



Brussels, October 2013

CONFERENCE REPORT

EPHA 4th Annual Conference

4-5 September 2013, Brussels

Brave New World

Inclusive growth & well-being
or

vested interests & lost generations?

Download the Conference's:

- ✓ Agenda 
- ✓ Speakers bios 
- ✓ [Press statement](#)

- Photo gallery 

A photograph of a conference room. In the foreground, the backs of an audience of people are visible as they sit in rows of chairs. At the front of the room, two people are seated at a long table on a stage. To their left is a large white projection screen. To their right is a large screen displaying a presentation slide with a logo and text. The room has a high ceiling with several spotlights hanging from it. The overall lighting is bright and professional.

DAY ONE

4th September 2013

OPENING

Our health, our economy, our society our future - A brave new world

Opening ▀ Outgoing EPHA President **ARCHIE TURNBULL**

Mr Turnbull welcomed all conference participants and speakers, and he explained that it marked **EPHA's twentieth anniversary**. He also expressed his delight at the fact that people working at such high level appreciated EPHA's contribution.

Moderator ▀ **MARTIN MCKNEE**

Professor of European Public Health, London School of Hygiene and Tropical Medicine and President elect European Public Health Association

Mr McKnee provided an opening speech recalling the conference theme, 'Brave New World', derived from Aldous Huxley's eponymous novel. While Huxley's was a dystopian post-Fordist world in which people became dispossessed pawns in a machine, there was also a sense of a brighter future. McKee said this resonated with the situation today in the sense that, **although an economic recovery was occurring, this was clearly not benefitting everybody.**



Mr McKnee

While the fortunes of the rich and powerful remained stable during the crisis, **low-skilled Europeans and young people in particular were suffering from poverty and unemployment.** McKee stressed the importance of inclusive growth and wellbeing, quoting George Santayana, *“those who cannot remember the past are condemned to repeat it.”*

Mr McKnee pointed that **smaller EU Member States are unable to negotiate the same medicine prices as the larger countries,** and stated that health could not be ‘depoliticised’ describing **co-payments as a ‘zombie policy that was coming back to life again’.**

TONIO BORG - Video message
European Commissioner for Health Policy

Mr Borg summarised the added value of EU legislation in health – for example by coordinating cross-border health threats and food crises; setting safety standards of medical devices, blood tissue and organ donations; or harmonising pharmaceutical policy.



Mr Borg delivering his video message

He said that the **EU played a key role in the debate over health system sustainability and constraints.** He stated that health was a crucial component to boost economic growth and prosperity; hence it was vital to invest in health and reduce health inequalities. Improving health could make people live longer, reduce long-term treatment costs and improve health outcomes.

Future EU health policy should build on the value that EU cooperation can help build better health outcomes

Mr Borg concluded that **the crisis had stressed a number of problems such as ageing and chronic diseases**, *“in response to these, it was important to foster cost-effective innovation to achieve social cohesion and poverty reduction.”*

YVES LETERME ( download presentation)

Former Belgian Prime Minister and current Deputy Secretary General of the Organisation for Economic Co-operation and Development (OECD)

Mr Leterme described EPHA as an important counterweight to other lobbies who mainly sought to ensure their interests at the expense of European citizens and taxpayers. He thanked EPHA for drawing attention to the need for investment in public health, and also expressed his gratitude to the Lithuanian Presidency. After five years of crisis the



Mr Leterme

first signs of economic recovery were palpable in spite of high levels of unemployment and growing inequalities. **Public health supporters had to fight hard amongst competing claims for expenditure but the crisis underlined the need for ongoing investment**, including in training and recruiting doctors, developing medicines, etc. In the past, money had not been spent efficiently which led to an unsustainable

situation, including decreased public health expenditures.

Mr Leterme warned it would be a long time before regular increases in health spending will occur again, as had been the case prior to the crisis. The new fiscal reality meant that “more” has been replaced by “no more”, and policies and health systems still required adaptation. Instead, **increases in co-payments affected households, and health workers’ salaries were reduced without creating any efficiency.** While there was an urgent need to spend on prevention and healthy behaviours to tackle obesity, alcohol consumption, etc., prevention had suffered the biggest cuts in 2010 and 2011. **Prevention required a higher profile and this needed to be heard at all tables.**

*“Co-payments stating they created false savings as they discouraged ordinary people from seeking help. **Europe’s challenge is to deliver value for money while tackling inequalities**, hence uniformity in service provision should be actively sought to spend money wisely.”*

While many countries have taken more cost-effective approaches to pharmaceutical expenditure (e.g. by improving generics utilisation) there was scope to expand these activities to medical devices and hospital services.

Mr Leterme concluded that instead of targeting the poor, **the focus of price increases should be on people least likely to change their consumer behaviour.** Healthcare was not a luxury and cuts should be avoided.

ZSUZSANNA JAKAB ( download presentation)
Director of the World Health Organisation (WHO) European Region

Mrs Jakab congratulated EPHA on its achievements and ability to identify emerging public health challenges. She said that **while there were gains in life expectancy across the European Region there were increasing health inequalities** between and within countries that needed to be better understood. Mrs Jakab stated we must not forget communicable diseases, NCDs and mental health problems rooted in social and economic circumstances. Socially-determined behaviour, (e.g. heavy drinking and smoking) reflects stress in people's lives - **tackling health determinants over the life course required shared priorities between health and other sectors** - a whole society governance approach.

Unless urgent action is taken the social gradient would increase. Mrs Jakab announced that a [WHO Europe report on social determinants and health divide](#) would be launched in September.

Current economic difficulties were a reason for action: a more flexible, team-oriented health workforce is needed, and public health requires strengthening and integrating health systems mainly at primary care level. **While governments felt daunted by growing health expenditures, the cost pressures also provided a strong economic case for effective preventive measures.**

Wide-ranging strategies are needed to address multiple determinants of health across social groups, including individual and community behaviours.

Mrs Jakab pointed that tobacco control programs were very cost-



Mrs Jakab

effective. She expressed her hope that the revised EU Tobacco Directive goes through unchanged.

“The benefits of health promotion, fiscal measures, promotion of physical activity, and prevention of depression - the single biggest cause of disability worldwide. She pointed that investing in education meant investing in health”

Asked **how to best persuade policymakers to put prevention and health promotion on top of the agenda while ensuring ongoing quality treatment of expensive diseases** like cancer and HIV/AIDS, Mrs Jakab acknowledged the problem that preventive strategies brought no immediate returns, which makes it challenging to invest in since results were not visible straight away. A new type of horizontal governance was needed.

VYTENIS POVILAS ANDRIUKAITIS ( download presentation)
Lithuanian Minister of Health

Mr Andriukaitis explained that the main public health priority of the Lithuanian Presidency of the Council of the European Union (July to December) 2013 was to support modern, accessible and sustainable



Mr Povilas Andriukaitis

health systems. He also said that the key issues for [the Lithuanian Health Forum](#) were medical devices, clinical trials, tobacco, rational use of medicines, primary care, 'brain drain', mental health; cross-border patients' rights, and pharmaceutical restructuring.

Although the timeline for action was fairly short, Lithuania aims to find solutions that culminate in the Council Conclusions by the end of 2013.

Mr Andriukaitis suggested that **EU Member States should focus on the reorganisation of healthcare services, and link the pricing of pharmaceuticals to their effectiveness.** She said that more attention has to be paid to integrated care, health technology assessments, eHealth, health promotion, and innovation.

He went on to say that the economic crisis had positive and negative impacts. On the one hand, it was an opportunity to improve efficiency and health outcomes. On the other hand EU Member States were unable to safeguard access to health services. Mr Andriukaitis underlined that health needed to be a value in itself given its potential for creating economic growth, boosting innovation, fostering new skills and generating jobs. Mr Andriukaitis underlined that a high level of public health meant a high state of social and economic advancement, and the principles of solidarity, equality, universality must spread across the continent.

“Patients and their families needed to be empowered as they play multiple roles in the health system.”

SESSION 1

Future of care, how do we get there? Innovation, equality and sustainability

Moderator ▀ **HERDIS GUNNARSDÓTTIR**
European Federation of Nurses Associations

Moderating the first session on the future of care, Ms Gunnarsdóttir confirmed that the main challenge **was to bring about cost-effectiveness while maintaining quality health outcomes**. To achieve this, innovation, integration and cooperation were needed. She underlined the **objective of the session, which was to explore the opportunities afforded by innovation for achieving equality and sustainability, as well as the challenges**.

ROBERT MADELIN
Director-General of DG CONNECT

Mr Madelin stated that more partners than only health stakeholders were required to deliver ‘health everywhere’, and that it was a matter of embedding health in all aspects of our lives beyond ‘Health in all Policies’.

He highlighted the [European Innovation Partnership \(EIP\)](#) on Active and Healthy Ageing and the 2012-2020 eHealth Action Plan as examples of bringing research and innovation closer to the market. Especially the

'partnership' concept promises future success as it involved academics and industry, care providers, advocacy groups and regional players. The EIP drove innovative interventions for increasing healthy life years. Mr Madelin added that the regions were particularly important, as they count with good practice examples provided by the reference sites, like developing state-of-the-art patient records. He also cited the three million lives programme in the UK and the Silver Economy project as examples of well-functioning networks.

Regarding the [eHealth Action Plan](#), Mr Madelin said *the key word is interoperability*, and that the Connecting Europe Facility would support interoperability in crucial areas like e-identity, access to and integrity of patient records.. In spite of the crisis, there is a new vision to make things better, however changing politicians' minds was a marketing challenge since health was not 'sexy'.

eHealth apps have to be used as drivers for health literacy without becoming tools for charlatans

MARK PEARSON
Director of Health at the OECD

Mr Pearson welcomed the chance to look beyond the crisis. He mentioned that fantastic **innovations are emerging including genomics, big data, computing power increases, and new patents for medical devices**. Mr Pearson pointed that health has a terrible record in using innovation to reduce costs, and innovation has added to the cost of the business. There were also no incentives for innovations that reduce costs.

He named three policy areas which needed to do better: **1.** Payment system (i.e. finding ways to pay pharmaceutical companies for the value of medicines instead of reimbursing their costs) **2.** Health workforce - a

more flexibility in roles. Physicians should not block practitioners able to perform tasks more cheaply. Mr Pearson cited the example of physician assistants and advanced nursing practitioners in the USA; **3.** Prevention required more emphasis and spending must be a lot higher than 3% in the future.

RICHARD BERGSTRÖM

Director of the European Federation of Pharmaceutical Industries (EFPIA)

Mr Bergström argued that even the wealthiest countries need to find ways to absorb innovation without breaking the bank. He affirmed that **off-patent medicine volumes were taking off, and there is an increased willingness to collaborate at EU level** and that **economists' judgments of health sector performance are limited** as the only indicators are life expectancy and death rates. He stated that **new Member States are simply not investing enough in healthcare or medicines** to get the required outcomes, but it was difficult to explain that some countries needed to invest more than others.

It is of Mr Bergström's view that EU health values are a political decision - he is a believer in competition but co-payments should be income-related not flat. Moreover, efficiencies were required not only in the pharma sector. **Still Europe's health sector was performing much better than the United States.** The question was how to deliver universal equitable healthcare within the budget. The **pipelines for pharmaceutical products and medical devices are also better than ever**, as a wave of products for hepatitis, multiple sclerosis, tuberculosis and so were being developed. Unfortunately, these new medicines will not be given to everybody in Europe. A sustainable model for **innovation is urgently needed and not just pricing changes.** Thanks to the crisis it was possible to have this conversation now, unthinkable five years ago.

LUIS MENDÃO

The European AIDS Treatment Group (EATG)

Mr Mendão stated that **there are huge differences in medicines pricing between EU Member States** (almost forty percent between France and Bulgaria). The world had always sought to exclude certain individuals and the poor, drug users, undocumented migrants and people with HIV were amongst the first. In Eastern Europe, the coverage of HIV treatment was only 20% of what was considered effective.

He argued that differential pricing needed to be introduced to avoid that people will be excluded in both rich and poor EU countries. Innovation such as new hepatitis C treatments must be available to everybody, and the question of who received treatments should not be swept under the carpet.

ELLEN T'HOEN

Independent consultant in medicines policy and law

Ms T'Hoен discussed the issue of *international solidarity*. She said the EU had lofty goals for global health which were often at odds with trade investments. The European Commission's Directorate-General for Development and for Trade displayed a distinct lack of coherence. It must be possible for innovation to benefit people in low- and middle-income countries; the example of HIV showed that millions could have access to treatments. However, there **was no mechanism yet to guarantee that people could access medicines before patents expire**. Ms T'Hoен stated that tiered pricing was not nearly as effective in lowering prices as generic competition. Health impact assessments of trade agreements and Intellectual Property were also crucial.

The current system of market exclusivity for medicines was all about getting the product out to as many as possible in a short time. A **wider variety of innovation models and payment mechanisms was needed**, like de-linking innovation from the price of a product or prize funds. **Transparency was key for building faith in regulatory institutions**; this included access to clinical trials data since there was still resistance to full disclosure of results and debates were ongoing over ‘commercial sensitive information’.-

✓ Questions and answers

Participants wondered **how greater innovation in prevention and health workforce could be communicated to politicians**, and whether awarding companies for innovation might clash with global trade policy obligations. The potential cost-effectiveness of integrating **Complementary and Alternative Medicine (CAM)** methods into the health system were also highlighted.

Referring back to *medicines pricing*, Mr Bergström stated that **some pharmaceutical companies charged different prices in different countries** in return for better access. This was however **impossible in the EU** as Member States were referring to one another. However, it was only fair that people who could pay more should do so. **Ms T’Hoen** stated that *greater transparency over trade agreements* was required and that public health experts must be part of the table.

Mr Mendão stated there was enough evidence that *inequity was growing*. **Universal access to best standards in healthcare was needed**. Not having a unified price in the EU would lead to the exclusion of entire groups of people.

Mr Madelin stated that interoperability and data issues were high on the Lithuanian Presidency agenda. *Data protection* was becoming easier and fears needed to be put aside so that innovation could become ‘sexy’.

Monika Kosińska, EPHA Secretary General, refuted the claim that health was not sexy, stating that sales go up if something is labelled as healthy - *health is a winning product*. She also commented on the disruptive nature of innovation, stating that it disturbs people benefitting from the existing system. **Physicians** are historically the leading innovators in public health, they **need to engage more in this debate**.

SESSION 2

Breaking the cycle of inequalities – building more equal and healthier societies

Moderator ▀ **JEAN LAMBERT**

Member of the European Parliament (Greens, UK)

Ms Lambert stated that healthcare was featured in her recent report on the impacts of the crisis on vulnerable groups, pointing that there is **growing stigmatisation and inequality across Europe**, and the cycle had to be broken. There were limits to what could be done in the

healthcare sector alone.



Panel of speakers at Session 2, with Ms Lambert speaking (second left)

She pointed that the **overall theme of the session was to join up forces for widening healthcare, as vulnerable groups are often difficult to reach.**

BRANKO MILANOVIC

Lead economist at the World Bank Research Group

Mr Milanovic noted that **Europe is fairly equal but on the basis of *wealth inequality* and an uneven distribution of education levels and of capital.** He cited the example of Sweden as a country that had very large wealth inequality in spite of very low income inequality. He explained that, when the crisis started as a financial crisis, the assumption was that inequality would go down as it would mainly affect people with assets, but then unemployment amongst the weaker and poorer population went up, which changed the scenario.

He explained that, although the mean income had not changed much between 2007 and 2011, **the top 1% had profited from the crisis while everybody else had lost.** Viewed as a single country, inequalities in EU-28 would not be significantly lower than in the United States. In **Europe inequalities were primarily related to large gaps between Member States.** Ending on an optimistic note, Milanovic stated that global inequality was stagnant and even on the decline despite rising inequalities in China and India.

STEPHAN BEVAN

Director of the Work Foundation

Mr Bevan deplored the uneven distribution of quality jobs across Europe. **The rise of youth *unemployment* during the crisis has cast a big shadow over Europe and impacted on health.** In addition, there was **growth in underemployment** due to the gap between people's skills and the requirement of the job market – Europe needs 'more and better jobs'.

Many people experienced less variety, they had less of a voice, and fewer opportunities for growth.–**Two-tier labour markets are the norm in many**

EU countries involving the 'hollowing out' of intermediate-level jobs.

Other trends were casualisation (temporary and part-time work, job insecurity), a growing precarious workforce, even an increase in 'presenteeism' (people going to work when ill). Mr Bevan argued that welfare policy needed to focus on preventing job losses and on the needs of an ageing workforce - more investment in prevention and early intervention paid for itself.

ROBIN IRELAND  download presentation)
Chief Executive of the Health Equalities Group

Mr Ireland gave the example of Liverpool as a city where men were more or less expected to be on medication at the age of fifty. Hence it was crucial to engage communities and take ownership of health. Life expectancy in Liverpool was up to 10 years less than that of more affluent parts of Europe. This was combined with *food poverty* as 30% of the population were living on means tested benefits. He explained that local food banks were dishing out processed foods, with the result that 15% of children were classified as obese and with tooth decay.

Noting the findings of the Cochrane Review, Mr Ireland said that **educational and counselling initiatives in isolation do not work - the key was to shape the environment to make it easier for people to live healthily.** The recent move of public health into local government in England may present opportunities in this respect. Quoting the Marmot Review, he stated that **money must be put into fiscal and legislative changes at all levels: local, national and European.** Only this could make a real impact for disadvantaged people.

ANA MOHR

NGO Carusel (Romania)

Ms Mohr talked about Carusel work on harm reduction amongst Roma drug users. Romania experienced a big HIV outbreak in the late 1980s. Following this peak, national legislation illegalised sex work and drug possession, leaving sex workers particularly vulnerable. There was a noticeable **increase in the number of *HIV infections* amongst drug users as a result of the crisis, very similar to Greece**. Although many were Roma, other groups were also affected. The *Roma community* is **more vulnerable than the general population** because it has poor access to medical care and social services, and often they lacked papers for medical insurance. Unemployed and discrimination were added problems. According to a Carusel survey, 52% of drug users were HIV positive.

Carusel was developing an advocacy project targeting Roma organisations including the National Agency for Roma in order **to make clear references to harm reduction, and provide medical support for drug users**.

✓ Questions and answers

During the ensuing discussion, commentators stated that **health inequalities appear to have grown due to EU demands on poorer Member States**. The EU Charter of Fundamental rights mentions equal access and this should be demanded by the European Commission.

Members of the audience underlined the **need to keep advocacy going as there was very good evidence of the economic benefits of decreasing inequalities**. Research needed to be used more efficiently to tackle inequalities, and better knowledge and more innovation had to be coupled with investments in health promotion and prevention. Moreover, people often did not understand what their rights are and therefore they did not demand them. It was important to **improve the**

educational attainment of children to raise expectations of health. In this sense, Ana Mohr stated that many Roma drug users do not have expectations as they self-exclude themselves coupled with blame by mainstream society.

In Greece, the regulation of *labour legislation* also made it easy for people to get sacked when they were sick. Mr Bevan added that rebuilding the economy and investing in prevention were not easy to reconcile. **Robin Ireland** deplored the patronising attitudes **of some health professionals who are unwilling to discuss certain health topics with patients.**

Mr Milanovic stated that **politics was increasingly being undermined by the forces of money:** rich people were unlikely to vote for laws against them. Hence there were steady increase in inequalities over the last decades.

“Mitigating health inequalities was not enough and one needed to look at their causes in the system; this is also an issue of policy ownership,”

SESSION 3

Tackling the elephant in the room – increasing the efficiency and better use of our resources

Moderator ▀ **MONIKA KOSIŃSKA**
EPHA Secretariat General

Ms Kosińska stated that there was a need for *self-reflection* about what could be achieved. She noted that flexibility was at the heart of resilience – ‘if we are not flexible, we break’.



Panel of speakers at Session 3, with Ms Kosińska speaking (second left)

BERNARD HEPP
President of the European Healthcare Fraud and Corruption Network

Mr Hepp talked about the need to change providers’ behaviour to reduce *‘waste’ in the healthcare system*. **Fraud, corruption and waste were big problems, however the latter was difficult to estimate** or measure: in Belgium, it represented between 3 – 10%, however it could even reach 30%.

He explained there was no distinct definition of 'waste' and a typology of infringements was required. Billing for services which were not provided was the most important issue, but also non-compliant billing, over-utilisation of services (e.g., resistance and provocation tests for diseases) and offering overly expensive services. Tools were needed to measure fraud and corruption, coupled with judicial and legal accountability including sanctions and enforcement.

BEATA STEPNIEWSKA

Deputy Director General & Head of Regulatory Affairs - European Generics Medicines Association

Ms Stepniewska discussed how the *generics industry* could **contribute to solving the problem**. Not only did generics provide savings but they also increased access for patients, like the launch of a biosimilar drug for oncology patients has increased access to this product by 44% in the UK. She stated that **investing in health should be an integral part of EU 2020 strategy**.

The generics industry had a lot to offer to achieve this objective. However, the problem was the short-term thinking of decision-makers and payers who focused on cutting prices but did not consider the long-term consequences of price reductions.

DAVID MCDAID

Senior researcher at the London School of Economics (LSE)

Mr McAid argued that investments in *mental health and psychological well-being* represented another elephant in the room. There is excellent evidence from the United States which shows that **psychological interventions amongst diabetes patients lead to better outcomes for physical health**. Mental health had an impact on

physical health, for example a large percentage of smokers in England suffered from depression and anxiety disorders.

Early years interventions for children to promote physical and mental well-being are important since a poor start in life had profound consequences for adulthood. There was a need to invest in pre-school and in-school support. A clear economic argument for investing early on (lower employment rates, higher crime rates, etc.) could be made without even mentioning health. Other sectors had to co-deliver health. McDaid added that **better psychological health at work brought many benefits for large and small organisations** (e.g. more creativity, innovation, and job retention). Many felt the psychological impacts of austerity: the long-term unemployed will continue to feel these even after the recession. Another elephant in the room was the issue of implementing recovery: for example, it was important to offer free access to debt advice for individuals and to increase financial literacy to avoid future problems.

SUSANNE LOGSTRUP

Director of the European Heart Network (EHN)

Ms Logstrup noted that the **lessons from cardiovascular prevention have not been learned either**. She advocated for **policy responses that reach the whole population** since a mass approach was the only answer to a problem of mass disease. She pointed out that **cardiovascular disease is the leading cause of death in the EU**. A comprehensive approach would imply, *inter alia*, controlling the intake of transfatty food, reducing obesity, and increasing physical activity. The goal was to reduce premature mortality by 25% by 2025.



Susanne LOGSTRUP, Director
European Heart Network (EHN)

Ms Logstrup stated that, as Mrs Jakab had

stated, one should not expect too much from individual health education. It is a matter of **identifying people who are high-risk as they will benefit the most from interventions**. Moreover, mass **behaviour needs to be influenced by looking at mass determinants, both social and economic**. If smoking rates could be reduced by 2%, this will have an enormous effect on cardiovascular diseases. This **requires legislative measures on price, availability, accessibility**.

ANDREW LONG

Professor of Health Systems Research, University of Leeds

Mr Log called for broadening the way of thinking and **move beyond the medical model towards a broader social model of thinking about ill health**. There was a need to enhance knowledge of one's own body, improve self-resilience, and promote critical health literacy. The entire person needed to be looked at since health is inherently individual. **He stated that *Complementary and Alternative Medicine (CAM)* must be recognised and should be evidence-based** - CAM holds huge benefits since it does not have the polypharmacy problem (e.g. in treating co-morbidities).

“We have to move away from the ‘search for magic bullet’ approach towards a ‘whole person’ view”

Methods such as acupuncture and shiatsu not only helped patients but made them more aware about themselves and empowered them to take charge and regain control. CAM also involved being listened to. Making CAM available to patients was thus another way of addressing inequalities and inefficiencies in the system.

✓ Questions and answers

In the ensuing discussion, Ms Kosińska stated that **CAM is still a taboo subject**, and she would like to explore why public health settings are still a bit uneasy with the whole person approach. Andrew Long indicated that many patients will not tell their doctors they are using CAM, which can also be a patient safety concern.

Other commentators noted that *patients are an underused resource*.

Health systems have to restructure more on the needs of users as patients do not necessarily ask for the most expensive treatments but for those that work. Some of the attendees spoke of the paradigm shift from treatment to prevention, which was

also important in terms of *patient safety*. **Bernard Hepp** mentioned that in 2010, Belgium introduced a new programme on responsibility of healthcare providers and the need to follow guidelines. Sanctions were the last step when there is proof health providers want to damage the system.

Martin McKee closed the day by saying that the media tends to follow the views of the 0.1 percent of people who live on a different planet: *“in their world, it was unimaginable that you should regulate industries and that big companies should pay taxes.”* Mr McKee noted that **calls for a fundamental reorganisation of society are weak at a time when new alternative narratives were needed**.



DAY ONE
5th September 2013



Session 1

What has Eurozone austerity mean for health and health systems?

Opening ▀ Outgoing EPHA President **ARCHIE TURNBULL**

Mr Turnbull announced that **EPHA was launching a new Health Think Tank for Health Actors by Health Actors called European Public Health Futures.**

“EPHA members decided to set up a health think tank due to the lack of quality in discussion on health issues and thought leadership in the field of public health“

EU’s competences in health have increased over the past 10 years and with new economic powers, the EU has a bigger role to play in health systems than previously seen in the past 30-40 years.

PAOLA TESTORI COGGI

European Commission’s Director-General for Health and Consumers

In her speech, Mrs Testori Coggi pointed out that “in its Annual Growth Survey and Country Specific Recommendations, the European Commission encourages **EU member states to make sure that their health systems are more cost effective and sustainable, while ensuring the access to quality health care.**”

Mrs Testori Coggi said that this is part of an *Investing in Health* approach, as established by the Commission in a paper of February this

year, which also includes **investing in effective health promotion and prevention, and fighting inequalities in health** as they are a waste of human potential and an economic loss at the same time.

“To go beyond mere efficient gains like lower pharmaceutical prices and lower wages, and initiate genuine structural reforms for patient centred health systems, EU member states have a broad range of tools at their disposal such as health technology assessments, e-health, and innovation.”

JOSEP FIGUERAS

Director of the European Observatory on Health Systems and Policies

Mr Fugueras pointed that the **debate on economic governance and health is meant to give the health community the needed tools to engage in EU processes and examine the impacts of austerity** on health systems and population health: *“economists will agree that with the crisis there is a rise in suicides, but the situation is not dire.”*

Dr Sarah THOMSON ( download presentation)

Senior Research Fellow, European Observatory on Health Systems and Policies and Deputy Director LSE Health

Dr Thomson indicated that several European Countries have reduced their health budgets for three to five years, *“throughout Europe **there are countries which have taken the opportunity to make needed changes in public health**, such as broaden the revenue base for health systems, ring-fenced public health budgets, implemented health technology assessment and eHealth, improved integrated care and increased benefit coverage protection to population.”* She added **that these policies are**

difficult to introduce as many require initial investments, yet these measures policies go a long way in improving efficiency.

Dr Thomson said that there are **challenges in terms of resources**, capacity of ministries of health and health workforce, as well as barriers to face vested interests, “this has **lead to some countries to implement short-term solutions that can be detrimental to health and patient safety**, exclude certain groups from coverage, implement user-charges, salary or hiring freezing, and delaying investments in health infrastructure”. Dr Thomson concluded that reform is possible, but difficult, *“policy makers have choices to make. There is strong pressure for short-term savings, however savings does not equal efficiency. Good governance and leadership are crucial.”*

Dr RAED ARAFAT

Romanian Secretary of State for Health

Dr Arafat presented **the impacts of the economic crisis on the Romanian health system**, indicating that some measures were imposed as part international interventions. These agreements do not allow Romania to take on debt to invest in health.



(Sarah THOMSON, Senior Research Fellow, European Observatory on Health Systems and Policies and Deputy Director LSE Health (left); Raed ARAFAT, Romanian Secretary of State for Health (centre); Josep FIGUERAS Director of the European Observatory on Health Systems and Policies (right))

Austerity measures have lead to understaffed sections of the health system – there has been a drop of 19% in the number of nurses in Romania, many of whom have left to work overseas, as well as young

Doctors. **Due to budget cuts, many hospitals and rural clinics have been closed down and user charges were implemented.** The result is that patients have to travel to receive care or pay for expensive medicines and treatments, making treatment inaccessible for many vulnerable groups and causing patients to delay seeking treatment. This has the potential to create a public health emergency for communicable disease and privatisation. Mr Arafat pointed that the **Romanian Parliament succeeded in preventing a complete privatization of funding, insurance and public procurement.** Now Bucharest is trying to use structural funds to invest in health infrastructures. Dr Arafat argued for a European approach, as decisions in one country can impact in other states.

Dr. KATHIA VAN EGMOND ( download presentation)
Medical Coordinator at Médecins du Monde (MdM)

Dr Vaz Egmond said that austerity measures compromise the values of health systems: universality, access to good quality care, equity and solidarity. She presented the findings from a report MdM published on access to healthcare for vulnerable group: [“Access to Healthcare in Europe in times of Crisis and rising Xenophobia.”](#) She pointed at the paradox that *cuts to services and user fees impact vulnerable populations with the worst health status* and have the most trouble accessing service. *“Many migrants do not understand their rights,”* the phenomenon of health tourism is a myth, argued Dr Van Egmond.

She gave the examples of Brussels, where in its Roma migrant community only 6% of children are properly vaccinated, and the one of Spain, where 62% users of MdM services had been denied public healthcare. She went on to say that in Spain, adult undocumented migrants are excluded through Royal Decree - Law 16/ 2012 on ‘urgent measures to ensure the sustainability of the national health system’.

✓ Questions and answers

The response from the audience was one of shock to hear the situation on the ground. Participants asked if a **change was needed in health governance** in order to transition from emergency responses to long-term solutions.

This led to a debate on treaty change and EU competences. If there was going to be a **response at EU level, would this go beyond the current health competence.**



Session 2

A new economic European order and new future for health and health

Dr RITA BAETEN  download presentation)
Senior Policy Analyst, European Social Observatory

Dr Baeten presented the EU governance system to give participants an understanding of the framework in which these decisions are taken. She said that the EU has an even greater role in the Eurozone countries, “in 2011, health system reform to achieve financial sustainability was included in the Annual Growth survey (AGS) and endorsed by the Council, which gave the European Commission a mandate to recommend health system reforms, “in 2013 there were significantly more detailed Country Specific Recommendations (CSRs) in regards to healthcare.” Health was also referenced in the labour market and social services. In Greece, Portugal, Ireland and Cyprus, no National Reform Programme (NRP) or CSRs are drafted as they countries sign economic adjustment programmes.

Ms Baeten said in the economic adjustment programmes there are implications to health: an expenditure cap on health spending, reduced prices, salary freezes, increases in co-payments, reduced benefit packages, and centralised procurements. Dr Baeten presented one of the weak points of the European Semester - health ministers are not involved, *“the CSRs are endorsed by Finance ministers. None of the CSRs regarding health has ever been amended by the Council, although they have the possibility to do so.”*

What is the legitimacy of DG Economic and Financial Affairs and finance Ministries to deal with content of health system reform?, Dr Baeten wondered. The AGS does not capture tensions between different objectives; boosting employment, sustainability, and reducing poverty.

Lastly, said pointed it is not clear how stakeholders are involved in the process, *“transparency, enhanced surveillance, and involvement of health actors could bring concrete improvements to the European Semester.”*

NATALIE CHAZE

Head of Unit Health Systems, DG Health and Consumers

Ms Chaze stressed the importance of looking at the real situation and being pragmatic. The legal basis for the European Semester is article 121 of the treaty in economic policy, *“health expenditure is a big part of public spending and national budgets therefore cannot be excluded from the concept of economic governance.”* There have been improvements, in 2013 for the AGS the **joint aim in health system reform is financial sustainability and access to high-quality healthcare**. In the current economic climate, health budgets cannot grow. There is not a link between the amount of money spent and health outcomes.

Ms Chaze explained that another goal of the AGS is the modernisation of health systems, *“member states are invited to present NRPs and include their plans for health system reform.”* She stressed that the Commission analyses the NRP and the outcome is the staff working document: access to healthcare, the impacts on employability and social inclusions are included in the analysis. **In 2013 several CSRs included access to healthcare for vulnerable groups, strengthening integrated care, and improving primary care.**

Ms Chaze argued that more could be done by health actors to stress the benefits of health to social care, *“the Employment, Social and Consumer Affairs Council does not discuss the EU semester.. On 8 October the European semester will be discussed at the Senior Level Working Group on Public Health. Afterwards, we will see if there is any greater uptake from the Member States or political will to be involved in the process,”* concluded Ms Chaze.

FABIAN ZULEEG

Chief Economist, European Policy Centre

Mr Zuleeg pointed out that **health ministers may not want an EU competence in economic governance for health systems**, *“it will mostly likely happen through the ‘back door”*. In his view, the importance is the objectives the EU wants to achieve, *“so far, policy makers have been operating under the belief that everything can be achieved ... you can **achieve affordability, accessibility, or lower public costs**. There will be some wins and some loses, but decision makers **will have to make tough choices and consider trade-offs**.”* Mr Zuleeg argued that the health community needs to implement 'hard economic' measures for the benefit of social investments and strengthen the evidence base to convince Finance Ministers that *public health matters in economic terms*.

CAROLA FISCHBACH-PYTTEL

General Secretary, European Federation Public Service Union (EPSU)

Mrs Fischbach-Pyttel shared the experience of the trade union movement in being involved in the European Semester. **Public sector workers are not among the richer part of economy, but the contribution they make to health and economy is vital**. EPSU has noted the democratic deficit as a barrier by the treaties, *“it is difficult for civil servants to be involved in the European semester, as the process moves quickly and mixes competences across different sectors of government.”*

*“As a response to the crisis and boosting growth, there has been a growing **push to privatise healthcare provision and delivery**. There is a public responsibility. Privatisation does not necessarily improve efficiency in itself.”* Mrs Fischbach Pyttel called for a social investment plan as austerity is not a solution, *“some of the measures are 'bleeding the patient dry' similar to what was done in the medieval ages.”* Mrs Fischbach-Pyttel concluded her intervention by

saying that “to respond to the social crisis, **Europe needs a shift away from "fiscal consolidation" to "social investment"**. To achieve this, quick action is needed and there must be strong political will.”

What next for EU health and Economic Governance?

Closing remarks ▸ **PAOLA TESTORI-COGGI**

Director General DG Health and Consumers (DG SANCO)

Ms Testori-Coggi urged the health community to respond quicker that *health is a value and driver of growth*, “unfortunately in tough economic climates, all expenditure comes under scrutiny and health is one of the first areas to get cut.”

She went on to say that this was one of the reasons why the European

Commission adopted the [Staff Working Document "Investing in Health"](#).

“**Around 15% of national budgets is healthcare**, and for this reason DG SANCO has been trying to work with member states,” pointed Ms Testori-Coggi. She also told the audience that an **expert panel on investing in health was launched** and will provide independent expertise on where cuts should be made and how to make the most of every EURO spent to improve health outcomes. The 2013 AGs and several CSRs also aim to improve the efficiency of health spending and care.

Ms Testori-Coggi shared DG SANCO’s experiences in working on economic governance and there is limited ability to influence programmes



Josep FIGUERAS Director of the European Observatory on Health Systems and Policies (left); Paola TESTORI-COGGI Director General DG Health and Consumers (centre); and Natalie CHAZE, Head of Unit Health Systems, DG SANCO (right)

structural adjustment programmes, “*there are also limitations to the EU competence in the organisation of health systems that have to be taken into account. But the crisis and enhanced economic governance have provided possibilities that few would have thought possible in the past.*”

She concluded his intervention by saying that **with the 'two pack', the European Commission can provide comments on how national budgets are being spent.**

Summary and closing ▸ Dr JOSEP FIGUERAS

Director of the European Observatory on Health Systems and Policies

Dr Figueras noted that **many speakers had called for a silent revolution and paradigm change**, yet the European semester is a very "top down" approach to policy making.

He also pointed that many of the participants had noted that in the EU economic integration

was about serving people's interests and health at the beginning, “*when it changed did not become clear, but the audience was dismayed that*

vulnerable populations are being left behind.” The tradeoffs that the public health community would be willing to accept were debated. **Several participants asked where does one stop when making economic arguments about the value of health.**



Josep FIGUERAS Director of the European Observatory on Health Systems and Policies (center); Paola TESTORI-COGGI Director General DG Health and Consumers (right); Carola Fischbach-Pyttel General Secretary, European Federation Public Service Union (EPSU) (left)

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