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ADAPTING EU HEALTH POLICY TO AN EVOLVING EUROPE

WHAT THE EU SHOULD 'START', 'STOP' OR 'DO DIFFERENTLY'

Final report of the Health Working Group

Spring 2015

Some of the familiar faces and household names who have used **Friends of Europe**'s high-profile yet neutral platform to put across their ideas to decision makers and to public opinion

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This report has been drafted on the basis of a series of meetings and discussions from the members of the Health Working Group, under the sole responsibility of Friends of Europe. Members have agreed to co-sign this report as they have judged it to be a fair and balanced exercise. The views expressed in this report are opinions of the individuals in the Health Working Group, and not necessarily the views of the organisations they represent, nor of Friends of Europe's Board of Trustees, its members or partners.

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Author: Tamsin Rose
Publisher: Geert Cami
Director: Nathalie Furrer
Programme Managers: Lindsay Digneffe & Jean-Yves Stenuick
Design: Marina Garcia Serra

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FOREWORD

There is no better time than now to reflect on what the European Commission and the European Parliament could achieve for health at EU level.

We believe that health is a significant asset for Europe. The recognition by all EU countries of universal access to healthcare as a fundamental right is an important aspect of citizenship, contributing to better population health. The health sector has a well-educated workforce with opportunities for future growth of employment. Europe has a well-established scientific community that increasingly collaborates on generating new knowledge and a flourishing life sciences industry featuring companies that are world leaders in the sector.

However, it is clear that despite facing shared challenges, the EU does not capitalise sufficiently on its health assets. The European region has very high levels of chronic disease, much of it preventable but health systems give a low priority to prevention and health promotion activities. There is a focus on expensive hospital-based curative services at the expense of stronger primary care networks that could deliver patient-centred healthcare in community settings. There is a growing shortage of skilled healthcare workers and a need to update and reform legacy healthcare systems.

That is why we were pleased to take part in an ambitious Health Working Group, convened by the Brussels-based think tank Friends of Europe. The Health Working Group met several times over the course of last year to explore how the EU could become the catalyst for much needed changes for Europe's health systems and policymaking.

The final report of this ambitious process outlines, in a list of 21 concrete recommendations, what the Health Working Group believes that the EU should 'Start', 'Stop' or 'Do Differently' during this new mandate to improve the health of Europe's citizens.

We support and endorse the recommendations that emerged from this innovative exercise. We hope that they will help EU leaders understand that the time has come for Europe to be in the business of delivering better health. If stakeholders get clear signals that the EU is serious about using all of its instruments to promote health and wellbeing, they are more likely to align their own strategies to this new agenda and commit more resources and efforts to achieving the shared vision.

We hope that this report inspires new thinking for health in Europe over the coming years.

The Health Working Group's members

MEMBERS OF THE HEALTH WORKING GROUP

Nicola Bedlington, Secretary General, European Patients' Forum (EPF)

Roberto Bertollini, Chief Scientist and Representative to the EU, World Health Organization (WHO)

Angela Brand, Professor of Social Medicine and Public Health Genomics, Institute for Public Health Genomics, Maastricht University

Josip Car, Director, Global eHealth Unit, School of Public Health, Imperial College London and Director, Health Services and Outcomes Research Programme, LKC Medicine, Imperial College London - Nanyang Technological University, Singapore

Nathalie Chaze, Deputy Head of Cabinet to EU Commissioner for Health and Food Safety Vytenis Andriukaitis, then Head of Unit, Health Systems at the European Commission Directorate General for Health and Consumers

Francesca Colombo, Head of Health Division, Organisation for Economic Co-operation and Development (OECD)

Christine Dawson, Director, European Social Insurance Platform (ESIP)

Philippe De Backer, Member of the European Parliament Committee on Industry, Research and Energy, and Rapporteur on 'The European Semester for Economic Policy Coordination: Implementation of 2014 Priorities'

Jo De Cock, Chief Executive Officer, National Institute for Health and Disability Insurance, Belgium

Lieven De Raedt, Attaché, International Relations Department, Federal Public Service of Health, Food Chain Safety and Environment, Belgium

Giulia Del Brenna, Deputy Head of Cabinet to EU Commissioner for Research, Science and Innovation Carlos Moedas, then Member of the European Commission Task Force for Greece

Toon Digneffe, Director, Government Affairs and Public Policy, Baxter World Trade

Ruxandra Draghia-Akli, Director for Health at the European Commission Directorate General for Research and Innovation

Corinne Duguay, Vice President, European Public Affairs & Head of Brussels Office, Sanofi

Isabelle Durand-Zaleski, Chief of Public Health, Henri Mondor Hospital, Paris

Jaroslaw Fedorowski, President, Polish Hospital Federation

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

Maria Eva Foldes, Assistant Professor, Institute for European Integration Research, University of Vienna, and Expert at the European Health Forum Gastein since 2010

Loic Frerejouand, Senior Director, Health Policy, Sanofi Pasteur MSD

Nathalie Furrer, Director, Friends of Europe

Maciej Gajewski, Director, European Government Relations and Public Policy, Shire

Ghebremedhin Ghebreigzabiher, Health Attaché, Permanent Representation of Italy to the EU

Evi Hatziandreou, Scientific Director, Maria Tsakos Foundation

Jean-Philippe Huchet, then President, Association Internationale de la Mutualité (AIM)

Karin Kadenbach, Member of the European Parliament Committee on Environment, Public Health and Food Safety

Maarit Kokki, Senior Adviser to the Director & Head of International Relations, European Centre for Disease Prevention and Control (ECDC)

Eero Lahtinen, Ministerial Adviser, Ministry of Social Affairs and Health, Finland

Yann Le Cam, Chief Executive Officer, European Organisation for Rare Diseases (EURORDIS)

Denis Maguain, Head of International Affairs and Studies Unit, Ministry of Social Affairs, Health and Women's Rights, France

Mihaela Militaru, Director, European Cancer Patient Coalition (ECPC)

Giovanni Nicoletti, Head of Unit, Department of Public Health and Innovation, Ministry of Health, Italy

Antonyia Parvanova, President, National Movement for Stability and Progress, then Member of the European Parliament Committee on the Environment, Public Health and Food Safety

Mark Pearson, Deputy Director, Directorate of Employment, Labour and Social Affairs, Organisation for Economic Co-operation and Development (OECD)

Alojz Peterle, Member of the European Parliament Committee on Foreign Affairs, Trustee, Friends of Europe and former Prime Minister of Slovenia

Pavel Poc, Vice Chair of the European Parliament Committee on Environment, Public Health and Food Safety

Milena Richter von Iterson, Senior Director, European Public Affairs, Sanofi

Tamsin Rose, Strategic Adviser, Quality Europe, Friends of Europe

Andrzej Rys, Director, Health Systems and Products at the European Commission Directorate General for Health and Food Safety

Audrius Sceponavicius, Director, Public Health Department, Ministry of Health, Lithuania

Marc Schreiner, Director, EU Policies and International Affairs, German Hospital Federation

Ad Schuurman, Head of the Business Contact Centre and International Affairs, National Health Care Institute, The Netherlands

Marc Sprenger, Director, European Centre for Disease Prevention and Control (ECDC)

Karen Strandgaard, Head of EU Relations and Brussels Public Affairs Office, Novartis European Affairs

Christoph Thalheim, Deputy CEO & Director External Affairs, European Multiple Sclerosis Platform (EMSP)

Erick Tyssier, Head of Government Affairs Europe, Teva Pharmaceuticals

Marc Van Ranst, Head of the Laboratory of Clinical and Epidemiological Virology, University Hospitals Leuven

Ana Xavier, Deputy Head of Unit, Employment Analysis at the European Commission Directorate General for Employment, Social Affairs and Inclusion, then Policy Co-ordinator, Economist at the European Commission Directorate General for Economic and Financial Affairs

Marina Yannakoudakis, then Member of the European Parliament Committee on the Environment, Public Health and Food Safety

PREFACE

Europe's health systems are in urgent need of reform. This report, the product of a working group on health organised in 2013 and 2014 by the independent Brussels-based think tank Friends of Europe, seeks to contribute to the strategic thinking of the new Members of the European Parliament and the European Commission by helping to prioritise what can be achieved during their mandate. This is especially important given the negative impact of Europe's prolonged economic slowdown and austerity policies on health spending.

The Health Working Group brought together a diverse group of stakeholders from across Europe representing policymakers at EU and national level, international organisations, academia, health-related industries and non-governmental organisations. It met under Chatham House Rules, which allowed participants to discuss their ideas openly and sought to define coherent messages from the health community.

The result: a list of 72 potential recommendations for what the European Union should 'Start', 'Stop' or 'Do Differently' during the next mandate. The long list was distilled into a final list of 21 recommendations through consensus-building, a process which can help policymakers see what measures are attainable with broad support.

The economic crisis has heightened the sense of urgency and sharpened the focus on reform of health systems. In the past, member states have fiercely defended their exclusive right to manage healthcare systems and therefore have been reluctant to actively engage at EU level on broader health issues. This, in turn, led to health being a low profile portfolio within the European Commission, and the Directorate General for Health and Consumers not being seen as a

major player in policy discussions. The European Parliament has been more supportive of EU action on health, perhaps due to the intensity of interaction between Members of the European Parliament (MEPs) and health stakeholders such as patient groups. The Working Group's view is that the perspective of the EU institutions is converging and the time is now ripe for a more concerted effort for harnessing the power of the EU to support health and healthcare systems. As the new Commission mandate begins and the broad policy priorities to replace Europe 2020 are developed, health needs to be recognised as a key contributor to societal and economic welfare. In this report we focus on the EU role and how it links to the major determinants of health and how policymakers at EU level could maximise their contribution towards efforts to tackle the societal challenges for health.

EXECUTIVE SUMMARY

Overview

Over the course of 2013 and 2014, the independent Brussels-based think tank Friends of Europe organised a Health Working Group to tackle urgent policy issues which the newly elected European Parliament and the new European Commission will need to act on.

The working group, comprised of policymakers at EU and national level, international organisations, academia, health-related industries and non-governmental organisations, agreed that the key societal challenges for health in the EU for the incoming period include:

- Demographic changes, including an ageing population with higher life expectancy
- Rising demand for care and the high cost of new technologies and treatments
- Health inequalities and the lasting impact of the recent financial crisis
- The increased burden of chronic disease and unhealthy lifestyles
- Shortages of skilled health workers.

Vision

The group agreed that a new vision for health involves a paradigm shift so that health is no longer the domain of professionals with patients as passive recipients of care. Individuals need to be empowered to make positive decisions for their wellbeing, supported by enabling social and professional environments that make effective use of appropriate technology tools. Integrated health and social welfare systems would facilitate this primarily through preventive and promotion services with access to quality specialist care when needed. Although the need for this paradigm shift has been acknowledged politically for many years, change has been hard to achieve.

The group noted the key importance of core health determinants such as nutrition, alcohol consumption, smoking and levels of physical activity. The EU already has a strong focus on these determinants through the first, second and third public health programmes. The group acknowledged these efforts and therefore chose to explore other ways that the EU could contribute towards better health outcomes.

Assets

Health is central to European society, economy and communities. Without good health, Europeans are unable to enjoy a sense of wellbeing, participate in the economy and contribute to social capital. The universal health coverage in all EU countries is a unique feature of the European region. In the 1990s and 2000s, investments in European health systems have steadily increased above inflation levels and employment in this sector has also grown strongly. Life expectancy has steadily risen as living and working conditions have improved and most citizens can expect to enjoy long periods of good health, accessing care when they need it. There is a well-educated workforce readily available and funding for health research has been ring-fenced, contributing to the growing body of scientific knowledge. Europe hosts a thriving life sciences industry with world leading companies that are producing new drugs and vaccines, medical devices and diagnostic tools. The diversity of health systems across Europe presents opportunities for shared learning and exchanges of experiences. EU level data collection gives insight into the operational efficiency of different health systems and allows benchmarking and realistic target setting. New technology such as eHealth and mHealth have the potential to radically transform the efficiency of healthcare services and the big data solutions could tackle some of health's most complex research challenges.

Good health is a result of socio-economic status, genetics, access to quality healthcare and prevention policies, enabling physical environments and individual behavioural choices. In this respect it is closely linked to the political decisions which influence these factors either positively or negatively. The health status of the population is therefore an indicator of the overall fairness of the society, the equity of the economy, the accountability of the policymakers and the efficiency of the healthcare services. As such, improving health must be a shared goal of decision-makers, stakeholders and economic actors as well as individuals. The EU could and should capitalise more on its health assets to achieve better health outcomes.

Barriers

The Working Group discussed barriers to reform such as strong vested interests and power imbalances in the system, the complexity and diversity of health and care systems, information asymmetries between users and providers of care, silo thinking (and acting) within the health sector, entrenched cultural beliefs, short-term crisis management rather than long-term strategic planning and legacy health services provider institutions that are not adapted to the current models of care delivery. A stronger primary healthcare system which supports a full spectrum of prevention initiatives and closely integrated with welfare and rehabilitation services would allow more healthcare services to be provided in community settings rather than in hospitals.

Overview of recommendations

Recognising the need for change, the opportunities and the barriers, the Working Group sought to empower policymakers, health actors and patients through 4 clusters of recommendations.

An overarching recommendation was to develop convincing and clear messaging for health that the EU values and supports health through all of its policies. Health should be made a higher political priority, linked to Europe's economic wellbeing and social cohesion.

1. **Improve information for decision-making:** Shift focus and resources towards prevention to improve population health and avoid more costly interventions later. At the same time, collect quality, comparable data: Streamline and rationalise data collection, make better links between data and policymaking.

2. **Foster and support greater innovation:** Use EU funds strategically to encourage all forms of innovation for health, not just research into new cures and treatments but equally, for example, innovations in delivery of healthcare services.

3. **Improve health governance and governance for health:** Improve the consistency and relevance of EU actions on health.

4. **Reduce the political risk for implementing change:** Support efforts to revitalise and change health systems at national or regional level through evidence, sharing of experience and innovative pilot programmes.

These recommendations are further developed in with specific policy measures to ‘Start’, ‘Stop’ or ‘Do Differently’. The objective is to help fast-track reforms by demonstrating there is broad support among stakeholders to carry them out.

It is now up to the policymakers to act.

THE RECOMMENDATIONS

1 – Improve information for decision making

START

- Improve the quality of data collection including information on successful prevention programmes. Collect data through public surveys and exchange cross-border information.

- Begin effective implementation of Health System Performance Assessment (HSPA) especially the effectiveness of new technologies.

- Promote the translation of data into policies and action plans, encourage the use of existing public health knowledge and supporting specific research in member states.

STOP

- Developing new indicators without considering the added value or usefulness. Make the existing ones work better.

DO DIFFERENTLY

- Replicate the cross-border collaboration exemplified by the European Network for Health Technology Assessment (EUnetHTA) in other key areas of policy.

- Collect health data through appropriate means with proper follow-up. Make the information collected available to stakeholders to use.

2 – Foster and support greater innovation

START

- Create a more coherent and explicit link between innovation for health and EU Structural Funds investments.

- Promote value-based rather than cost-based innovation, which needs to address public health as well as medical science.

DO DIFFERENTLY

- Assess and evaluate health, social and economic outcomes of new technologies and innovations.

- Innovation should also be applied to policy and real-world settings and compared with global best practices. Encourage market uptake of new ideas and tools.

- Define and review obstacles to innovation in science. This could include ethics in research issues, bio banking, privacy, etc.

3 – Improve health governance and governance for health

START

- Progress towards a comprehensive strategy for patient empowerment – a meaningful involvement in health at national and EU level.

- Estimate waste and inefficiency in health systems and then commit to eliminate them. Focus on stopping ineffective interventions.

STOP

- Drafting reports/recommendations with no policy follow-up.

- Short-termism and considering health policy solely from a financial perspective.

- Recommendations from the EU level without considering how they will be used by and in overburdened national systems.

DO DIFFERENTLY

- More effective use of research results for good governance.

4 – Reduce the political risk for implementing change

START

- Define health objectives and long-term strategic goals beyond political terms.

- Make health a key outcome of government action at EU level.

STOP

- The perceptions that it takes a long time to achieve tangible results from public health interventions.

DO DIFFERENTLY

- If efforts to change or reform health systems are blocked politically by vested interests at national level, use the EU to maintain the momentum for change.

STATE OF PLAY AND CHALLENGES

The good news is that Europeans are living longer - life expectancy at birth has increased in EU countries largely thanks to rising living standards (nutrition, sanitation and housing), improved lifestyles, better education and greater access to quality health services. In 2012, across the EU the average life expectancy at birth was 76.1 years for men and 82.2 years for women[1]. This is a rise of more than 5 years of life since 1990.

Eurostat projections show that by 2060 there will be 15% less adults of working age in the population. By this time, most EU countries will have reached a level of one dependent elderly person to two working age adults – a ratio never seen before[2]. This means fewer economically active people contributing to the tax revenue base needed to pay for the health and social care of the larger number of dependent older generations.

However, the overall improvements in recent decades in health status and life expectancy have not been experienced equally across Europe. There are widespread inequities in health between and within societies, reflecting the different conditions in which people live. In all EU countries, the level of disease and age that people die of are strongly influenced by factors such as (un)employment, income, length of education and ethnicity. The World Health Organisation (WHO) has established that the greatest determinant of health status is poverty and there are also associations between socioeconomic circumstances and risk factors for health, including tobacco and alcohol use and obesity. The 2009 European Commission Communication 'Solidarity in Health' noted that the chances of a child dying before its first birthday differs by a factor of five across the EU and that life expectancy at birth varies by 8 years (for females) and 14 years (for males). Population groups that face social exclusion and discrimination such as Roma and migrants experience poorer overall physical and mental health and have the least access to quality care.

[1] OECD/EC (2014), Health at a Glance: Europe 2014, OECD Publishing, p. 16.
[2] http://ec.europa.eu/eurostat/statistics-explained/index.php/Population_projections

Europe's key health challenges

The priorities of the new Commission as set by President Jean-Claude Juncker include boosting employment and investment, a better-connected digital single market and a fairer internal market. These are all areas where health has a significant role – as a source of new jobs and supporting worker productivity and competitiveness. Health is also an exciting new frontier for major IT infrastructure investments and software development. The new €315 billion EU Investment Plan announced in late November 2014 by Vice President Jyrki Katainen seeks to leverage significant new funds for strategic projects with high impact for the economy such as education, research and innovation. These sectors are also critical for the updating and transformation of Europe's health systems – education to meet the estimated shortage of 1 million healthcare workers, research to find new tools to prevent or manage disease and innovation to improve the performance of health systems.

Most importantly, at a time of deep apathy and disinterest among citizens about the future of the EU project, health is a policy area of high relevance for the public, always scoring highly among their list of personal priorities. A proactive EU role in leveraging policies and funding for public health could help to bridge the increasing gulf between citizens and the EU institutions. The incoming Commission President has already promised to invest more in social Europe, marking a shift from the economic growth-driven austerity measures. Given the close linkages between poverty, social exclusion, unemployment and health, this is an important development. Health should rightfully claim a central space in the future social Europe initiatives and the messaging thereon. The Commissioner for Health would need to get fellow Commissioners to buy into the vision of health as the key outcome of EU actions.

All EU member states have well-established healthcare systems that provide universal access to treatment and the right to health is enshrined in the European Convention on Fundamental Rights. Furthermore, the EU Treaty states that all EU policies should ensure a high level of human health protection. Health is also significant for Europe because it represents 8% of employment and has been identified as one of the key sectors with high potential for growth in new jobs[3].

[3] http://ec.europa.eu/europe2020/pdf/themes/05_health_and_health_systems.pdf

Health is an important element in Europe's social welfare systems, contributing towards social cohesion and economic growth. Health expenditure is an average of 9% of gross domestic product (GDP), ranging from 6% in Bulgaria to above 11% in Denmark, Germany, France, the Netherlands and Austria. In most member states, more than 70% of health expenditure comes from public sources. Before the economic crisis in 2008, health spending was among the largest and fastest growing government budget items. The deep recession that has gripped Europe has led to fundamental questions being asked about how to maintain the financial sustainability of health systems. This is even more urgent given that the Organisation for Economic Co-operation and Development (OECD) predicts that unless cost containment measures are put in place, going forward an extra 1% of GDP will need to be spent every decade on health and a further 0.5% of GDP for long-term care[4].

Crisis and adaptation

The 2009-2014 EU mandate has had to address the deepest and most prolonged economic crisis in Europe for 70 years. The resulting severe budget cuts and austerity measures have had an impact on health, welfare and social spending across the continent. In many countries, salaries for healthcare workers have been frozen or cut, leading to mass exit from key professions and brain drain[5]. Some health systems experienced shortages of medicines, medical equipment and staff. Other cost-cutting measures have included higher co-payments or user charges, sometimes accompanied by measures to protect vulnerable population groups, rationing and limits on the basket of services available[6].

Getting a complete picture of the impact of crises on human health is difficult because of complexity of the interactions of factors that influence health. The changes to healthcare services as a result of the austerity are both visible and measurable and therefore more easily quantified. However, there is much less research available on how the health status of the population might be affected. This is partly because the effects of health cuts or limited access to healthcare services will last well beyond the current crisis and therefore will need time to be visible in data collection. The close link between employment and health

[4] http://dx.doi.org/10.1787/5k44v53w5w47-en
[5] http://www.epsu.org/IMG/pdf/Article-Impact-Crisis_Austerity-Measures-Health-Systems_Workforce_Patients-04-12-13.pdf
[6] http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf

status does provide some immediate insight into health impacts. The stress of precarious work contracts or unemployment takes a heavy toll. Unemployment in the EU has risen from 7.5% in 2007 to 12% in 2013 with youth unemployment levels reaching 22.8%. Mental health problems are often twice as prevalent amongst unemployed people (34%) as those in employment (16%). A rise of 1% in unemployment is associated with increases in suicides and murders and a rise of 3% or more is linked to higher alcohol-related deaths. The trend of gradually reducing suicide levels for people under 65 years has recently reversed, leading to a sharp increase in deaths. Even infectious disease patterns change during times of economic crisis, with poorer health outcomes from communicable diseases during recessions among vulnerable groups (migrants, homeless, prisoners) and both ends of the age spectrum, infants and the elderly, at greatest risk. In Greece, a rise in the number of new human immunodeficiency virus (HIV) infections was seen, partly linked to the cut to harm reduction services like needle exchanges[7].

In June 2014, EU Council Conclusions on the economic crisis and health noted the shared concerns of Health Ministers, noting the Council:

"Recognises the challenges for the health systems such as population ageing associated with the rise of chronic diseases and multi-morbidity, rapid technology diffusion, shortages and uneven distribution of health professionals, increasing citizens' expectations and increasing cost of healthcare in the context of budgetary constraints due in particular to the economic crisis require the implementation of policies and measures aiming at increasing cost-effectiveness and improving cost-containment while ensuring sustainability of the healthcare systems, safety of patients and equitable access to high quality healthcare;"

The key issue is how to reinvent health systems so that they are resilient enough to meet these challenges and are innovative to ensure both greater efficiency and return on investment. The need for reform is clear and the opportunity for innovation is enormous. But solutions cannot be found at national level alone. Coordination at EU level is vital. The Council Conclusions highlight two examples of where the European Commission could support member states – managing

[7] De Vogli, R. (2013), Financial crisis, austerity, and health in Europe, Lancet.
http://www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making/publications/2012/health-policy-responses-to-the-financial-crisis-in-europe

workforce planning to reduce the brain drain of skilled health workers and information exchange to support pharmaceutical pricing policies, particularly for smaller countries.

A crisis can also be an opportunity to implement much needed reform: Austria, Latvia, Poland and Slovenia toughened their stance in price negotiations with the pharmaceutical sector and Denmark, Greece, Latvia, Portugal and Slovenia accelerated the restructuring of the hospital sector. Other governments chose to ring-fence or protect health spending.

Tackling the chronic disease burden

The Working Group emphasised the need for more focus on and investment in prevention and health promotion. Chronic diseases are interrelated, are largely preventable and have common risk factors – tobacco use, poor nutrition, physical inactivity, alcohol consumption, and environmental factors. Among the six WHO regions in the world, Europe is the region most affected by non-communicable or chronic diseases. It has the highest smoking rates in the world for both men (38%) and women (19%). Europeans drink more alcohol (12.5 litres of pure alcohol per year) than in any other part of the world – almost double the global average. Only North America has a higher proportion of obese citizens (26%) than the European region (22%) where more than 50% of men and women are overweight. In terms of physical activity, 35% of the people in Europe are insufficiently physically active.

It is therefore unsurprising that these high risk factors impact on health. Chronic diseases affect more than 80% of people aged over 65 years (> over 100 million citizens) and cause nine out of ten deaths in Europe. Chronic diseases carry significant human costs (human suffering, reduced workforce, social exclusion, health inequalities etc.). As a consequence, chronic diseases absorb 70% to 80% of health costs corresponding to €700 billion in the EU. This figure is expected to rise in the coming years as unhealthy lifestyles contribute further to the chronic disease burden[8].

[8] Source includes WHO Euro figures, background papers for the EU Chronic Disease Summit 2014. http://ec.europa.eu/health/major_chronic_diseases/docs/ev_20140403_mi_en.pdf

More and better prevention is urgently needed

The EU addresses primary prevention through targeting the key health determinants of chronic diseases by strategies (nutrition and physical activity, alcohol consumption), action plans (cancer) and communication campaigns (smoking). However, each of these activities has its own methodology for quantifying the size of the problem and policy responses. A more coherent approach to prevention is needed, integrating primary and secondary and tertiary prevention activities. Work on prevention by the OECD, supported by the European Commission, has moved in this direction since 2007.

In line with the UN focus on chronic disease, the EU has created an integrated response to chronic disease, which links risk factors across sectors and policies, enhances prevention efforts and strengthens health systems, improves disease management with an emphasis on patient empowerment. The European Commission is funding Joint Actions with member states on chronic diseases (CHRODIS) and cancer (European Partnership for Action Against Cancer (EPAAC) and Comprehensive Cancer Control (CCC)). In addition, the European Innovation Partnership (EIP) on Healthy and Active Ageing is a multi-sector, multi-stakeholder platform bringing together a broad range of actors from the private, public and academic sectors. It seeks to generate a 'triple-win' of growth of jobs and industry, better individual health and greater sustainability for health systems. The EIP provides a mechanism for information exchange, generation of new ideas and opportunities to test and assess innovative approaches.

Despite the positive development of a move away from vertical disease specific programmes and towards an integrated approach to chronic diseases, the major problem remains the unbalanced nature of health spending, 97% on curative services and just 3% allocated to prevention and promotion activities[9]. This is despite the strong evidence on the efficacy of prevention (primary, secondary and tertiary) and its cost effectiveness. Thus there is an urgent need for policy change.

The working group recommends that EU and national policies redirect more healthcare funding towards prevention.

[9] OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing, p.10.

Repurposing health systems

Health systems in Europe are still largely sickness systems, focussing on curative services delivered in high-intensity care settings such as hospitals. Within these expensive health institutions, there are shortages of health workers and unacceptable levels of poor quality care. An estimated 8-12% of patients admitted to hospital in the EU suffer from adverse events while receiving healthcare. One quarter of these adverse events are healthcare-associated infections (25%), but there are also medication-related errors, surgical errors, medical device failures, errors in diagnosis and failures to act on the results of tests.

If we could prevent or reduce the more than 750,000 harm-inflicting medical errors per year, there would be 3.2 million fewer days of hospitalisation, 260,000 fewer incidents of permanent disability, and 95,000 fewer deaths per year. An average of one in twenty hospital patients (4.1 million individuals) get an infection associated with healthcare every year, adding €5.4 billion of hospital costs. The Commission's 2014 Patient Safety Package shows that progress has been made since 2009 through national programmes for patient safety and mechanisms for patients to report adverse effects. However, the education and training of healthcare workers remains a challenge and implementation of patient empowerment tools is lacking[10].

Breaking down the silos

The Working Group identified silo mentalities within health systems and between health and welfare systems as barriers that need to be addressed. The boundaries between health and social welfare services need to be removed so that integrated care packages can be developed for patients, particularly those managing chronic conditions or the elderly. Much greater proportions of healthcare could be delivered in the home or community settings provided that there was appropriate connection to rehabilitation and social support. Large numbers of patients with manageable conditions, often elderly people, are unnecessarily kept in the hospital because they have completed treatment in one part of the care chain (the hospital) and are waiting for admittance to the next part of the chain (e.g. nursing or care home). This delayed discharge (often described as 'bed blocking') is a major problem in Sweden, the United Kingdom (UK) and Austria. The cost of this to the UK alone is estimated to be £200 million per year.

[10] http://ec.europa.eu/health/patient_safety/policy/package_en.htm

Well-defined patient pathways that provide continuous support before, during and after healthcare interventions could free up scarce resources within both the health and social care systems. Healthcare will increasingly be delivered closer to the patient in more community settings or their own homes. This is part of the process of reconfiguring health systems to become more patient-focussed, with a stronger emphasis on prevention and self-management of health conditions.

Making the whole new Commission a champion for health

In these hard economic times, health is scrutinised as a drain on scarce public budgets rather than an asset for individuals, communities and countries. EU policy documents need to explicitly acknowledge the health contribution to a well-functioning economy and cohesive society. This will help to overcome short-term, crisis thinking and the definition of health as just the burden of healthcare costs. The Working Group emphasised the positive contribution of health to social capital and cohesion as well as the competitiveness and dynamism of the European economy.

There are some useful policy developments that would assist the Health Commissioner in making the case for change. The utility of GDP as a measure of societal progress is being questioned. The OECD is developing the Better Life Index (BLI), which is a more nuanced basket of 11 criteria to measure performance ranging from income and housing to health and work-life balance. The concept of 'return on investment' for health systems also needs revision. The ultimate goal of health systems is to improve health status and quality of life. Thus assessing 'return on investment' means focussing on these issues rather than measuring healthcare services as the output of health systems.

WHAT COULD THE EU DO BETTER? RECOMMENDATIONS FOR CHANGE

The Working Group developed a series of proposed changes in health policy to be considered by the new EU leadership. While not exhaustive, they are key orientations supported by the diverse cross-section of stakeholders in the group. The following is a complete list of recommendations on how to 'Start', 'Stop' or 'Do Differently'.

Recommendation cluster 1: Improve information for decision making. At the same time, collect quality, comparable data

Improve information for decision-making

The evidence base for health is growing but there are still gaps. For example, evidence is being generated about specific diseases and the related health burden and costs but these tend to use their own methodologies and data sources. There are already many indicators being gathered through the European Core Health Indicators (ECHI) system and Eurostat, the challenge is translating the information into a policy framework.

Better tools are needed to help decision-makers understand which policy measures or strategies are effective and deliver the best return on investment. A comprehensive and scientifically sound model is needed for comparative measures of the future burden of disease and injury. It would also need to take into account the environmental, biological or behavioural risk factors and the socio-economic factors contributing to that burden. The Working Group emphasised the importance of good information but cautioned against adding new indicators without assessing the feasibility of collecting the data and the quality. They recommended that information should be more closely linked to policy by making the information available to stakeholders to use and adapt.

Collect quality and comparable data

Information is critical for all stages in the policy process, from setting priorities, identifying goals and targets to generating activities and monitoring progress.

The EU has a role in collecting quality, comparable data in order to generate an accurate picture of population health trends and on the effectiveness of health systems. Good data can indicate where more efforts are needed and assess the performance of health systems so that they can be managed more effectively. For example, data shows that the European region is failing to meet two key targets on tuberculosis (TB) and measles. The European region has the fastest growth in drug resistant TB in the world. Although overall TB cases in the EU are declining (down 6% in 2012), only one in three patients with Multi-Drug Resistant TB (MDR-TB) successfully finishes treatment – well below the 70% target set in the EU Action Plan to fight TB. Only 10 EU countries have reported levels of measles in children at less than one case per million, the threshold figure for the EU 2015 target of eliminating measles. The data on both measles and drug resistant TB are signals of weaknesses in public health and healthcare systems. Measles outbreaks highlight failures to achieve vaccination levels in the overall population that result in herd immunity and provide protection for subgroups that cannot be vaccinated. Since risk of TB is so closely linked to poverty and social exclusion, the rise of drug resistant TB is a result of poor integration of health and welfare services, inadequate diagnosis and treatment options, and inconsistent follow-up of patients.

The Working Group acknowledged that a multiplicity of data is collected by the European Commission, WHO Euro and the OECD. Although significant efforts have been made to coordinate and avoid duplication of data collection, it is also important that data collection is connected to policy processes in a meaningful way. Even within the Commission there may be multiple Directorates General involved in using health information for policy. For example, member states are discussing the new HSPA in three different Commission processes: Directorate General for Economic and Financial Affairs (DG ECFIN)/Economic Policy Committee; Directorate General for Employment, Social Affairs and Inclusion (DG EMPL)/Social Protection Committee and Directorate General for Health and Food Safety (DG SANTE)'s reflection process.

Given the Working Group's emphasis on more prevention, data collection should also capture successful prevention initiatives which can be shared with stakeholders so that they can achieve greater impact with their efforts.

The EU should START	1. Improve the quality of data collection including information on successful prevention programmes. Collect data through public surveys and exchange cross-border information. 2. Begin effective implementation of HSPA especially the effectiveness of new technologies. 3. Promote the translation of data into policies and action plans, encourage the use of existing public health knowledge and supporting specific research in member states.
The EU should STOP	4. Developing new indicators without considering the added value or usefulness. Ensure the existing indicators work better.
The EU should DO DIFFERENTLY	5. Replicate the cross-border collaboration exemplified by the EUnetHTA in other key areas of policy.

Recommendation cluster 2: Foster and support greater innovation

The EU has set itself the goal of becoming the most dynamic, knowledge-driven economy in the world and innovation is a key lever for achieving this. In health, innovation tends to be defined as the creation of new medicines or devices and such intellectual property rewarded financially. This is a narrow view of innovation that does not address the need to support organisational change, new partnerships and decision-making tools. Using an outcomes-based rather than price-based procurement of medicines would help to realign the concept of innovation. Improved health outcomes may be a result of partnerships and collaborations across sectors such as transport and urban planning. Health actors need to be encouraged to step outside the boundaries of health systems to seek opportunities for innovation elsewhere. The assessment of innovation therefore needs to take into account social outcomes as well as the results of testing in real world settings. A disappointing development is the disappearance of a separate funding line for public health in Horizon 2020 which increases the risk the EU financing for innovation in health will be limited to healthcare system issues and particularly new medicines. Recognising that the existing models are insufficient, new tools or incentives at EU level are needed to boost innovation for public health and healthcare delivery models.

EU Structural Funds are a reliable and predictable source of financing that public authorities can access but they need to be used effectively to implement change. Member states with resource constraints have access to the greatest proportion of Structural Funds with low co-financing requirements. This is a key opportunity to leverage additional money for modernising and reorganising health systems to be more efficient and improve health outcomes. These funds could also be used to test new approaches and innovate such as strengthening primary care and prevention services delivered in communities.

The process of evaluating new technologies for health is complex, time-consuming and expensive. The EU has a clear added value, providing the economy of scale and avoiding duplication of effort. The European Commission funds a Joint Action on Health Technology Assessment (HTA) for member states to share expertise and methodologies to create objective information about the medical, social, economic and ethical issues of health technologies. It also convenes a voluntary network of member states specialist centres on HTA to undertake peer reviews and share knowledge.

The EU should START	1. Create a more coherent and explicit link between innovation for health and EU Structural Funds investments. 2. Promote value-based rather than cost-based innovation which needs to address public health as well as medical science.
The EU should DO DIFFERENTLY	3. Assess and evaluate health, social and economic outcomes of new technologies and innovations. 4. Innovation should also be applied to policy and real-world settings and compared with global best practices. Encourage market uptake of new ideas and tools. 5. Define and review obstacles to innovation in science. This could include ethics in research issues, bio banking, privacy, etc.

Recommendation cluster 3: Improve health governance and governance for health

The focus of this cluster of recommendations is increasing transparency in decision-making within health systems and creating the supportive conditions for patients to become more involved in their own care. The European Commission has already launched new projects on surveying health literacy policies and tools across Europe to find common elements that could be used to monitor changes. The Working Group welcomed these efforts, noting that changing health systems from sickness systems to wellbeing facilitators requires involving patients and non-health stakeholders and giving them meaningful opportunities to contribute.

The EU role in health is shaped by the limited competence as set out in the current EU Treaties. Some health experts have advocated for a stronger EU legal mandate in health including expanding the mandate of the European Centre for Disease Prevention and Control (ECDC) and greater focus on public health. The Working Group discussed the importance of a strong vision for health within the European Commission and the value of effective leadership in getting health out of its policy silo. Previous efforts at 'Health In All Policies' at EU level have largely failed to gain traction partly due to the challenges of getting health stakeholders to have a real say in policies which affect health but over which they have no direct involvement or ownership. For example, agriculture, trade, education, transport, environment, etc. This leads to a lack of joined up policy within the European Commission and in the way that the member states engage in European policies that affect health. For example, attempts to strengthen alcohol control measures at EU level such as minimum excise duties or restrictions on advertising are often undermined by member states acting to protect the economic interests of their alcohol producers.

The prolonged economic crisis in Europe has led to a new economic governance process, known as the 'European Semester'. The European Commission led by DG ECFIN develops Country Specific Recommendations (CSRs) that scrutinise national plans for public investment and expenditure. All member states are subject to CSRs, not just those in receipt of EU bailout funds. In 2013, sixteen countries received CSRs that addressed health in increasing level

of detail covering aspects of health systems such as referral systems, co-payments, reducing institutional care and pharmaceutical spending, Diagnosis Related Group (DRG) payments, reform of long-term care, prevention and rehabilitation, ensuring access, etc. These CSRs approach health from the context of macroeconomic concerns as a cost to be managed and are increasingly detailed on the content of health policies with potential sanctions for non compliance. This moves discussions on financing and organisation of health away from the realm of Health Ministers and into the arena of Finance Ministers and economic advisors.

The EU should START	1. Progress towards a comprehensive strategy for patient empowerment - a meaningful involvement in health at national and EU level. 2. Estimate waste and inefficiency in health systems and then commit to eliminate them. Focus on stopping ineffective interventions.
The EU should STOP	3. Drafting reports/recommendations with no policy follow-up. 4. Short-termism and considering health policy solely from a financial perspective. 5. Recommendations from the EU level without considering how they will be used by and in overburdened national systems.
The EU should DO DIFFERENTLY	6. More effective use of research results for good governance.

Recommendation cluster 4: Reduce the political risk for implementing change

The EU has a limited mandate in public health based on the Treaty, with restricted capacity to introduce legislation. Instead, there is a lot of 'soft law' in the area of health such as Recommendations or Communications from the Commission or Council Conclusions linked to a Presidency Priority. Many of these end up being 'one-off' initiatives with little or no policy follow-up. Identifying long-term strategic goals at EU level would ensure that reports or recommendations would be linked to policy efforts to meet these goals.

The EU could take on more leadership to support efforts at changing health systems. For Health Ministers in post for a short timeframe, initiating change means taking on vested interests with entrenched positions and risking political capital for potential benefits that will accrue over a longer timeframe. This is not conducive to encouraging ministers to take risks and accept the possibility of failure. The EU could explicitly seek to support ministers with relevant experience derived from other countries, models to assess the impact of policy changes and financial support for pilot actions. Introducing change will require the support of patients/citizens and new alliances beyond traditional partners in health. In return, stakeholders will require greater transparency and accountability from health systems, an area where the EU can also contribute.

This also means challenging perceptions that public health interventions are expensive, complex and take a long time to deliver measurable results. Many public health measures like bans on smoking in public places produce results within 12 months, with lower incidences of asthma or respiratory distress and cardiovascular episodes.

The EU should START	1. Define health objectives and long-term strategic goals beyond political terms. 2. Make health a key outcome of government action at EU level.
The EU should STOP	3. The perceptions that it takes a long time to achieve tangible results from public health interventions.
The EU should DO DIFFERENTLY	4. If efforts to change or reform health systems are blocked politically by vested interests at national level, use the EU to maintain the momentum for change.

PILOTING THE 'START', 'STOP', 'DO DIFFERENTLY' RECOMMENDATIONS THROUGH NEW APPROACHES TO INNOVATION AND PREVENTION

A new mandate brings fresh faces and thinking to EU policies in the European Commission and the Parliament. There is an opportunity to make health an explicit goal of policymaking and support urgent efforts to re-align health systems so that they are resilient enough to meet the expectations of citizens and are financially sustainable.

The Working Group has developed two case studies to test the practical application of the recommendations. On public health, the focus is on strengthening prevention efforts and stopping ineffective interventions. Within health systems, the theme is finding new approaches to innovation with particular reference to where the current models are not delivering such as rare diseases and antibiotic resistance.

ANNEX I: CASE STUDY ON INNOVATION

New approaches to pharmaceutical innovation are needed for the whole discovery process to ensure equitable access and to respond better to patient's needs. These approaches should notably address areas where the current models fail to deliver adequately for example, on antimicrobial resistance (AMR) and for rare diseases.

Europe has a significant life sciences industry which generates new knowledge, employment for skilled workers, government revenue and represents a large proportion of the global pharmaceuticals market. However, the existing model of pharmaceutical innovation has limitations, particularly when it concerns therapeutic areas which do not provide sufficient economic rationale for substantial R&D investments, and many companies do not have large numbers of new medicines in the innovation pipelines. This is for example the case of rare diseases and this has been recognised at EU level by the European Orphan Medicinal Products Regulation which incentivised investments by pharmaceutical companies. The results of this legislation have been positive – it has led to a big increase in funding for research in orphan drugs, which resulted in almost 100 orphan medicines approved in Europe since 2000. The complexity of researching and testing new medications with small patient numbers remains a challenge and new approaches are still required to meet the needs of patients with many rare diseases. Health authorities across Europe need to balance limited budgets with the health needs of the general population and with the need to provide adequate support for relatively few patients suffering from rare diseases who require sometimes expensive care. The ongoing public health problem of TB in Europe also demonstrates the weaknesses of the current innovation model. There have been no new diagnostic tools or medications for this disease for forty years and new global public private partnerships (PPPs) such as the Tuberculosis Vaccines Initiative (TBVI) have been developed to fill this urgent gap.

Antibiotic resistance is a major problem which threatens the viability of modern health systems. It is estimated that 70 per cent of the world's bacteria have now developed a resistance to antibiotics. We have used – or are using – the drugs of last resort. These resistant bacteria already claim the lives of more than 25,000 people a year in Europe alone. The problem is complex, linked to the use of antibiotics for animals for intensive farming, over-prescription and over the counter sales, medical tourism and globalisation as well as failure to invest by the pharmaceutical industry because of poor profit potential. In the past 45 years only five new antibiotics have been brought to the market and no new classes of antibiotics have been developed since 1987. Before antibiotics, infections caused 43% of deaths in the UK. Currently the figure is 7% but a post-antibiotic era could start within the next two decades. This would mean both routine surgical procedures and modern medical treatments would become impossible.

The EU is already engaged in combatting AMR through enhanced surveillance by the ECDC and funding for research through EU framework programmes. But greater efforts are needed to develop new and alternative models. There are some novel approaches being tested. The UK government has funded a new research unit on AMR at the National Institute of Health Research. The Medical Research Councils have, for the first time, joined forces to promote more streamlined research by coordinating their funding calls. The Horizon Prize for better use of antibiotics has been proposed to encourage research teams around the world to compete in drug discovery . New forms of PPPs are also being proposed to stimulate funding for drug discovery[11] and greater collaboration within the industry. At European level, the Innovative Medicines Initiative (IMI), itself a ground-breaking process between the EU, member states and the pharmaceutical industry, features a programme to develop new antibiotics.

Although the lack of new antibiotics is critical, it is only part of a complex and multi-faceted problem. We also need to address how and where antibiotics are used and this will require big changes in behaviour by patients, health practitioners, health managers and policymakers. New thinking on a broad scale is

[11] http://ec.europa.eu/research/horizonprize/index.cfm?prize=better-use-antibiotics

needed, bringing together stakeholders from multiple industries and sectors. The EU Action plan against the rising threats from Antimicrobial Resistance intends to serve that purpose[12].

This issue would particularly benefit from a new governance mechanism within the College of Commissioners to coordinate more effectively across policy areas such as agriculture, animal health regulations and human health in order to improve health outcomes.

START	
Recommendation	Implementation
Improve the quality of data collection including information on successful prevention programmes. Collect data through public surveys and exchange cross-border information.	There are examples of good practice that have reduced AMR such as tackling Methicillin-resistant Staphylococcus aureus (MRSA) in hospitals and improving prescribing behaviour for antibiotics. It is important that the data collected at EU level captures these and serves the goal of cutting AMR. For rare diseases, it is important to invest in rare disease patient registries and the infrastructure that will allow data aggregation and interchangeability across Europe. There is a role for the European Commission in providing funding and establishing proper framework for such registries as highlighted in Council conclusions in 2009[13].

[12] http://ec.europa.eu/dgs/health_food-safety/docs/communication_amr_2011_748_en.pdf
[13] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:151:0007:0010:EN:PDF

Begin effective implementation of HSPA especially the effectiveness of new technologies.	The effectiveness of new technologies for health needs to be evaluated and there are several processes at EU level that could address this – EUnetHTA, the HTA network established by the Directive on Cross Border Care or the HSPA framework. Including the cost of new procedures and technologies in DRGs will improve the comparability of the results. For rare diseases, it is critical to adapt existing HTA methodologies in the way that will enable fair assessment of orphan drugs, which require a much broader set of assessment criteria, beyond simple cost-effectiveness.
Promote the translation of data into policies and action plans, encourage the use of existing public health knowledge and supporting specific research in member states.	There are wide variations in patterns of consumption of antibiotics across the EU which demonstrates the scope for improvement. The EU should define goals for tackling AMR including patient and doctor education, improving access to relevant information, promoting the development of clinical and prescription guidelines at the EU level and training for health professionals. Given the global relevance of this issue, the EU needs to play an active role in international efforts. For rare diseases, it is important to provide adequate support to the European Reference Networks (ERNs), which are the key drivers of cross-border research and clinical proactive exchange across Europe.

Define health objectives and long-term strategic goals beyond political terms.	The crisis of antibiotic resistance should trigger a wide discussion at EU level on the type of innovation that is needed to meet long-term strategic health goals. Once a clear health vision is established, more concrete proposals could be made to align the EU research agenda and funding with unmet needs and the gaps in innovation revealed through the analysis of real-life data. The Joint Programming Initiative on Antimicrobial Resistance (JPIAMR) just developed such a strategic research agenda[14]. Other areas of potential EU added value would be encouraging further cooperation between regulators, HTA agencies and industry on the parameters and value of innovation. The EU could also invest in supporting the flow of skilled workers and specialists into research and development for AMR.
Progress towards a comprehensive strategy for patient empowerment – a meaningful involvement in health at national and EU level.	The overall approach to pharmaceutical innovation should focus on health and patient-driven outcomes, not just from the perspectives of technology, economic growth, or scientific novelty. Innovation can only translate into better health outcomes if patients are at the heart of the process – particularly for rare diseases.

[14] http://www.jpiamr.eu/wp-content/uploads/2014/04/SRA1_JPIAMR_TOTAL_DEF-3.pdf

	In rare diseases, this is already taking place through patient involvement in various European Medicines Agency (EMA) committees. The same should be applied also in the area of HTA assessment.
Estimate waste and inefficiency in health systems and then commit to eliminate them. Focus on stopping ineffective interventions.	Antibiotic resistance is driven by ineffective healthcare practices such as over-prescribing and poor compliance with guidance on use of medicines. There is huge potential for stopping ineffective and inefficient behaviour in health systems around antibiotics. A focus on medical education and updating curricula for healthcare professionals would increase their understanding of antibiotic resistance.
Create a more coherent and explicit link between innovation for health and EU Structural Funds investments.	The Structural Funds provide limited funds for public health but there are bigger investment streams for research. This is an opportunity to use Structural Funds to enhance the capacity of new member states for pharmaceutical innovation. Several of them have regions that feature strong academic biomedical faculties, generics industry or a manufacturing capacity which could be better linked and strengthened.

Promote value-based rather than price-based innovation which needs to address public health as well as medical science.	Further work on the EU Research Agenda, for example broadening the Priority Medicines Report to move beyond pharmaceutical innovation and include medical devices and treatments. From a public health perspective, generic and biosimilar products could be used more systematically and effectively within health systems. Parallel imports of pharmaceuticals are a sensitive topic at EU level but the potential value needs to be discussed.
STOP	
Recommendation	**Implementation**
Developing new indicators without considering the added value or usefulness. Make the existing ones work better.	Given the complexity of the problem of antibiotic resistance, better use could be made of indicators from different policy sectors (healthcare, agriculture, tourism, and environment) in order to monitor the issue more closely.
DO DIFFERENTLY	
Recommendation	**Implementation**
Collect health data through appropriate means with proper follow-up. Make the information collected available to stakeholders to use.	AMR is not a high-visibility issue in public awareness of health or among health policymakers and practitioners. Data collected which highlights aspects of this problem (consumption patterns of antibiotics, hospital acquired infections, morbidity and mortality rates linked to infection)

	should be publicised widely so that stakeholders can engage. The European Antibiotic Awareness Day (EAAD), launched in 2008, has been designed in this intention.
Replicate the cross-border collaboration exemplified by the EUnetHTA* in other key areas of policy. *EUnetHTA is a network of organisations (from EU member states, the European Economic Area and accession countries) and relevant regional agencies and not-for-profit organisations that produce or contribute to HTA in Europe. It is co-funded by the European Commission and enables scientific cooperation between HTA bodies that provide recommendations on the medicines to be paid for or reimbursed by the health system in a particular member state.	There are opportunities to build on pilot activities of cross-border collaboration such as EUnetHTA to bring together pricing agencies and increase transparency between member states on prices and medical indications. Better pharmacovigilance (temporary licences) and sharing of best practice on instructions on drug packages would also be valuable. Note that over time, some drugs thought to be effective may not prove to be as therapeutically useful and regular re-evaluation is therefore needed.
More effective use of research results for good governance.	Health professionals and the EU should not only focus on the safety aspects of the Managed Entry Agreements (MEA) but also look at the benefits for the largest possible population with a progressive evaluation. Everywhere where there is a real medical need, the approach to risk must be considered differently and should involve the patients concerned. This new approach is currently being initiated in the MEA and will allow for more flexibility from a regulatory perspective. New innovation models need to take into account both added value of the

	product and volume of the market as well as including evidence-generated post-market entry.
Assess and evaluate health, social and economic outcomes of new technologies and innovations.	To support a functioning EU market for new medicines and technologies that could reduce health inequalities, the EU could coordinate assessments of effectiveness using health and social outcomes and facilitate sharing among member states on related pricing.
Define and review obstacles to innovation in science. This could include ethics in research issues, bio banking, data protection issues and privacy, etc.	The concept of innovation in health needs to be broader and more integrated with health needs rather than market opportunities. This means moving away from a 'drugs only' model and exploring new processes and forms of collaboration for health. Innovation in health needs to encompass issues of usability of products and accessibility, which can be a problem of equity. There are also regulatory obstacles to overcome as well as from the lack of cooperation between member states. New business models are needed for innovation in health, particularly in the area of rare diseases and antibiotics. Given the emergence of new models such as PPPs to bridge the innovation gap, a dialogue on pricing and reimbursement earlier in the process of innovation than drug approval could be envisaged.

ANNEX II: CASE STUDY ON PREVENTION

Prevention is better than cure but hard to deliver: what would an EU fully engaged in prevention look like? The health sector is slow to learn and change: how do we get better at stopping delivery of ineffective or inappropriate health interventions? What is the EU's role?

Prevention should be a key priority for health systems, yet less than 3% of health budgets across Europe are dedicated to promotion and prevention activities. In December 2014, EU Council Conclusions on vaccinations highlighted both the success of immunisation programmes in reducing ill health and premature death and their cost effectiveness[15]. The Council called for the European Commission and member states to reinforce efforts to meet key targets for vaccination by communication and investing more in research on immunisation throughout the life course. This is particularly important in the context of demographic change because prevention can result in better health, higher quality of life and slower functional decline for older people[16]. Overall, many prevention actions could be delivered and funded outside of the health sector, which underlines the critical importance of joined-up public policies.

Chronic inflammatory respiratory diseases kill more than one hundred and fifty thousand people every year and are responsible for over 1.3 million annual hospital admissions in Europe. Two common conditions, asthma and chronic obstructive pulmonary disease (COPD), are largely preventable so reducing exposure to risk factors, early diagnosis and slowing the progress of the disease are critical in managing these illnesses which cost Europe more than €200 billion a year. The EU has invested in primary prevention measures to reduce the burden of asthma and COPD. However, secondary prevention focuses on interventions that happen after diagnosis of asthma or COPD and seeks to halt or slow the progress of disease in its earliest stages. These might include screening tests for people with known risk factors and patient education for better disease management. However, a diagnosis of COPD is often delayed, many patients are underdiagnosed and patient adherence to treatment is notoriously low. There are opportunities for greater EU support for secondary and tertiary prevention activities to empower the healthy, those at risk and people already affected in order to adopt healthy habits and life-styles. For example, primary care spirometry programmes allow routine screening of patients and support early diagnosis. A Danish initiative involving 10% of general practitioners (GPs) found that 35% of patients screened had COPD, most at a mild or moderate stage. Such early diagnosis and treatment generated annual costs savings of €180 million. Efforts also need to be directed at improving the education of healthcare professionals, particularly upskilling those working in primary care to be able to interpret the results of lung function tests. A 10-year Finnish asthma programme focused on implementation of new knowledge in primary care resulted in significantly lower costs for care, fewer hospitalisations, pension disabilities and deaths. In terms of tertiary prevention, there can also be gains in health status for asthma patients by supporting health workers to be able to train patients effectively on correct use of inhaler technologies. By shifting more health resources and focus into the full spectrum of prevention activities, the EU could reduce some of the major burden of chronic diseases.

Successful health promotion efforts also mean stopping ineffective or inappropriate interventions. Evidence-based medicine was introduced in 1992 after research demonstrated a time lag of 10 years for new knowledge to enter into clinical practice. Over the past 20 years, there has been a significant effort to generate, synthesise and deliver evidence to support policymakers and health professionals. However, ineffective practices in health systems and irrational use of medicines undermine the health outcomes of treatment. In order to release scarce health funds for more effective, high-quality care, there is increasing interest in methods to identify ineffective, obsolete, needless interventions and technologies. This is a relatively new element in health policymaking and there are no universally applicable frameworks or tools that can be used. In Europe, Spain, the UK, Sweden and Germany have developed strategies to address 'disinvestment' in ineffective health interventions. Some countries have chosen participative strategies that involve stakeholders and others use HTA tools. The emphasis also varies from reducing over-diagnosis and treatment to replacing obsolete technologies with better alternatives. The

[15] http://italia2014.eu/media/3789/council-conclusions-on-vaccinations-as-an-effective-tool-in-public-health.pdf
[16] http://www.euro.who.int/__data/assets/pdf_file/0004/235966/e96956.pdf

most frequent issues addressed are imaging techniques, the use of antibiotics and screening techniques. For example, Austria is above the EU average both in terms of numbers of magnetic resonance imaging (MRI) scanners and MRI scans performed. A study of disinvestment programmes in different countries identified 200 recommendations that could be applied by the Austrian health system to reduce MRI scans for specific conditions because they are no longer therapeutically necessary. This would represent significant savings in human resources and equipment without negatively impacting on health outcomes but it would require a change in practice by the relevant health professionals and institutions[17].

New approaches to prevention are more holistic, multidisciplinary and multi-sectoral and they seek to improve population health by tackling risk factors at an individual, community, and societal level.

At EU level, the political importance of shifting resources and focus in health towards prevention has been recognised in reports from the European Commission including DG ECFIN[18]. It is also mainstreamed in the 3rd Public Health Programme (2014-2020) and various Employment, Social Policy, Health and Consumer Affairs Council (EPSCO Council) Conclusions. The WHO and the OECD also recommend a re-balancing of health budgets to invest more in prevention and promotion. Therefore, there is consensus among international and national policymakers on the need to refocus health policymaking on health outcomes rather than inputs. This allows for more nuanced measurement of cost effectiveness of health investments and strengthens the case for prevention. There is an opportunity for the European Commission to show leadership and make a political commitment to mainstreaming health prevention across all Directorates General. This is crucial because many effective prevention mechanisms need to be implemented outside the health sector. In this new mandate, a new governance mechanism within the College, led by the Health Commissioner, could coordinate the best use of EU policy initiatives, legislation and funding mechanisms to contribute towards better population health outcomes.

[17] http://www.htai2014.org/temp/20147479600/OR73.pdf
[18] http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf

Building on the policy approach of measuring health outcomes, there needs to be common indicators across the EU that are both relevant for the policymaking process and can be used to evaluate the effectiveness of primary, secondary and tertiary prevention efforts. To facilitate the learning across the Union, the European Commission could support the cross-border capacities to measure and monitor the effectiveness of health investments.

As the connection between evaluation of data and policy at EU level improves, there will be greater urgency in addressing delays in data availability, inconsistency and data duplication.

START	
Recommendation	Implementation
Improve the quality of data collection including information on successful prevention programmes.	Significant amounts of data are already available on prevention and waste in health systems but it needs to be presented in a format and timeframe that are useful for the policymaking process.
Collect data through public surveys and exchange cross-border information.	In addition to sharing good practice, it would be useful to also explore failures through a 'blunder book' so that evidence of errors cannot be ignored. Many best practice prevention strategies are initiated at local level and we need mechanisms to identify and share them. For example, the Finnish asthma and allergy programmes could serve as models for other disease areas. The Directive on Cross-Border Healthcare invites countries to publish data on the quality and safety of their health systems.

	This could be the framework for initiating discussions on data collection and shared indicators. Common methodologies are needed to analyse data on health outcomes and shared indicators across the EU to measure them. Recognise and develop the collection of real life data (e.g. asthma and COPD) on an EU level to develop clear, evidence-based documentation for demonstrating value of different treatment options.
Begin effective implementation of HSPA especially on the effectiveness of new technologies.	HSPA should go beyond a system of ranking member state health systems and towards an evidence-based methodology which looks at disinvestment for ineffective interventions and all aspects of prevention such as healthcare professionals having the skills to train asthma patients on using their inhaler correctly. Using a broad definition of prevention (including early diagnosis and disease management in primary, secondary and tertiary settings), develop information on cost effectiveness of prevention. Facilitate the sharing of experience among EU countries on strategies for disinvestment in obsolete or ineffective technologies in health. Integrate this concept into HSPA approaches.

Promote the translation of data into policies and action plans, encourage the use of existing public health knowledge and supporting specific research in member states.	Review the mandates of the EMA and the ECDC to ensure that they can more effectively foster use of existing public health knowledge as well as supporting targeted research at member state level. There should be shared indicators across the EU to measure health outcomes as well as common methodologies for data analysis. Member states should have an obligation to collect and share ECHI data. Furthermore, efforts should be made to identify and share best practices in prevention strategies on the local level. EU action plans for health tend to be broad and non-binding. They should be more focused and tangible with less emphasis on what member states should do and more on the potential actions of a broader range of health sector actors, particularly health professionals. This will help to create pressure for change within medical and scientific communities which is essential to encourage ending ineffective interventions and a pro-prevention approach.
Define health objectives and long-term strategic goals beyond political terms.	Current EU objectives for health systems such as 'sustainability, equity and solidarity' are too general. The objectives need to be more specific and include fixed and systematic monitoring tools on issues like prevention and reducing ineffective care.

	An example would be to explore the creation of reference networks or centres of excellence on management of chronic disease. An EU 2020 health prevention strategy would help to link the work across all policy areas and identify specific goals, indicators and financing for all health actors to support. An example of long-term goals on asthma and COPD could be: prevalence needs to be declined by X% by 2025. Another long-term objective could be to have a European centre of excellence for chronic disease management. Overall EU health objectives should focus on improving health outcomes and not on financial cost management. Similarly, the setting of goals and targets for health needs to be long-ranging and not victims of short-term political thinking. Inspiration on long-term planning and strategy for health may be found beyond the EU's borders.
Progress towards a comprehensive strategy for patient empowerment – a meaningful involvement in health at national and EU level.	The concept of patient empowerment covers several key elements such as education and literacy, access to information, motivation and compliance with medical treatments. Patient empowerment begins with underlining the importance of citizen engagement in health – both for their individual wellbeing and to help identify appropriate health outcomes for policymaking.

	There are major differences across the EU in cultural approaches to patient empowerment. Bridging these gaps means identifying barriers to increased patient empowerment and supporting mutual learning between patient organisations to increase their capacities. Examples of empowerment for asthma and COPD patients include easy-to-access information about risk factors, prevention and the importance of an early diagnosis. Patient education, awareness and compliance training programmes and facilitation of better patient/doctor dialogue to improve the management of the disease.
Estimate waste and inefficiency in health systems and then commit to eliminate them. Focus on stopping ineffective interventions.	Improve cross-border collaboration to reduce waste and inefficiency based on a solid system of data collection, evaluation and sharing of best practices. The scope for change is huge – an estimated 30% of interventions in health systems are ineffective. Good information channels are needed between local health services and policymaking because inefficient practice can be both identified and changed locally. Evaluate how better primary, secondary and tertiary prevention could reduce waste and inefficiency within health systems. Review data collected from health systems especially older health practices on a regular basis in order to evaluate them. Look beyond the Quality-Adjusted Life-Years (QALYs) to include socio and macro-economic aspects.

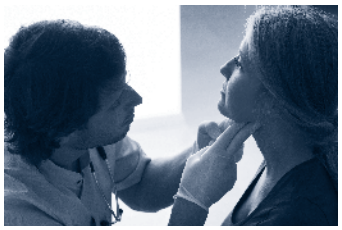
	Ensure that the definition of waste and inefficiency in health systems is based on a change from measuring transactions in healthcare to an approach that prioritises population health outcomes.
Make health a key outcome of government action at EU level.	A lack of coherence across European Commission policies such as trade, internal market and public health undermines overall efforts to improve population health. It also allows a cognitive dissonance by member states which may lobby to protect a specific industry regardless of the impact on health outcomes. A stronger governance mechanism within the Commission College to strengthen the focus on improving health outcomes would eliminate internal inconsistencies across EU policies.
Create a more coherent and explicit link between innovation for health and EU Structural Funds investments.	EU Structural Funds are a predictable stream of financing for investing in public services such as health. Programming priorities are set at national and regional level so it is up to member states whether to utilise these funds for health. A specific mechanism could be created within the Structural Funds to be used for implementing proven health prevention activities. This could provide economy of scale to prevention efforts. For example, funding could be earmarked for ERNs for which little support exists in practice.

STOP	
Recommendation	Implementation
Developing new indicators without considering the added value or usefulness. Make the existing ones work better.	Make better use of existing indicators and link them to the policy cycle, particularly the European Semester. Where possible, create connections between positive aspects of health such as productivity, social capital and economic data. Indicators need to measure all aspects of disease management. For example, many countries have made advances in education, prevention and access to treatment for asthma and COPD patients. Improvement is still needed in rehabilitation, support services and home care.
Recommendations from the EU level without considering how they will be used by and in overburdened national systems.	The CSRs linked to the European Semester need to be carefully monitored and the impact on equity and solidarity of health systems assessed.
Drafting reports/recommendations with no policy follow-up.	Drafting policy papers with no follow-up is burying the European Commission in paper and blocking progress towards crafting effective policies aimed at prevention. Member states need to report regularly on progress towards agreed long-term goals and health outcomes such as a Health European Semester.

Short-termism and considering health policy solely from a financial perspective.	Defining health objectives should not be undertaken in political or financial terms. Targets and goals need to reach to the future and not become victims of short-termism. Look to other parts of the world for inspiration for long-term planning and strategy. Health goals need to be based on the broader economic aspects of prevention not just financial costs.
DO DIFFERENTLY	
Recommendation	Implementation
Collect health data through appropriate means with proper follow-up. Make the collected information available to stakeholders to use.	Member states should have an obligation to collect and share ECHI data as well as common methodologies for data analysis. Release the data to encourage other stakeholders to use data for innovation in health and care services.
Replicate the cross-border collaboration exemplified by the EUnetHTA in other key areas of policy.	Build on the experience of European network for HTA to develop other voluntary system for sharing experience and methodologies particularly on prevention and disinvestment strategies.
More effective use of research results for good governance.	Enhance governance of health systems by using research results to build strategies for disinvestment in ineffective health practices and introducing proven prevention tools.

LIST OF ABBREVIATIONS

AMR	Antimicrobial Resistance
BLI	Better Life Index
CCC	Comprehensive Cancer Control
CHRODIS	Joint Action on Chronic Diseases
COPD	Chronic Obstructive Pulmonary Disease
CSR	Country Specific Recommendation
DG ECFIN	Directorate General for Economic and Financial Affairs
DG EMPL	Directorate General for Employment, Social Affairs and Inclusion
DG SANTE	Directorate General for Health and Food Safety
DRG	Diagnosis Related Group
EAAD	European Antibiotic Awareness Day
ECDC	European Centre for Disease Prevention and Control
ECHI	European Core Health Indicators
EIP	European Innovation Partnership
EMA	European Medicines Agency
EPAAC	European Partnership for Action Against Cancer
EPSCO Council	Employment, Social Policy, Health and Consumer Affairs Council
ERN	European Reference Network
EUnetHTA	European Network for Health Technology Assessment
GDP	Gross Domestic Product
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HSPA	Health System Performance Assessment
HTA	Health Technology Assessment
IMI	Innovative Medicines Initiative
JPIAMR	Joint Programming Initiative on Antimicrobial Resistance
MDR-TB	Multi-Drug Resistant Tuberculosis
MEA	Managed Entry Agreement
MEP	Member of the European Parliament
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
OECD	Organisation for Economic Co-operation and Development
PPP	Public Private Partnership
QALY	Quality-Adjusted Life-Year
TB	Tuberculosis
TBVI	Tuberculosis Vaccine Initiative
UK	United Kingdom
WHO	World Health Organisation



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Friends of Europe was responsible for guaranteeing editorial balance and full independence, as evidenced also by the variety of the working group's members and the collective agreement on the recommendations

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Friends of Europe – Les Amis de l'Europe
4, Rue de la Science, B-1000 Brussels, Belgium
Tel.: +32 2 893 9825 – Fax: +32 2 893 9829
Email: info@friendsofeurope.org
Website: www.friendsofeurope.org