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SMART (DIS)INVESTMENT CHOICES IN HEALTHCARE

REPORT

friends of europe

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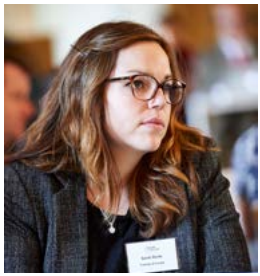


In 2014, Friends of Europe convened a health working group to explore recommendations on what the EU should stop, start and do differently for the 2014-2019 European mandate to improve the health status of Europeans. One of the recommendations that emerged from this group was to stop doing things that are inefficient or ineffective. This report on health (dis)investment responds directly to this recommendation.

With this in mind, Friends of Europe launched a reflection process on health (dis)investment in Europe. A diverse group of stakeholders have been convened for roundtables to discuss the complementary issues of smarter investment for better health and disinvestment in health interventions that are ineffective, inefficient and outdated. This exercise takes place at a crucial moment. 2019 will see the election of a new European Parliament and the arrival of a new college of Commissioners. The purpose of this publication is to help think through as well as inform the policy choices and recommendations of the new European mandate. The reflection process and contributions herein have enabled us to pull together a set of specific and measurable actions, taking a multistakeholder approach and always keeping citizens at the heart of the action proposed. This is a part of our #Europematters initiative, aiming at bringing together business leaders, policymakers, civil society representatives and citizens to co-design a Europe that still matters in 2030, to think ahead and plan for the future we want.

The world has committed to universal health coverage through SDG 3, and Europe has much to share as a testbed for new ideas on how to achieve this. The EU could play a key role as a convenor of conversations about citizens' expectations of healthcare; as a catalyst

for change through platforms for data exchange, modelling and evidence generation; and as a funding resource to prototype, evaluate and scale up health interventions. The objectives for healthcare reform are clear – what is more challenging is identifying the steps needed to satisfy them. Given that competence for health policy remains in the national context, the EU can offer a much-needed long-time perspective and an extended horizon for reflecting on how to achieve the transformations needed for health systems to fit the 21st century.

There is an overwhelming rationale to provide more care for lower cost. At the same time there is an urgent need to revolutionise healthcare systems that were largely designed and built in the 1950s. A key challenge is financing. The economic crisis triggered deep cuts in healthcare spending across most EU countries and although healthcare budgets have started to rise again, they were well below the levels seen in the pre-crisis years.

There is significant opportunity to spend better and reduce waste and inefficiency by re-orienting resources away from low-value intervention into things that work and deliver better health outcomes. Beyond the debate about how much to spend on health, we argue for a more strategic approach to investment and disinvestment, exploring how both existing and new money could make a positive difference for health outcomes. These discussions are more topical than ever at EU level as the European Commission seeks to allow scarce health resources to be streamlined. It also wants to ensure that economies of scale are generated through a shared approach to Health Technology Assessment (HTA) and the new initiative of the Health System Performance Assessment (HSPA).

Not all existing money in health is well spent. A vast majority of healthcare models around Europe are still too expensive, inefficient and not designed around the expectations and needs of today's patients. Access to new diagnostics, drugs and medical devices is unequally distributed within countries, let alone across Europe. Moreover, public healthcare systems are increasingly unable or unwilling to pay high prices for expensive innovations.

Many of the required improvements in health systems will involve at least some upfront investment but also clear disinvestment strategies that can help re-distribute allocated budgets in a smarter, effective and innovative way. Digitalisation of healthcare systems, for instance, is rapidly driving policy choices towards innovation, big data and disruptive models of healthcare, such as e-health and community-led healthcare systems. These new models are also decreasing the importance of hospital-centric care, paper-based administration and the use of outdated technologies and medical practices. A systematic approach to spending should both earmark funds for innovation and release resources from practices that are no longer medically useful and that don't deliver better health results. Including an effective health (dis)investment strategy in national and European policies can help generate a good return on investment and improve health outcomes.

Given that good health is the business of everyone, healthcare, by its very definition, needs to be inclusive and connected to other sectors of society and the economy. Transforming the landscape of health means opening up opportunities for players from other sectors who can contribute much-needed expertise, human resources and

capital. By putting innovation at the centre of healthcare reforms, policymakers need to create space for different business models to co-exist, from start-up social enterprises to large public-private partnerships, and everything in between.

According to a 2017 Eurobarometer survey, 70% of Europeans want the EU to do more for health. In all countries, the share of GDP used for health spending is projected to increase in the coming years, mainly due to population ageing and the diffusion of new diagnostic and therapeutic technologies. These changing demographics, combined with fluctuating budgetary constraints, require profound adaptations to the health systems of EU countries in order to promote more healthy ageing and respond in a more integrated and patient-centred way to growing and changing healthcare needs. Economic growth can only be built by healthy and resilient populations. Friends of Europe's recent survey conducted by Dalia in September 2018, reveiled that 64% of citizens aren't convinced that life would be worse without the EU. A strong European Union can only survive if its citizens feel that the issues dearest to their hearts, such as health and access to healthcare, are addressed as priorities.

Sarah Bentz
Programme Manager
at Friends of Europe

INTRODUCTION

CAN EUROPEANS AFFORD TO LIVE LONGER AND LIVE WELL?

Europe is going grey. By 2030, we will be the oldest continent in the world. This is an extraordinary achievement, a legacy of the social model and welfare system which offers support from cradle to grave. On average, we have added two years to life expectancy every decade.

As Europeans have enjoyed better life opportunities, they have had smaller families. In many countries, the number of births has dropped below the numbers needed to maintain the population. Over time, the demographic shape of Europe is changing dramatically. The fastest growing part of our community is the over 80-year-olds. Silver-haired pensioners (above 65) will soon outnumber their younger cohorts. This change will have enormous impact on all aspects of life, from housing and living arrangements to the labour market and even political parties.

The cherished welfare system in Europe means that the ageing population will weigh heavily on public finances. In 2015, healthcare costs accounted for 10.1% of GDP in the EU and up to 80% of this came from government spending. Across the EU, there are big differences in what is spent on health and by whom. There is a strong link between income (national and individual) and health spending. In many new member states, private spending on health is significant and growing. These countries spend less than the EU average on healthcare but as their economies expand, there is also an upward convergence trend.

By 2070, the numbers of people in work and paying taxes compared to retired people (old age dependency ratio) will have dropped from 1 in 3 to 1 in 2. Fewer people contributing and more people drawing down pensions leads to an unsolvable equation which isn't just a question of balancing payments into the system and withdrawals for services. Other factors driving health costs higher include expectations for more widespread and improved care as well as access to the latest treatments and technologies. It remains to be seen whether rising demand for healthcare will be matched with a greater willingness to pay more either as private citizens or through tax contributions.

A conservative estimate of the impact of demographic change is that it will require an additional 1.1% of GDP to be spent on health. The key question is whether getting older means more ill health and disability. OECD countries already spend 2.4% of their GDP on incapacity-related benefits, and globally the International Labour Organization estimates that 4% of GDP is lost as a result of occupational diseases and accidents. In 2013, more than 1.2 million people in the EU died from preventable illnesses and injuries. Some causes of ill health (cardiovascular and chronic respiratory disease) have become less disabling but the burden of other conditions such as musculoskeletal diseases and dementia has grown. Medical advances mean that previously fatal conditions have now become chronic diseases; for rare diseases, there are some treatments where none existed. As we age, people have to cope with multiple chronic conditions which in turn require a more intensive use of healthcare systems.

However, there is good news. If we can stay healthy into old age, the cost of increased longevity on healthcare budgets drops to 0.2%, a reduction of 80%. Of course, modelling long-term trends is not an exact science but the potential gains to individuals and the economy of healthy ageing sets the imperative of our first recommendation, empowering people with information to live well.

The health sector is the most labour-intensive element of the economy. As the population ages, so too does the health workforce just as the demand for health and long-term care increases. Of course, the digital revolution can ease some of this pressure. Bringing in automation can streamline the process of organising care. For example, in a recent pilot at three UK-based hospitals, virtual assistants operated with artificial intelligence were eight times more productive to manage routine referrals and test results than medical secretaries. While the health sector is the most data-rich sector, it uses data the least. Big data and ICT tools will be catalysts for the necessary transformation of health systems away from institutions towards tailored, integrated patient-centred care.

Tamsin Rose
Senior fellow at Friends of Europe

PART 1: SMART INVESTMENTS FOR BETTER OUTCOMES IN HEALTH

Time to loosen the belt and open the wallet

Working group meeting highlights

In summer 2018, many EU economies finally reached the employment figures and GDP levels of those in October 2008, before the financial crisis hit. During several lean years, investments in updating health infrastructure and upgrading technology were postponed, and salaries for staff were frozen. Health systems struggled with a growing demand for care while having fewer resources to deliver.

As economic growth is finally returning to Europe, we now have the opportunity to reinvest in health systems and address new concerns, such as the continent's ageing population. Instead of just plugging existing spending gaps, governments could make smart choices about how and where to inject increased funds to transform creaking health systems.

Health has always been a significant part of government spending and more money is always needed. The demographic shift – Europe will be the world's oldest continent by 2030 – means that long-term care for older people will eat up another 1 to 1.5% of GDP in the coming decades.

This will require careful analysis of the financial incentives within healthcare systems, putting a stop to outdated or ineffective practices and embracing digitisation. Now is the time to reflect on how to best use funds that may become available.

How to get all money for health working together

There is huge public interest in health. In a recent Eurobarometer survey on perceptions of fairness in Europe, 98% of people chose good health as the key for getting ahead in life. When a representative group of citizens was asked by the European Commission to design ten questions on the future of Europe, improving access to quality healthcare was one of the topics that emerged.

Consumers already spend enormous amounts of money on products and services that promise to make them feel better, from acupuncture to vitamin supplements. There is a thriving marketplace for devices and apps that help people to monitor different aspects of their physical and mental well-being. Financial analysis predicts strong growth in the health and wellness sector, and investors are interested in getting their share of this business.

But European health services are closed ecosystems. Governments are rightly cautious about the use of public funds. When it comes to health, it is difficult to define and calculate return on investment. Not all 'innovations' are innovatory and deserve to be funded. Some attention is needed to re-balance risk and reward incentives for patients and other health system users.

Potential innovators face huge barriers in accessing funding for their ideas as well as in mainstreaming them. Many frustrated entrepreneurs with good ideas leave Europe for the ‘greener pastures’ of the thriving US start-up culture and venture capital scene.

Investors are keen to invest in the 'wellness' sector, which is less tightly regulated, largely self-financed by consumers and aimed at preventing or managing health-related issues. As a result, health systems are missing out on the extraordinary potential that this wave of technology could generate for better health. Ownership of individual and aggregate data is unclear, as are the potential insights that might come from analysing these huge data clusters. This is a strategic loss for Europe because it is the foundation for future breakthroughs in the medical field, for personalised medicine in particular.

The starting point of the working group was that there are potential investors – public, private or philanthropic – for health. The key question was how to make sure that the extra funds available go towards making a difference in health outcomes. With 2030 in sight, the group came up with some radical ideas on health for the European Union to take up.

Thinking out of the box

Radically reform the definition of 'health professional'. We need a much wider range of people with more diverse backgrounds to enter healthcare systems. In the foreseeable future, most of the people working in the health sector will no longer be medical staff. The day-to-day work of doctors and other clinical staff is changing radically but the type of qualifications needed to enter medical school are not keeping up with this trend.

Help people prepare for a longer life. Just as expecting parents receive training on what lies in the horizon, all citizens should receive mandatory training on how to age well, how to stay healthier and how to be more active in each life stage. For example, advice on how to maintain strength, balance and flexibility could help people live independently in their own homes as long as possible, which will save money on long-term care, ultimately benefitting health.

Create special economic zones for health innovation. Cluster together researchers, clinicians, patients and funders to create unexpected synergies. Develop an innovation-friendly eco-system that includes angel investors and mentors, access to lab and manufacturing facilities as well as support for prototyping and clinical trials.

Establish a common medical benefits package for all Europeans. This would tackle two big challenges simultaneously: the fragmentation of health systems and the big geographic inequalities when it comes to accessing care. A common benefits package would generate cost savings through economies of scale and also by simplifying the bureaucracy.

Put in place all of government 'Profit and Loss Account'. This would be necessary to reinforce the critical links between economy, environment, society and health. Thinking in silos at government level often means that economic growth is prioritised over health issues caused by, for example, car emissions and chemical exposure.

What does this mean for the next EU mandate?

The renewed focus on the social aspects of Europe (Social Pillar of Rights, fairness and inequality) is a key opportunity to make the case for what the EU actually delivers for its citizens. For now, EU action on healthcare has been limited by the unwillingness of member states to share power in this key area. In the future, a bolder approach needs to be able to fully harness the power of the EU for health.

Guiding private biopharmaceutical investment towards societal needs

Adam Parnaby, Senior Director for Market Access Policy at Celgene

In 2018, the biopharmaceutical industry will invest $172bn in finding new medical treatments to treat diseases and improve human health. In 2017, there were over 7000 medicines in development worldwide, of which 563 were for cardiovascular diseases, 1261 for infectious diseases, and 1919 for cancer. Although some policy makers are concerned that persisting, unmet clinical needs represent a misalignment of research and development investments (Panteli and Edwards 2018), the Institute for Health Metrics and Evaluation's (IHME) Global Burden of Disease estimates that cardiovascular, common infectious diseases and cancer are the top three causes of global disability and mortality, as measured by lost Disability Adjusted Life Years.

Biopharmaceutical industry investments have demonstrated a proven pathway to address society's healthcare needs through dramatic declines in death rates for diseases such as HIV/AIDS, cancer, polio, and measles. Despite the great progress achieved to date, society's need for innovative medicines remains higher than ever. Ageing demographics and the increasing prevalence of chronic diseases will continue to challenge healthcare systems to meet the needs of their populations. Europeans live on average 18.4 years with disability or illness, with over €900bn spent on sickness and disability transfers every year (EU Commission 2010).

As daunting as this challenge may seem, it is not a fatality. Biopharmaceutical innovation is part of the solution by keeping people healthy and productive for a longer time, away from expensive hospital care, thus supporting our economies and limiting the costs for our healthcare systems. The private biopharmaceutical sector has delivered innovations across the spectrum of health needs and is continuing to invest in developing effective solutions to tackle the most pressing health challenges.

To sustain R&D investment and ensure it is channelled towards public health priorities, the right framework of conditions and signals from policy makers, regulators and payers is required. Of critical importance is a robust and predictable intellectual property protection regime. Biopharmaceutical investments are highly risky with few medicines making it through to regulatory review. A predictable IP regime is

key to incentivising companies to take the risk of investing the significant financial resources required to develop medicines.

The Orphan Medicines Regulation (2000), in conjunction with the recommendation for member states (EU Council 2009) to develop action plans in the field of rare diseases are a strong example of this mechanism working. The 3.3-fold increase in orphan drug private R&D investment (Charles River Associates 2017) and surge in the number of orphan medicines authorised from eight in 2000 to 153 in July 2018 addressed the high unmet need for rare disease treatments. Intellectual property and market incentives maintain an environment for companies to sustain investment and tackle society's unmet needs.

Policy initiatives can also act as signals. The fight against cancer was prioritised on the public health agenda when US President Nixon launched "The War on Cancer" followed by the National Cancer Act in 1971. With the burden of cancer continuing to rise across the globe, it remains one of the top priorities and significant public funding is dedicated to it. This also catalysed private investment in oncology drugs and immunomodulators, which more than doubled between 2009 and 2016 (CMR International 2017).

Health Technology Assessments (HTA) also provide powerful signals for company investments in clinical development programmes. HTA typically values new medicines that deliver improvements in patient-relevant outcomes (such as the quality of life, the safety profile) over existing therapies. This stimulates companies to invest in therapies that deliver the most significant health improvements versus existing treatments. HTA bodies and payers may also place more value on health benefits for certain diseases, they may account for the direct and indirect consequences of health interventions or even the size of patient populations. As medicine development becomes more rapid and technologies become more complex, HTA systems will need to adapt and utilise methods that capture the impact of innovative technologies like cell and gene therapies to ensure systems continue to reward innovation.

Despite the success in advancing human health and the continued growth in pharmaceutical investment to beyond $200bn in the coming years, there are still significant challenges that society needs to address. There is still work to be done in providing the right incentives to invest more in diseases which disproportionately impact developing countries. However, policy makers are beginning to recognise the need for additional mechanisms for steering and incentivising R&D into diseases which have not attracted enough investment. As private companies respond to signals, policy makers have a crucial responsibility in ensuring that those signals are the right ones. The incentives policy makers provide through their policies need to be well calibrated and aligned with their definition of valuable innovation and their expectations in terms of therapies that meet true societal needs.

Patients should be the drivers of the discussion

Bettina Ryll, Founder of the Melanoma Patient Network Europe and Chair of the Patient Advocates Working Group of the European Society for Medical Oncology (ESMO)

For money to be better invested into getting better health outcomes, we first need to stop taking the current system as a given. The repair mechanism that currently exists in European health systems, with a focus on patching up problems, is no longer efficient. Healthcare systems across Europe need to start from the outcomes they want to achieve and engineer backwards from there. The issue is, of course, that countries are worried about costs which then leads to too much cost-control and rationing.

Patients are the ones who can put the pressure on their governments, as they are the ones ultimately paying the price of the decisions taken. Yet current discussions on how to better leverage the power of patients are not taking place at right levels. These discussions need to take place across all communities – and patients are just one factor in the mix. The reality is that patients are tax payers and tax payers are also patients: once this realisation becomes clear, it is easy to see that there is a huge overlap between different stakeholder groups, with miscommunication between them.

For instance, while closing down a hospital always leads to some backlash, it can sometimes be necessary if the institution is no longer cost-effective or fails to deliver promised care. However, the reasons behind such decisions are rarely properly communicated to all the different stakeholder groups, leading to opposition and misunderstandings. This regularly happens when decisions taken at political level contradict the overarching aim of the game.

It is unrealistic to lead patients into believing that they can have the best care – and the same care – anywhere in their country. Not every doctor can be aware of every rare disease that exists, and not every hospital has the same expertise available. We need to spend more time thinking about leveraging new innovations, such as artificial intelligence and electronic health records, to see how we can, despite the complexity of it, provide more care that is more personalised and closer to home. For this, investing in efficient communication and better adapted infrastructure is critical. Europe now has the perfect opportunity to

think on how to reshape its future and the future of its citizens. This opportunity should be seized.

While Europe is good at initiating innovation, it isn't as strong when it comes to developing it. Incentivising affordable – and not just expensive – innovation could help unlock the situation.

Whatever the case, patients should be the drivers of this discussion. Yet the challenge remains: how can patients acquire a better "bigger picture" understanding of the healthcare system?

Acknowledging the interconnectedness of health will bring benefits

Barbara Prainsack, Professor at the University of Vienna Department of Global Health and Social Medicine; Professor at the King's College London; and author of "Personalised medicines opened patients into the 21st century"

We have to stop thinking of healthcare as existing in a vacuum.

In reforming healthcare and redirecting investment, we have to make sure healthcare is properly integrated with other fields of practice and policy, including welfare, environmental policy, education, and, above all, housing.

In many countries there is a clear inverse relationship between investments into social care and healthcare. If everyone in Europe had access to stable and affordable housing, for example, there would be less need for spending in healthcare. This may sound trivial, but systematic approaches to better integrate social and health policy and planning are sorely lacking.

Another key area where we need a major re-think is in measuring healthcare outcomes.

All too often we are failing to measure what really matters. Things that make a difference to the way people feel, that impact on patients' lives and wellbeing, are often not currently measured.

If we want to invest in achieving the desired healthcare outcomes, we need first to work with patients and clinicians to establish new metrics that measure value as experienced by patients. They are the most important stakeholders here.

Traditional approaches to determine value in healthcare through measuring cost effectiveness aren't working. We have to work more with patients, both individually and collectively. This also means that we need to change our financial incentives to reward healthcare professionals who talk to patients. Human contact – both to establish what individual patients really want and need, and also because human contact is often 'healing' in itself – needs to receive a more prominent place in our healthcare systems. Patients have to be treated as individuals, not a category.

Another way of bringing value as experienced by patients to the foreground is by creating and using validated tools to measure these, such as patient-reported outcome and experience measures (PROMs, PREMs). This allows us to capture that physicians often cannot pick up intimate things that patients may be reluctant to discuss, such as functional changes that only patients know.

More focus has to be placed on reducing waste, cutting interventions that have low or no value for patients. A number of movements all over the world are addressing this, such as Choosing Wisely, an educational programme that aims to enhance doctor–patient relationships and develop patient-centred care that avoids over-use of medical resources. Even things that are cost effective in the traditional sense may still have no or little value for a particular patient because it does not fit with what they want for life. That's why it's important to develop individual solutions.

The goal has to be empowering all healthcare players – patients and professionals – so they can stop doing things that don't work.

Genomics and other new health innovations won't go far without the patients' trust

Lili Milani, Research Professor, the Estonian Genome Center, University of Tartu

As costs for genetic sequencing plummet and the true potential of genomics becomes more and more obvious, it's without a doubt that they must and will play a pivotal role in the evolution of health care systems in Europe and the world.

There's no need to look farther than the skyrocketing demand for at-home genome analysis kits to see that the technology is being widely embraced by the public. People support genomics, and we now have enough evidence to start using it to improve our healthcare systems.

One of the primary reasons this area of medicine is so crucial to the future is the enormous role it can play in supporting systems that are based on preventative care. Early detection and targeted tests of genetic predisposition are critical in tackling a slew of health issues, from cancer to cardiovascular disease and other common chronic diseases.

Not only does preventative care lead to a healthier society – early detection is critical at increasing survival rates for many illnesses – it's also much more cost-effective for hospitals to invest in prevention over treatment.

At the moment, most hospitals are paid for the procedures they conduct, meaning that they are paid to deal with the consequences of disease. However, recent pilot studies in the United States have shown that when given the option to manage their own budget, hospitals would rather put money into primary care clinics and disease prevention.

However, world countries need to ensure that the benefits of gene tech aren't just available for the wealthy. Estonia has dealt with this remarkably well with its Personalised Medicine Initiative, which allows all of its citizens to join the biobank and have access to this service, as a part of its healthcare system.

The value of health data, and specifically genomics data, is being increasingly recognised. This means that there are

good opportunities for bringing in external funding from the links of venture capitalists, pharmaceutical companies and even insurance companies. These are all huge players in the field, with big pockets that are willing to pay large amounts for access to data that can be used to find causes of diseases and poor treatment results. Investing in machine learning and the development of prediction models that can be incorporated into health management systems or used for drug development would thus be of interest to many funders.

Whatever the innovation, the success of any future healthcare system cannot be achieved without securing the trust of the patient. Fundamental to this strategy is the need for improved ways of consulting and communicating with patients, in addition to ensuring their data is used in accordance with the expectations and consent of the participants.

Demographic challenge? Innovation in healthcare is Europe's ageing solution

Jean-Luc Lemercier, Corporate Vice-President of Europe, Middle East, Africa, Canada & Latin America, Edwards Lifesciences

Economic growth and progress are built many factors including good health, which, in itself, is the foundation of sustainable development.

Today, European healthcare systems are at a tipping point, driven by the increasing burden of providing world-class care for ageing populations. This comes at a time when the long-term effects of austerity measures are putting pressure on healthcare spending; and medical technology innovation expenditure in particular.

From our perspective, more attention should be paid to the related areas of healthcare, the dynamics of ageing and the positive role that technology can play in addressing both.

The potential of disruptive technologies to improve the sustainability of healthcare systems for the benefit of patients is not fully realized in Europe. This is despite the fact that innovations could transform medical practices, result into faster procedures and reduce the length of hospital stays. As a consequence, more

patients can reap the benefits. Moreover, there is a strong case to argue that innovation could potentially even reduce long-term costs, both within the healthcare system and in social care.

It is often said that health innovations largely come from the United States, but, in our experience, the initial brilliant thinking often originates in Europe. The US mindset better understands that the development of innovations is a continuous process that requires time, investment and collaboration between industry, physicians and healthcare systems. This process often leads – in both the US and Europe – to an incremental development of innovative technologies which result in significant improvements in patient outcomes. Europe can gain significantly in terms of health by acknowledging and encouraging this continuous innovation.

Europe does not lack the necessary ingenuity, but rather the system does not allow this ingenuity to thrive, and for this reason we need to rethink our attitude to healthcare innovation. Europe's health technology assessment and reimbursement systems should be reformed to encourage and reward disruptive innovation over the whole lifecycle, from the initial breakthrough to the achievement of a fully developed therapy. With this approach, we would be set for a triple win: we ensure the best possible healthcare provision for patients while reducing inequalities in access to healthcare across Europe; we create room for economic growth and we give much needed encouragement to the European medical technology industry.

Healthcare innovation is an important contributor that enables active and healthy ageing, as it allows us to effectively treat reversible conditions that can lead to functional decline. Minimally invasive medical technology has, for instance, transformed the management of structural heart diseases such as heart valve disease. As a result, senior citizens can return to an independent, good quality of life more rapidly, thus reducing the burden on the healthcare systems.

Too often people see Europe's ageing demographic from a purely negative viewpoint, which I believe is a mistake. By changing our mindset we can appreciate the positive contribution of the older generations to families, communities and economies and build a social contract based on intergenerational solidarity. Europe's senior citizens play an essential role in caring for their grandchildren so that their own children can go back to work. Others amongst them are key players in keeping families united, while many continue to work or volunteer, allowing communities to function properly.

In reality, the ageing demographic does not have to be seen as our biggest challenge – instead it should be seen as the source for our most effective solutions.

PART 2: HOW TO SPEND IT? SMART DISINVESTMENT CHOICES IN HEALTH

Facing up to unwelcome truths

Working group meeting highlights

Europe is rightly proud of the universal access to healthcare that characterises the continent, and this has contributed greatly to the overall increase in life expectancy across the European Union. However, not all healthcare interventions are equally good; some have limited or no benefits while others can even be harmful. Medical technologies, medicines and medical tests are routinely abused either by overuse or underuse.

The OECD estimates that about 20% of healthcare is wasteful and that 10% of people are hospitalised due to the medical care they have previously received. Of particular concern is that up to 50% of antibiotic prescriptions are unnecessary. Across a range of high-volume and high-cost health interventions, such as heart bypass or knee replacement operations, there are big variations in patient outcomes within countries as well as across the EU. The status of one's health is therefore largely a result of one's geographical location as well as social standing.

The working group discussed ways of disinvesting in interventions that don't deliver health benefits. The aim of a disinvestment strategy would be to identify – and then eliminate – low-value interventions. These include interventions that are inefficient (those for which better alternatives exist), ineffective (produce no health benefits and may cause harm) and inappropriate.

Making different choices in healthcare

Could better approaches to purchasing and procurement deliver smarter investments? At least it would be a way to overcome the current fragmentation of healthcare systems. Some countries have already begun joint procurement initiatives for vaccines and pharmaceuticals. However, as decisions are never made in a vacuum but within a specific political or economic context, powerful lobbies of vested interests, public opinion and the media

headlines, for example, are all important factors that constrain decision-making. Politicians often lack a detailed understanding of health systems and the stamina to get to grips with closed health ecosystems.

Policy makers have a number of tools at their disposal as leavers for disinvestment,In terms of governance, such as policymakers have a number of tools at their disposal from clinical guidelines and audits to minimum benefit packages and priority sorting. They can also make use of delisting and negative listing, Health Technology Assessment (HTA) and Health System Performance Assessment (HSPA). These are all levers for disinvestment.

Yet, Europe's healthcare environment is complex, involving multiple layers of authorities with different decision-making powers. In most EU member states, the healthcare sector and/or public health is devolved to regional or local government. Responsibility for financing, organising and delivering healthcare is often split between different branches of government at different levels. This creates additional challenges when looking at governance approaches to health disinvestments.

Knowing what is wrong and how to fix it

Good information is key. Policymakers and clinical managers need to be better informed of the bottlenecks in the system, and they also need robust evidence on what doesn't work and why. A lot of hope is placed on the potential of big data to generate valuable insights on the health outcomes of treatment protocols as well as on the cost efficiency of interventions and processes. But big data requires resolving key issues related to ownership, quality assurance and security of data before it can be adequately addressed. In most countries, patients have to choose to opt-in for sharing their data and so far, the public is not convinced of the benefits or the integrity of these systems designed to process their data of often sensitive nature.

Thinking in silos is harmful in healthcare, whether it happens between health professionals or people working on healthcare budgets and management. While people might be able to identify the problem areas in their respective fields and sectors, there are limited occasions on which to act on this knowledge.

Understanding the challenges ahead

Health disinvestment is a key element of investment strategies and not a synonym for budget cuts. It is designed to improve efficiency and improve health outcomes instead of saving money.

Disinvestment will disturb working practices and business models. It is disruptive and therefore provokes opposition. Stakeholders within the system know what doesn't work so making them part of the process can help motivate those in opposition to reconsider their positions.

Disinvestment can help redistribute powers within healthcare to patients and individual healthcare practitioners. This is possible because practitioners will have the power to signal where disinvestment is needed (e.g. duplicate tests, outdated treatments).

What could Europe do?

The EU, specifically the European Commission, has a key role to play. As a neutral player in national healthcare debates, it could effectively crowdsource ideas across member states, with these ideas then contributing to national decision-making on health. Building on the foundations of the 'State of Health in the EU' initiative, the next EU mandate could take a lead in developing an active approach to disinvestment. This would require the European Commission to take on a number of roles:

Convener of frank conversations on health disinvestment, bringing healthcare players out of their silos and broadening the range of inputs from other sectors

Clearing house for information and a platform for mutual learning, drawing on national and regional experiences of health disinvestment policies (e.g. Scotland, Spain, Netherlands, Austria)

Generator of new tools and strategies through EU funding programmes and services such as Horizon 2020, the Joint Research Centre, EFSI and Structural Funds

Catalyst through a wide range of financial tools (projects, grants, credits)

Facilitator of change (test projects, peer visits, award schemes), measuring impact and benchmarking policies

The kindest cuts: disinvestment will ensure health funding gets where it's needed

Patrick Jeurissen, Director and Professor at the Celsus Academy on Fiscally Sustainable Healthcare at the Radboud University, the Netherlands

Finance ministers may not agree but cutting healthcare budgets is easy.

They can just lop off a generic percentage point here or there as a mere accounting procedure and it's done. What's harder – and what healthcare systems really need in the long term – is targeted disinvestment.

To do that, policy makers need to be much better informed, so they can shift investment away from low-value infrastructure or procedures – then re-invest efficiently.

For the long term, we need a completely different healthcare delivery landscape, with investment in things like e-health and personalised care. That requires a substantial transformation agenda for both disinvestment and investment.

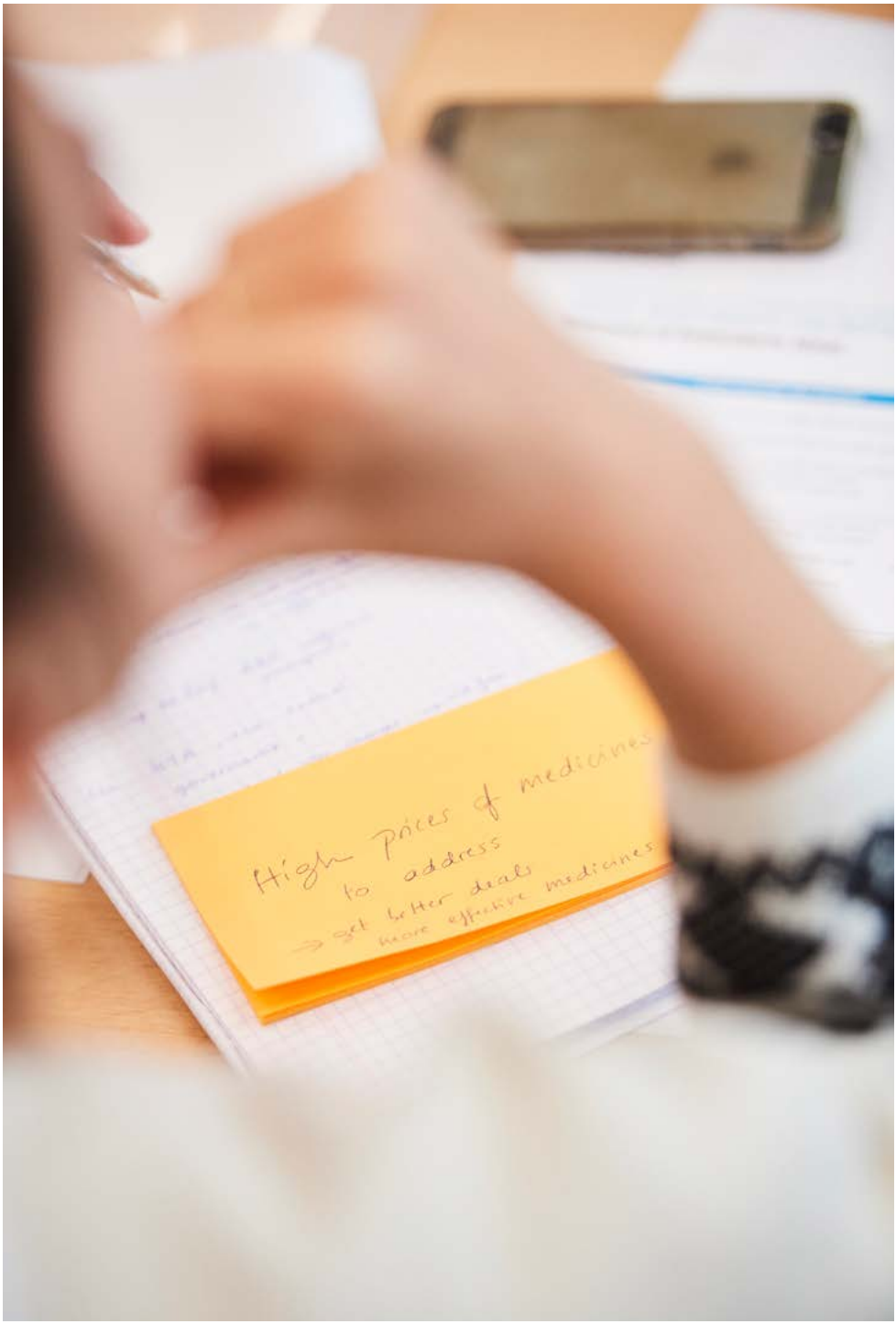
Disinvestment decisions are tough – it's never easy to shut down hospitals or halt funding for time-honoured treatment. Still, policy makers and the public have to be made aware that solutions of the past are not necessary the solutions of the future.

Of course, this cannot be done overnight but we cannot simply say: "we are paying 10% of gross domestic product on healthcare now, we'll pay 20% in 10 years' time and everything will be okay". It will not be okay. We need to create efficient healthcare delivery systems to safeguard future sustainability.

At a time of fast-changing medical advances, what we spend money on matters much more than how much money we spend. Just look at the United States, where they spend nearly 10% more on healthcare than in Western Europe but actually buy less health.

Public willingness across Europe to pay for healthcare out of state budgets is substantial and robust. People are ready to see their tax euros support national health systems. However, to maintain that public confidence in our healthcare systems we need to ensure that the public money is spent on the right things. These things matter. In the end, public legitimacy depends on how well this money is spent and this will become more relevant as patients are increasingly demanding greater participation and greater transparency with their healthcare.

The European Union can play a role here. The EU could help health systems with an investment policy using structural funds to make systems more efficient and sustainable for the future. To build resilience, we need to invest more in developing a flexible workforce with a varied skill mix as well as investments in capital. The right decisions now can create the resilience our healthcare systems will need 20 years from now.


High prices of medicines
to address
→ get better deals
more effective medicines

Waste and inefficiency in healthcare need to be tackled across OECD countries

Francesca Colombo, Head of the OECD Health Division; Chris James is an economist in the OECD Health Division

Across OECD countries, spending on health accounts for a significant share of the economy, averaging 8.8% of GDP in 2015 (OECD 2017a). Ensuring that health spending is both high-performing and financially sustainable is necessary in light of pressure on government and household budgets. Rising incomes and advances in medical technologies increase expectations of what health systems can achieve. Ageing populations and changes in lifestyles affect patterns of morbidity. Productivity gains, while achievable, are made more challenging by the labour-intensive nature of health care services. These factors create strong upward pressures on health spending. The latest OECD estimates project health spending to reach 11.3% of GDP by 2030 if costs are not adequately contained (OECD forthcoming).

There is nothing wrong with health spending accounting for a large share of economies, if this is what people value. But three out of four euros spent on health are funded from governments, and health spending accounts for 15% of total government spending across the OECD. There is little room for additional reallocations of budgets to health spending, and there is a strong imperative for health systems to maximise value for money.

Yet too much health spending is at best inefficient, and at worst, wasteful. One in ten patients in OECD countries is unnecessarily harmed at the point of care, and over 10% of hospital expenditure goes to correcting such harm. A sizeable share of emergency hospital admissions is for care that could have been addressed outside of hospitals. One in three babies in OECD countries is delivered by caesarean section, whereas medical indications suggest that C-sections should be 15% at most. Up to 50% of antimicrobial prescriptions are unnecessary, with up to 90% of antibiotics inappropriately used in general practice.

The potential for generic medicines remains underexploited in many countries, too, with market penetration less than one-quarter of

the market in Luxembourg, Italy, and Greece. A number of administrative processes add no value, with loss to fraud and error amounting to more than 6% of health expenditure. Taken together, up to a fifth of health spending is wasteful (OECD 2017b).

But effort must go beyond dis-investment in wasteful health spending. Policymakers must also refocus attention on where to invest more.

To start with, across the OECD, only 3% of health spending is spent on health promotion and disease prevention. This needs to change, as investing in disease prevention is not only cost-effective, but it also generates wider economic returns. Risk factors such as smoking, harmful alcohol consumption, poor diet and sedentary lifestyles pose significant direct costs to health systems. They also damage labour market outcomes. For example, obesity negatively influences employment, particularly for women, and obese people earn up to 18% less than non-obese people for equivalent positions. Labour productivity is impaired, too. Addressing these risk factors through effective health promotion policies saves money and improves lives (OECD 2017c; OECD 2015).

Second, health systems must shift their focus from acute, episodic and hospital care to better continuity of care and anticipation of illness. Primary health care must raise its standards and play a central role. Investing in out-of-hours primary care services and community care centres and improving care coordination improves efficiency by addressing health needs before complications arise and by reducing overuse of hospitals.

Third, health systems must become more agile. For a start, there is a need to invest in the right jobs and skills. Today, health labour markets are rigid, with entry into employment restricted through controlled access to training and tasks restricted according to particular employment types. Many nurses are not fully using the skills they have; many physicians report not having the training or transversal skills to perform the tasks they are given. New approaches that extend the scope of practice for non-physicians can produce cost savings with no adverse effects on quality of care, as shown for example in Canada, the Netherlands and the United States.

Health system must also become more knowledge-based. Big data offers huge opportunities for research, clinical optimisation and system management. Yet data collected across different parts of the health systems sit in silos. Encouraging better linkages and use of health data, while also promoting privacy protection and data security, is both possible and necessary. Starting to measure not just what providers do but also what matters to people is critical. This helps pinpoint services that make no difference to service users as well as those that are most valued, ultimately making health services more people-centred.

Health spending will continue to rise

Source: OECD Health Statistics (2018), OECD De La Maisonneuve & Oliveira Martins (2013)

2%

Average per capita health spending in Europe (2018)

Average growth rate in the 5 years since the crisis has been

-50%

the pre-crisis levels

Greece, Portugal and Italy had per capita health spending levels

lower in 2016 than in 2010

This will happen in a context when several "mega-trends" are emerging in our economies

The old-age dependency ratio

will double

in the next 35 years

Inequalities are

growing

Worldwide annual supply of industrial robots

will double

by 2030

There is a need to refocus attention of investing in the right things

Source: various OECD reports

Only 2.8%

of OECD health budgets are spent on health promotion and disease prevention in 2015

50% of doctors, 40% of nurses

report that they do not have the training and skills to perform their given tasks

70 to 80% of doctors

reported being over-skilled nor using their skills to full capacityprevention in 2015

We spend poorly in health – there is still significant waste in health systems

Source: OECD (2017) Tackling Wasteful Spending on Health

1€ out of 5€
spent on health is ineffective or wasteful

1 in 10 patients
in the OECD are unnecessarily harmed at the point of care

13 to 17%
hospital expenditure goes to correcting preventable medical mistakes or infections in hospitals

1/3 babies
are delivered by caesarean section

medical indications suggest that rates should be

max 15%

50%
of antimicrobial prescriptions are unnecessary

3%
of health spending represent costs of administering health systems

Belgium, Canada, France, Italy and Portugal
report at least one in five emergency department visits as inappropriate

Over 6%
of health expenditure is lost to fraud and error

Over 1/3
of citizens consider the health sector to be corrupt or extremely corrupt

The hospital care environment has never stopped evolving

Willy Heuschen, Secretary-General, European Association of Hospital Managers (EAHM); and President, Belgian Association of Hospitals

To achieve better health outcomes across the healthcare system, hospital managers have a complex and crucially important role to play. Not only do they have to manage outcomes in terms of financial results, they also pay careful attention to the improvement of patients' health as well as the general health situation within the hospital.

The shift to a 21st century landscape of health and the changes linked to it have a direct influence on hospitals – some less impactful than others. Examples of important developments include cut-offs in hospitals budgets to deal with financial crises and changes in health economics; an ageing population with higher expectations from patients, also leading to hospital staff shortages and medical workforce burnouts; and new technologies and procedures which boost incentives for healthcare reform in Europe. They all have a direct impact on what future hospitals are going to look like. When defining and redefining priorities for hospital strategies, integrating these factors into the equation, specifically with regard to patients and patient power, will be a matter of urgency.

Patients need to learn how to better adapt to the evolving health landscape and accept that the role of hospitals is changing. Previously viewed as the principle "care provider", patients now need to consider hospitals as "healthcare partners". Through their willingness to share their care processes, patients now have to take responsibility when it comes to their healthcare, starting with the right information and actions when it comes to illness prevention. Mindset and behavioural change will be integral to this process.

To help ease this process, the European Association of Hospital Managers (EAHM) has launched and adopted a new working model, also known as the IMPO approach, based on Inputs, Management, Process and Outcomes. Outcomes are the overriding objective and should be patient-centred. IMPO is working to guide the activities as well the scientific programme of the association. Through this process, hospital managers will first define the procedures by defining key spaces of activities. They then prioritise the outcomes and the objectives as well as fix the processes to implement this procedure. This allows for outcomes to be measured and changed if necessary.

CASE STUDY

THE FINNISH EXAMPLE

With a current spending rate of €20bn for social and healthcare activities, the Finnish health budget is projected to rise to €29bn by 2029. The new goal is to spend a maximum of €26bn, which means a disinvestment worth €3bn. To achieve this ambitious goal, Finland has had to take a critical look at its healthcare system as a whole, deciding to launch a new 'Reform of Health and Social Services' which includes these following four points:

Restructuring health and social care services. Finland currently has 200 municipal organisations which are responsible for the administration of health services. This number will be reduced to 18 counties and/or regions. The future goal is for each Finnish county to become responsible for ensuring that patients receive the health and social services they need.

Thorough integration of services. Finland currently integrates its social and healthcare services at political level as well as at legislative level. This negates the need for costly services, both within the social and health sectors. This will also help patients to navigate between these two services with more ease, as they are physically located in the same place. Within this existing structure, a new sort of integration – known as 'vertical integration' – will be implemented. This requires breaking down the separation between primary and specialised healthcare services. As primary healthcare services will be allowed to provide a certain number of specialised healthcare services, it will be easier and faster for patients to receive the treatment they need.

Information-led system. Online services give access to comprehensive information and various services, such as online doctor consultations. At all levels of social health services, the personal details of patients need to be systematically collected and allowed to flow effortlessly through the entire system. This data can also be used to help direct the priorities of the new 18 counties and regions that are to be created, with their financing being subject to results and targets which are set and subsequently analysed by the Finnish government. Some examples of using good quality data for patients already exist in Finland, which work by evaluating the standard of the services and care provided. A significant element of financing service providers will be linked to the quality provided by such services.

Stronger emphasis on prevention and the promotion of good habits. 200 Finnish municipalities will remain responsible for the preventative elements in health and social care. They have to integrate youth work, employment efforts, environmental efforts and traffic measures so that they can also provide health benefits for citizens. With this new reform, municipalities will no longer receive financing for health and social care services. In the next decade, the governmental subsidies received by municipalities will also include an extra amount reserved for health promotion, measured by specific indicators chosen by the municipalities themselves.

A slow process by nature, it can take 10, 20 or even 30 years before the results of this new disinvestment reform are tangible. The most important goal for Finland is to connect its economic policies with its welfare, social and health policies. Social and healthcare spending should not only be seen as money spent, but also as a strategic way to reduce costs.

THE WAY FORWARD

These recommendations draw on the viewpoints and ideas presented by the authors of the articles in this report and the conversations at the series of working groups organised by Friends of Europe in Spring 2018. Underpinning the recommendations are principles of multi-stakeholder collaboration and focusing on a set of concrete actions to modernise health in the 21st century.

1. EMPOWERING CITIZENS

ISSUE

Inequalities across Europe are entrenched and growing. Social disadvantage, low functional literacy and ill health are closely interlinked. Where you live geographically can have a dramatic impact on your health status. In some cities, life expectancies between different social groups can vary by as much as 10 years. The adequacy of primary care and health service provision can amplify or mitigate the impact of inequality in health. Accessing and navigating complex health systems can be a daunting challenge, even for those with insider knowledge. Health is both a universal right and an individual responsibility but without the core skills and knowledge, people cannot exercise their rights or fulfil their responsibility. Empowering citizens to manage their own health and lead healthy lives should become a core educational objective from formal schooling to lifelong learning.

ACTION

The 2018 European Council Recommendations on Key Competences for Lifelong Learning recognise that individuals need to know about the "components of a healthy mind, body and lifestyle". This is a good basis on which to engage and activate citizens. Member states should regard this as a cross-cutting priority across education, health, social and employment policies, as well as a key mechanism to reduce healthcare costs and improve health outcomes. Specifically, the EU should establish "an empowering healthy citizens task force" acriss all ages to deliver on this objective. The task force could build on health literacy efforts to develop related content for developing skills in different contexts. Throughout the next mandate, the implementation of the Recommendations should be tracked and the impact evaluated. Erasmus Plus is a good vehicle to take this forward.

OPPORTUNITY

An informed citizen takes action to improve their own health. This leads to healthier lifestyle choices, higher vaccination uptakes, healthy ageing, increased adherence to treatments, greater use of prevention or promotion services as well as stronger social control over unhealthy or risky behaviours. Patients will be more active in the co-creation of health and will take greater ownership over health outcomes. They will demand better performances from health systems, adding much needed public pressure to break down the professional and institutional silos in care. For governments, this provides a potential pathway to reduce waste in the healthcare system. In an area of limited EU regulatory competence, it allows the EU to contribute to an active and healthy citizen.

2. AN OUTCOME-BASED APPROACH TO HEALTH

ISSUE

Healthcare systems and national health plans are target-based and needs-based, as opposed to outcome-driven. To solve the investment–disinvestment conundrum, a better entry point into the health debate would be to identify the health outcomes to be achieved through the system. This approach can provide sharp relief in thinking about the balance between prevention and cure, the long-term vs. short-term, safe choices vs. out-of-the-box choices and an opportunity to triangulate demographics, with the demand and supply of future healthcare.

ACTION

The EU has a key role to play. As a neutral player in national healthcare debates, it could effectively crowdsource ideas across member states and these ideas could then add value to national and local decision making on health. Building on the Foundations of the "State of Health" initiative, the next EU mandate could take a lead by developing a 21st Century health panel, to chief a new and frank conversation between all players in and out of the healthcare system. This will allow to converse about appropriate allocation of ressources in health and how to innovate in service provision and increase accessibility for all, among other issues. This conversation needs to have a multi-stakeholder approach with a strong mandate to make citizens part of the process. The answers gathered from public European consultations, such as the "Consultation on the Future of Europe", launched in 2018, could be a good starting point for a real long-term conversation.

OPPORTUNITY

At member state level, there will be a better business case for transitioning to a 21st century health system and for moving from a fragmented transaction-based process to a responsive and integrated patients' path and disease management, supporting individuals in their goals for a healthier life. The EU will be able to demonstrate the real added value it brings to member states in how they plan, implement and budget for current and future health systems. Contributing to a vibrant exchange on how to improve healthcare systems positions the EU as a champion of citizen interests.

3. A HEALTH DATA-ZONE

ISSUE

Healthcare policies and planning often take place in the absence of comprehensive data about need, impact and effectiveness of interventions. While healthcare generates the largest amount of data in any sector, it uses it the least. The data that would simplify and streamline service planning or create medical breakthroughs sits in separate silos. EU GDPR goes some way towards creating the ethical, security and privacy framework for data to flow. The remaining barriers to free-flowing data across the EU are politics, issues of sovereignty and differential standards and approaches to health management.

ACTION

The European Commission Directorate-General for Communications Networks, Content and Technology, together with the Directorate-General for Health and Food Safety (and future replacement bodies), should enable a clearing house for health data across the EU. By establishing a public, transparent and secure platform, their role would be to centralise information and health data. Earmarked funds could support a proof of concept for health data sharing across member states. As health is managed at national, regional and local level, this clearing house needs to be accessible by all levels and include data shared by health practitioners, private sector representatives and patients on an opt-in basis. The results of such rich data exchange will allow for mutual cross-border and cross-sectoral learning. This would enable member states to understand the art of the possible, the risk management framework, the potential efficiencies to be gained, the improvement in processes and policy refinement.

OPPORTUNITY

The EU could do more to promote the sharing of data beyond Eurostat datasets. European countries like Estonia and Finland are already global pioneers in public infrastructure to securely host data exchanges. Big Data and artificial intelligence can process the enormous reserve of underutilised health data, with huge potential impact. The health data platform will allow healthcare systems and any participating stakeholders to be co-responsible for the quality of data and the co-ownership of the results. Accessible data provided and managed in this manner enables a new pathway to better understand healthcare needs, identify trends and simplify approaches to improve resource allocation and reduce waste. This could provide a pathfinder for the EU to lead in other data sharing opportunities in a wide spectrum of policy areas.

4. NORMING INNOVATION IN HEALTH

ISSUE

Innovation in healthcare and healthcare systems is sporadic, ad hoc and not consistently shared across the EU. Bringing a wider range of players together can maximise the opportunity of digitalisation and find the means to create the conditions and infrastructure to seed innovation in healthcare systems. We need to jumpstart a health-tech revolution in the EU.

ACTION

The European Commission Directorate-General for Communications Networks, Content and Technology, together with the Directorate-Generals for Research and Innovation, as well as for Health and Food Safety (and future replacement bodies) should create a health technology sandpit for Europe. This experimental space would allow the private sector, entrepreneurs, health policymakers, clinicians and patients to jointly elaborate on problems and explore solutions. The sandpit should be connected directly to a funding pipeline, co-invested by public and private investors, including EU and national funds as well as venture capital. This would support the full cycle of innovation from seed finance, proof of concept, prototyping, market development, trials and scale-up. Vitally, this would generate new investment models in health for the private sector in addition to finding innovative ways of financing tools such as “health-tech bonds” as well as crowdfunding.

OPPORTUNITY

The health sector is ripe for transformation through innovation. A health technology sandpit could help turn ideas for change into practical reality, allowing all players to unleash their creativity. With a greying population, European health systems represent a predictable growth market with potential for sustainable returns on investment. Although healthcare is largely funded through public resources, this doesn’t always have to be the case. The recommended approach could pave the way for radical changes in the financing of healthcare by introducing multiple actors across public, private, philanthropic and individual citizen investors. This would assist in transforming health financing from a deficit model into a co-investment model.

5. REDESIGNING HEALTH

ISSUE

Current healthcare systems are a legacy of post-war Europe and need urgent reform to become a model fit for purpose in the 21st century. They were designed to fit the “boom generation” and do not fit the ageing population, nor the transformation that European societies are heading to. The cornerstone is a flourishing primary healthcare system which is the basis of Universal Healthcare Coverage (UHC – SDG 3). Everyone involved in healthcare agrees on the direction of travel, from hospitals towards a person-centred, locally delivered and data-supported system of care. Getting there is not easy, some players will lose out and there will be resistance in the system. Now that Europe's economy is growing again, there is room to explore greater investment in health. But this needs to be targeted towards the transformation of healthcare rather than just plugging existing gaps.

ACTION

TThe EU should establish a “health system transformation fund” drawn from several European Commission Directorate-Generals and their relevant budget lines (regional policy, research and innovation, industrial strategy, human capital development, health). This would co-fund activities by coalitions of countries or regions committed to redesigning their healthcare systems. It would support research and modelling on smart investments for health, explore regulatory or administrative barriers to innovation, identify low-value interventions for disinvestment and rethink the hospital organisation as well as its funding systems. Its focus should be to provide incentives and data to reduce waste and inefficiency. Preconditions for this funding would be for patients to be at the heart of the redesign process, which would take into account prevention, promotion and greater health self-management opportunities.

OPPORTUNITY

Healthcare systems devote most of their efforts and funds to firefighting existing needs with little focus left for the forward planning needed for transformational change. Disinvestment in ineffective care and cutting down on waste will release scarce funds for better care and improve patient health. The EU can provide some much needed horizon scanning and be a catalyst for change by applying a sharp focus on transformation processes and by utilising funds to test out ideas. This can lead to more accurate, personalised and more effective care delivered efficiently across EU member states.

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