone is evidence in itself of its successful role in establishing and legitimising the need to discuss, debate and exchange on a pan-European level, with the Conference itself providing the focal point of a single high-level space to do this."

Nathalie Moll: "This is my first Forum, but as I look to the future, we should be excited by the science and innovation on the horizon. Introducing transformative treatments in the context of the challenges faced by health care systems will require dialogue and partnership between patients, clinicians, health systems and the innovative industry. The Forum can be an excellent catalyst for that dialogue."

INVESTING IN HEALTHIER CITIES – MULTISTAKEHOLDER ACTION TO PREVENT NONCOMMUNICABLE DISEASES

By: Téa Collins, Bente Mikkelsen, Oddvar Kaarboe, Siegfried Walch and Oleg Chestnov

Summary: Noncommunicable diseases (NCDs) are the leading cause of death worldwide. To address NCDs, policy coherence between health and other sectors, as well as the implementation of health in all policies through the whole-of-government and whole-of-society approaches are paramount. Healthy Cities is a platform to promote multi-sectoral work on NCDs through building sustainable partnerships between public and private sectors to act collectively and overcome the global NCD challenge. Healthy Cities could be used as a novel tool to implement the 2030 Agenda for Sustainable Development and make linkages among NCDs, universal health coverage and resilient and sustainable cities, and promote partnerships for action on NCDs.

Keywords: *Noncommunicable Diseases, Health Promotion, Disease Prevention, Healthy Cities, Universal Health Coverage*

> #EHFG2017 Workshop 1: Invest in healthier cities: "insuring" prevention

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Introduction

Noncommunicable diseases (NCDs) – mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – are the leading causes of death worldwide. The World Health Organization (WHO) estimates that in 2015, 15 million people between the ages of 30 and 69 died from NCDs. Over 80% of these premature deaths were due to these four major groups of NCDs.[1]

The impact of NCDs is alarming in the European Region. Taken together, the four NCDs, along with mental disorders, account for an estimated 86% of deaths and 77% of the disease burden in the Region.[2] They represent a challenge not only from the health perspective but also from the perspective of economic development, due to unnecessary labour productivity losses. A consensus is growing that to address NCDs, policy coherence between health and the sectors impacting health, as well as the implementation of health in all policies through the whole-of-government and whole-of-society approaches, will be paramount.

The need for a multistakeholder and multisectoral approach to counter NCDs was clearly articulated in the political declaration and the outcome

document of the two United Nations High-level Meetings on NCDs, first in September 2011, and then during the second follow-up meeting in July 2014. In addition, the new agenda for sustainable development – *Transforming Our World: the 2030 Agenda for Sustainable Development* – recognised NCDs as an important part of the agenda and included a target of a one-third reduction of premature mortality from NCDs by 2030.[3]

> building sustainable partnerships between public and private sectors

However, the translation of the high-level political commitments into country-level action has proved to be difficult. Some have argued that the "neglect of NCDs is a political, not a technical failure, since cost-effective interventions are available."[4] In many languages, *policy* and *politics* are the same word. Therefore health in all policies can be interpreted as health in all politics as well. Politicians' involvement is critical to ensure that health is visible in other sectors.

The politics of NCDs can best be addressed through strong local government leadership and collaboration between health and social services, business, industry, transport, education, insurance, education, economic and environment sectors.[5] Local government should be empowered to improve citizens' health and well-being, prevent disease and promote health, and support health literacy for building resilient communities. Health promotion and disease prevention should be considered a shared societal value and a political goal for all. This requires intersectoral cooperation, which is particularly relevant at the local level, where global policies are adapted to local needs and priorities. Many social determinants of health can be effectively tackled at either the local government or local community levels. However, implementation challenges remain and are often due to poor governance for health and financial constraints.

We suggest Healthy Cities as a platform to promote multi-sectoral work on NCDs through building sustainable partnerships between public and private sectors to act collectively and overcome the global NCD challenge. The concept of healthy cities is nothing new. WHO has been promoting the healthy cities concept for decades, recognising health as a core city value and acknowledging the role of every stakeholder to fulfil their responsibility for creating healthy environments.[5] However, what we believe is novel is using the platform as a tool to implement the 2030 Agenda and making linkages with NCDs (SDG 3.4), universal health coverage (UHC) (SDG 3.8) and resilient and sustainable cities (SDG 11), and to promote partnerships (Goal 17) for action on NCDs.

In practice, this means bringing together city governments and the insurance industry along with other actors in joint efforts for shared governance for health to overcome the NCD challenge. With a growing interest in private insurance as countries around the globe strive to achieve UHC, public-private partnerships with insurance companies may be a win-win solution. According to WHO, 39 countries have private health insurance (PHI) exceeding 5% of total health expenditure. The dependence on PHI varies from region to region and country to country depending on the variation in income level and institutional development. However, even in countries where health care systems are primarily publicly funded, PHI provides important supplementary coverage. For example, in France over 85% of the population buys supplementary private insurance policies, while in the Netherlands this number is over 90%. Australia and Ireland are known for encouraging private insurance to complement public financing.

From the public sector, local governments are best placed to provide leadership for health. City mayors are well positioned to integrate public health into local governance and build solid inter-sectoral alliances for sustainable urban development. On the other hand, the insurance industry, which increasingly favours healthy consumers to avoid the proliferation of health care costs due to chronic illness and overuse of medical technologies, has an inherent interest to work with city governments to build healthier communities. As a result, new kinds of insurance models are emerging based on a health rather than a sickness paradigm.[6]

Urbanisation and health

Since 2008, a majority of the world's population lives in cities. Between 2000 and 2014, one billion people were added to urban areas globally.[7] Rapid urbanisation is expected to continue, and by 2050, two in three people will be living in cities. This is not surprising given the major transition that is taking place from an agrarian to an industrialised, service-oriented economy, with cities playing a central role in ensuring major economic, political and cultural opportunities. It is estimated that 600 cities are providing over 60% of global economic output.[8]

In addition to economic progress, urbanisation has a strong health dimension. Evidence shows that there is an "urban advantage" with respect to better availability and accessibility to health care services when compared to rural areas, due to better health system infrastructure and high concentration of human resources in cities. On the other hand, urban lifestyles tend to create an environment conducive to unhealthy behaviours, such as a lack of physical activity, diets rich in processed fast food lacking essential nutrients and high in fats and sugar, as well as use of tobacco and alcohol abuse. Cities can also concentrate urban poverty and ill health and exacerbate inequalities in health outcomes due to inequities in access to health resources, and contribute to the rise of NCDs. According to WHO, urbanisation is one of the key challenges of public health in the 21st century.[9]

Involving cities in discussions on UHC

The emerging importance of NCDs increases the imperative for health promotion and disease prevention.

Preventing diseases rather than caring for the sick can have a huge impact on population health, yet it is often overlooked in UHC efforts. Although prevention is justifiable economically, as well as from the health and human rights perspective, it is common for health care systems in general and health insurance plans in particular (e.g. social insurance in Europe, as well as private insurance companies) to focus on curative care without sufficient attention to health promotion and disease prevention. Rapid urbanisation, demographic changes (such as ageing populations and migration), and epidemiological transition with a growing burden of NCDs, are posing multiple challenges to city mayors and municipal authorities in their efforts to ensure the health of their citizens in the context of competing priorities and fiscal constraints.[10]

> potential to make lasting and positive changes

As national governments move forward to achieving UHC and/or expanding benefits packages, cities should be part of the dialogue on a wide range of policies related to health and social services, as well as the determinants of NCDs. Traditionally, health promotion activities have focused on immunisation, family planning, breastfeeding, water and sanitation and preventing violence. However, a contemporary agenda for health promotion needs to address the NCD risk factors, such as tobacco, alcohol, over-nutrition, physical activity, substance abuse and injuries.[11]

The commercialisation of health promotion

Some argue that 21st century health promotion is increasingly being privatised, with the private sector embarking on a "wellness revolution" with the explosion of media that focus on health and wellness in electronic and print outlets, the Internet and TV programming, and the growing wellness market with dietary supplements and functional foods that help manage specific diseases (such as diabetes). The commercialisation of health promotion calls for a shift from a traditional approach to regulate industries producing unhealthy products (such as tobacco or highly processed food) to educating communities to increase their health literacy and take charge of their lives. On the bright side, the interest of the private sector in health and wellness offers opportunities for partnerships to increase the attractiveness of health promotion messages and encourage healthy competition for positive lifestyles.[12]

Companies have already started using technologies to drive behavioural change. For example, SidekickHealth, a company developed by researchers from Harvard University and the Massachusetts Institute of Technology (MIT), provides an interactive eHealth platform to help employers and health care providers deliver programmes that promote health and tackle chronic diseases. The company uses smartphone technology with a data-driven approach to engage people to adopt healthier behaviours by increasing their motivation to get better results and improve their health.[13]

Digital Inclusion

Technology-driven smart cities are most successful when their focus is on people and when they actively engage citizens in creating, using and monitoring the smart devices designed for them, as well as improving their living environments and quality of life. Digital inclusion is becoming central to ensuring no one is left behind by providing e-training to older and technologically challenged people,

Box 1: Mayors' ten priority Healthy City Action Areas

As mayors we commit to ten Healthy Cities action areas which we will integrate fully into our implementation of the 2030 sustainable development agenda. We will:

1. Work to deliver the basic needs of all our residents (education, housing, employment and security), as well as work towards building more equitable and sustainable social security systems;
2. Take measures to eliminate air, water and soil pollution in our cities, and tackle climate change at the local level by making our industries and cities green and ensure clean energy and air;
3. Invest in our children, prioritise early child development and ensure that city policies and programs in health, education and social services leave no child behind;
4. Make our environment safe for women and girls, especially protecting them from harassment and gender-based violence;
5. Improve the health and quality of life of the urban poor, slum and informal settlement dwellers, and migrants and refugees – and ensure their access to affordable housing and health care;
6. Address multiple forms of discrimination, against people living with disabilities or with HIV AIDS, older people, and others;
7. Make our cities safe from infectious disease through ensuring immunization, clean water, sanitation, waste management and vector control;
8. Design our cities to promote sustainable urban mobility, walking and physical activity through attractive and green neighbourhoods, active transport infrastructure, strong road safety laws, and accessible play and leisure facilities;
9. Implement sustainable and safe food policies that increase access to affordable healthy food and safe water, reduce sugar and salt intake, and reduce the harmful use of alcohol including through regulation, pricing, education and taxation;
10. Make our environments smoke free, legislating to make indoor public places and public transport smoke free, and banning all forms of tobacco advertising, promotion and sponsorship in our cities.

Source: [14]

and helping them lead productive lives, re-entering the workforce in new, less demanding ways and further contributing to the economy.[14]

Conclusions

Health is a cornerstone of sustainable development and therefore including health in all policies is important for coherent public policies with a major developmental impact. NCDs are responsible for premature death and lower quality of life for millions of people. Partnerships between public and private sectors led by local governments have the greatest potential to making lasting and positive change. Of the many actors at all levels of government, city mayors and local government leaders are uniquely positioned to contribute in a major way to making cities healthier and reducing NCDs via action on the risk factors and the social and economic determinants of health. Mayors and local leaders also play a defining role in delivering on the 2030 Agenda. They have the political responsibility to ensure that health becomes an important value in cities' vision for future development and draws together all relevant sectors for action on population health.

The evidence to date is encouraging: many city governments now have the power and support to work across sectors, departments, independent agencies and community groups to develop partnerships with a common purpose to promote health and prevent disease. There is evidence that most Nordic countries, notably Finland, have transferred the main responsibility for health promotion to the municipal level. Similarly, public health in England, which was the responsibility of the National Health Service since 1974, was transferred back to local government.[5] More recently, 100 mayors from around the world came together on 21 November 2016 in Shanghai, China at the 9th Global Conference on Health Promotion, and committed to making bold political choices for health and implementing healthy cities programmes of action (**see Box 1**). The time is ripe for cities to make the political, economic, moral and ethical arguments for action for collaboration across sectors and to ensure the health of their citizens.

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Portugal: health system review

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While overall health indicators for Portugal have notably improved in recent years, they still hide significant health inequalities, which are mostly related to health determinants, such as child poverty, mental health and quality of life.

Even though the Portuguese National Health Service (NHS) is universal, comprehensive and almost free at point of delivery, there are also inequities in access to health care, mostly related to geography, income and health literacy. The so-called health subsystems, the special health insurance schemes for particular professions or companies that exist next to the NHS, as well as private voluntary health insurance, provide easier access for certain groups.

Since the financial crisis, health sector reforms in Portugal have been guided by the Memorandum of Understanding that was signed between the Portuguese Government and three international institutions (the European Commission, the European Central Bank and the International Monetary Fund) in exchange for a €78 billion loan. Measures were implemented to contain costs, improve efficiency and increase regulation. Nonetheless, financial sustainability of the Portuguese health system remains a challenge. Due to cuts in public workers' salaries the increasing migration of health care workers risks negatively affecting the quality and accessibility of care. While several reforms are aimed at improving coordinated care and developing the use of Health Technology Assessment, there is still scope for increasing efficiency in the health system.

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INCLUSIVE WORK-PLACES TO AVOID SOCIAL EXCLUSION

By: Katalin Sas and Timothy Tregenza

Summary: Employment is key for social inclusion as well as being an important determinant of health. To improve health, occupational safety and health cannot operate in isolation from public health and other policy areas. Creating inclusive workplaces and reducing health inequalities requires policy initiatives that bring together different actors and stakeholders.

Keywords: *Employment, Workplaces, Social Inclusion, Social Rights, Inclusive Labour Markets*

Employment is key for social inclusion

The European Union (EU) has long been combating social exclusion and sees work as playing a key role in this. Active inclusion strategies look to get as many people as possible into the labour market and keeping them healthy and safe while they are in work.

The European Commission's Communication on the European Pillar of Social Rights[1] moves forward efforts at building a fairer Europe and strengthening its social dimension. It reaffirms existing rights in the EU and in the international legal acquis while complementing them to take account of new realities and seeking to make them more visible and explicit for citizens and for actors at all levels. The Pillar sets out the main principles and rights to promote the social dimension in Europe, including among others, equal opportunities, access to the labour market and secure employment, and a healthy, safe and well-adapted working environment.

Employment is key for social inclusion as well as being an important determinant of health. Having a job or an occupation not only means income and financial security, it is also an important determinant of self-esteem. It provides a link between the individual and society and enables people to contribute to society and, ideally, to achieve personal fulfilment. Long-term unemployment presents a risk for social exclusion and the loss of a job or the threat of losing a job is detrimental to health.[2,3] In the context of an ageing workforce, keeping people in employment and increasing employment rates is essential for ensuring the sustainability of Europe's social model, welfare systems, public finances, and economic growth. Yet too many workers leave the labour market permanently because of health problems or disability, and too few people with reduced work capability manage to remain in employment.

Do working conditions affect health?

While recognising the importance of employment for social inclusion and

> **#EHFG2017** Workshop 8: Social inclusion, work and health

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health, physical and psychosocial aspects of work can pose a risk to health. Data from European Working Conditions Survey (EWCS)[4] show that a relatively high proportion of European workers still report exposure to chemicals (17%), vibration (19%), noise (27%), and that their work involves repetitive movements (31%), lifting or carrying heavy loads (31%) or tiring and painful positions (13%). At the same time, many workers report exposure to psychosocial risk factors, such as working at high speed (23%) and to tight deadlines (26%), handling angry clients (11%). They also face restructuring (23%) and job insecurity (16%). Across Europe the levels of absenteeism, unemployment and long-term disability claims due to work-related stress and mental health problems have been increasing; in many countries they have now overtaken musculoskeletal problems as the leading cause of absence from work and withdrawal from the labour market.[5]

In addition, there is evidence that people in lower occupational positions experience unhealthy working conditions more often than those in higher positions, as shown in a study by Siegrist et al.[6] This was demonstrated for distinct chemical, physical and biological hazards, in terms of exposure to carcinogens, repetitive movements, vibration, manual handling, rapid work pace, or biological pathogens, depending on the type of job. Workers with lower degrees of qualification and lower occupational positions suffer from substantially heavier exposure to these occupational hazards, and consequently suffer higher prevalence of disease. The social gradient was also demonstrated for health-adverse psychosocial work environment, and elevated unemployment risks and job instability. The authors claim that well-developed labour and social policies at the national level contribute to an improvement of health-adverse working conditions in respective national working populations. This holds particularly true for active labour market policies integrating disadvantaged groups of adult men and women.

Promoting inclusiveness requires cross policy cooperation

Poor working conditions are associated with poor health outcomes. Frequent and long-term sickness absence is a risk factor for disability and job loss. Unsafe, unhealthy work environments result in earlier exits from active life. The key role of health is recognised and health is an integral element in many EU strategic initiatives. Fighting social exclusion and unemployment, reducing health inequalities and improving working conditions and promoting inclusive labour markets should go hand in hand. In the context of an ageing and increasingly diverse workforce it is important to ensure that workplaces can accommodate workers of all ages, women, people with disabilities and chronic diseases, and migrants.

> adapting work and the work environment to the capabilities and needs of the individual

At the workplace level, an inclusive and supportive work environment encompasses health protection and promotion, career development and training, flexible work arrangements and working time, equal treatment and non-discrimination, age management and intergenerational cooperation, and absence management and return to work. This requires good cooperation between those involved in safety and health and human resources management, between management and worker representatives, and with and between support services such as occupational health services and health insurance providers. In terms of occupational safety and health (OSH), it means adapting work and the work environment to the capabilities and needs of the individual, based on diversity-sensitive risk assessment.

At policy level, creating an inclusive labour market requires cross policy cooperation, involving all relevant policy areas: OSH, public health, employment, equal treatment, and life-long learning and vocational education. Return to work and rehabilitation is a particular area that needs a collaborative, multi-disciplinary approach. Research published by EU OSHA highlights this, alongside the need for early intervention.[7,8]

The legislative and policy framework

The principle form of regulation for health and safety in the EU is through transposing European Directives into national legislation. The legislation consists of a goal-oriented "framework" Directive[9] setting out the central concepts of OSH management, the requirement to undertake a risk assessment, and establishing the hierarchy of prevention. The framework Directive is complemented by individual Directives on specific hazards, workplaces of elevated risk, single tasks, or vulnerable workers (for example[10]).

European priorities in OSH are set out in the 2014 "strategic framework",[11] taken forward by the European Commission's 2017 Communication on Safer and Healthier Work for All – Modernisation of the EU Occupational Safety and Health Legislation and Policy.[12] This foresees a review of the EU OSH legislation alongside the Commission's ongoing work on a European Pillar of Social Rights to adapt EU legislation to changing work patterns and society. The consultations and debates on the Pillar have confirmed the importance of occupational health and safety at work as a cornerstone of the EU acquis and put an emphasis on the implementation or enforcement of already existing legislation and rights to ensure a more effective protection of the health and safety of workers.

Equally important for creating an inclusive labour market is Council Directive 2000/78/EC.[13] This Directive sets out a general framework to ensure equal treatment of individuals in the EU at the workplace regardless of their religion or belief, disability, age or sexual orientation. It stresses that employment and occupation are key elements in guaranteeing equal opportunities for all and contribute strongly to the full participation of citizens in economic,

cultural and social life and to realising their potential. However, according to EWCS 7% of workers report being subjected to discrimination at work in the last 12 months.

In the context of rapid technological change and new patterns of work, life-long learning is a precondition for sustainable employability. The Social Pillar reaffirms everyone's right to quality and inclusive education, training and life-long learning to maintain and acquire skills that enable them to participate fully in society and successfully manage transitions in the labour market. Comprehensive life-long learning was also one of the key policy priorities set by the Commission in its Agenda for new skills and jobs,[14] proposing targeted approaches for more vulnerable workers, particularly the low skilled, unemployed, younger and older workers, disabled people, people with mental health conditions, or minority groups such as migrants and the Roma.

The linkage between occupational and public health

In terms of health, the need for cross-policy cooperation between OSH and public health is obvious and it goes beyond workplace health promotion. Since we spend a considerable proportion of our adult life at work, the impact of the work environment – physical and psychosocial – on health cannot be neglected. According to the estimates by the Dutch National Institute for Public Health and the Environment (RIVM), 122,600 people were newly diagnosed with cancer in 2012 in the EU-28 caused by past exposure to carcinogenic substances at work and an estimated 79,700 cancer deaths were attributed to work-related exposure to carcinogenic substances in 2012.[15] This is in line with Takala et al. who estimated that dangerous substances at work cause about 74,000 deaths annually in EU-27 countries. In addition, health care expenditure and productivity losses are estimated to cost between €4–7 billion annually to the EU.[16]

Thus, it is obvious that cancer prevention has to include an occupational component, reducing exposure to carcinogens and mutagens. Additional policy interventions are needed to reduce the future burden of work-related cancer in the EU. This is recognised in the Commission's 2017 Communication on Safer and Healthier Work for All, proposing stepping up the fight against occupational cancer as one of the top three OSH actions.

> ensure equal treatment of individuals in the EU at the workplace

To conclude, the workplace is not only an ideal arena for the promotion of the general health of the population and the reduction of socioeconomic and gender-specific health inequalities but also a gateway to social inclusion. Cross-policy cooperation is essential for creating an inclusive labour market accommodating the needs and capabilities of an increasingly diverse labour force and enabling people to fully participate in society.

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TRANSFORMATIVE APPROACHES FOR EQUITY AND RESILIENCE – **HARNESSING THE 2030 AGENDA** FOR HEALTH AND WELL-BEING

By: Monika Kosinska, Adam Tiliouine and Christoph Hamelmann

Summary: Tackling pressing global public health challenges and meeting common goals requires commitment to strengthened intersectoral action for health and well-being for all. This poses governance challenges at the global, regional, national and sub-national levels. The adoption of the United Nations 2030 Agenda for Sustainable Development provides a renewed political impetus for tackling the determinants of health by all sectors and actors. The European Region has a long standing history of leadership and innovation in relation to intersectoral action for health and well-being for all, which provides an opportunity to bring about transformative change.

Keywords: *Intersectoral Action, Health 2020, Policy Framework, Whole-of-Government Approaches Well-being*

> #EHFG2017 Forum 4 & 10: Transformative approaches for equity and resilience

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Introduction

Intersectoral action is at the heart of the policy approaches currently being taken forward at national and sub-national level across the WHO European Region, as part of the concerted effort by countries to implement *Health 2020, the European strategy and policy framework for health and well-being*[1] and the transformative *2030 Agenda for Sustainable Development* adopted by governments in September 2015.[2] The ambitious 2030 Agenda stresses that health is both an integral investment for social, economic and sustainable development as well as an outcome of good policies and actions across other sectors and by other actors. The indivisibility of the Sustainable Development Goals (SDGs) reinforce Health 2020 in both calling for inter- and multi-sectoral approaches to today's challenges that influence health and well-being, as well as in their objective to address issues of equity and leaving no one behind.

In 2015, the Regional Committee of the WHO European Region working paper, *Promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice,* proposed four strategic intersectoral approaches for action on health and well-being; intersectoral action for

health; whole-of-government; Health in All Policies; and governance for health.[3] These four approaches are central to the implementation of Health 2020 and the 2030 Agenda.

> A good start in life generates significant dividends

Tackling inequalities has been central to the improvement of health and well-being for the Region throughout the implementation of Health 2020, and has been given particular prominence since the publication of the review of social determinants and the health divide in the WHO European Region.[4] The WHO Regional Office for Europe is committed to supporting countries in their work to improve health and health equity through supporting the transfer of knowledge on the intersectoral approaches in the European Region.

Preconditions and challenges to work across and between sectors

The work to strengthen intersectoral action in the Region has highlighted a number of commonalities as preconditions and challenges: almost all countries report that political will is essential for the adoption of whole-of-government approaches, where health is a goal of overall government policy. Implementing whole-of-government approaches mean strengthening policy coherence between sectors. In addition to strong leadership from the Ministry of Health and excellent communication across sectors, providing a strong evidence base and an economic case for action can trigger and support the political choices to invest in intersectoral action.

The experience of the European Region shows that intersectoral working is also possible where political will still needs to be fostered: time, buy-in from other sectors and partners, and capacity to take action forward are core criteria for success. A first step in this process is identifying co-benefits for joint working.

In addition to the ongoing work of the WHO Regional Office for Europe to support and strengthen intersectoral action, three important developments have put intersectoral working as high level priorities for countries in the European Region:

1. the localisation of the 2030 Agenda;
2. the renewed commitment to the Environment and Health Process; and
3. the convening of the Regional Platform for Working Together for Better Health and Well-Being for All, focusing on bringing together the health, education and social sectors.

All three mark important milestones in the journey to improved health and well-being for all in the European Region.

Implementing the 2030 Agenda through intersectoral action

The 2030 Agenda and its 17 SDGs present a significant opportunity for the public health community to step up intersectoral action on the various determinants of health, and through engagement with a wide range of stakeholders. The unprecedented political commitment to the SDGs – seen by global health being discussed during meetings of the G7 and G20 for example – together with the transformative demands of the 2030 Agenda give the public community impetus to innovate and adopt new and wider partnerships.

Many countries have established inter- and multisectoral mechanisms to support action. However, more action is needed to tackle the burden of disease from environmental exposures, climate change and food systems; to address the risk factors for non-communicable diseases (NCDs); communicable diseases and antimicrobial resistance; and to strengthen the factors that support the social determinants of health and empower people through education and training. The adoption of the Roadmap to implement the 2030 Agenda for Sustainable Development, building on the Health 2020 policy framework, at the 67th session of the WHO Regional Committee for Europe in Budapest, Hungary in September 2017 marks an important milestone to support countries in their localisation of the 2030 Agenda and improving health and well-being for all.

Tackling the environmental determinants of health

The European Region has many years of experience and lessons learnt on intersectoral action for improved health and well-being. One key area of success is the work in the environment and health area, and this learning and experience needs to be transferred to other areas, including the social and economic determinants of health.

In 1989, concerned about the growing evidence of the impact of poor environments on human health, the WHO Regional Office for Europe initiated the first ever international environment and health process for addressing environmental determinants of health. The European Environment and Health Process (EHP) is steered by ministerial conferences that bring together different sectors and stakeholders to agree on commitments and shape shared European policies and actions on environment and health.

Despite the successes achieved since 1989, the environmental burden of disease is still stubbornly present in some geographic areas. There are many opportunities for progress; for example through changing production and consumption patterns and fostering healthy and environmentally friendly approaches in energy, transport, housing, urban management and agriculture, as well as in the health sector itself. In Ostrava, Czech Republic, in June 2017, the countries of the European Region adopted the Declaration of the Sixth Ministerial Conference on Environment and Health which recognises the inseparable link between development, environment, human health and well-being and resolves to fulfil the vision of a healthy planet and healthy people through partnership with relevant sectors and stakeholders.[5]

Scaling up action on the social determinants of health

The sustainable development of the WHO European Region and the implementation of the 2030 Agenda cannot be achieved without ensuring a sustainable and healthy future for future generations. This requires a renewed focus on children and adolescents, their families and communities: investment in people and human capital is at the heart of achieving health and well-being. Currently, inequalities among children exist between and within countries in the Region: disregarding these inequalities contributes to their perpetuation, to reduced social cohesion, and puts societies at risk of instability.

> the education and social sectors play a particularly important role

A good start in life generates significant dividends for health and well-being.[6] Investing in all children early in their development provides the greatest return on investment at any point during the life-course: it is crucial to address inequalities early so they do not continue and perpetuate throughout generations as the earlier the investment during the life-course, the greater the benefits.

While a number of determinants affect child and adolescent health and well-being, it is the education and social sectors that play a particularly important role. Educational settings, from child care and pre-schools in early years to school during later childhood and adolescence, promote cognitive, emotional and executive function, support social development and encourage participation in activities that build individual resilience. In the social sector, household income (through decent work and pay as well as social transfers, such as child or housing benefit) remains the strongest determinant of child health and well-being.[7]

In December 2016, in Paris, France, the countries of the European Region came together as the health, education, social and other relevant sectors for the first time during the High Level Conference *Promoting intersectoral and interagency action for health and well-being in the WHO European Region*. They committed to tackling health inequalities and improving the health and well-being of all children in the Region, including through the establishment of the Regional Platform for Working Together for Better Health and Well-being, which brings together the health, education and social sectors. The evidence of policies that effectively work in addressing social determinants of health and health inequities is there[8] – it is urgently time to implement them coherently.

Conclusion

The development and implementation of policies to advance health and well-being in the 21st century cannot be achieved without breaking down silos between policies and sectors. It is crucial for allowing and encouraging health to make the maximum possible contribution to sustainable development. Although the experience of the European Region shows that sustained and consistent intersectoral action is not easy, there are many good examples in countries that can act as inspiration and lessons learnt on how to move forward. Intersectoral action calls for the strengthening of evidence-based approaches, development of economic cases for action, a better understanding of the co-benefits of joint action as well as strengthened approaches to governance for health and well-being. This includes the legislative and policy frameworks that support greater accountability and policy coherence for better health and well-being outcomes, as well as systematic approaches to addressing conflicts of interest and the commercial determinants of health. These issues become increasingly important as the complexity of governance of intersectoral action increases, with a plurality of stakeholders and actors at the decision-making table.

Intersectoral action is not a universal panacea and it is imperative that the health sector leads by example, tackling the inequalities in access and barriers to universal health coverage, as well as the employment, social and environmental conditions affecting its own workforce. However, the current political environment provides a renewed mandate, impetus and direction to strengthen action between and across sectors. It is imperative, therefore, that all actors in public health look to their engagement and partnerships and to step up work to bring together the relevant stakeholders to allow us to meet our common goals and objectives. There is no alternative to intersectoral approaches and intersectoral working if the ambitious goals of Health 2020 and the 2030 Agenda are to be realised.

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CONSIDERING THE **FUTURE OF HEALTH SYSTEMS** IN EUROPE

By: Hans Kluge, Nick Fahy, Jo De Cock, Elke Jakubowski, Govin Permanand and on behalf of the WHO Regional Office Health Systems Foresight Group

Summary: European health systems face challenges and financial pressures which threaten their long-term sustainability and the values of equity, universalism and solidarity which underpin them. Towards understanding potential future health system directions and how to plan for them, the WHO European Regional Office has established a Health Systems Foresight Group. The group will work with the Division of Health Systems and Public Health to develop scenarios and pragmatic and policy-oriented advice for policy-makers to address these challenges, also with the aim of ensuring that European health systems remain oriented around their shared values.

Keywords: *Health Systems, Values, Financial Sustainability, Future*

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Health decision-makers in Europe face a number of common challenges. Among the most notable are the increasing cost of health care, demographic change and population ageing, the changing burden of disease, concerns around the health workforce, and growing patient demand. These, in turn, raise broader health system issues around affordability and sustainable financing, adequate human resources for health (not just in numbers and distribution, but in training and quality), and systems' ability to adapt to meet such challenges while still providing quality care.

European health systems have long faced similar concerns. Researchers, experts and policy-makers have often sought to draw attention to unsustainable health care costs, changing patterns of disease and demographic change, and difficulties in meeting growing demands, and have called for sustainable forward-looking responses. What is perhaps different today, however, is the intensity of the challenges, particularly in view of the financial pressure on health systems also driven by medicines and technologies, where pharmaceutical spending is increasingly skewed towards high-cost products.[1] (See also the article by Edwards and Panteli in this issue). The result being that ensuring universalism and solidarity – the values that have traditionally underpinned health systems in Europe – is potentially under threat.[2]

The global economic crisis has served to worsen this, where progress towards universal health coverage (UHC) in some countries is being unpicked.[3] Also new

is the context. For this comes at a time when countries all over the world have committed to the 2030 Agenda and the Sustainable Development Goals (SDGs) – stressing UHC and promoting good health and well-being for all[4] – at the same time as populist and nationalist forces are making gains in domestic spheres and many economies face growing austere conditions.

A strong commitment to shared values

WHO's commitment to the provision of health based around shared values can be traced back to its founding constitution in 1946. This stipulates the "enjoyment of the highest attainable standard of health" as a fundamental human right, that "informed opinion and active co-operation on the part of the public are of utmost importance", and that governments are responsible for the health of their people through the "provision of adequate health and social measures".[5] More recently, and specific to the European Region, the 1996 Ljubljana Charter on Reforming Healthcare opens with a number of 'fundamental principles', of which "health care systems need to be driven by values" is the first.[6] This clear statement of the Region's shared understanding of such an approach was strengthened in the 2008 Tallinn Charter: Health Systems for Health and Wealth.[7]

Calling for health systems which have solidarity, equity, participation and accountability at their core, the Tallinn Charter anticipated future challenges – even if not the immediacy of the financial crisis which took hold the following year – and the need to ensure that health systems are seen as promoters of health, wealth and societal well-being while adhering to those values. The Charter has proven important in helping countries design and develop their health systems and policies,[8] and its values are reflected in the commitment to people-centred health systems in Health 2020, the regional health policy and framework for the WHO European Region since 2012.[9]

That said, what does the future hold for European health systems? What are the key issues to be addressed or overcome, and can health systems remain value-oriented? How can national policy- and decision-makers take informed directions to prepare for the future? And what can we, as the broader public health community, do to help? While there are no ready answers, it is important to anticipate trends and directions in order to help chart appropriate and longer-term policy choices. Policy-makers across the region are in need of pragmatic and policy-oriented advice.

With such questions in mind, the WHO Regional Office for Europe has established a 'Health Systems Foresight Group'. Under the direction of the Division of Health Systems and Public Health, it aims to provide perspectives on the long-term future of health systems in Europe, their priorities and orientation. The aim is not to be predictive. Rather it is to help develop proposals for health policy- and decision-makers which can support their systems' adaptation to the main challenges and trends going forward.

Box 1: Major trends relevant for health system reform

- **changing health needs:** not just demographic ageing, but changing disease patterns and patients increasingly presenting multiple chronic conditions – what does this mean for the structure of health care provision, and what social structures and expectations does this require in terms of the responsibilities of the individual, the family, civil society and public services?;
- **continuing and growing inequalities in needs, interventions and provision:** there are uneven patterns of need, with only a small proportion of patients accounting for the bulk of expenditure, and the spread of new treatments – where they exist – is unevenly distributed even within countries;
- **innovation and implementation:** this relates to issues around the link between research, development, evaluation and implementation processes, where current systems linking research to need and the use of evidence in developing good practice are far from perfect;
- **information and efficiency:** we know the general benefits of information technology in health care, but one of the long-standing challenges around health systems remains the need to measure what matters; our current health information systems are heavily skewed towards inputs and processes and we crucially need more on outcomes;
- **a changing health workforce:** technology is already changing the nature of health professionals' roles, as is changing patterns of disease, and calls for the development of new functions or professions entirely; and difficulties associated with an ageing health workforce, and the retention and distribution of health workers will continue;
- **challenges in relation to understanding and incorporating the social determinants of health:** socioeconomic inequalities in society and across the region impact on health systems, in turn affecting the wider economic and political sustainability of health systems, also in terms of maintaining a strong value orientation; and
- **health system resilience:** the challenges to health systems are set to continue, and a crucial issue for all policy-makers is to improve their capacity to identify challenges at an early stage in order to be able to adapt their systems to them.

Identifying future challenges and trends

Of the numerous challenges and trends that the Foresight Group is looking at, a number bear mention. While European health policy-makers are committed to shared values, and their systems may to varying degrees reflect them, the region's health systems remain very different. The three traditional models of Beveridge, Bismarck and Semashko have all been adapted in different national contexts and have evolved over time. And even if these categorisations no longer apply in practice, each has left its own historical legacy in terms of health system structure and design, resources, infrastructure (buildings), and expectations about how the health system should work; all with specific country adaptations. So while all countries may have acute resource and hospital infrastructure issues, for example, they have different starting-points and potential trajectories when planning to address these for the future; in some cases vastly so.

Another challenge relates to the financial pressure on health systems, now exacerbated by the global economic crisis. The period 2009–2013 saw a general drop in health spending in many countries, but since then expenditure on health systems has been rising again across the region. Also, because health systems in Europe are mostly publicly financed, this financial pressure is typically expressed as a challenge for public budgets. Responses to it are thus not only about private choices regarding insurance or saving, but rather are understood as a matter for society as a whole. Recalling the importance of solidarity to European health systems, not only are questions being asked about the economic and financial sustainability of current health system expenditure, but now whether it is politically and socially sustainable as well; how much money is the population going to accept being spent on their health system?

Advances and improvements in medical technology, techniques and medicines are key to delivering quality care, but they are increasingly expensive. With a focus on high-cost products, medicines and technologies are a major factor in driving health system expenditure.[1] It is also unclear whether the prices of many of these improvements reflect their comparative value-added to health and health systems – cancer treatments being a current example, where spending more on cancer care does not correlate directly with improved outcomes as prices for new drugs (and existing off-patent medicines) continue to rise at an alarming rate.[10] Moreover, many innovations do not necessarily align well with the needs of the health system, nor with those of patients. Mental health stands out as an under-served area, as does the increasing threat posed by antimicrobial resistance where innovations and new drugs are not readily forthcoming.

Already noted above, existing health system infrastructure is an issue for the future in all countries as it reflects past needs and approaches. This covers both the traditional 'hard' physical infrastructure such as hospitals and facilities, and the 'soft' infrastructure such as mechanisms of administration, financing, monitoring, recording and providing health care, and the training and distribution of health professionals. Bringing these, and the associated professional and institutional mindset, into the future is not an easy proposition.

A final challenge requiring mention is the poor capacity for long-term policy-making and implementation. The combination of sustained financial pressure and the relatively short terms for health ministers (with health also often being an 'easy' budget cut), has led to a focus on short-term policies and structures. Additionally, as health systems and their challenges become more complex, the process of change within them has become more difficult and time-consuming. This risks creating a structural incapacity for strategic, long-term reform of health systems, and difficulties in meeting global aspirations and targets such as under the SDGs. These five areas in no way constitute an exhaustive list of all (current) challenges for the future – indeed one task of the Foresight Group is to identify others – but they are important ones for policy-makers to consider going forwards. In addition, in terms of more specific trends that national health policy-makers will face in future. **Box 1** identifies several main ones (from a growing list).

A WHO/Europe 'Health Systems Foresight Group'

The new Health Systems Foresight Group comprises an array of expertise from within and beyond the European Region (**see Box 2**). The Group's work will follow four central principles: action-focused; explore alternative futures; participatory; and multidisciplinary. It will work through three stages: diagnosis (understanding where we are), prognosis (exploring future and different scenarios), and potential prescription (recommending ways forward). The process is iterative rather than sequential and the group is not time-bound.

Other groups have also been looking at the longer term future for European health systems, including: the Calouste Gulbenkian Foundation – which supported a report on the future of the Portuguese health system;[11] the World Economic Forum – which has set up a 'System Initiative on Shaping the Future of Health and Healthcare', aiming to provide a unifying framework for health preservation and improved health care delivery;[12] and the European Health Forum Gastein itself – which has recently set up a 'Health Futures Project' to look at how the various factors that influence health might evolve over the next twenty years (see the article by Kjaer in this issue); and no doubt there are others. The Foresight Group will work with and alongside these initiatives as appropriate, but through the specific lens of WHO's value-oriented approach and its focus on UHC.

Box 2: Health Systems Foresight Group

Policy-makers, managers, private sector representatives, academics and researchers, technology experts and innovators are involved; all with a shared interest in working towards adapting health systems in Europe for the future.

The Group held its first meeting in Brussels on 7 July 2017, hosted by the Belgian National Institute for Health and Disability Insurance.* Organised into thematic working groups, the one-day meeting provided a first brainstorming on the challenges facing health systems in Europe, including the issues that they raise, and scenarios for the future.

An important scenario to emerge from the group's first meeting was that we cannot take solidarity in health care (far less in other spheres of life) for granted. That is, while we may take certain values as givens when it comes to society and the design of our health systems, future generations may be increasingly unwilling to do so.

* The authors, on behalf of the WHO Regional Office for Europe, gratefully acknowledge the Belgian government's generous hosting of the first meeting of the group.

The Tallinn Charter tenth anniversary meeting

In executing its mandate, the work of the Foresight Group coincides with the Regional Office's restatement of its commitment to strengthening health systems on the basis of shared values. To mark the tenth anniversary of the Tallinn Charter, a high level technical

meeting entitled "Health Systems for Prosperity and Solidarity: Leaving no one behind" will be held in Tallinn, Estonia (13–14 June 2018). The meeting will be supported by the European Observatory on Health Systems and Policies, which is marking its own twentieth anniversary. It will be oriented around three overarching themes: *Include* – improve coverage, access and financial protection for everyone; *Invest* – make the case for investing in health systems; and *Innovate* – harness innovations and systems to meet people's needs, all of which espouse a strong value base. These themes are also in line with the new WHO Director-General, Dr Tedros Ghebreyesus's view that while UHC is indeed a political choice, it is more fundamentally an ethical one.[13] The Foresight Group will report its initial findings at the Tallinn meeting in order to inform and sensitise policy-makers to the main issues at stake and what future scenarios exist.

The Group will continue its work beyond the Tallinn meeting. The future is not static, and neither can we be in our efforts to strengthen our health systems. It will be important to harness the insights of the group on an ongoing basis in order to help policy-makers plot appropriate health system directions.

There is always the risk that in future, health system policies in Europe may take a more individualist path, where the care received is increasingly based on ability to pay and where much of the progress in recent decades in narrowing inequities is diluted. In response, the Regional Office will continue to assist European health systems in maintaining their shared values relating to equity, universalism and solidarity. The Health Systems Foresight Group will have a crucial part to play in helping us plan in this direction.

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TAKING A 'PEOPLE-CENTRED' APPROACH TO IMPROVING **ACCESS TO HEALTH CARE** FOR UNDERSERVED COMMUNITIES IN EUROPE

By: Denis Onyango, Eberhard Schatz and Jeffrey V. Lazarus

Summary: Many marginalised communities in Europe are at a significantly higher risk of poor health than the general population and yet remain underserved by health systems. These groups experience severe inequities in access owing to a complex interplay of barriers. Health inequalities have been a policy topic of increasing concern at the European Union level. Achieving real breakthroughs will require continued policy responses that are rooted in constructive engagement with civil society and community representatives at the front line. Successful models of care could be identified and shared to inform service redesign and transition current systems towards people-centred, efficient, community-based care.

Keywords: *Inequalities, Vulnerable Groups, Marginalised Communities, Social Cohesion, Community-based Care*

> #EHFG2017 Forum 3: Nobody left behind

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Introduction: health care access is a human right

Although health systems vary significantly across Europe, the foundations on which they are constructed share common values and principles that include solidarity and equity in access to services. Indeed, such rights of access to preventive health care and to medical treatment (under conditions established by national laws and practices) are enshrined in the Charter of Fundamental Rights of the European Union (EU) and other international instruments.[1]

However, in practice a growing number of people in Europe are underserved by health systems and thus do not benefit from these core values. These groups include many of Europe's most marginalised and socially excluded people, such as the homeless, migrants, sex workers, prisoners, people who inject drugs (PWID), and lesbian, gay, bisexual, transgender/transsexual and intersexed (LGBTI) groups. These communities are at a significantly higher risk of poor health than the general population and have a substantially higher risk of contracting

infectious diseases such as HIV, hepatitis C virus (HCV) and tuberculosis. At the same time, they experience severe inequities in access to health care, reflected in limited uptake of screening, prevention, harm reduction, treatment, maternal care and associated support services, owing to a complex interplay of legal, political, economic, social and organisational barriers.[2,3] In short, many groups most in need of care are amongst the least likely to receive it.

> health services are not designed and organised to optimally reach and serve these groups

This article highlights some of the key health challenges among marginalised groups and discusses many of the barriers that result in inequities in care access, with a focus on common issues that span these diverse communities. We then outline approaches to help inform policy-making and service re-design to address these pressing challenges.

Key health issues in marginalised groups

Individuals within vulnerable or underserved groups are at an increased risk of multiple health threats, as compared with the general population. These include:

- **Men who have sex with men (MSM):** MSM are the only key population in the EU that has not seen a decline in new HIV infections during the last decade. Across the EU/European Economic Area (EEA), the annual rate of reported HIV diagnoses was 16% higher in 2015 than in 2005. Across Europe, sexual transmission between men is the most commonly reported mode of HIV transmission, accounting for 42% of newly reported cases.[4] This illustrates that a significant shortfall exists in uptake of prevention measures amongst MSM and suggests that a concerted effort to improve understanding and service accessibility could yield significant results.
- **Sex workers:** In 2012, HIV prevalence among sex workers exceeded 1% in 22 EU/EEA countries.[5] Countries reporting the highest HIV prevalence rates in sex workers were Latvia (22.2%), Ukraine (9.0%), Portugal (8.9%), Lithuania (6.7%) and Estonia (6.2%), indicating that prevention services and outreach are falling short in many countries, particularly where sex workers may not speak the national languages.
- **Homeless:** Mental illness is a particular problem associated with homelessness. It is estimated that around 25% of homeless people suffer from some form of severe mental illness, compared with only 5% of the general population. Mental illness is the third largest cause of homelessness for single adults.[6]
- **PWID:** Globally around two-thirds of PWID have chronic HCV infection, a leading cause of liver cirrhosis and liver cancer. Injecting drug use currently accounts for 80% of attributable HCV infections in the EU and yet uptake rates for harm reduction and treatment are low among PWID and warrant urgent action.[7] This situation and associated costs to the health system could be avoided with appropriate screening, prevention and care , including treatment.
- **Prisoners:** According to pooled analysis of EU countries with data, around 20% of prisoners have chronic HCV infection,[8] mainly due to injection drug use. In many EU Member States, prison settings lack preventive care, including harm reduction facilities, thus exacerbating the problem.
- **Migrants:** The majority of migrants are vulnerable and therefore at increased risk of numerous health problems, including infectious diseases and mental health disorders.[9] Other important problems include a lack of maternal care: it is estimated that almost half of pregnant migrant women in Europe have no access to antenatal care.[10]

Why don't these groups access health care?

There are many complicated personal and structural barriers to accessing health services, as viewed from the perspective of vulnerable or marginalised groups who are outside of 'mainstream' society. Although some barriers are unique to particular groups, many issues are common to all. These barriers do not occur in isolation and in combination may make a person even less likely to engage, re-engage or maintain engagement with health services.

For example, members of marginalised communities often lack awareness and understanding about health services and their entitlements. Many individuals may not engage with health services because they fear legal consequences such as prosecution (e.g. PWID and sex workers) or deportation (e.g. migrants). Complex administrative processes can present barriers: for example, the lack of a fixed address amongst homeless people or migrants can itself be a barrier to accessing services that require an administrative inscription to even proceed. Further, only a few EU countries officially provide universal access to health care for migrants and even these have administrative challenges (e.g. fixed address or tax status required or GPs being required to report undocumented migrants), which make access difficult in practice.[11]

Importantly, many barriers to access occur because health services are not designed and organised to optimally reach and service these groups. For example, services are less likely to be used if they are provided only in hospitals, if they require users to make appointments far in advance and attend multiple centres, or if point-of-care costs are prohibitive. For migrants, additional specific barriers include a lack of interpreter services or suitable cultural adaptation.

A major barrier commonly experienced by all of these marginalised groups is institutionalised discrimination and widespread stigma within the health care systems.[12] Negative experiences with health services can destroy users' confidence or trust and hence dissuade them from using them again. For instance, PWID are much more likely than the

general population to delay seeking health care until their condition becomes severe, owing to fears about persecution and judgement. This may lead to complications requiring emergency or secondary care, conferring significant health care costs and pressures that could be avoidable with earlier intervention. Even when services are accessed, PWID are often reluctant to disclose their drug use or its extent, which can compromise the quality of health care they receive by denying health care providers a full picture of the patient's health. Corresponding issues of persecution and stigma also commonly apply to migrants, sex workers, MSM and LGBTI communities.

Specific education and training is needed to improve the attitudes of health professionals towards patients with substance use disorders and those who engage in other high-risk activities if we are to improve such people's experience with the health system and desire to seek care.[13]

What barriers exist from the health care provider perspective?

Negative attitudes among health professionals towards marginalised groups (e.g. those with substance use disorders) can diminish empathy and engagement and compromise care standards.[13] Many health care providers lack up-to-date education and training to deal with the complex challenges faced by marginalised populations. This can be compounded by a lack of evidence-based guidance and support structure from hospital management or health authorities and/or the prioritisation to do so.

A lack of coordination between different health and social support services and the separation of departmental budgets and responsibilities (for example, health or justice budgets with respect to prison health) pose key barriers in some European countries.

Policy commitment at EU and international level

Health inequalities have been a policy topic of increasing concern at the EU policy level. Joint efforts by the Directorate General for Health and Food Safety (DG SANTE) and the Directorate-General for Employment, Social Affairs and Inclusion (DG EMPL) around the 2009 communication 'Solidarity in Health: Reducing Health Inequalities in the EU'[14] prompted change. However, a midterm review found real progress only in pockets across Member States. Generally, health care interventions targeting marginalised populations have been chronically underfunded and treated as short-term and isolated projects. The European Commission is starting to address this deficit with the launch of a Joint Action on Health Inequalities in the second half of 2017, and several pilot projects (**see Box 1**).

In addition, the Commission and World Health Organization (WHO) have jointly launched the Migration and Health Knowledge Management (MIHKMA) project, which will develop technical guidance and webinars aimed at building capacity of health professionals working with migrants.

Given the growing policy focus, an increase in resourcing and initiatives is expected to be directed to this area. In addition to the above, these may include specific funding allocations, development of tools, guidance and standards, and multi-country activities and platforms to strengthen the capacity of Member States to better meet the health needs of underserved people. It is also important that information and insights be used to inform change both 'upwards' towards EU institutions, but also 'downwards' towards regional level organisations and non-governmental organisations.

Further, high-level political attention and policy direction is needed to ensure that the appropriate legal frameworks are in place to support access and support for vulnerable groups, such as the recent call by the Special Rapporteur on adequate housing to treat housing not as a commodity but as a human right in order to achieve the goal of "ending homelessness by 2030".[15]

User engagement is crucial

Groups that are marginalised from mainstream society are often systematically excluded from participating in the process of policy-making and planning with respect to health care provision, even though these groups are at increased risk of poor health and have specific needs. Indeed, marginalised groups are often not even involved in the design of services intended to target these same groups, such as screening, harm reduction and treatment programmes. The resulting misalignment between service design and the needs of the target groups limits the uptake and effectiveness of services.

Constructive engagement with civil society organisations and representatives of underserved communities is essential therefore to inform policy-making to improve access and address broader goals such as equity, solidarity, and social cohesion. Organisations offering outreach services should be engaged as they have first-hand experience with many of these groups and can transfer what they see, hear and learn through their work. The knowledge gathered through outreach could then be utilised to understand the needs and advance the rights of people living in the margins of our society.

Redesigning care pathways to improve outreach

Underserved groups are often described as 'hard to reach', whereas, from the perspective of users, it is the services

Box 1: Pilot projects under the Joint Action on Health Inequalities

- **Health4LGBTI** aims to reduce health inequalities experienced by LGBTI people
- **VulnerABLE** will explore how best to improve the health of people living in vulnerable and isolated situations across Europe, including the long-term unemployed, victims of domestic violence, homeless people and prisoners
- **MyHealth** aims to improve health care access for vulnerable migrants and refugees, in particular women and unaccompanied minors who have recently arrived in Europe
- **MigHealth** is focused on producing a roadmap for effective community-based care models to improve physical and mental health services, support the inclusion and participation of migrants and refugees in European communities, and reduce health inequalities.

that are often hard to reach. Multiple points of entry into the health system are required and an outreach approach is therefore essential to take services to the users.[16] Clinics that deliver care by specially trained staff in community care centres or by using mobile units are more likely than hospital-based clinics to attract persons who would generally avoid seeking care until the urgency is high. Providing basic and preventive health care from such clinics may therefore reduce use of emergency and acute medical services, avoiding costs while improving outcomes. Moreover, such settings offer opportunities for the provision of screening and care beyond the initial reason for contact, and in implementing evidence-based guidelines. For example, many PWID regularly use and trust needle exchange and opioid substitution therapy clinics, creating a potential environment where other aspects of health care, support and health education can be provided. Sex workers may be encouraged to have a similar confidence in a community sexual health clinic.

Peer-to-peer support can be effective in some situations to motivate users to seek health care, to support their access, and to help them navigate the health system. Greater resources could be allocated to underpin these programmes and support training of local community advocates who are usually from similar backgrounds, culture and faith. The wider implementation of this function could be usefully evaluated and supported via an EU pilot project. In tandem, education initiatives are needed to address negative attitudes and improved sensitivity amongst health care professionals.

The process of pathway redesign for underserved communities should be informed by specific disease control strategies, such as the WHO Action Plan for the Health Sector Response to Viral Hepatitis.[17] More broadly, this process is also in alignment with the paradigm shift toward integrated, people-centred health care models that provide a continuum of health promotion, disease prevention, diagnosis, treatment, management and rehabilitation according to users' changing needs throughout life. This fundamental reorientation, together with the need for modernisation of delivery models, was supported by Ministers attending the Organisation for Economic Co-operation and Development (OECD) Health Ministerial meeting in January 2017.[18] In 2016, the WHO launched its European Framework for Action on Integrated Health Services Delivery.[19] This Framework calls for interwoven actions across four domains to:

- Populations and individuals: identifying people's health and multidimensional needs and to partner with specific populations and individuals;
- Service delivery processes: ensuring that these are responsive to needs identified;
- System enablers: aligning to other health and social system functions to support services delivery to perform optimally; and
- Change management: facilitating the strategic management of these transformations.

Health authorities are encouraged to select the policies and interventions that best fit their national or local needs and to customise them to match their priorities and resources.

Conclusion

Europe has fundamental obligations towards vulnerable, marginalised communities who are currently underserved by health services. In order to fulfil their commitment to contribute to the health and well-being of all, European health care systems should ensure that these groups are not left behind. Providing these communities with non-discriminatory access to good-quality health services not only improves their health outcomes, but will also benefit broader public health objectives and promote social cohesion. Preventive care and early intervention could also reduce overall expenditure and administrative burdens. Further, improving testing and treatment for blood-borne viruses will help achieve the WHO goals of 90–90–90 targets for HIV as well as HCV elimination by 2030.

Real breakthroughs will require continued strategic EU and national-level policy responses that are rooted in constructive engagement with civil society and community representatives working on the front line. Appropriate, sustainable funding is required, together with service redesign to tailor 'people-centred', community-based health services for these communities, based on an evidence-based, collaborative approach. Successful models of care should be identified and shared to inform service redesign. EU policy-makers, together with other important stakeholders, such as WHO and the OECD, can play an important role in supporting and coordinating these efforts.

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CO-CREATING HEALTH TO MEET LOCAL NEEDS: HOW TO MAKE SOLUTIONS WORK FOR REAL?

By: Hubertus JM Vrijhoef, Antonio Giulio De Belvis, Matias Ignacio de la Calle, Stella De Sabata, Dagmar Kownatka, Nick A Guldemond, Sabrina Montante, Dario Pelizzola, Claus Rehfeld and Markku Saraheimo

> **#EHFG2017** Workshop 7: Co-creating health to meet local needs

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Summary: An Integrated Care Pathway (ICP) is a plan of anticipated clinical practice for a group of patients with a particular diagnosis or a set of symptoms. Modern information technologies (IT) can support ICPs by enabling patient empowerment, more efficient management and communication, and monitoring of care by multidisciplinary teams. An analysis of best practices across Europe identifies commonalities and success factors to establish good practices for IT-supported ICPs in diabetes care. Building on this, the next step is to identify specific solutions addressing the challenges faced by health care providers in locally implementing IT-supported ICPs for patients with co-morbidities.

Keywords: *Integrated Care Pathway, Patient-Centred, Chronic Diseases, Communication Technology, Diabetes Mellitus*

A major public health issue

Diabetes mellitus represents one of the major health issues worldwide due to its growing prevalence among the adult population. According to World Health Organization (WHO) data, the global prevalence of diabetes has nearly doubled since 1980, rising from 4.7% to 8.5% in the adult population.[1] Diabetes is one of four priority non-communicable diseases (NCDs) targeted for action by world leaders in the Global Action Plan for the Prevention and Control of NCDs 2013–2020. Associated with co-morbidities including depression and cardiovascular diseases, diabetes requires a multi-disciplinary, coordinated, and sustainable intervention connecting all phases of the health care continuum.

Integrated health care is referred to in the literature as a strategy characterised by structured and continuous collaboration and communication among health care professionals for the development of a comprehensive treatment plan to address the biological, psychological, and social needs of the person.[2] Within this framework, integrated care solutions are also designed for early detection of people at risk of or living with chronic illnesses. Integrated care pathways

(ICPs) are personalised, structured multidisciplinary care plans outlining essential steps for the holistic care of patients with specific clinical and/or social problems.[3][4][5] ICPs hold the promise to enable continuous quality improvement, taking patients' needs as the starting point for redesigning and optimising their care to a person- centred approach.[6]

> technology was observed as a key enabler

Evaluating integrated care pathways

Due to the growing trend of adapting integrated care solutions locally, a multi-disciplinary expert group made up of leading experts in the fields of diabetes, integrated care and eHealth was constituted to identify integrated care practices for the optimal management of diabetes and other chronic conditions, and to determine the role of technology as an enabler of improved decision making within health care services.[7]

To evaluate ICPs, a methodological triangulation strategy, including comparative desk analysis of sixteen case studies, follow-up qualitative interviews with nine respondents, and a non-systematic review of 434 PubMed search results, was used to identify commonalities and gage the health economic evidence collected.

The research could not prove the effectiveness of the interventions due to the lack of health and economic data and revealed a high degree of heterogeneity, which is likely to be conducive to the absence of a standardised definition of ICPs. Nevertheless, the qualitative analysis suggested great adaptability in local implementation of integrated care solutions to local specificities and improved health monitoring processes of multidisciplinary approaches that are enhanced through technology. In this analysis, technology was observed as a key enabler for seamless data exchange between people living with diabetes or other chronic conditions and the multidisciplinary teams.[8] **Table 1** provides an overview of the main findings of the qualitative interviews that were conducted through semi-structured questionnaires with seven respondents (out of sixteen) who agreed to participate in the phone interview. Even though only three best practices had collected data in a systematic way through surveys, semi-structured interviews and workshops, almost all practices reported a perception of increased satisfaction of patients or health care professionals as well as an improved doctor-patient relationship.

Designing interventions from real-life patient journeys

Stemming from these results, the work of the expert group is now focused on the planning of person-centred approaches to integrated care that derive from real-life patient journeys. This is to understand how services can be tailored to patients and whether integrated customisable IT solutions can flexibly respond to individual patient needs in their daily lives and throughout the life-course. Based on observational data of people living with type-1 and type-2 diabetes, an unpublished Roche Diabetes Care study shows daily and life-long unmet needs that are mapped according to people's health behaviour. The data for people living with type-2 diabetes are now being validated by the expert group and will be used to test whether IT customisable solutions can flexibly respond to the identified needs and support seamless care, with the intent of developing a methodology on how to design integrated care interventions based on patient needs and through co-creation approaches.

Co-creation of health: changing local management strategies – the Gastein experiment

Given the importance that people attribute to their health as the main source of happiness,[9] the development of more responsive, person-centred and adaptable integrated care models built on people's behaviour and attitudes is an important building block for a better future for Europe. To test the viability and feasibility of co-creation approaches for the development of person-centred solutions, EHFG 2017 workshop #7 aims to identify specific solutions to address the challenges faced by a health care authority in locally implementing an IT-supported integrated care pathway.

Through a full immersion experience delivered with a theatrical twist, participants will become constituents of the Zealand Region and will be involved in a co-creation exercise where organisational, structural, and cultural factors will be debated to find the most suitable solutions to local challenges. The workshop aims to demonstrate that by tapping into the expertise and know-how of public, non-state and private stakeholders from a given health care environment and respecting local processes and culture, optimal and people-centred solutions can be delivered to better support people living with diabetes across the life course. The ultimate aim is to show that European expertise can address local challenges when adopting the appropriate design methodology.

> person-centred approaches derived from real-life patient journeys

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Table 1: Results of the in-depth qualitative interviews

	INDICATORS				
NAME OF BEST PRACTICE	**mHealth tools***	**eHealth tools****	**Patient increased satisfaction measured**	**HCP increased satisfaction measured**	**Patient-HCP communication improved**
SAM:BO Cooperation on care pathways in the Region of Southern Denmark (DK)	no	yes	yes	no	yes
Personal Health Record system and patient/ citizens empowerment – TreC – Cartella Clinica del Cittadino, Fondazione Bruno Kessler	yes	yes	yes	n/a	yes
Ferrara The Diabetes Integrated Management Pathway, AUSL Ferrara _ ASSRRERIT (IT)	no	yes	yes	yes	yes
eCare eCare Network in Bologna, ASSRRERIT – CUP2000 (IT)	no	yes	no	no	yes
Dutch management programme Dutch diabetes management programme – 'Bundled payments' (NL)	n/a	yes	yes	yes	yes
The Super Six model of diabetes care, Wolverhampton, Derby, Leicester, Leicestershire and Rutland, North West London, Portsmouth (UK)	yes	yes	yes	yes	yes
PALANTE Patient leading and managing their healthcare through EHealth, Regional Minister of Health and Social Welfare Andalusia (ES)	yes	yes	yes	yes	yes

Notes:

* mHealth is considered as technology enabling the transmission of health data from patients to healthcare professionals by use of mobile devices.

** eHealth referes to the use of any type of information and communication technologies (ICT) for health.

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PATHWAYS TO **BETTER AND AFFORDABLE MEDICINES**

By: Suzanne Edwards and Dimitra Panteli

Summary: The pharmaceutical sector has been recognised as a key driver for economic competitiveness in the European Union. Balancing industrial interests with health policy goals is becoming increasingly difficult as new, high-priced medicines – often with unproven and variable value – and imperfect alignment with public health priorities enter the market. In order to stimulate the creation and dissemination of true medical innovation that meets the needs of the European population, governments will have to consider solutions that go beyond those that have already been attempted to date. This article presents a number of existing and potential future options in context.

Keywords: *Pharmaceuticals, Health Needs, Innovation, Access, Sustainability*

The growing tension between Europe's innovation economy and health systems

The value of the pharmaceutical sector to the European economy was estimated at just above €200 billion in 2016.[1] Not only is the industry a major contributor to the EU's trading power, it also employed some 725,000 people in 2016 with one of the highest labour productivity rates of any sector. Its innovative nature and high R&D intensity (with an estimated investment of €35 billion in 2016),[1] is a key factor in driving economic competitiveness. In 2012, the European Commission identified the pharmaceutical sector as a 'strategic sector' and prioritised it for further competitive strengthening.[2] However, the sector also comprises one of the most sizable budget components for health systems. Among OECD countries, average pharmaceutical spending accounts for approximately 20% of total health expenditure.[3] The vast majority of EU Member states finance more than half of this spending through statutory sources (average 64%, with a range of 83% in Germany to 20% in Cyprus in 2014).[2] Moreover, due to the impact of the economic crisis, pharmaceutical cost containment was a frequent priority among EU countries' health system responses and is likely to remain so moving forward. In several countries, this has been combined with an increasing tendency to shift the cost burden towards private households.[3]

Like most markets, the supply side (manufacturers) and demand side (health systems) of the market are linked through medicine sales. In the case of innovative medicines development there is almost complete reliance on market exclusivity privileges (including patent-based monopoly) to strengthen the magnitude of sales-based rewards and provide an incentive for innovation. Implicitly and perhaps theoretically, this means governments allow developers to set the prices as high as they expect the system to bear. In the context of finite resources,

> **#EHFG2017** Access to Medicines Track (Forum 4, Forum 11, Lunch Workshop 1, Lunch Workshop 3)

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the tension between industrial and health policy objectives has always presented governments with challenges. However, in the last five years, this issue garnered increasing political attention, due in part to the market entry of breakthrough therapies with large target populations and steep price tags (such as the pharmaceuticals against Hepatitis C), and the proliferation of high-cost specialty medicines. In fact, spending on the latter accounts for 30 to 50% of total pharmaceutical spending in OECD countries and is projected to remain one of the central drivers of future spending growth.[4] In response to these pressures, the Netherlands Presidency of the European Council in 2016 starkly placed the imbalances in the system in the limelight and raised questions about the sustainability of the current system for Europe and Europeans.[5]

Market failures in the pharmaceutical sector

There are a number of ways in which pharmaceutical markets currently fall short in optimally serving patients. The main issues are considered briefly below.

Unmet clinical need

Medical needs are imperfectly represented by the market forces of supply and demand.[6][7][8] Because return on investment for new medicines is dependent on market revenues through sales, if these revenues are expected to be low or unpredictable, some clinical needs may be underserved or neglected by developers. This is often the case for small target populations (e.g. rare conditions or specific patient groups, such as children and pregnant women) or short courses of curative treatment (e.g. antibiotics). While this problem has long been acknowledged in the developing world (diseases with high or exclusive prevalence in countries with limited ability to pay), the disconnect between clinical need and innovative solutions is now also becoming a political issue in high income countries, especially following a resurgence in the threat from infectious diseases manifested in recent pandemics, the growing incidence and visibility of multi-drug resistance and the realisation that health systems do not currently have adequate tools to address these challenges.

Although governments have the opportunity at various points along the product life-cycle (from the issuance of patents to the decision on pricing and reimbursement) to communicate and signal to companies what are the most important and valuable medical products for their populations, product labels still fail to truly align closely with societies' greater unmet need.

> "the disconnect between clinical need and innovative solutions is becoming a political issue

An innovation challenge

A second problem lies with defining and assessing what constitutes true medical innovation. In spite of record numbers of market approvals for new medicines by stringent regulatory authorities, such as the European Medicines Agency (EMA) and the US Food and Drug Administration (FDA), there is an increasing body of evidence to support that only a few of these new products offer any (substantial) clinical advantage over existing therapies.[9] While it has been recognised that small and medium enterprises (SMEs) as well as academia are important sources of pharmaceutical innovation, most newly authorised medicinal products are marketed by large and intermediate-sized companies.[10] To overcome these issues, creative solutions are required, for example in removing the barriers to the dissemination of complete and unbiased research findings, particularly those resulting from public funding, and addressing the complexities of conducting clinical trials in the most vulnerable patient populations.

Limitations in access and availability

A third problem is related to reimbursement and pricing decisions and strategies that may hamper product availability and access to pharmaceuticals. Long post-marketing evaluations may contribute to an increased time to market, while the widespread use of external reference pricing may induce strategic launching.[11] Furthermore, two pricing practices have recently gained in prominence to the concern of public payers: the very high launch prices of certain new products and the increasing incidence of 'price gouging', or sudden steep price increases of older, frequently off-patent products.[12] The first particularly impacts medicines that have been either developed for niche patient populations or are based on new enabling technologies, such as biologics. While these medicines are concentrated within certain therapeutic areas (e.g. oncology), examples of price increases of older medicines are more broadly spread. These practices may generate additional pressures that need to be curbed by regulatory instruments in the context of constrained public budgets, for example by increasing patient cost-sharing. Cost-sharing for pharmaceuticals is widespread and is not always capped or linked to other financial protection measures.[11] Because high prices are generally concentrated in few therapeutic areas, health system spending is becoming skewed towards a relatively small proportion of patients, compounding existing challenges of health system equity.[13] Finally, unsatisfactory projected revenues, either due to small country populations or regulated prices, may lead to products being withdrawn from the market or even not being launched at all.

Availability and access can also be curtailed by medicine shortages. This is not a new phenomenon but its incidence seems to be increasing in recent years, raising questions about the long-term supply of essential medicines. Problems leading to such shortages lie both on the demand and on the supply side and include strict rules on tenders and shelf life requirements as well as increasing competition for raw materials, unreliable information from peripheral facilities and payment issues.

The potential of future policy responses

In light of the aforementioned characteristics of the pharmaceutical sector and the need to tailor responses to new or evolving challenges, a number of options are under discussion. However, it may be time for a more comprehensive review of the whole innovation cycle. Despite the apparent divergence in governments' industrial and public health policy objectives, innovative policy options could provide win-win solutions to simultaneously achieve and strengthen both.

Prioritising therapeutic needs

According to the UN high-level panel on access to medicines, efforts to improve the alignment of innovation with unmet clinical needs to date *"tend to be fragmented, disparate and insufficient to deal with priority health needs on a sustainable, long-term basis"*.[14] To address this, EU Member States could step up cooperation to better identify and prioritise current and future therapeutic needs based on burden of disease and assess the greatest anticipated benefit from genuine therapeutic advances. This greater coordination could help eliminate the use of overly broad incentives.

In the mid-term, national research funding could be aligned to these agreed priorities. The WHO, which has already taken steps to communicate and signal public health priorities more clearly to the private sector with initiatives such as the development of a priority pathogen list and the R&D Blueprint (a global strategy and preparedness plan for epidemics), could provide important support to such an initiative. Collaboration with the WHO's R&D Observatory could be institutionalised to ensure that knowledge is shared with other funders globally to improve efficiency, synergies and coordination of increasingly scarce financing.

Furthermore, EU Member States could reignite discussions[15][16] around the creation of a pooled financing mechanism for implementing new R&D models and providing incentives for therapeutic areas or populations that will never be well served by the current system. This could also be a source of support for a) clinical trial networks to facilitate the testing of new compounds in challenging but often high-need patient groups and b) greater assistance to SMEs in translating and commercialising their innovations.[17]

> national research funding could be aligned to agreed priorities

Strengthened goverance

While important steps have already been taken to address fragmentation and duplication in market authorisation procedures and speed up market approval based on a product's perceived priority, this should not lead to lowering patient safety standards or lessening evidentiary requirements with respect to the actual patient benefit of new products. These concerns were recently demonstrated in the debate over the EMA's adaptive pathways pilot.[18] Furthermore, expedited market access schemes should be accompanied by broader and more systematic post-market checks as well as clear and tested redress and delisting pathways if safety and innovation goals are not fulfilled. Post-launch data collection on the safety and effectiveness of new and established products could be further systematised and fostered. This would include reviewing and strengthening real-world evidence generation and introducing appropriate regulatory requirements towards expediting the timely and high-quality collection, harmonisation and incorporation of information into regulatory and health-system decision-making. This may involve broadening the mandate of regulators and expanding their post-market resources and powers.

Increasing access

Where products are slow to launch or not made available to countries, additional tools could be mobilised such as the implementation of national compassionate use programmes. Governments could also consider additional legal mechanisms to removing proprietary barriers to (publicly financed) knowledge generation and dissemination, such as public-health justified waivers to data and market exclusivity to facilitate the possibility of compulsory licenses by Member States.[19] EU Member states could further facilitate the improved reporting and oversight of anti-competitive/anti-trust practices that undermine optimal post-patent market functioning. In conjunction, scrutiny, application and coherence across anti-competitive/anti-trust tools in the EU could be strengthened.

Member States could enhance transparent, proactive collaboration in activities such as horizon scanning, post-marketing evaluations (Health Technology Assessment) and other stages of procurement to better anticipate budgetary impacts and strengthen bargaining power, especially for Member States with small markets. This would also facilitate a) the consideration of rewarding priority medicines with preferential rates or premium prices and b) the more appropriate and effective use of outcome-based managed entry agreements (conditional reimbursement schemes), which have already been established in many countries to mitigate the impacts of new, high-cost products. Finally, the EU could also consider the establishment of medicine shortage reporting systems as a first step to improve knowledge and enable appropriate responses to medicines supply issues.

Conclusion

New challenges facing pharmaceutical markets require solutions beyond those that have already been attempted to date. A number of options could be considered that would be beneficial on both the demand and supply side of the market. Existing initiatives along the product life-cycle could be critically reflected and built on if appropriate across policy sectors. In general, considering the whole system as a single 'innovation entity' would ensure a more cohesive policy response. From a European perspective, an overall streamlining, defragmentation and

re-orientation of the policy and regulatory landscape towards a more transparent needs and innovation-centric system for ensuring sustainable and timely access to one of the largest patient pools in the world should remain the overarching goal.

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COMMENTARY

SENDING THE RIGHT SIGNALS: TACKLING MARKET AND POLICY FAILURES IN THE PHARMACEUTICAL SECTOR

By: Vinzent Rest, Federal Ministry of Health & Women's Affairs, Austria

During its upcoming EU Presidency in 2018, Austria intends to put policy failures within the pharmaceutical sector into focus, in an effort to secure sustainable access to medicine for European patients and to enhance innovation. Here are some of the policy factors behind the decision.

Pricing models and ethical conduct

Lacks of access, shortages, and delayed market entry of innovative products have long been considered problems of the developing world. In pre-crisis Western Europe, few feared that the supply of medicines could be a concern to health policy. The current price setting model for pharmaceuticals does not take the ethical conduct of manufacturers into much consideration. When the first product to cure Hepatitis C (HCV) entered the market in 2014, the initial price for a therapy cycle in Austria came close to €50 000 per patient. This has served as a wake-up call to many policy-makers and also – to some extent – the public in Europe ever since.

The high price charged by the producer seemed out of proportion with the expenses actually encountered during the development phase. Policy-makers were shocked to find how few tools they had at their disposal to counter these dynamics within national legislations. They found themselves confronted with globally acting organisations. For the first time, the public at large was confronted with the inability of their respective health care systems to provide all patients with promising drugs without jeopardising the overall financial viability of the entire system.

The need for co-operation and scrutiny

The HCV case also shows that European governments need to act in close cooperation with one another and to put utmost scrutiny on assessing both the clinical and economic evidence of medicines, asking the right questions of producers in the pre-approval stage and using the right parameters to assess the economic impact. Several Council Presidencies have declared the topic a key issue in health care. The council conclusions of the Dutch Presidency stand out as the most notable example so far. Passed in June 2016, they called for immediate action to adapt some of the adversarial dynamics within the pharmaceutical sector. This includes regulations on the approval of orphan drugs as well as the current intellectual property protection regime through patents. Patents appear to secure rewards for innovators by granting market exclusivity; however, evidence suggests that they might negatively impact on follow-up innovation.

Enhancing availability and research

While high-income Member States draw their particular attention on the issue of high prices for medicines, many members in Southern and Central Europe are encountering sheer non-availability. This is particularly the case for products with small patient populations. The fact that some markets are considered less attractive for marketing activities also affects the research situation for certain medical areas. This has led to the emergence of medical gaps, with antimicrobial resistance (AMR) being the most notable example. Unfortunately, the public sector finds itself in a position with little say in determining research foci. Considering its contribution of up to 30% of research funds allocated to pharmaceutical research, this is somewhat surprising. Research should be needs-based and address the most pressing challenges within the health care sector.

Addressing policy failures

All of the dynamics described derive from policy failures. Policy failures are rooted in a lack of coordination and alignment of government agencies and/or in laws that foster adversarial behaviour in certain market participants. There is often little to no communication between actors along the pharmaceutical cycle, from clinical trials through approval to reimbursement decisions. This goes for both public agencies and producers. In terms of the legal aspects of policy failures, the biggest issue appears to be the confidentiality clauses that apply for both real prices and clinical data, causing information asymmetry between manufacturers and buyers.

ALL.CAN — CALLING FOR **GREATER EFFICIENCY IN CANCER CARE** THROUGH NOVEL PARTNERSHIPS

By: Suzanne Wait, Kathy Oliver, Vivek Muthu, Wendy Yared, Tit Albreht and Deepak Khanna
on behalf of the All.Can initiative*

Summary: Improving efficiency to attain financial sustainability is a dominant topic in health care, particularly cancer. All.Can defines improving efficiency as achieving optimal outcomes for patients with the resources at hand; patients must be at the core of all decisions. This requires a whole-system vision. Cross-sector collaboration is key; multi-stakeholder initiatives will be increasingly important as the complexity of the cancer landscape evolves. Reliable data are essential, while technological advances offer enormous potential but need appropriate systemic infrastructure. Efficiency must not be viewed as an end in itself – what is crucial is how it improves outcomes for cancer patients in Europe.

Keywords: *Cancer, Policy, Efficiency, Patient outcomes, Data*

> **#EHFG2017** Forum 2: Making cancer care more efficient

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Note: *All.Can is an international, multi-sectoral initiative that was created to explore what could be done to improve the efficiency of cancer care, where waste and inefficiencies occur in cancer care, and where policy efforts should be focused to yield the most meaningful benefits for patients. All.Can comprises leading representatives from patient organisations, policy-makers, health care professionals, research and industry. It is made possible with financial support from Bristol-Myers Squibb (lead sponsor), Amgen and MSD (co-sponsors). For a full list of All.Can members, see: www.all-can.org

Introduction

Improving the efficiency of health care as a way of ensuring its financial sustainability is now, more than ever, a dominant topic among stakeholders – and cancer has been a particular area of focus for these discussions.[1] Calling for greater efficiency is simple. Implementation, particularly at scale, is another matter. In their inaugural policy report, All.Can members called for politicians to focus on four key areas to improve the efficiency of cancer care (**see Figure 1** – overleaf).

A focus on what matters most to patients

The patient perspective must be central to the planning, delivery and evaluation of cancer care – this is a fundamental premise of All.Can's work. Efforts to improve efficiency should be defined by what matters most to patients (patient-relevant outcomes), and should be measured against achievement of these outcomes. All.Can members fervently believe that improving efficiency is defined as achieving the best outcomes possible for patients with the resources at hand.

The Martini Klinik Centre of Excellence in Prostate Cancer in Hamburg, Germany, is an often-cited example of where an outcomes-based approach to care has been applied successfully. The clinic asked prostate cancer patients to define the most meaningful outcomes for prostate cancer surgery, and now systematically collects these outcomes for every surgery

performed in the clinic. Data are then fed back to the care team, so that they can continually assess and improve their own performance. Since putting this effort into practice, the clinic has achieved far lower rates of incontinence and erectile dysfunction compared with the national average.[3] [4]

Data: underpinning all efforts to improve efficiency

As evidenced in the above example, reliable data are a key ingredient to drive efficiency. Also key is finding meaningful data that can accurately reflect the impact of interventions and care models across the cancer care continuum – looking at the entire patient experience, and not limiting assessment to a single episode or isolated aspects of care. Unfortunately, this is often challenging given the known limitations of health care information systems[5] – fragmentation of data between areas of care and hospital departments, poor linkages between data sets, lack of uniform data collection practices, data governance issues, etc.[2] Yet these data are essential to continuously evaluate health care delivery, instil a culture of efficiency and patient-centricity, and create accountability for change across the system. This whole-system vision for improving efficiency across cancer care is illustrated in **Figure 2** – overleaf).

> multi-stakeholder initiatives are providing unique insights into the future of cancer care

Data is transforming cancer care

The potential for data solutions to improve outcomes for cancer patients is ever-evolving. We now have the computing power and systems to allow us to simultaneously collect and analyse massive amounts of data to help inform multiple aspects of cancer research and care.[6] Complex computer systems allow us to rapidly sift through many thousands of patient records to screen for patients eligible for enrolment in clinical trials, cutting down recruitment time significantly. Web-based applications can provide patients with active follow-up, precluding the need for overly frequent test or clinic visits, and contributing to better quality of life and reassurance for patients after the active phase of treatment.[7] Cutting-edge data equipment, including wearables and mobile health devices, allows us to gather large volumes of real-life data from multiple settings of care to help understand how effective interventions are in practice.[8] [9] [10] Advances in artificial intelligence have allowed the development of sophisticated expert systems, which health care professionals can use to guide their treatment decisions. Moreover, machine-learning techniques allow these systems to constantly adapt to new data and knowledge as it comes in.

Disruptive innovations – improving patient outcomes in the long run?

The above solutions may be considered as disruptive innovations, in that they will invariably require changes in the way cancer care is delivered. There is a need for new ways of working among different health professionals, as well as other stakeholders including patients, to achieve their full potential in improving patient outcomes.

The field of personalised medicine offers an important illustration of this. Personalised medicine means that the treatment depends on stratifying patients and – based on the result – of selecting a treatment appropriate for each subgroup of patients. In such a context, health literacy becomes critical, as patients need to fully understand, process and act on genetic information being made available to them. Health literacy at an institutional level is also needed: open dialogue and clear communication between physicians and their patients becomes that much more important to ensure that treatment decisions reflect each patient's personal preferences and objectives pluralise roles. At a system level, the necessary organisational and testing infrastructure must be in place to make sure the most up-to-date testing practices are being used, and used appropriately.

The need for multi-stakeholder, cross-sector collaborations – now more than ever

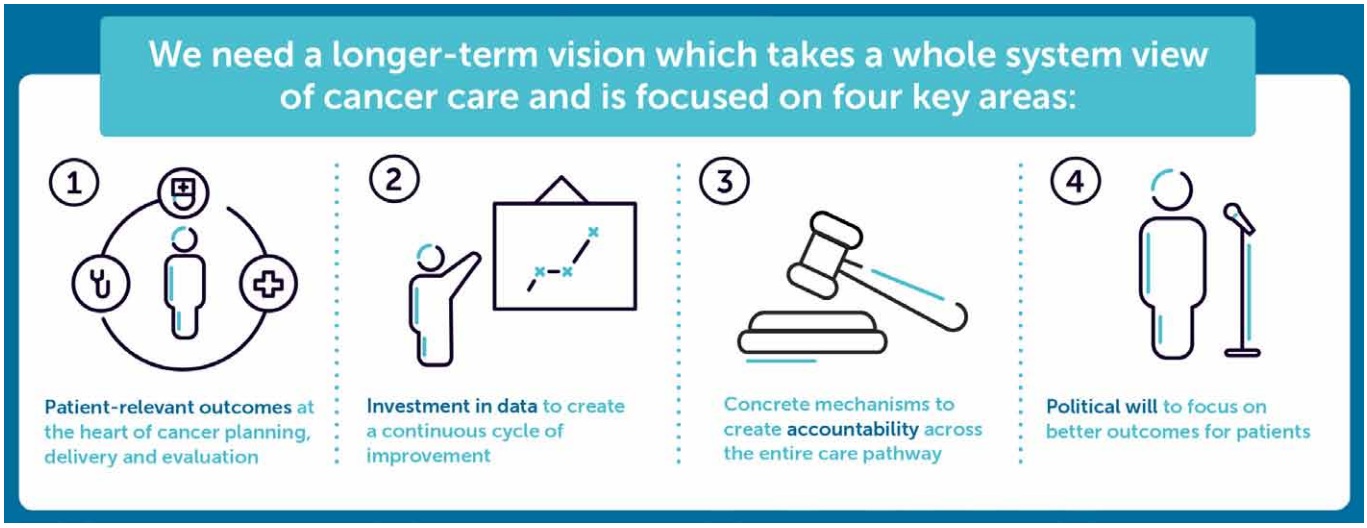
To help decision-makers keep up to date with the complex, ever-evolving and continuously expanding universe of cancer care, close collaborations between all sectors involved are key. There are several promising examples of multi-stakeholder initiatives that are providing unique insights into the future of cancer care.

For example, the EU Joint Actions in cancer – including the European Partnership for Action Against Cancer (EPAAC) and the upcoming Innovative Partnership on Action Against Cancer (iPAAC) – have and will continue to gather experts from across Europe to address challenges in cancer care and, importantly, ensure these proposals are integrated into national cancer plans.

The Joint Action on Cancer Control (CanCon) provided several important recommendations where patient role and preferences were central to the issues in question. They include: improving issues in quality-based Comprehensive Control Networks, the need to develop guidelines for after-care that are meaningful and beneficial to patients, and the need to set up a survivorship care plan for all cancer patients.[11] CanCon gathered experts from across Europe to address challenges in cancer care, and, importantly, ensure these proposals are integrated into national cancer plans. These efforts will be implemented and further developed by the future Joint Action.

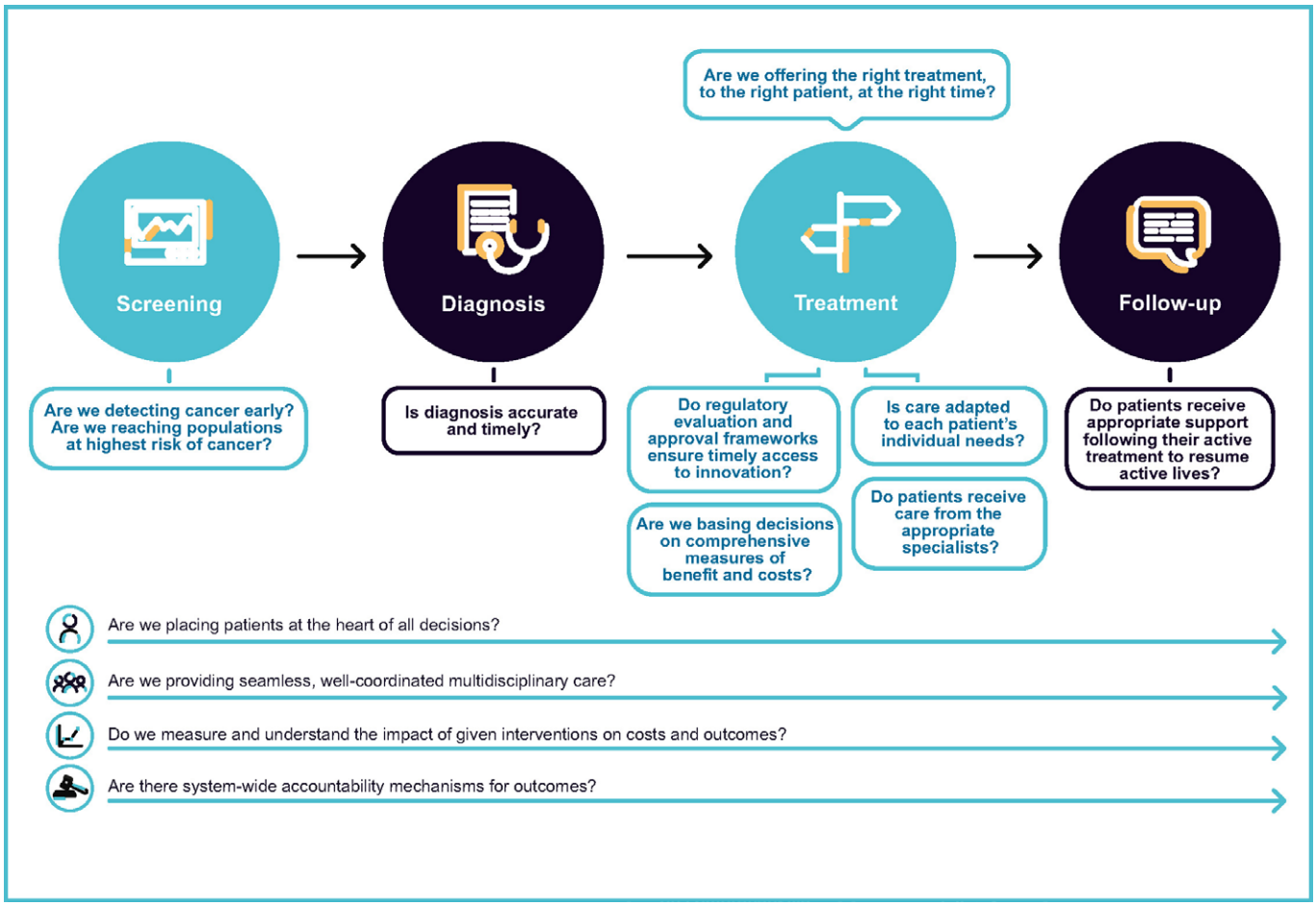
Other public–private endeavours, such as the Innovative Medicines Initiative (IMI), are doing important work in looking at complex issues from a multi-sectoral perspective – including that of the European Commission, which co-funds the IMI's work.

Figure 1: Four key areas of focus to improve efficiency in cancer care (All.Can call to action)



Source: [2]

Figure 2: A framework for improving the efficiency of cancer care



Source: [2]

Another example of multi-sectoral collaboration is EURACAN, the European Reference Network (ERN) which provides for a system of networks of health care providers, laboratories and centres of expertise, which are organised across borders to improve outcomes for patients with rare cancers. Patients and patient advocates working closely and at every level with all stakeholders in the rare cancer journey are at the heart of this new and promising pan-European initiative.

The MEPs Against Cancer (MAC) informal group at the European Parliament regularly organises roundtable dialogues between policy-makers and a wide range of stakeholders, including the European Commission, NGOs, academia and industry.

> the end goal is never efficiency itself, but to also improve the quality outcomes of care

Such collaborations are going to become increasingly necessary as the complexity of the cancer landscape evolves further because of technological and process innovation. Involving different facets of cancer care (prevention, diagnostics, surgery, radiotherapy, medicines, palliative care, etc.), as well as newer sectors such as digital health, information technology and secure data capture, will be critical if we are to create cohesive policies addressing the entire spectrum of cancer care.

Creating political will to focus on efficiency across all cancer care planning and management

It is also very important to consider the role that policy-makers can play in collaboratively encouraging a culture of efficiency in cancer care. While policy-makers may not be directly involved in cancer care, political will is essential to initiate and guide change in any policy field. Giving more prominence to the patient voice in all aspects of cancer planning and delivery is an important starting point. Governments may also play a key role in contributing to more outcomes-driven cancer care by investing in appropriate support roles to help ensure patients' clinical, psychological, emotional and social needs are met throughout all phases of treatment and after-care. Belgium, for example, has specific funding for oncology nurses, onco-psychologists, social workers and data managers to encourage a multidisciplinary care approach in all cancer centres. The financing of this extra manpower is integrated into the Belgian national cancer plan.[12] Policy-makers may also help create accountable health care systems by investing in appropriate data and evaluation systems. For example, a resolution was recently accepted by the European Parliament to include measures of health system efficiency in the European Semester, essentially holding national governments to account for how well they use resources within health care. This resolution is currently being considered by the European Commission.

Improving the efficiency of cancer care must be a priority and prerogative for all stakeholders

All stakeholders in the cancer journey should forge new collaborations, engage in open dialogue, and make bold and creative decisions to allow true changes and innovation to occur. And at the core of these efforts, we must not forget that the end goal is never efficiency itself, but to improve the quality and outcomes of care for cancer patients. This must always be done, first and foremost, by listening to the patients' perspectives and understanding what is of value to them in terms of outcomes.

The forthcoming Gastein forum will offer a unique opportunity to discuss what role different stakeholders play and to encourage new, productive collaborations to form and flourish, thereby advancing a more patient-focused approach to cancer care, and helping to implement sustainable solutions to improving the efficiency of cancer care overall. Discussions during the All.Can forum session will be incorporated into All.Can's work to help develop focused recommendations and tangible ways to implement these within different policy contexts across Europe.

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NEW PUBLICATIONS

Implementation of the right to health care under the UN Convention on the Rights of the Child

By: W Palm, C Hernandez-Quevedo, K Klasa, E van Ginneken

Status report for the European Union, 2017

Number of pages: 64

Freely available for download: http://www.euro.who.int/__data/assets/pdf_file/0009/343908/UNCRC_final.pdf?ua=1

Article 24 of the UN Convention on the rights of the child (UNCRC), which was adopted in 1989, establishes a fundamental right for every child to access services and facilities for the treatment of illness and rehabilitation of health. This study assesses the legal right to health care for children living in any one of the 28 EU Member States, all of which have ratified the UNCRC.

Irrespective of the actual implementation of this right to health care and the extent of coverage, the report highlights that even in terms of eligibility to health services certain groups of children are left with insufficient coverage or without coverage at all. Children living in a country with no regular residence status are clearly the most vulnerable group. Access is often conditional and restricted to emergency care. But even other children may in some cases fall between the legal cracks. Only a few Member States have introduced a legal disposition that guarantees all children living in their territory a right to health care, regardless of their legal status.

Contents: *Key messages; Induction and Objectives; The convention and the universal right to health care; methodology; summary of results; country overviews.*

Assessing the economic costs of unhealthy diets and low physical activity: an evidence review and proposed framework

By: CJ Candari, J Cylus and E Nolte

Copenhagen: World Health Organization, 2017 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Number of pages: 91

Freely available for download: http://www.euro.who.int/__data/assets/pdf_file/0004/342166/Unhealthy-Diets-ePDF-v1.pdf?ua=1

Unhealthy diets and low physical activity contribute to many chronic diseases and disability; they are responsible for some two in five deaths worldwide and for about 30% of the global disease burden. Yet surprisingly little is known about the economic costs that these risk factors cause, both for health care and society more widely.

This study pulls together the evidence about the economic burden that can be linked to unhealthy diets and low physical activity and explores:

- How definitions vary and why this matters
- The complexity of estimating the economic burden, and
- How we can arrive at a better way to estimate the costs of an unhealthy diet and low physical activity, using diabetes as an example.

The study's findings are a step towards a better understanding of the economic burden that can be associated with two key risk factors for ill health and they will help policy-makers in setting priorities and to more effectively promote healthy diets and physical activity.

Contents: *Chapter 1 Introduction; Chapter 2 The economic costs of unhealthy diets and low physical activity; Chapter 3 Estimating the economic costs of unhealthy diets and low physical activity is complex; Chapter 4 Taking available approaches to determining the economic costs of unhealthy diets and low physical activity further; Chapter 5 Discussion and conclusions.*

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