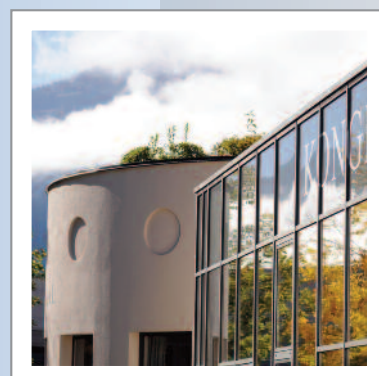
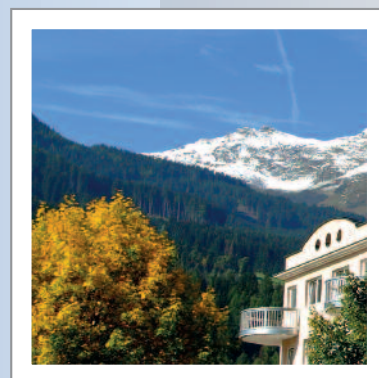


European Health Forum

GASTEIN



Crisis and opportunity

Health in an age of austerity

2012

Conference Report



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More information about International Forum Gastein and European Health Forum Gastein is available at www.ehfg.org

Video summary of the 15th European Health Forum Gastein is available at www.ehfg.org/1014.html

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Günther Leiner

Honorary President of the European Health Forum Gastein

This year's conference was entitled "Crisis and Opportunity. Health in an Age of Austerity" and the parallel forums, workshops and plenary sessions all focussed on a range of complementary specific issues related to this overarching theme.

In 2012 we were fortunate to bring together over 600 health experts and decision-makers from 50 countries. Together we discussed policies, actions and tools to improve health across Europe and beyond. I hope we can now work together to put these ideas into action and improve health for all.

I would like to take this opportunity to thank all participants, speakers, sponsors and friends of the Gastein Forum for the wonderful collaboration I have enjoyed over the past 15 years. I am very pleased that we were able to establish such a successful and important platform to exchange views and discuss current and future public health issues. I wish the new president of the EHFG, Professor Helmut Brand, all the very best in continuing the Forum's developmental journey – here's to the next 15 years!

I hope you will join us again in 2013.

Helmut Brand

President of the European Health Forum Gastein

The 15th European Health Forum Gastein, which took place in October 2012, was yet again an important platform for experts, practitioners and stakeholder representatives to exchange views and debate the current and forthcoming healthcare issues, challenges and opportunities which Europe is facing.

This publication provides an overview of the main topics of the Forum. In this edition you will find reports from the plenary sessions, parallel forum sessions and for the first time we are also presenting the reports from all seventeen workshop sessions. If you require any additional information on a specific session or speaker, these can be found on the EHFG website.

Health communication and the future development of healthcare were two of the key topics at the 2012 Forum. We also looked at the performance of European health systems in times of economic crisis and both the challenges and new possibilities that such conditions create for healthcare. The global governance forum highlighted the interdependencies between health and other sectors and panellists asserted that globalisation and other factors mean an innovative approach is required for global health governance, which should be led by the EU and WHO championing health as a human right. A challenging non-communicable diseases session

pitted industry against academia and considered a range of policy options to tackle the problem from nudge to regulation. Personalised medicine was once more high on the agenda with participants considering whether Europe could lead the way in this innovative field, and how we can prepare for the main challenges ahead.

I would like to draw your attention to one of last year's EHFG outcomes – the Gastein Health Declaration, which has been prepared by a group of Young Gasteiners. It not only highlights the main findings and discussion points from the Forum, but also gives suggestions on solutions for European healthcare, which I recommend to be considered.

Over the past fifteen years the EHFG has been a great success and evolved to become one of the most important public health events in Europe. I would like to thank you for your support of the Forum over the years and for welcoming me as the new president of the EHFG. I intend to follow the well-trodden path that the Forum is already on, but I am also going to introduce some changes with the guiding principle in mind: "Evolution not Revolution" – changes which I am sure you will welcome as well.

I hope you will join us for the "old-new" 16th European Health Forum Gastein in October 2013!

Gastein Health Declaration 2012

By Tania Lourenco, Laura Otero Garcia, Sofia Ribeiro,
Iva Rincic and Rosalind Way

It is clear that the sustainability of our healthcare is at stake: there are higher patient expectations, new and often expensive treatments are being made available, and living with the realities of decreased budgets is inevitable.

Over the years there have been key improvements made in life expectancy and child mortality but the economic crises are threatening this work. We know that societal problems linked to the financial crisis, such as unemployment, have high impacts on health: there is double the risk of illness and 60% less likelihood of recovery from illness associated with unemployment.

Health systems are an integral aspect of the economy and a crisis in the economy can cause a crisis for healthcare. However, perhaps there is no need to be overly pessimistic - in times of crisis the 'system' may be able to respond and adapt faster than when no crisis is upon us, and the healthcare system is more experienced at this than most. The case must be made for an integrated whole-government, indeed whole-society, approach to health.

The only way forward is to increase efficiency

In this time of austerity, many countries are facing an enormous challenge in securing financial sustainability in keeping with the founding values of EU health systems such as universal coverage, solidarity, equity of access, and the provision of high quality health care.

During the 15th European Health Forum Gastein, it was advocated that health care has become increasingly expensive and we cannot continue to deliver care in the same ways. However, if austerity can be used as an opportunity and driver for change then we must grasp this and renew commitments to health to secure it for the future.

There were no easy answers to this major challenge that Europe is facing, however some trends have emerged:

Healthcare to Humancare

Healthcare today is becoming more patient-centred and our systems must take advantage of this. Patient empowerment is a crucial aspect not for only the better management of chronic conditions but also to enable patients to decrease the cost of healthcare: early screening and detection must come hand in hand with better lifestyle choices. Through empowering patients to know their rights, to know how to access information, and working with them to make the right decisions about their own health, we can enable savings to be made through compliance and system wide efficiency gains.

Innovation and Health Technology Assessment

A new approach to manage health rather than sickness is required, and eHealth may allow us to live longer and healthier by creating mechanisms contributing to the prevention of disease by helping people making healthier choices, improved management of conditions, and patient flow, which might ultimately contribute to efficiency gains for the health system. Moreover, continuity of care is a major challenge for health systems, and one that we may not be able to overcome this unless we adopt electronic medical records.

However, with technological advances in computing and data storage, legal regulations and ethical norms are imperative to safeguard the use of personal data. Questions like who owns the data, and who uses it, must be considered.

In conclusion, to improve efficiency in health systems we need more innovation and we need to maximise the use of technology to improve efficiency – the effective use of health technology assessment is fundamental. Policy-makers must make sure that choices made in deploying new technologies respond to demonstrated cost effectiveness. It is not just about deploying technology but also understanding the benefits.

Health research

Research is needed not only in disease prevention, but also in translational research. Efforts will be made to make sure that the health system is able to cope, and therefore, we will need to bridge the gap between knowing and doing.

Efficiency

Fiscal sustainability – the ability of a government to finance its expenditure programme – must be regarded as a constraint, and not a policy objective. Cost containment is different to efficiency. Short-term cuts that are aimed at only securing fiscal sustainability may fail to address the underlying efficiency problems, but it may also aggravate them by potentially cutting cost-effective interventions resulting in the reduction of financial protection and health gain.

Governments should therefore avoid implementing policy tools that risk undermining health system goals such as: reducing coverage, reducing the scope of essential services, increased waiting times for essential services, and attrition of health workers due to reductions in salaries. If short-term cuts in health are unavoidable at this present time, governments should consider adopting policies that will minimise adverse effects on the health system, where any extra spending should demonstrate value, be transparent and explicit about tradeoffs, increasing in performance and reducing costs through efficiency, for example, hospital reconfiguration, improve purchasing, use health technology assessment and evidence based medicine as tools to support decision-making.

Health is an investment, not a cost!

The state of the economy is not just related to money. To work against the financial crisis there must be healthy, active and productive citizens. Healthcare has a direct implication to all of us, and it must be considered as an investment and not a cost. The health system makes a large contribution to the economy, accounting for 10% of GDP, and being the largest employer in the EU. During EHFG 2012, an appeal came out for Finance Ministers and Health Ministers to communicate more and better in the making of health policy decisions. This calls for the establishment of institutional dialogue, clarification of roles and the realization that we all share in the same objectives.

Is it time for a new ‘big conversation’ about health?

EHFG 2012 demonstrated that in this time of austerity, there is a need for an open attitude regarding how to sustain healthcare today and for the future, and that this crisis presents an opportunity for change. There must be a renewed focus on how to improve efficiencies across the whole system in order to continue work in improving health and reducing inequalities.

We must all work together to rethink healthcare. Expectations must change and this must be done through empowering individuals, and society as a whole, to be accountable for their lifestyles and health. Reducing the burden of illness will not only improve health outcomes but will also help to overcome the economic crisis.

Health and well-being in times of austerity

By Natalia Zylinska-Puta

The opening plenary of the 2012 European Health Forum Gastein showed its keynote speakers were keen to explore the opportunities presented by the financial crisis rather than dwell unduly on crisis issues. Moderated by [Armin Fidler](#), World Bank Lead Advisor for Health Policy and Strategy, speakers included Estonian President Toomas Hendrik Ilves, WHO Europe Regional Director Zsuzanna Jakab and Member of the European Parliament Antonyia Parvanova who presided over the presentation of the 2012 European Health Award.

EHFG President [Günther Leiner](#) opened the session on Wednesday afternoon and gave a short introductory message on behalf of the President of the Republic of Austria, Heinz Fischer.

In his own speech Leiner stressed that crisis is an opportunity. He concentrated on one of the consequences of the financial crisis, namely its impact on our mental health. The ongoing race to be better, faster, more efficient, such cruel competition, he said, puts a lot of pressure on all of us, we no longer take time-off to relax any more. That, combined with long working hours, stress and other unhealthy lifestyle factors affects us in many ways, and now more frequently than ever has fatal consequences. Leiner took as an example part of the health workforce – German and Austrian doctors. They are at greater risk of suffering from a heart attack or being more suicidal than many of their western colleagues. Over 30% of them even regret their choice of profession! Leiner's key point was that even (or especially) at a time of financial crisis, we should not forget that the well-being of humans is of the utmost importance.

The second speaker was the Mayor of Bad Hofgastein, [Friedrich Zettinig](#), who also welcomed all guests to Gastein. In his opinion, the financial situation required savings and reorganisation of services, which have to be approached carefully in such a fragile area as healthcare. He expressed the hope that politicians will use the results of this conference to improve the situation in their states.

The organisers of this year's Forum were also glad to host [Toomas Hendrik Ilves](#), President of the Republic of Estonia.

During his speech Ilves briefly presented the outcomes of the report *Redesigning Health in Europe for 2020* (www.president.ee/images/stories/pdf/ehtf-report2012.pdf) prepared by a Task Force set up in 2011 by a number of Member States and the European Commission. Today, healthcare costs in Europe are climbing. Within the EU, the working population in 2012 was 67%, in 2060 projections show that this number will decrease to 56%. At the same time the percentage of the population who are 65+ will increase from 17% to 30%.

A radical redesign of the healthcare system is therefore needed. Technology can help health systems to respond to these challenges, by delivering greater efficiency, lower costs and better health outcomes. Up until now medicine has dealt with people who are already sick.

Our current challenge should be a transition to focus on preventing individuals from becoming sick in the first place. At the same time the issue of data is becoming more important. Individuals are the owners and controllers of their own health data, with the right to make decisions over access to the data and to be informed about how it will be used.

[Giuseppe Ruocco](#), Director General of the Directorate General for Prevention in the Italian



Toomas Hendrik Ilves, President of the Republic of Estonia

Ministry of Health gave a very interesting speech, where he reminded everyone that the right to health is an essential and traditional notion with complex and multifaceted connotations, which should not be forgotten. On the one hand, it is considered as a right to freedom and on the other as a right to receive a service.

Today, the true challenge is to reconcile the public health service with dwindling resources, and the protection of rights and planning must have a reforming role. Not long ago, the right to health was deemed to be compatible with public expenditure. Today this no longer seems to be the case: its costs must be reduced as much as possible and they may even be adjusted to the individual income level. He advocated strongly that we do not want to give up this universal service, the protection of this right and the reduction of inequalities.

It is absolutely necessary to avoid the slow erosion of welfare, because the weakest segments of the population would suffer the most.

Paola Testori Coggi, Director General in the Directorate-General for Health and Consumers of the European Commission admitted that the title of the Forum captured the mood of the day.

Healthcare costs are rising, people are sick and treatments are more expensive, but at the same time there is less money in the system. Usually in a time of crisis, systems adapt faster to work under new terms. In a time of austerity we need to involve all stakeholders to make wiser decisions and to support healthcare progress.

Patients should be empowered, so they can become more active and better follow treatment. By making healthier choices in their lives, patients influence the resulting increase or decrease in healthcare costs (for example an



Paola Testori Coggi, Director General, DG SANCO, European Commission

obese patient generates 20% more costs per year than a non-obese one).

During the transformation of healthcare systems long term sustainability should be treated as a main requirement. Greater increases in costs are stimulated by an ageing population and the availability of new and more advanced technology, which at the same time is much more expensive.

Therefore, first of all we have to make sure that the choices which we made on medical equipment and technical innovations were really cost effective and helped our citizens. Nowadays we are all partners, who need to think how we can ensure that the structural funds are effective and successfully used, how to better integrate healthcare with the focus on hospital management and how we can measure if spending on healthcare is effective, because healthcare expenditures grow 2% more than our economy.

Zsuzsanna Jakab, WHO Regional Director for Europe assured the audience that health in the age of austerity is central to WHO work.

The financial and economic crisis is threatening the gains made across Europe in recent decades, and exacerbating the longer term challenges facing our health systems. Countries in Europe differ greatly in the extent to which their public finances have been affected by the financial crisis. Health promotion and disease prevention programmes may help to avoid greater costs. Health prevention should be treated as an investment not a cost. An increase of 1% in life expectancy results in a growth of 6% GDP (OECD), meanwhile absenteeism due to illness is estimated at 4.2 days/worker level (EU, 2009) generating an average cost of 2.5% of GDP.

Summarising, she said that the crisis should be navigated by avoiding across the board budget cuts, targeting public expenditure more tightly on the poor and vulnerable and thinking long-term and implementing counter-cyclical public spending.

Barbara Kerstiëns, head of the Public Health Section within the unit of Infectious Diseases and Public Health in the Health Directorate of the Directorate-General for Research and Innovation at the European Commission stated that smart investments in research and innovation are vital to create jobs and put Europe back on the path to growth.

She cited this as the reason why the current 7th Framework programme will be replaced in 2014 with a new funding framework: *Horizon 2020* (http://ec.europa.eu/research/horizon2020/index_en.cfm?pg=home&video=none), with a proposed budget of eight billion Euros over seven years.

Through *Horizon 2020* the EC will also look into ways of how to achieve a stronger impact from their funding through achieving more innovation – a smarter way to support researchers and innovators in Europe – so as to further boost excellence and to help ensure that good ideas that centre on addressing societal challenges reach the market.

In the future, disease prediction and prevention, and better management of chronic diseases, will become even more important. Ways must be found to ensure that healthcare providers and other partners involved in innovation give these themes the necessary attention they deserve. All these developments require a new mind-set and open attitude – the will and skill to strike the right balance between knowledge sharing and the protection of intellectual property, and the search for new business models by all those involved.



Find out more about this session at
www.ehfg.org/923.html?eid=23

Communicating health

By David Ritchie and Edwin Maarserveen



This forum looked at the challenges of communicating health to both citizens and policy-makers. Communicating health is a timely subject for discussion as health systems urgently require a paradigm shift towards promotion and prevention orientated services in response to the financial crisis and the need to ensure sustainability of services. In order to achieve this, effective communication to citizens (on healthy behaviours) and to policy-makers outside the health circle (advocating for investment in health and a health in all policies approach) is essential.

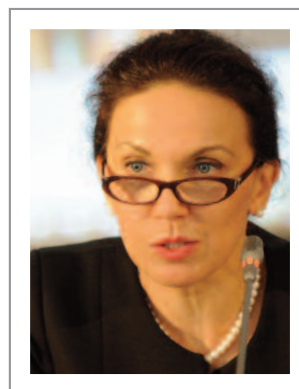
Are EU citizens health literate and aware of healthy lifestyles?

The first session of this forum dealt primarily with the strategies that health actors need to employ when communicating to both citizens and policy-makers. [Paola Testori Coggi](#), Director General of DG SANCO, opened the session by setting the social, political and scientific context for the debate.

Testori Coggi pinpointed the growing NCD burden in European populations as the case for action. The health community has to engage with citizens, using modern techniques, to encourage behavioural change that will lead to short and long-term benefits for health. Moreover, economic policy-makers have to be made aware of the value of investing in health. To do this, the health community must use accurate, reliable and coherent data in a uniform manner, in order to be credible and convincing.

[Antonyia Parvanova](#), MEP, emphasised the importance of health literacy as understood in its broadest sense, addressing the environmental, social and political factors that determine health. Parvanova noted that in Bulgaria 70% of citizens express difficulties with health literacy, which is clearly a barrier to supporting the behavioural changes that will lead to healthier populations. Parvanova stated that health actors have to communicate health to the entire population (to avoid distortions of health inequalities) but not all in the same way.

Anotnyia Parvanova,
MEP, Bulgaria



[Olivier Ouiller](#) from the French Strategic Analysis Centre gave a challenging presentation which queried the evidence base underpinning current approaches to communicating health. Ouiller stated that information is not sufficient, as demonstrated by the fact that individuals often perform to the contrary of what is beneficial for them. Environmental influences on behaviour are overlooked in current approaches. This is important as individuals display a tendency to resonate with the behaviour of others, looking at how the majority behave. This method implies that a more positive message should be delivered, which is more likely to be effective with both individuals and policy-makers.

A practical example of this approach was given by [Jordi Mones Carilla](#), a member of the Board of FC Barcelona, who presented the adoption of the *Ex-Smokers are Unstoppable* campaign by FC Barcelona (<http://quitsmokingwithbarca.eu/uk-en#.UMWrJVH6Dm4>). This campaign and the approach used by FC Barcelona demonstrate

Jose Moes Carilla,
Director of Medical
Services,
FC Barcelona





Panellists:

Clive Needle, Director, EuroHealthNet; Anonyia Parvanova; Paola Testori Coggi; Jose Mones Carilla; Mariana Dyakova, University of Warwick; Oliver Oullier, Adviser at the French Centre d'Analyse Strategique and moderator; and Delia Meth-Cohn, Editorial Director CEMEA, The Economist Group

how positive messages and group dynamics can exert lasting behavioural change that promotes a healthier lifestyle.

Finally, [Mariana Dyakova](#) reminded the audience of the importance of ethics in communicating health and the close proximity between effective communication and art (as communication is not simply conveying information), whilst [Clive Needle](#) from EuroHealthNet concluded by presenting the case for effective communication with policy-makers, stressing the importance of understanding what factors influence them.

Key discussion points related to the level of self-reflexivity in the health community. Both Needle and Oullier challenged the degree to which health actors are aware of the effectiveness and appropriateness of their health communication strategies to both individuals and policy-makers. It is vital to acknowledge and understand how unhealthy actors communicate their messages to citizens and policy-makers, as without interrogating the reach and reception of current health communication approaches, effective communication of health will not be achieved.

The main outcomes from the debate were:

- The need for double evidence-based policy-making
 - gathering the scientific evidence for the content of the communication; plus
 - understanding what channels work in order to influence the form of communication.
- Realise that one size does not fit all
 - therefore information must be tailored to the audience.
- Understand the influences on the behaviour of individuals and policy-makers

- acknowledge the environmental factors and group dynamics influencing individual behaviour, and orientate messages with a positive aspect.
- Understand the pressures and influencing factors on policy-makers, and be self-reflexive and do your homework if your message is not getting through.
- Be creative and courageous – be aware of conflicting messages from unhealthy actors and be prepared to adapt to this challenging landscape. Health actors need to be imaginative with existing resources, but also courageous enough to use all available levers for communicating health.

How can we best use ICT as a tool for communicating health?

The leading theme in the second session's discussion was how can we communicate health in a better way and what can we learn from other sectors about health communication. The moderator of this meeting, Robert Madelin, Director General of the DG CONNECT challenged the panellists and the audience to put forward questions which weren't answered in the previous session and also to consider what people could do within their own domain to facilitate the better communication of health issues.

A significant controversy discussed in this session was that the health sector is not in the driver's seat any more. We cannot lead social media and the development of "apps" and nor should we try to. Instead, we should focus on trying to make sense of the new opportunities provided by technology. We need to create platforms for positive engagement and empowerment, whilst maintaining high levels of quality and safety.



Ulrich Schulze-
Althoff,
Medisana Space
Technologies

Nowadays, Google is an important health actor. The health sector is changing, we can no longer think in the role of traditional actors, the world has moved on. Not everybody is a communicator, but we should realise that there are new actors and welcome their ideas.

One of the panellists posed the question: “Why are communication experts not here in Gastein?” The bottom line is, we know what works, we know the power of network and dialogue, we just need to ensure the health sector is fully engaged in the development of communications.

It follows that in the future society and patients will be leading the development of health policy communications. The former roles of health actors, as “gatekeepers” guarding safety, providing information and addressing problems will no longer work. Nowadays people and patients are underestimated when it comes to health communication and health information. The current stakeholders will try to protect their interest. This is the same in all domains: health care provision, health financing, health law and public health. It is all about the business models of these stakeholders. We should find a way to break open these interests.

Disruptive innovation is the keyword. With new technologies – and new policies – old ways of thinking become obsolete. In our own domains we have to train ourselves to change and be open for change.

During the panel session it became very clear that there is a lot to be gained from

communicating health in a better way. There is a world of opportunity, but we should shift the discussion from public budgets and introduce new partners, seeking new opportunities for collaboration. We should avoid sticking within our box of health policies and look instead at system architecture and the system as a whole, not only health policy.

Conclusion

Communicating health can be viewed as *the* opportunity of the financial crisis.

The current political and economic situation is such that key policy-makers outside the health circle are more susceptible than ever to the possibilities offered by positive behavioural change at the citizen level and renewed investment in health at the policy level.

Especially in the second session the crisis was not represented by budgetary austerity, but through the manner in which the health policy field continues to look at health. There are huge opportunities to be seized by better communicating health, especially when we are open to learning and prepared to change the conservative way in which we think about communicating health.

There are also huge profits to be made when we really start interacting with other domains and start tapping into their ideas about communication. For too long the healthcare sector has been focused on the traditional patient-doctor relationship to communicate health. Now is the time to start doing things differently. The crisis of national budgets brings with it new opportunities that technical and social innovations are ready and able to adopt. The healthcare sector must also be ready and able to collaborate with technological innovators and seize the upcoming opportunities.



Find out more about this session at
www.ehfg.org/923.html?eid=25

Global health governance

By Lillian Li Chi Yan, Katharina Bauer, Michaela Told and Christoph Aluttis

In a globalised world health has become a global public good. Understanding that the determinants of health go beyond national borders suggests that state and non-state actors will need to cooperate to confront the global health challenges of today. Global governance of health issues among interdependent states presents challenges as well as opportunities.

This two-session parallel forum discussed how health can be governed at the global level and how common goals can be achieved.

Zsuzsanna Jakab from the WHO Regional Office for Europe highlighted that in a globalised world, countries need to act together to ensure the health of their populations and to drive progress. Managing interdependence has moved up the policy agenda of global policy-makers. Health has become a global economic and security issue where collective action is needed.

Jakab sees the WHO as the legitimate agency for coordinating efforts between the many global health actors. The WHO/Europe has already begun to adapt to these situations; one example is the *Health 2020* (<http://www.euro.who.int/en/what-we-do/health-topics/health-policy/health-2020>) initiative, which involves many partners and can be understood as an instrument to strengthen collective efforts to influence factors that impact on global health.

Ilona Kickbusch challenged the notion that health can continue to operate on a charity model and illustrated how new partnerships and modes of governance need to be developed for health issues. Key developments over the last decade have shown that global health is about more than richer countries helping dependent, “poor” countries. A refined global model should provide a mechanism for partners to share common goals and to collaborate with each other at all levels of government.

Global governance for health in practice

Latter sessions reviewed examples of global health governance by addressing environmental

and demographic determinants of health.

Regarding environmental determinants, there is evidence that reduction in the unnatural increase in CO₂ in the atmosphere would not only tackle climate change but produce health co-benefits: preventing premature deaths, ischaemic heart disease and cerebrovascular disease. However, such changes are contingent on cooperation between public, private, bilateral and multilateral actors. However governments can take an active role to integrate efforts from science and advocacy communities to build holistic health strategies and promote changes that simultaneously benefit both society’s health and the environment. One example is active travelling at local or global levels.

Demographic change driven by travel, tourism and globalisation indicates that protecting the EU population against communicable diseases also requires a global approach. It was stressed that due to global social and environmental developments, the drivers for infectious diseases are changing as well. This requires renewed efforts to effectively tackle pandemics in the future, and here the European Centre for Disease Prevention and Control (ECDC) is a key actor.

The future of global health

The EU, WHO and Member States are also working towards a common approach to global health. In the EU, health has been an important



Ilona Kickbusch, Director, Global Health Programme



K Srinath Reddy,
President of the
Public Health
Foundation of India

part of foreign policy since the *Oslo Declaration* in 2006. Europe has also recognised the need to work in a joint manner and to collaborate with partners outside and in particular, with BRIC countries (Brazil, Russia, India and China).

Gong Huan Yang from China and **K Srinath Reddy** from India both reiterated the role of Europe as a “good” actor and partner for health at the global level, as also expressed by the many international agreements and frameworks, which include health, passed across sectors.

At the core of the discussion in this forum was the understanding that health has lost much of its national sovereignty. Globalisation and a complex network of actors and determinants require a different and novel approach to global health governance. However, bureaucratic challenges stemming from fragmented activities often hinder developments in health and in the ministries of health. WHO and the EU must take responsibility to address this challenge by leading collaborations to promote health as a human right. This also requires partnerships with the private sector, which is also influenced by the changes and power shifts in the global architecture.

One example was given by **David Boyd** from GE Healthcare. He showed that healthcare no longer solely originates in the “wealthy” North. Innovations are nowadays produced everywhere in the world and it will require a substantial

paradigm shift in business culture to understand this phenomenon and to benefit from it commercially. Collaborations between private and public sectors were widely regarded as beneficial, if guided by a set of rules and regulations.

The forum concluded with the general consensus that agreed goals constitute the basis for cooperation. The next step is to clarify leaders for health governance. In order to do so, coordination among actors and a clear distribution of responsibilities and tasks are necessary. Furthermore, the accountability of all parties involved has to be defined and new financing mechanisms developed.

Policy recommendations

- Recognise that, in particular at the global level, health has determinants outside the health sector: environmental, demographic, and economic determinants amongst others. Thus, managing health cannot only be concentrated in the health sector.
- Specific global health challenges of the future are climate change, ageing and unequal access to public health resources, financial pressure and lifestyle changes due to globalisation.
- Global health governance is about finding common policies and politics on the basis of shared agendas for health.
- Managing global health requires the collaboration of countries, organisations and institutions at local, national, regional and global levels. Therefore, it is essential to raise political and social awareness that multilateral organisations with convening power are needed.



Find out more about this session at
www.ehfg.org/923.html?eid=4

Health systems sustainability

By Ian Forde, Charlotte Hosbond and Diana Beglaryan

Policy-makers, professionals and patients are delivering and using healthcare in a time of severe austerity, unprecedented in living memory for many. Financial austerity, however, is not the only challenge facing stakeholders.

At the same time, most European countries are undergoing a transition to a more elderly demographic. By most estimates, at least four fifths of the elderly population suffer from a long term condition such as diabetes or hypertension, in many cases, multiple long term conditions are present in the same individual. Even if living healthily, this demographic shift inevitably implies increased contact with, and support from, the healthcare system.

Patient expectations are, rightly, also increasing, particularly around coordinated care for long term conditions and around the quality and safety of healthcare.

Finally, technological advances in drugs and other therapeutic or diagnostic modalities can frequently (although not always) imply increased healthcare expenditure; most often, the true cost/benefit remains unclear until after several years of system-wide implementation.

To examine how to respond to these challenges, the first session looked at protecting and expanding the fiscal space for high quality healthcare, and the second session looked at reforming the healthcare model.

Protecting and expanding the fiscal space for high quality healthcare

The first session began with [Philipa Mladovsky](#), Research Fellow, European Observatory on Health Systems/ LSE Health, reporting on the results of a 2011 survey of responses to the financial crisis in 45 European countries.

Reassuringly, the breadth and scope of statutory health insurance was unaffected in most countries. Using specific country experiences, Mladovsky demonstrated that the financial crisis can, and should, be taken both as an opportunity to increase efficiency, as well as an opportunity

to increase access and equity for low income groups.

[Michael Borowitz](#), OECD Senior Policy Analyst, emphasised the need for closer working between Ministries of Health and Ministries of Finance to create a stable environment within which to realise efficiency gains. He reported on a meeting of senior budget officials in Tallinn in June 2012 where the absence of a common language between Ministries to address the challenges of sustainability, let alone explicitly shared objectives or time frames, was striking.

Illustrating the need for closer working, [Triin Habicht](#), Head of Department of Health Care, Estonian Health Insurance Fund, outlined the lessons learned from the Estonian health system's experience of the global economic downturn, including avoiding over-reliance on payroll taxes during rising unemployment and a shrinking working age population; the value of a mix of provider payment methods (DRG, FFS, capitation, and P4P) to balance the pros and cons of each; and, reiterating both Mladovsky's and Borowitz's observation, the need for a long term perspective.

As an example of this, [Anita Charlesworth](#), Senior Economist, the Nuffield Trust, discussed the likely long term fiscal scenarios for UK healthcare. Charlesworth's main point was to emphasise that the historically generous funding levels which the UK and many other health systems enjoyed prior to the global economic



Anita Charlesworth, Chief Economist, Nuffield Trust



Patrick Jeurissen,
Special Advisor,
Ministry of Health of
the Netherlands

downturn will not return. Several implications arise: health systems may need to reduce coverage or generosity of the benefit package, taxes and other sources of revenue may need to be increased, or other public services may need to be cut to protect health system spending. Given that none of these are likely to be politically feasible in the current climate, the only remaining option is for health systems to increase productivity.

The same set of fiscal trade-offs was identified by [Patrick Jeurissen](#), Special Advisor, Ministry of Health of The Netherlands, in his discussion of Holland's new health system of managed competition between insurers. Although it is still too early to assess all the effects of the reform, the following lessons are already apparent:

- The fact that “real” monetary risk seems to be a crucial condition for combining fiscal sustainability.
- The need for technical competence and improved governance at every level of the healthcare system.
- The need to support competing insurers to coordinate activity where beneficial (in block purchasing, for example) and the need for all stakeholders (patients, providers, payers and workforce) to realise that fiscally constrained circumstances are likely to continue and may imply the need for increased risk-bearing across all actors.

Reforming the healthcare model

In the second session speakers explored other facets of the sustainability challenge by arguing for reforms of the health care model.

[Eric de Roodenbeke](#), CEO of the International Hospital Federation, argued that market-oriented hospital payment systems have often failed to

show the positive results expected in terms of health outcomes and patient satisfaction, relative to cost. [De Roodenbeke](#) argued that hospitals should move from organ- or disease-based organisational models to matrix- or patient-centred models, which might better serve patients. However, he also pointed out the challenges implied by such a transition, including the education of doctors, the challenge of delivering highly complex treatments and maintaining quality for low-volume treatments.

Along similar lines, [Thomas Plochg](#), Assistant Professor at the University of Amsterdam and Senior Policy Advisor at The Netherlands Public Health Federation, argued for reconfiguration of healthcare professionals. Specifically, medical specialisation as currently organised forces health professionals to think and act disease-by-disease. In the future, multi-morbidity generalists may be a more appropriate workforce.

[Beth Lilja](#), Head of the Danish Society for Patient Safety, argued that poor quality and safety is inefficient, as well as damaging to patients. She presented results showing that the number and severity of bed ulcers created annually (and wholly avoidably) in European hospitals is enough to occupy the entire Danish and Norwegian hospital systems put together. Hence, it is possible to ensure higher quality and safety and reduce waste resources at the same time.

Along the line of other speakers, [Robert Johnstone](#), Patient Advocate, also underlined the need for a new matrix based health care model (integrating both primary and secondary care and health and social care) as well as new attitudes and new skills amongst healthcare professionals. Johnstone stated that patients are part of the solution and not the problem: improving health literacy, access to high quality information and implementation of shared decisions are all vital elements in making health systems sustainable.

Thomas Plochg,
Researcher,
Academic Medical
Centre, University of
Amsterdam





Beth Lilja, CEO,
Danish Society for
Patient Safety

Issues arising during discussion

Several issues were raised from the floor during open discussion at each session. One theme was the extent of public willingness to pay for health (that is, bear increased taxes). There were divided opinions on this, but overall it was agreed that this was a political economy decision, rather than a technical one, and in due course increased taxes to support publicly funded healthcare are not implausible.

Another theme centred on whether increasing privately funded healthcare (through out-of-pocket co-payments, for example) was a sensible solution to austerity. In general, it was felt that this was likely to lead to a fragmented health system, with less solidarity and, indeed, less efficiency. It is known, for example, that co-payments tend to reduce consumption of necessary (as well as discretionary) healthcare, leading to an overall reduction in system efficiency.

A third theme of discussion focussed on the barriers to the implementation of health sector reform. Some of those identified included poor governance and/or lack of leadership and/or of political will, particularly around the issue of joint finance and health ministry working, as earlier discussed; similarly, a lack of conceptual coherence and aligned incentives *within* the healthcare sector (across primary and secondary care, for example); and a lack of technical capacity, at every level, whether institutional or central government, were identified as fundamental – but not insoluble – barriers.

Conclusions and policy recommendations

The healthcare model of today is unlikely to be able to withstand the challenges of fiscal constraint on the one hand and increasing healthcare demand and costs on the other. Nevertheless, austerity can, and should, be taken as an opportunity to increase value for money, as well as to increase access, quality and equity in health systems. Most vital is the need to keep health system objectives clearly in mind during times of fiscal constraint, that is, the goals to protect and improve health, to protect individuals and families from financial catastrophe and to preserve equity and build social well-being. If these objectives are not kept in mind, fiscal consolidation can be achieved simply by making cuts with no thought as to the consequences.

Thereafter,

- **at system level:** Ministries of health and of finance need to work more closely together to create a stable environment within which to realise efficiency gains, keeping a long term perspective which does not sacrifice longer term structural reforms at the expense of short term financial gains.
- **at institutional level:** Hospitals and other providers must look for ways to increase productivity, recognising that it is possible to ensure higher quality and safety and reduce inefficiency at the same time. Barriers to rapid adoption of good practices which achieve both of these goals must be identified and overcome.
- **at clinical level:** All stakeholders must see patients as part of the solution to the challenge of health system sustainability and seek to improve health literacy, expand access to high quality information and encourage shared decision making.



Find out more about this session at
www.ehfg.org/923.html?eid=5

Public health challenges by 2050

By Nicole Rosenkötter and Annamaria Szalay



The parallel forum session on Public Health Challenges 2050 focused on the anticipated health challenges as well as on projections of future developments in healthcare and their implications for the European research agenda *Horizon 2020* (http://ec.europa.eu/research/horizon2020/index_en.cfm?pg=home&video=none), the future EU Framework Programme for research and innovation.

What will be the main challenges and opportunities by 2050?

Future environmental changes will bring challenges such as rising temperatures and extreme events like floods and droughts and may affect health outcomes such as air pollution and water related diseases, and emergence of food and vector borne diseases that have not been common in Europe so far. There is a need to better foresee these effects and to develop strategies for health systems that can anticipate and respond in a flexible way to changing patterns of diseases in an integrated way.

As mentioned during the discussion, the environmental footprint of the healthcare sector must also be addressed. The demographic and societal challenges include an increased ageing population, the need for effective preventive measures that are adopted in an early stage of life, rising healthcare costs and a persistent social gradient in health. However, a healthy aged population will also be a huge valuable



Line Matthiessen, Head of Unit, DG RTD, European Commission

resource that should be turned into an opportunity for society.

Additionally, it was discussed that in the absence of effective policies, current lifestyles will further boost unhealthy behaviour: lifestyle related health threats will continue to be a strong driver of health conditions. The realisation of healthy choices being the default choices of the population is an area of future research which generates a struggle between science, practitioners, and policy making: how can the implementation of effective preventive measures be assured?

These changes in environmental, societal and lifestyle factors as well as possible economic decline, urbanisation, migration and technological innovations will influence the set-up and financing of our health systems. The three major driving forces of healthcare costs will be a continuing increase in life expectancy, the availability of technological advances, and a rise in public expectations of healthcare.

Accordingly, we must tackle one of the consequences of ageing, namely the increase in non-communicable diseases and multi-morbidity, alongside an increasing healthcare demand and a decrease in the health workforce. It is estimated that by 2020 the EU will have a shortfall of one million healthcare workers. Moreover, the financing typology of health systems must be adapted and new models must be developed among others redefining the share of public and private health spending. At the same time policies to reduce greenhouse gas emissions can also have major impacts on public health particularly by reducing risks of non-communicable diseases. Increasing physical activities in urban areas should reduce the risk of diseases related to sedentary lifestyles.

The pharmaceutical industry is considering future scenarios in which the exact pathways of diseases are known and new disease classifications are used. Advanced technologies will lead to the convergence of engineering and medicine, targeted treatments and preventive options will be available. These scenarios will



Dipak Kalra,
Professor at UCL
Centre for Health
Informatics and
Multiprofessional
Education, UK

require new collaborative mechanisms between healthcare providers, industry, the governmental sector and potential new players like IT companies, to put the individual at the centre and to take into account the possibilities of a “Digital Age”.

The scenario of future information and communication technologies in healthcare will also be person-centred. These technologies will offer potential for predictive and preventive health information that is pervasive and peer connected. The “Information Age” will shift healthcare roles so that the individual, friends, families and self-help networks are positioned at the forefront; the healthcare experts having a more facilitating and cooperative role.

The transformation of the health services and revitalization of public health requires a multi-skilled health workforce whose skills and knowledge must be adapted to tackle the health challenges of the 21st century, with a focus on communication and collaboration among providers but also between providers and patients.

What was controversially debated during the forum?

The challenges identified led to lively discussions between the experts on the panel and the audience. The main focus of the discussion was on the discrepancy between available knowledge and the knowledge uptake by the individual, practitioners and policy-makers. How to move from knowing to doing? How can pro-health choices be rewarded?

Another major focus of the discussion was the need for radical health system changes, the potential catalytic role of information and communication technologies and the related fear of loss of privacy and concerns regarding the capability to integrate sufficient security and

integrity measures. Some argued that future generations will not share these fears, that information and communication technologies will be a normal part of their lives. Nowadays, society should be more open and brave regarding technologies in order to enable change. Society should start the discussion about the transformation and modernisation of health systems to address the long term needs, the societal models on which future health systems in Europe could be based, and the realisation of intersectoral governance for health.

A strong emphasis in the discussions was given to the values of universal access to healthcare, solidarity, equity, and the empowerment of citizens for active participation in health.

What are the emerging topics for a European research agenda?

Based on the challenges identified, the following set of research needs was compiled:

- Modelling and projection of future scenarios (for example, demographic, environmental, technological and economic) and their interactions and potential impact on health.
- Linking of environmental and health data sets and surveillance systems that identify environmental health threats.
- Adaptation procedures/strategies of the population and of healthcare systems in a changing environmental setting.
- Approaches to reduce the healthcare systems environmental footprint.
- Development of comparable epidemiological data and health information systems across Europe to model, monitor and evaluate the health situation including identifying disease patterns and health behaviour trends.



Petra Keil, Head
Global Public Policy,
Novartis



Anders Olason, Chairman, AGRENSKA

- Developing new or improved prevention measures (population or personalised) for life style related diseases and disorders. These should, among others, include the evaluation of policies and technologies to reduce greenhouse gas emissions.
- Comparative effectiveness research in the areas of health promotion, disease prevention and health services, while taking advantage of both the commonalities and the diversity across the EU.
- Development of comprehensive individual health information systems that combine all relevant health information (including information about genomics, proteomics, metabolomics), and make individualised recommendations that fit the personal life course.
- Address how to translate theories and interventions into “everyday practice” at the

level of the individual, practitioner and policy maker.

- Understanding of the biological processes of ageing instead of disease-centred research.
- Reforming of the existing disease classification by focusing rather on molecular pathway characteristics than on the classification by organs.
- Identification of ways to integrate and apply information and communication technologies in health care.
- Development of new health financing mechanisms including cost-effectiveness and cost saving approaches for healthcare.
- Addressing health inequalities, especially in a changing healthcare system that might be based on individual responsibilities and empowered citizens.
- Health systems research dealing with topics like the balancing of preventive and curative care, innovative transformation of health systems, provision of intervention packages instead of single interventions, and timely knowledge implementation by policy-makers and practitioners.



Find out more about this session at www.ehfg.org/923.html?eid=11

Personalised medicine

By Alessandra Ferrario and Michael Eder

The aim of this forum on personalised medicine was to present progress since 2011, to discuss how we can prepare for the new challenges ahead, and to debate whether Europe can lead the global way in this innovative field.

Stakeholders' perspectives

Stephane Berghmans, Director, Centre d'Innovation Médicale, and former Head, Biomedical Sciences Unit, European Science Foundation, gave an overview of the 80 recommendations contained in the European Science Foundation (ESF) report *ESF Forward Look. Personalised medicine for the European citizen* (http://www.esf.org/uploads/media/Personalised_Medicine.pdf).

ESF's vision calls for revised models and decision-making processes which reflect a focus on the individual citizen at all levels, from assessment of the safety and efficacy of interventions, through HTA and reimbursement, to diagnosis, treatment and prevention. Moreover, the ESF recommends that emphasis is placed on stakeholder participation, interdisciplinary interaction, public-private and pre-competitive partnerships, and translational research in order to develop the frameworks that support the vision of personalised medicine and healthcare. All this will not be achieved without the necessary infrastructure and resources. Dedicated funding and governmental support must be provided to ensure the availability of core infrastructure, including access to core technology and frameworks for education and training of professionals and the wider community.

Kurt Zatloukal, Professor, Medical University Graz, Austria, discussed ways of addressing global health challenges through research collaboration by focussing on the examples of the EU Flagship proposal Information Technology Future of Medicine (<http://www.itfom.eu/>) (ITFoM) and the Biobanking and Biomolecular Resources Research Infrastructure (<http://www.bbMRI.eu/>) (BBMRI).

In an attempt to find new collaboration models, innovative solutions such as public-private partnerships implemented in a pre-competitive environment represent a possible win-win solution for both sectors. The public sector contributes with medical data, biological samples and knowledge while the industry contributes with data, funds and expertise. Such models are envisaged to improve innovation through collaborative research, lead to better usage of finite resources, and create the basis for data sharing.

Focusing on biomarker-driven treatment approaches, **Andreas Penk**, Regional President Oncology Europe, Pfizer, emphasised how policy and legislative changes are needed to foster a conducive environment for personalised medicine in Europe.

More specifically what is needed is adapting authorisation procedures for medicines to take into account innovative clinical trial designs that personalised medicines will depend on, closer regulatory links between diagnostics and treatment, and rules on data protection that safeguard privacy while permitting scientific sharing of data as required.

In addition, wider coordination on research in Europe through *Horizon 2020* is necessary, better access to information for researchers, doctors, pharmacists and patients as an essential pre-requisite to promote research, new approaches to assess the value of personalised medicines, high-quality molecular testing facilities in Europe, multi-disciplinary training of healthcare professionals, and increased awareness of patients. In this process, the European Alliance for Personalised Medicine (EAPM) is a key advocate for change.

Robert Wells, former Head Biotechnology Unit, Directorate for Science, Technology and Industry, OECD, discussed the need for a global approach to personalised medicine and the recent OECD efforts relevant in the area.

Wells identified the following areas where increased effort would be beneficial: greater coordination among national bioeconomy and stratified medicine strategies, greater coordination among regulatory bodies, the development of new models for clinical trials to reduce costs and speed time to market/patients, better use of large employers especially the self-insured companies, better use of ICTs, more patient and stakeholder advocacy groups, greater international discussion of ethical, legal and social issues, faster turn-around in the policy environment.

The future paradigm of medicine will be the four “Ps”: Predictive, Personalised, Pre-emptive, and Participatory according to [Werner Christie](#), Chairman of World Health Connection, Norway.

However, because the market pull is pathogenesis (factors that cause disease) while salutogenesis (factors that support human health and well-being) is affected by market failure, the four “Ps” will not be enough to move from a system characterised by curative medicine towards a system based on preventive public health.

Christie’s conclusions were that:

- Personalised curative and pre-emptive medicine have come to stay.
- The four “Ps” will be important, but insufficient as a public health strategy.
- Commercial pressure will place the priority on personalised medicine.
- Political pressure and funding must also aim at developing preventive population strategies based on evolutionary systems biology.
- Public-private partnerships are needed.
- A Public Health Genomics European Network III with preventive focus and related research funds for basic science is much needed and should be welcomed.
- Political and personal health literacy must become part of cultural competence.

[John Bowis](#), Co-chair, European Alliance for Personalised Medicine, talked about the *EAPM Manifesto* (<http://img.euapm.eu/resources/eapmmanifesto.pdf>) which defines the requirements to take advantage of the opportunities offered by personalised medicine.



Werner Christie, Chairman, World Health Connections

These include adapting the regulatory environment to allow early patient access to novel and efficacious personalised medicine, increasing research and development into personalised medicine and providing the incentives for translating laboratory innovation into medicines and other innovations, adjusting education and training of healthcare professionals, the development of new approaches to reimbursement and public health assessment tools including health technology assessment, health needs assessment and health impact, developing health literacy including awareness.

[Stephen Friend](#), President, Sage Bionetworks, USA, presented a new community based vision of open access innovation in personalised medicine.

In his opinion, access innovation in personalised medicine is going to be harder than we think but inevitable, it will be unaffordable without deep citizen activation, and will need to fundamentally change sharing data and models between researchers especially between and within universities.

Sage Bionetworks aims to create a “commons” where integrative bionetworks are evolved by contributor scientists and citizens. Using networked team approaches, it is trying to address challenges regarding usable data, privacy barriers, tasks distribution, rewards for sharing, education and bioinformatics. This will be achieved through a computer space for collaborative research (synapse platform), introduction of portable legal consent (weconsent.us), and the use of ‘co-opetitions’ (cooperative competition) like the Sage/Bionetworks/DREAM breast cancer prognosis competition which aims to build better models for disease prediction.



Wolfgang Boch,
Head of Unit,
DG CONNECT,
European Union

Wolfgang Boch, Head of Unit, DG CONNECT, European Commission, presented the EU Flagship initiative of DG CONNECT.

FET (Future & Emerging Technologies) Flagships (http://cordis.europa.eu/fp7/ict/programme/fet/flagship/home_en.html) were requested by the scientific community, and by the Council of the EU to enable the targeting of outstanding challenges via a structured effort, to open new horizons by the creation of pioneering ICT foundations in other S/T domains, and to reduce fragmentation and avoid duplication of efforts by effectively coordinating long-term research activities at national and EU level.

There were six initial pilot projects ending in 2012 of which at least two will be selected for funding (2013–2015). These pilots include the IT Future of Medicine FET Flagship for personalised healthcare (ITFoM), which will help develop the necessary technologies to help process the very large amount of biological data currently available and translate it into more reliable, faster, and successful healthcare to deliver truly personalised medicine. Using computer health simulations (virtual patients), it will be possible to predict health, disease, therapy and its effects for individual patients. Through clinical application, this will ultimately help to change the future of medicine.

Tom Lillie, Head Oncology International Therapeutic Area, AMGEN, discussed personalised medicine from the perspective of it being a panacea or rather representing a Pandora's Box.

Currently, personalised medicine is likely to look more like a Pandora's Box and Lillie suggested the following elements as key in making the transition process towards a successful panacea. These include the continuous investment in innovation, the availability of

flexible regulatory and reimbursement pathways, and incentives for collaboration with particular emphasis on bio-banking for biomarkers and public-private partnerships for drug development.

Lillie concluded that faster progress in the development of personalised therapies and diagnostics will require new clinical trials, regulatory and reimbursement approaches and the need for collaborative approaches and discussions between academia, industry, regulators and payers.

Min-Huei Hsu, Director of Bureau of International Cooperation, Department of Health, Taiwan, showcased how Taiwan successfully moved from electronic medical records (EMR) to personally controlled electronic health records which include EMR, public health data, genomic data and self-collected health data.

Telehealth is also used in the country and links community care, home care and residential care to a central telehealth station which telemonitors physiological parameters (blood pressure and/or blood sugar), provides relevant health information and medication instructions through a home gateway to the television, and offers consultations with healthcare professionals by videoconferences. Hsu concluded that Taiwan needs IT because like every other country it has limited resources and suggested the country's single payer system and its modest population as success factors in this process from EMR to electronic health records.

Nicolay Ferrari, Assistant Director, Institute of Cancer Research, Canadian Institutes of Health Research, Canada, presented some of the latest developments in PM in Canada.

To date four of the ten Canadian provinces have identified personalised medicine as a priority (British Columbia, Alberta, Ontario, and Quebec). In the first wave of initiatives, together with partners from the public and private sector, over C\$200 million were committed over five years to speed up the development of better and safer medicines for patients in Canada and across the world.

In terms of future directions, Canada is interested in engaging in a novel public-private sector partnership for the development of a new research models that would better address current needs and in liaising with similar initiatives across the world.

Stephen Spielberg, Deputy Commissioner, US Food and Drug Administration, USA, gave a US-view on PM by discussing perspectives on the future of precision diagnosis; some examples of successful applications of genomic science to drug development, evaluation, and clinical use; shortcomings of technology validation and the complexity of multi-factorial clinical conditions.

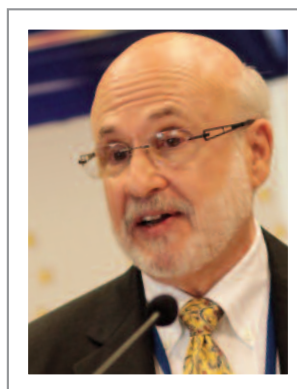
Marisa Papaluca, Section Head of Scientific Support and Projects, European Medicines Agency (EMA), discussed evidence for the need for personalised medicine and the need for a multi-stakeholder approach (four “Ps”) to decision making, including payer, prescriber, patient, public health, to achieve this.

Various initiatives of the EMA are going to have important implications in the field including the EMA innovation taskforce and qualification process, the pilot multi-stakeholders consultation early stage drug development, the EMA and EUnetHTA joint action start collaboration on European public assessment report contribution to relative effectiveness assessment, and adaptive licensing.

Papaluca concluded that personalised medicine offers an opportunity to streamline development and promote efficient and integrated regulatory oversight. To achieve this, partnerships, transparency and collaboration are key for facing the challenges ahead.

Angela Brand, Director of the European Centre for Public Health Genomics, summarised the main public health challenges currently facing healthcare systems in the move from stratified medicine to truly individualised medicine and concluded with an overview of the *European Best Practice Guidelines for Quality Assurance, Provision and Use of Genome-based Information and Technologies* ([http://www.degruyter.com/dg/viewarticle/j\\$002fdmdi.2012.27.issue-3\\$002fdmdi-2012-0026\\$002fdmdi-2012-0026.xml;jsessionid=72D0EF51F57FB9EB5193A8AD7AE7F49F](http://www.degruyter.com/dg/viewarticle/j$002fdmdi.2012.27.issue-3$002fdmdi-2012-0026$002fdmdi-2012-0026.xml;jsessionid=72D0EF51F57FB9EB5193A8AD7AE7F49F)), which have been developed by the Public Health Genomics European Network (PHGEN) over the past three years and have recently been endorsed by all EU Member States and relevant European organisations and institutions such as EMA or health technology assessment agencies (*Declaration of Rome* from 19.04.2012). These best practice guidelines will be implemented in the next few years in EU Member States.

Stephen Spielberg,
Deputy
Commissioner,
US Food and Drug
Administration



Key challenges and open questions

The key challenges included the need for ICT solutions, funding for infrastructure and education, the need for evidence-based quality criteria for samples and pre-analytics, the need to address current fragmentation of clinical research, consent and privacy surrounding patient data use and biobanks, the challenge of successfully establishing multidisciplinary, international and intrasectoral collaborations.

Open questions include whether personalised medicine will actually reduce health expenditure, how to achieve cross-disciplinary consensus, how to overcome challenges of biomarker-driven cancer treatment and the challenges in adding routine diagnostic testing to clinical practice. How to overcome challenges of open science regulatory issues and bottlenecks and privacy and consent issues for use of genomic data, and how to adapt reimbursement systems to the new healthcare environment, were further issues discussed..

To summarise the key question is probably how to ensure that all the positive expected effects of personalised medicine (for example, fewer side effects, savings for treating only people who will benefit) are actually going to happen in practice.

Future trends

One of the key messages in this area was that research will deliver. This is a given. What the discussions in the coming years will be about are issues and questions around data use, knowledge translation, regulatory framework(s), reimbursement, and use of resources.



Find out more about this session at
www.ehfg.org/923.html?eid=6

Non-communicable diseases

By Louise Boyle and Stephanie Kumpunen

These parallel forum sessions had two distinct themes. The first session debated the regulatory roles and potential partnerships between government and industry in the prevention of non-communicable diseases. The second session highlighted evidence on recent health system financing reforms to introduce NCD prevention and treatment schemes.

NCDs: what works? From nudge to regulation

The debates in the first session highlighted the potential roles of government and industry in the prevention of NCDs and questioned the benefits of collaboration between the two actors. Chair [Martin McKee](#), Professor of European Public Health at London School of Hygiene and Tropical Medicine, set the scene for presentations by asking the audience the following key questions:

- Should the public health community engage with industries that make and market the products that drive the NCD epidemic?
- Is nudging industry more efficient and acceptable than regulating them?

[David Stuckler](#), Lecturer in Sociology at Cambridge University, enthusiastically began the session by urging the audience to lobby governments for better investment in prevention measures rather than budget cutting in the name of austerity. He encouraged a focus on economic evidence suggesting that investment returns on health are 11, which is significant relative to returns gained on military (0.6–0.9) or foreign investment (1.6–1.7) expenditure, for example. Overall, his premise was that “investing in health makes money” in the long-term, and this is evidence that cannot be ignored.

Industry: “We have a role to play and we take it very seriously”

The biggest controversy of the session was the participation of [Clare Leonard](#), the Director of Scientific Affairs at Mondelez International (formerly Kraft Foods Inc). Leonard suggested that Big Food could contribute to governments’

prevention efforts via three sustained actions:

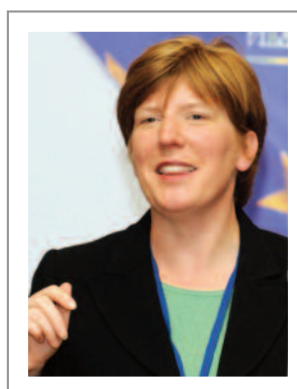
1. Products: making small changes to big brands sold around the world, such as making high calorie foods more wholesome, rather than making big changes to small products that would not be consumed by the wider population because of the assumed compromise on taste.
2. Partnerships: creating partnerships with initiatives to educate young people about eating less and exercising more.
3. Policies: creating policies that support education around food contents, portion sizes and upper calorie levels, and responsible advertising, such as not advertising in primary and secondary schools.

When the audience began asking questions it became apparent that Mondelez, which prides itself as a leader in the industry, sells its products in 75 countries but has some form of a regulatory partnership with only 19 national governments. When queried on this Leonard replied that many countries simply had not initiated discussions yet. But if Big Food takes its role so seriously then why wait for the other side to initiate the dialogue?

Is nudging the answer? Apparently not...

[Chris Bonell](#), Professor of Sociology and Social Intervention, Oxford University, was asked to comment on whether nudging companies would

Claire Leonard,
Director of Scientific
Affairs, Regulatory
Affairs and Nutrition,
Kraft Foods Europe





ST Chiou, Director General, Bureau of Health Promotion, Department of Health, Taiwan

If not nudging, can political champions strengthen public health efforts?

The presentation from [Shu-Ti Chiou](#), Director General of Taiwan's Bureau of Health Promotion, showed that where there is a will there is a way.

Chiou described a huge “whole society” campaign to raise public awareness and gain support for healthy public policy and moves towards stronger regulation, to counteract the encroaching obesogenic environment in the country. The campaign, ultimately involving 3% of the total population, mobilised 600,000 people to collectively lose 600,000kg of body weight. There was strong political leadership and support for the campaign, as the Prime Minister pledged to lose 10kg and has publicly tracked his progress.

suffice in guiding self-regulated industries. He described nudging as premised on *Thaler and Sunstein's theory* (<http://www.youtube.com/watch?v=xoA8N6nJMRs&feature=relmfu>) that everyday decisions made by individuals are not conscious or rational, but are instead guided by perceived norms and rely on poor information. Through the use of choice architecture it is therefore possible to influence individuals' behaviours in non-coercive ways.

Bonell purported that the UK's Conservative government had taken the stance of “rather than nannying people we will nudge them by working with industry to make healthier lifestyles easier.” By establishing the UK Public Health Responsibility Deal, the UK Government had a framework in which they could work with industry, thinking it might be faster, cheaper and more effective to get them to voluntarily self-regulate. Bonell was very critical of this initiative, citing that there had been patchy sign-up to pledges, which in many cases didn't break new ground, but just reflected existing standards.

He also described companies signing up to agreements that did not reflect their product line, such as the UK tea manufacturer Typhoo that committed to reducing trans fats in their tea products (within which there are only trace amounts). Furthermore many companies involved in the responsibility deal had opposed earlier public health initiatives such as traffic light warnings on food, one of the few measures for which there is strong evidence that consumers find this the easiest way to gauge how healthy a food is.

Bonell's conclusion... nudge and voluntary regulation does not work or at best currently lacks any evidence base. Therefore, individuals may have the freedom to be foolish, but industry must be regulated.

Corporations as a determinant of health and the growth of “industrial epidemics”

Conversations also turned to Big Tobacco and Big Booze, where [Anna Gilmore](#), Professor of Public Health and Director of the Tobacco Control Research Group at the University of Bath and [Judith Watt](#), Director of the NCD Alliance, suggested that the products of major industries are responsible for a significant and growing proportion of the global burden of disease. They argued strongly for greater regulation of industry and protested against partnerships between government and industry.

Gilmore's thesis was that “corporations have responsibilities to maximise profits” regardless of consequences to health, society or the environment, and to oppose policies that could reduce their profits.

Likely out of respect for the courage of Big Food to step into the lion's den at EHFG 2012, neither Gilmore nor Watt explicitly attacked the food and beverage industry; yet they argued that the



Anne Gilmore, Professor, Director of Tobacco Control Research Group, University of Bath

rhetoric of Big Booze and Big Tobacco are similar in that they both describe consumption of their products as a personal choice and responsibility, advocate for self-regulation (over legislation), influence the evidence base and criticise the “nanny state”, for example. They pointed out the irony that Big Tobacco is regarded as the root of all evil while the WHO recognises Big Food and Big Booze as valid participants of civil society.

In closing Watt listed the expected challenges in moving forward, which included, among others: establishing time limited goals and ensuring good leadership both inside and outside the health sector (as in the example demonstrated by Taiwan).

The second session asked government representatives and researchers to comment on the strategies recently introduced to incentivise clinical management of NCDs across many countries.

Taiwan: Early detection and disease management programmes

In Taiwan the National health insurance NCD prevention and treatment strategy is organised into two facets:

1. Integrated clinic-based and outreach “early detection” services (i.e. various types of cancer screening, hepatitis, flu vaccinations) integrated into one general wellbeing appointment.
2. Disease management programmes with quality excellence targets and bonus systems developed to encourage adherence to clinical guidelines.

Shu-Ti Chiou reported that success has been achieved in some areas; for example, there has been a 15% reduction in diabetes-related mortality rates in the last ten years. Furthermore, the quality of services has risen at treatment centres enrolled in the payment-for-performance (P4P) policies. Chiou said that the next step is to involve more institutions and patients in P4P-funded disease management programmes.

The Netherlands: Disease-specific bundled payments

In The Netherlands, the 2006 reform of the care delivery and financial reimbursement systems set off a priority to focus on care for people with chronic, rather than acute, illnesses.

Bert Vrijhoef,
Professor, Tilburg
University



Bert Vrijhoef, Professor of Chronic Care at Tilburg University described the cornerstones of the approach:

1. Care groups: the providers (or contractors for other providers).
2. Disease-specific care standards: documents stipulating the minimal required patient services to be covered and authorised by caregiver organisations.
3. Bundled payments: single fees for specific chronic diseases, paid to care groups by insurers to provide primary and specialist outpatient care as detailed in the care standards.

Results from an evaluation of bundled payments demonstrated that the management of some chronic diseases like diabetes and COPD were better organised, but only saw moderate effects on quality of care (e.g. better adherence to guidelines). There was also a 3% increase in the overall cost of care, which has been attributed to the employment of new practice assistants at the primary care level and hospitals billing twice for the same treatment. The implementation challenges were expected, yet Vrijhoef warned that the introduction of any reform takes more time than anticipated. The next step for the Dutch is to move towards a system of regional bundled payments.

France and Estonia: incentive schemes for disease management and quality

Isabelle Durand-Zaleski, Chief of Public Health at Henri Mondor Hospital in Paris, described the 2009 introduction of a new contractual agreement for physicians to incentivise quality; yet the focus of her discussion were the challenges faced when all of the French national-level stakeholders resisted its introduction.

Starting from its inception, Durand-Zaleski told the audience that all stakeholders were invited to review the guidelines and targets, and most thought they were poor. As a result of the review, the physicians' unions opposed the scheme, but many physicians signed up to the scheme anyway – aware that targets were not difficult to achieve and that they would stand to gain at minimum €3000 extra per year. A few years in to the scheme and unions have now yielded seeing evidence of the success of similar schemes in the UK and the Netherlands.

An alternative perspective showed that the challenges faced in France were not mirrored in Estonia. [Taavi Lai](#), Senior Health Policy Analyst at the Estonian Ministry of Social Affairs, described a different situation whereby physicians associations worked with insurers to develop and implement a voluntary quality bonus scheme. However the contention is now that physicians believe that targets are too high and insurers want them to remain high so that activity does not become effortless. Moving forward, Estonia will try to introduce an extra bonus to physicians who achieve all targets, and earmarked funds have been reallocated to allow physicians to follow up with patients more effectively.

Researchers reviewing innovations across 13 European countries

[Ellen Nolte](#), Director of Health and Healthcare, RAND Europe, then reviewed the evidence for the introduction of NCD treatment strategies (most often related to diabetes), and argued that nearly 50% of all studies report positive health outcomes, yet evidence for cost savings is limited.

In attempts to add to the literature, Nolte and colleague [Cecile Knai](#), Lecturer in European Health Policy at London School of Hygiene and Tropical Medicine, worked with key informants



Cecile Knai, Lecturer in European Health Policy, LSHTM

across 13 European countries to ask a number of questions on the context of the development of these programmes.

Nolte found that there are generally three approaches to disease management programmes:

1. Efforts to encourage one principal coordinator for care (usually GPs – especially in countries where GPs work in solo practices).
2. Multidisciplinary team working (frequently led by GPs).
3. Nurse-led approaches including managed discharge and case management.

Nolte argued that most of the programmes are funded through quality improvement initiatives, and the use of clinical information systems tends to be the least developed strategy in most approaches. She presented mixed results, for example, improved survival of German diabetes patients, and increased re-admissions and decreased patient satisfaction with their experience in England. Knai stepped in to suggest that the barriers to success may be linked to a lack of culture of evaluation in some countries (and lack of resources to undertake evaluations), feelings of reluctance to collect data – especially in countries where solo GP practices are common, and a lack of sustained funding for patient education.

Knai closed the session citing the key criteria for success of chronic disease management programmes: strong primary health care systems, buy-in from patients (as well as other key stakeholders), strong leadership, the emphasis within medical training on the importance of an evidence base (and therefore evaluation), and coherent IT systems.

Conclusion

Overall, across the two sessions, researchers, industry and government shared their successes. While no decisions were made on how to work together collectively, the forum identified future challenges for the global eradication of NCDs – which is a necessary first step in the right direction.



Find out more about this session at www.ehfg.org/923.html?eid=30

Health in an age of austerity

By Timo Clemens and Angelika Le Beau

As the financial and debt crisis has endured, this year's forum focussed once again on the health and health systems affected by economic downturn and reactive austerity policies. In contrast to EHFG 2009 on Financial Crisis and Health, where the potential damaging impact was anticipated and measures to protect health budgets were advocated, we witness now the first measurable effects on health and health systems and are able to take stock of envisaged and already implemented health system responses to the crisis. Moreover, we have realised that the financial crisis is not a short term event but is still persistent.

In this regard the Closing Plenary addressed three basic questions:

1. What do we know now?
2. What are strategies so far?
3. What are future directions?

The Closing Plenary involved two keynote presentations outlining the Austrian and EU response, a comparative analysis of health impacts, a video reflection and finally a panel discussion involving representatives of EU, OECD, WHO and civil society as well as academics.

What do we know now?

In order to set the scene [Philippa Mladowsky](#), Research Fellow, LSE Health/European Observatory, presented work on the impact of the financial crisis on health and health systems and the health policy responses that European countries are engaged in. Although she stressed that the impact and responses differ very much between countries, the key findings were as follows:

- There were significant negative impacts on some types of mortality and morbidity in countries with weak social protection.
- There have been reductions in the rate of growth of public expenditure on health.

- There have been increases in cost sharing and increases in unmet need.

She concluded by highlighting that fiscal sustainability should not become a health policy objective in itself. Rather resources need to be allocated more efficiently and proven to be of additional value to health. General cutbacks across the sector are not efficient. If cuts are inevitable they have to be transparent and trade-offs need to be explained. Lastly, we have to make the case for health better and emphasise its positive contribution to economic growth.

What are the strategies so far?

Beyond the comparative overview given by Mladowsky, [Alois Stöger](#), Austrian Minister of Health and [John Dalli](#), EU Commissioner for Health and Consumer Policy, elaborated on the Austrian and EU answers to the health challenges caused by the financial crisis.

Health Minister Stöger exemplified the Austrian way of investing in their health system in times of crisis as the background to his hypothesis that the current crisis is a "trust crisis". He regarded investments as the means to build trust and security by ensuring a social security net for its citizens. At the same time health investments offer economic growth and act as "stabilisers" in a generally unfavourable economic climate.

The way forward outlined by Commissioner Dalli was based on the assumption that in times of economic decline and lower levels of



Alois Stöger, Minister of Health, Austria



John Dalli, former EU Commissioner for Health and Consumer Policy, European Commission

government revenues “health, of course, is not immune”. “Delivering more healthcare with fewer resources” is possible according to Dalli due to existing inefficiencies in the system and is very much needed to ensure that future generations can benefit from affordable health care. Ensuring inter-generational equity is a long-term endeavour that requires structural reforms to be undertaken now.

Although both differed in their analysis of and broad approach to the crisis, and despite the different levels their measures operate on (national versus EU), their envisaged objectives and instruments for reforms resembled each other quite well. Both strived to use investments in health for the realisation of efficiency gains in the health sector. Both regarded coordination and cooperation among actors in the health sector and among member states as key to achieving better functioning systems. Both Stöger and Dalli saw a vital role for technology such as eHealth applications like the Electronic Patient File or prescriptions to ensure patient safety and increase efficiency. Moreover, both embraced additional efforts and investments in health promotion and disease prevention.

Prevention was regarded as a “key investment for the future” because it avoids suffering in the first place and pays off in the long run. In addition, both addressed governance issues such as health targets, the role of regulation and the stimulation of innovation to achieve these reform objectives.

The contributions of Stöger and Dalli resonated very much with his year’s EHFG in two aspects. Firstly, the two basic positions Stöger and Dalli represented in dealing with the crisis, one advocating that health budgets need to be preserved and shielded from cuts, the other

acknowledging that cuts are inevitable and that we have to deal with fewer resources: both positions have been inherent in many discussions throughout the days of the EHFG. Secondly, the instruments and objectives they addressed in their speeches mirrored at large the themes discussed in this year’s parallel forums and workshops.

Future directions

The video reflection and panel discussions raised more questions and aspects that need close attention, and highlighted persistent controversies as the crisis goes on, rather than providing fully-fledged answers. Some of these painstaking aspects of dealing with the crisis are presented here without claiming that this is a complete representation of the discussions.

Is austerity the new normal?

So far the recession is enduring. Is there an end in sight or do we have to accept austerity as the new norm? Assuming that the crisis situation will further persist, preparations are needed to preserve access to health services for the “worse-off” in society. In addition, what effects can be anticipated if temporary cuts become permanent? So far, countries have been able to catch up quite fast after the economic upturn began. Lastly, if tight budgets and reduced services are the new norm, should there be a societal conversation on our expectations for health?

Is austerity working in terms of economic development and what are its health effects?

In terms of economic development and the success of austerity, it has been recorded that the financial crisis is not solved yet. Nevertheless, austerity was regarded by some to work, for example in Ireland, but it is painful! However, austerity is certainly not the sole answer to the problem. As the discussions demonstrated inter alia macroeconomic imbalances between countries need to be addressed and wise investments have to be made.

As to the health effects of austerity, it was noted that Member States were trying to preserve the same quality and scope of services with fewer resources and that there has been a stimulus in many Member States advancing needed health system reforms in the right direction. However, the health effects of austerity are still unknown.



Panellists: Judith Watt, Director, NCD Alliance; Constantino Sakellarides, Professor Emeritus, National School of Public Health, Portugal; Mark Pearson, Head of Health Division, OECD; Monika Kosinska, Secretary General, EPHA; John Dalli, former EU Commissioner for Health and Consumer Policy, European Commission and Hans Kluge, Director of Health Systems and Public Health Division, WHO/Europe

Therefore, there has been a call for a Health Impact Assessment of austerity measures in general and especially for those measures the Troika is imposing for the worst affected countries in the framework of the economic adjustment programmes.

When cuts are decided... by whom? Who is accountable?

Contributions indicated that those regarded as the obvious advocates for cuts such as representatives of DG ECFIN and the IMF earlier this year rejected that they campaign for health cuts. Who is endorsing cuts then? Moreover, political stewardship was generally stated to be lacking in visibility. A civil society that is on the streets and the rise of right wing parties and civil riots have been regarded as symptoms of missing leadership. In answer to an apparently insufficient political leadership in the crisis, there were calls that we as health advocates would

have to present our case in a way that involves arguments and issues beyond our own field. In doing so we would need to be increasingly proactive but would rather stay reactive as the recipients of boundaries and limitations given to us.

Finally, the EHFG 2012 and the closing session in particular showed that the goals of maintaining the resilience of our health systems and demonstrating leadership in this financial crisis – already discussed in 2009 – are still valid. Attaining both goals needs our ongoing commitment and joint efforts!



Find out more about this session at www.ehfg.org/923.html?eid=24

Financial crisis

By Gabriele Pastorino

This workshop session explored the range of responses to the challenges that the financial crisis brought to the health systems of countries of the Commonwealth of Independent States (CIS).

The effects of the financial crisis on health systems in Russia and other CIS countries

The crisis impacted the CIS countries differently depending on a number of factors. Indicators like Gross National Income (GNI) show that some countries have not been as severely affected by the financial crisis as others: GNI is continuing to grow in all CIS countries except for Belarus and Azerbaijan, where the crisis had a stronger impact.

Other indicators, such as the Total Primary Energy Production, also explain the differential impact of the crisis in the region: for instance the Russian Federation, as the biggest producer of oil and gas in the region, is dealing better with the crisis compared to other Member States.

Those countries that already faced severe resource constraints had fewer options for maintaining equitable access to health services of a reasonable quality. But even resource-rich countries such as the Russian Federation have sought to contain or reduce health spending in a number of ways.

There are various options available to policy-makers for building resilience to and dealing with economic shocks to the health system when they arise in both resource constrained and resource rich economies. The most common interventions to address the effects of the financial crisis are containing or reducing health spending, improving technical efficiency and improving allocative efficiency.

In particular in the CIS, cost containment is associated with interventions like cutting budget expenditure, redefining the benefit package by introducing user charges, extending or limiting cover, and/or reducing public health spending, which in some countries was considered too high.

Introducing user charges: This intervention was implemented in a few countries for services like hospital care, primary care consultations, diagnostic procedures etc. However even in this area the CIS countries are not homogeneous: in the last five years some countries have seen an increase in private households' out-of-pocket payments (for instance in Armenia and the Russian Federation), while in others these have fallen (Uzbekistan and Kyrgyzstan).

Prevention: Some countries have decided to introduce sin taxes in the form of duties on tobacco and alcohol, allocating more money to health promotion and in some cases cutting expenditure and investments in health services.

Cost containment: Measures like price controls for pharmaceuticals, medical goods and equipment have been implemented to contain costs.

Common challenges in CIS countries

Presentations from high level representatives from the CIS countries highlighted some of the challenges that their countries are facing:

- In many CIS countries, like Kyrgyzstan, the *economy has been in transition* since the dissolution of the Soviet Union and this has had an impact on the health care sector. Also more recent crises (like the one of the year 2000 in Tajikistan) have impacted on their economic growth.
- *Common obstacles* in the CIS countries are the insufficient quality of medical care, low budgets, a lack of good infrastructure and a lack of human resources (both nurses and medical doctors).
- Several health systems are undergoing *significant changes*: for instance in Kyrgyzstan two programmes have been created to undertake health sector reforms, one including compulsory health insurance. The concept of family medicine has been recently established and has been working quite successfully and serious reforms have been conducted in the field of public health. In Tajikistan upcoming reforms are trying to

push forward the implementation of a payment system based on performance. In the Russian Federation important programmes have been designed to improve population health and fight against communicable diseases.

- Many countries like the Russian Federation and Armenia are investing in programmes to tackle *noncommunicable diseases* (NCDs) which cause 90% of all deaths in Armenia. The Russian Federation has also increased investments in cancer care by tenfold.
- Many countries face *severe problems in financing their health systems* (in Tajikistan, for instance, especially for primary care and prevention) and several ministries are working to maintain universal access to care but trying to maintain also the principle of solidarity. Even in richer countries like the Russian Federation the federal budget is now allocated by taking into account the international economic situation and considering the average price of oil.
- It is difficult to measure how the economic downturn affects health in the CIS countries. However looking at the data on different causes of mortality there is a worrying increase in *circulatory disease-related deaths* in the region.
- *Access to care*: There are issues in several countries in this area but current data relate to the pre-crisis period. National surveys have been carried out in several countries and they suggest that there are huge differences in access across the region.
- There are *general challenges* most countries face when trying to balance quality, accessibility and efficiency of the health system: it is difficult, for instance, to offer more services without increasing co-payments.

What can Europe learn from the experiences of the CIS countries?

The crisis Western European countries are facing is not comparable to the fall in GDP experienced by the CIS countries in the post Soviet Union transition period. However, it is extremely helpful to review their experiences in light of what is going on now in Europe.

In an economic crisis there are different ways the health system can react: one of these is to try to

bring more resources into the system (it is difficult to ask for more taxes but despite this the experience of the CIS countries shows that they managed to bring fresh money into the system).

In Europe we see an increasing tendency towards co-sharing payments and reducing access while the CIS countries worked to reduce informal payments. One of the main common concerns is how to protect the most vulnerable segments of the population.

A good lesson from the CIS countries is to look at how they managed to restructure health services by reducing the number of beds and introducing payment for performance.

It is important to stress the important role of public health at a time of financial crisis.

The role of the government is key and the health ministry has to be able to persuade the ministry of finance and the government to allocate more money to the health system.

Intersectoral governance and health in all policies (the importance of protecting the weakest part of the population by protecting them from unemployment etc.) play a key role.

Controversial issues

The use of sin taxes on alcohol and tobacco generated significant discussion in the workshop.

Sin taxes were considered to be very important tools but these measures were thought to be often difficult to implement because of the role of industry lobbies. It is also difficult to measure how much progress the countries that implemented the sin taxes have made.

Earmarking funds for health on revenues from taxation on tobacco and alcohol might make the State dependent on certain industries. Measures implemented should be a way to tackle the health issue and not as revenue, and states that use this leverage have to bear this in mind. Some questioned whether sin taxes should be used to support the transformation of the health system.

Alcohol has a huge impact on GDP growth in countries like Russia and it has very strong social implications and goes beyond being a health issue (the important role of social determinants of health and intersectional governance).

Other controversial questions also arose during the discussion:



Josep Figueras, Director, European Observatory on Health Systems and Policies; Willy Palm, Dissemination Development Officer, European Observatory on Health Systems and Policies; Varduhi Petrosyan, Assistant Professor, College of Health Sciences, American University of Armenia; Oleg Chestnov, Assistant Director-General, Non-communicable Diseases and Mental Health, WHO; Tatyana Chubarova, Academy of Sciences Institute of Economics, Russian Federation; Bernd Rechel, Senior Researcher, European Observatory on Health Systems and Policies; N Grigorieva, Head of the Center for Comparative Social Research MSU, Russian Federation; Elena Tkacheva, Head of Planning and Economics, Ministry of Health, Belarus; and Erica Richardson, Senior Researcher, European Observatory on Health Systems and Policies

- How to predict and regulate pharmaceutical expenditure in a time of financial crisis?
- How is it possible to build a democratic movement to support health involving civil society?
- How can we measure the scale and impact of health reforms in the CIS countries?

Conclusions

- The CIS countries have made amazing progress in reforming their health systems over the last 20 years.
- Solidarity has a central role in shaping the policies.
- The reaction to the financial crisis across CIS countries was not homogeneous: countries have implemented different reform programmes and have actually taken quite different directions.
- Evidence shows that in some countries even when the financial crisis had an impact on the economy this didn't necessarily lead to actual changes in policy making and to health systems. This was the case for

countries like Azerbaijan and Ukraine.

- In other countries, like Georgia, Kyrgyzstan and the Russian Federation, even when changes have occurred these were not necessarily direct responses to the financial crisis but rather part of programmes already planned and initiated by the governments.
- Only Belarus and Moldova implemented some substantial policy changes in response to the financial crisis.
- In some cases the financial crisis has been used to implement reforms that would have been otherwise politically difficult to implement. This is the case for countries like Armenia where some positive programmes were implemented during the economic downturn, and other decisions were taken for political reasons and not because of actual budget constraints.



Find out more about this session at www.ehfg.org/923.html?eid=1

Evidence of the effectiveness of eHealth: focus on telehealth

By Prit Kruus

eHealth has the potential to help European healthcare systems by improving accessibility to healthcare in remote locations, overcoming shortages of health professionals, bringing patients closer to managing their health, and having a positive influence on attitudes and the behaviour of patients resulting in better clinical outcomes. Although policy-makers do acknowledge this potential, large scale deployment of eHealth solutions in Europe still lags behind. Whether it is so due to remaining doubts about the evidence of the cost-effectiveness of eHealth or also because of other barriers such as organisational and financial limitations, are important questions.

The workshop focused on sharing the results of different research projects at EU and national levels, while stimulating a discussion among experts around the existence of real informed evidence on the effectiveness of eHealth. The level of evidence but also the use of evidence was discussed in the context of possibilities of eHealth supporting our health systems.

Different kinds of evidence needed

All the presentations showed that there is evidence that eHealth and telehealth can be effective, but the evidence is still coming mostly from research settings. There is a lack of evidence at the provision level and this means that more collaboration is needed among stakeholders.

Furthermore, cost-effectiveness measurements should take a more holistic view. The impact on the labour market and social system should be taken into account and both direct and indirect costs evaluated. It was also pointed out that maybe there is too much attention given to costs and the debate should be more focused on quality and outcomes.

Mostly the problem is not the amount of evidence, but the quality of evidence and its applicability to other settings. This can be seen as a barrier for wider use, although other aspects are also important. There is also a belief that the

focus of the evidence does not have to be on cost-effectiveness any more, but rather on decision making.

Communication is a key problem in implementation and involving stakeholders. Evidence building is difficult and contact between researchers and patients is needed. There should be on-going engagement of patients in the processes and this assumes skilled project management.

If all relevant stakeholders are involved, then the finalised evidence can be more easily put straight into practice. The evidence has to be built in the care settings, because specificity is high and it can be very hard to transfer the evidence to other regions. Evidence should not be over generalised and should focus more on localised methodologies. It could be useful practice for evidence building to be connected directly to provision – the same stakeholders who were involved in research should also continue to provide the service.

There is the question to what extent future research should focus on randomised controlled trials and to what extent on organisational issues. Maybe we must re-use the evidence we already have and focus on implementation and stakeholder involvement?

What should support the evidence?

Proving cost-effectiveness has to be complemented by new ways of providing care, whether it is modifying the care processes or patients playing a bigger role in their care.

The latter has some important preconditions regarding data use. Technology can play a role in personalising data more, but a vital component is also trust. Patients' access to health records is important and easy access to data should not be underestimated.

It should be noted, that eHealth on its own is not enough and it is problematic that organisational aspects cannot keep up with existing technology.



Heelen Riper, Professor, VU University Amsterdam, Claus Duedal Pedersen, Renewing Health Project

Innovation emerges from new processes and new provision models. Patients can see benefits in technology, but industry might perceive technology as disruption and thus the expectations of industry have to be managed appropriately. The key is developing processes which do not disrupt the existing organisational structure but enhance it and improve existing day-to-day processes.

This means giving the care providers an incentive to change their organisational design, which means sustainable investment assurance by not only the private sector but also the public sector.

As a supporting solution, a new type of health care professional could help to make better use of eHealth and the evidence built about its effectiveness.

eHealth in the age of austerity

Austerity can be both a burden but also a chance. eHealth could be a contributor to health system sustainability, but this means finding funds for investments. Furthermore it means cutting across the traditional levels of care and reducing the pressure of cost-containment with eHealth.

Political will is needed to get momentum into telehealth, but it is unrealistic to expect private investors to invest if they do not know that they will have a market to whom they can provide their solutions.

At both political and organisational levels there should be a change in attitude or even a constant attitude of change. Health systems have high inertia and there is a lack of understanding that the reimbursement system should be altered. Changes won't emerge unless the ones who carry the burden of change are rewarded for their work.

Conclusion

To conclude, the session highlighted the most important aspects of using evidence in health care. As eHealth is very connected to different aspects of health systems and there is such variety in health systems between countries and regions, it is hard to transfer evidence. We should move towards more integrated approaches.

All levels of the systems have to be incorporated into the building and using of evidence in eHealth. The industry has an important role in changing the way care is provided, but the national and EU level incentives have to also be there. The reimbursement system has to support organisational change in health care in order to realise the full benefits of eHealth.



Find out more about this session at www.ehfg.org/923.html?eid=2

Improving nutrition in Europe with flour fortification

By Sabrina Montante

Food fortification, the addition of essential vitamins and minerals to food staples, is implemented by countries throughout the world to prevent micronutrient deficiencies and reduce the incidence of neural tube defects, such as Spina Bifida. Fortification of at least one type of commonly consumed wheat flour is currently mandated by 74 countries. Despite the fact that flour fortification has been practiced in some countries for more than 60 years and that it has been a topic of discussion in European countries for a number of years, few have embraced this cost effective public health strategy.

The workshop outlined and addressed common concerns related to flour fortification as well as the nutritional and economic benefits of fortifying flour. Because foods made with wheat flour are commonly consumed throughout Europe, fortification has the potential to benefit millions of people in the region. The workshop also highlighted the evidence for fortifying flour with folic acid to prevent neural tube defects. EUROCAT, a network of population-based registries covering 1.7 million births in 21 European countries, reported between 1,130 and 1,344 neural tube defects each year from 2006 through 2009. None of the included countries has a mandate to fortify flour with folic acid, and only one fortifies with iron.

The Flour Fortification Initiative (FFI)

The Director of the Flour Fortification Initiative, [Scott Montgomery](#), outlined the wheat industry in Europe and potential benefits of flour fortification there. More than 600 types of flour are produced in Europe to meet consumer demands, according to the European Flour Milling Association. Foods made with wheat provide 23% of the population's protein supply and 22% of the total calorie intake, according to the Food and Agriculture Organization of the United Nations. Because wheat consumption across the region is at least 150 grams per capita per day, flour could be fortified with minimum levels of vitamins and minerals and still be expected to have a significant public health impact.

The FFI is an international network of individuals and organisations working together to make flour fortification standard industrial milling practice. Among the partners are flour millers, scientists, government ministries, and non-governmental organisations. An Executive Management Team representing global leaders in the public, private, and civic sectors provides strategic direction to the network.

The FFI global secretariat is at Emory University in Atlanta, Georgia, where students collect data on global flour fortification practices. Most countries fortifying flour include both iron and folic acid, a B vitamin, in their standards. Many countries include zinc plus other B vitamins; some countries include vitamins A and D as well.

Countries determine the type and quantity of nutrients to include in flour fortification based on their population's typical consumption patterns, diet and any specific health concerns. International meetings in 2004 and 2008 led to global guidelines to help countries make these decisions. Some regional guidelines are also available, but ultimately flour fortification is most successful when national leaders drive the process. From its beginning, the FFI network of partners has offered technical expertise to millers in countries initiating flour fortification. This technical support is expanding to include quality assurance and quality control training for industry leaders as well as government food safety authorities. FFI's partners are encouraging countries which have been fortifying flour for decades to update their fortification standards based on the newest scientific evidence. Technical support is available for countries wanting to monitor flour fortification programmes for their health impact.

FFI has historically focused on wheat flour. Plans are underway for the emphasis to expand to include maize and rice fortification. These three cereal crops are the most commonly consumed grains worldwide, and the fortification of each represents tremendous opportunities to improve global health.



Liven Bauwens, Secretary General, IFSBH; Francesco Branca, Director of Nutrition for Health and Development Department, WHO; Scott Montgomery, Director, FFI; William Dietz, former Director of Division, Centers for Disease Control and Prevention; Margo Whiteford, Vice-President, IFSBH; and Susan Horton, Chair in Global Health Economics, Centre for International Governance Innovation

Common concerns related to flour fortification

Common concerns about negative consequences of flour fortification are unfounded, said [William Dietz](#), former director of the US Centers for Disease Control and Prevention (CDC), Division of Physical Activity and Obesity. He presented evidence that:

- Fortification does not cause people to consume more than the tolerable upper levels of folic acid and iron.
- Fortifying with folic acid does not cause cancer or mask B12 deficiency.
- Fortifying with iron does not increase the risk of iron overload in people with beta thalassemia.
- An approach that targets women to take folic acid supplements before conception is less effective than fortifying flour with folic acid.
- Unfortified flour has many ingredients added and is not really 100% “pure”.
- Mandatory flour fortification preserves consumer choice.

Federation for Spina Bifida and Hydrocephalus (IF)

[Margo Whiteford](#), Vice President of the International Federation for Spina Bifida and

Hydrocephalus and a Consultant Clinical Geneticist, presented a photo description and scientific explanation of the different types of neural tube defects.

According to research findings, almost 75% of pregnancies affected by a neural tube defect are aborted. However most neural tube defects, such as Spina Bifida, can be prevented if the mother has at least 400 micrograms of folic acid daily at least a month prior to conception and in the early weeks of pregnancy. Children with Spina Bifida very often develop hydrocephalus, some paralysis, pressure sores and incontinency.

Whiteford was born with Spina Bifida and she described Spina Bifida’s physical challenges, as well as the impact on family life, from her professional and personal experience.

In the age of global austerity, flour fortification is a wise investment. Children born with Spina Bifida require a lifetime of medical treatment. In Spain, the annual medical costs per Spina Bifida patient per year are €3,500. In contrast, fortifying flour with iron, folic acid and other B vitamins could cost €0.16 per person per year.



Find out more about this session at www.ehfg.org/923.html?eid=3

Be aware of your kidneys

By Joanna Smolinska

The key topics of this workshop session during the European Health Forum Gastein 2012 were:

1. Problems for the healthcare system in calculating the costs of treatment and related expenditure of diseases like diabetes.
2. Decision-making between patients and doctors concerning dialysis or kidney transplantation.
3. Ethical issues and the balance between the interests of the donor and the recipient of the organ.

It is very important to increase the population's awareness of frequent diseases. Because many people do not know that they have kidney problems, they learn about the disease too late, when they must decide between dialysis or a kidney transplantation. When they begin treatment they should be extensively educated on the therapeutic options. This is necessary to find the optimal therapy, based on personal preference and on medical prerequisites. Health authorities should be encouraged to facilitate patient education.

We do not know how many patients exist who are unaware that they have renal disease. This awareness is important not only for patients but also because the health care system can't predict the potential costs of treatment.

Renal disease has many controversies, which become apparent when the health of one person depends on that of another. To find the right balance between the donor and recipient is crucial. We must always remember that post-transplantation the donor is left with only one kidney – does this then mean this person is still healthy or is now also vulnerable? We must consider the potential health implications of this.

Another problem is with the recipient, who receives a kidney, but the kidney does not last forever, a successfully transplanted kidney lasts "only" about 15 years. After this time, the patient must decide again between transplantation or




Erich Pohanka, Head of Medical Department, AKH Linz, Austria and Franz Vranitzky, former President of the Republic of Austria

dialysis. Thus post-transplantation, do we have two healthy people or two sick people, or maybe two healthy people for a limited period of time? We should also take into account that finding a donor takes time.

When we consider the different methods of renal disease treatment, we must also consider the different costs. A study has shown that transplantation of the organ is much more cost effective than dialysis. Costs of transplantation are around a quarter of the costs of getting a dialysis, however dialysis is more accessible for patients.

To summarise and conclude, people need to be more conscious that they are suffering from a renal disease and efforts should be made to ensure they start treatment earlier. The financial crisis is a problem but also an opportunity. It is a time when we must pay attention to the best and most cost-effective methods of treatment for patients. It is a good time to analyse once more all available treatments, and decide which of them are really beneficial. Thus the crisis also presents possibilities to discover new ways of treating diseases without redundant costs.

 Find out more about this session at www.ehfg.org/923.html?eid=7

Disease prevention

By Alena Ottichova

This workshop presented the very interesting topic of disease prevention and the value of life span immunisation. The four speakers, representing different institutions and having completely different backgrounds and education, spoke about the huge benefits of vaccination to children, adults and wider society; any controversial debate was missing. The session was moderated by [Karin Kadenbach](#), MEP Austria.

The issues of vaccination and immunisation of individuals are today more relevant than ever, one reason being because of growing migration. The question of costs in comparison to benefits resonates strongly with the theme of this year's congress: Crisis and Opportunity – Health in an Age of Austerity.

The debate

The main statement of the debate was: “We need vaccination and life span immunisation; we need easier and cheaper access to vaccination in our societies around the world. Immunisation extends the life of people and has a high value for society and protects communities against communicable diseases. The informed behaviour of individuals and their position in relation to immunisation is important.”

The debate centred, firstly, on the introduction of and investment in vaccination in developing countries. [Armin Fidler](#), Lead Advisor Health Policy and Strategy, World Bank, pointed out the problems of the vaccination market: low competition between producers, limited vaccine



Armin Fidler, Lead Advisor of Health Policy and Strategy, World Bank; Karin Kadenbach, MEP, Austria; and Stephen McMahon, International Alliance of Patients' Organisations

supply (which leads to relatively high prices), very high costs for vaccine development, and the availability of cheaper vaccines for the whole world.

A second important question was also asked by Fidler: how to achieve acceptance of immunisation as a prevention measure in Europe; and, further, if it should be fully paid as a prevention measure from a benefit basket.

[David Taylor](#), Professor of Pharmaceutical and Public Health Policy, University College London School of Pharmacy, underlined that vaccination should also be seen as a cost and optimally effective public health strategy. “Immunisation confers collective benefits within and between age groups, over and above individual protection”.

Further key questions included: Is drug resistance increasing the need for adult immunisation? What value has vaccination for older adults?

Taylor pointed out the value of and opportunities for immunisation:

- Interventions that extend immune-system life expectancy.
- Vaccines for use in treating different types of cancer.




David Taylor, Professor, University College London School of Pharmacy

- Development of vaccines against infectious diseases, such as malaria.

Stephen McMahon, International Alliance of Patients' Organizations, said: "Vaccination prevents diseases, saves lives and means social and economical opportunity." His perspective was that broad immunisation coverage was a necessary public health measure to protect all citizens, and that the focus should not only be on child immunisation.

Conclusions and recommendations

- Due to freedom of movement, we need more coordination of vaccinations to reduce inconsistencies in vaccination policies across Europe.
- We need more protection and immunisation programmes and guidelines; and more commitment from national governments and the EU.
- We need more screening in vaccinations (in order to provide a high security of immunisation).
- We need more information about vaccination and more interest in promoting global approaches.
- Easier and cheaper access to immunisation is necessary all over the world.
- Common standards within the EU should be definitively guaranteed.
- We need coherent adult immunisation.
- We need continued development of vaccinations.
- Local conditions need to be understood in order to define optimal local policies.

 Find out more about this session at www.ehfg.org/923.html?eid=8

Vaccines

By Andras Borsi

This vaccines workshop session was moderated by [Karen Kadenbach](#), MEP, who highlighted, that despite vaccines being a success story, they often seem to be a victim of their own success. She emphasised that nowadays people are often afraid to be vaccinated, due to social media and the rapid flow of negative information.

The first presenter was [Hildrun Sundseth](#), Board Member of the European Institute of Women's Health (EIWH).

Sundseth noted that this year three workshops were held concerning vaccines and vaccination, which reflect the importance of the topic. In her presentation Sundseth emphasised the importance of vaccination, which is the best tool to prevent infectious diseases.

Despite prior success – for example diseases like polio nearly disappeared thanks to vaccination – the public is still sceptical and afraid of vaccination. The main reason for society's lack of trust in vaccinations is because of the media. People are becoming increasingly hesitant to embrace vaccination, resulting in the potential for eradicated diseases to return. Having said this, Sundseth noted that distrust in vaccination is not a new issue and has been present throughout history.

The main public health objective should be restoring public trust in vaccination. In order to achieve this objective, concerns should be addressed early, accurate scientific evidence on benefits and risks should be presented, and a clear strategy is needed. She also highlighted the problem of the lack of leadership in vaccination by the public health community. It is crucial to invest in health literacy and EU action and a common strategy is necessary.

The second presentation of the workshop was given by [Gitte Lee Mortensen](#), an independent anthropologist, who provided an anthropological perspective on health related decision-making.

In her presentation Lee Mortensen underlined that the rational choice theory doesn't always seem to work in the health sector, because there are many other factors which determine our behaviour. In the field of health people do not always act rationally, for example lots of people don't get vaccinated, despite vaccination being effective. She highlighted that rationality is often socio-culturally defined, and communication takes understanding. Using HPV (human papillomavirus) vaccination as the main case study, the approach to vaccination in Denmark was discussed in the presentation.



Hildrun Sundseth, European Institute of Women's Health; Suzanne Suggs, Head, BeCHANGE Research Group, University of Lugano (USI), Switzerland; Karin Kadenbach, MEP, Austria; Gitte Lee Mortensen, Medical anthropologist and Research Consultant; and Boleslaw Samolinski, Professor, National Consultant in Public Health, Poland

The main message of Lee Mortensen's presentation was that information campaigns and advocacy could have a large impact on the thinking of the public, and that HPV should not be treated any more as a "girls only issue".

The third presenter of the session was [Suzanne Suggs](#), Assistant Professor at Università della Svizzera italiana.

The main topic of her presentation was the relationship between social media and trust in vaccination: how can we use social media as an instrument to restore trust in vaccination?

Urgent action is important, because of the current situation: for example currently, more than 250,000 people worldwide die annually from cervical cancer, despite the fact that there is a vaccination available against HPV, the leading cause of cervical cancer. In the European Union, the HPV vaccination rate is higher than 80% in only two countries, the UK and Portugal.

Suggs emphasised that commercial media does not work on its own (but could be used for social marketing), but that social marketing with an ecological approach is needed. She underlined, that social marketing is not equal to advertisement, and a one size fits all approach is not an appropriate strategy. Social marketing offers a coordinated approach, but it demands a sophisticated understanding of the target audience(s).

The final speaker was [Boleslaw Samolinski](#), Professor, National Consultant in Public Health.

In his presentation Samolinski summarised the measures which have been introduced in Poland regarding HPV vaccination. In Poland, 1800 people die of cervical cancer every year, which is a high number compared to other Western European countries. The main problems are lack of awareness and education, and the lack of population programmes on HPV vaccinations. The aim of an organisation called the Polish Coalition Against Cervical Cancer is to improve the current situation in Poland. The key conclusion of the presentation was that strategic cooperation is needed between professionals from different fields.

The main findings of the session were that providing information, setting up a clear message/strategy and improving health literacy is crucial in order to restore trust regarding vaccination. The presenters agreed that HPV vaccination should not be handled as a gender issue in the future.



Find out more about this session at www.ehfg.org/923.html?eid=15

Active and healthy ageing

By Dorothy Gauci

With its Innovation Union strategy, the European Commission aims to enhance European competitiveness and tackle societal challenges through research and innovation.

The European Commission has identified active and healthy ageing as a major societal challenge common to all European countries, and an area which presents considerable potential for Europe to lead the world in providing innovative responses to this challenge. The pilot European Innovation Partnership on Active and Healthy Ageing aims to tackle this challenge through three areas: prevention and health promotion, care and cure, and active and independent living of elderly people.

The overarching target of this pilot partnership will be to increase the average healthy lifespan by two years by 2020. This will foster innovations in products, processes and services, and in parallel facilitate the innovation chain and reduce the time to market for innovative solutions. Ultimately this will produce benefits for innovation's final users – the older people and care providers. In a time of austerity the need for innovative solutions to healthcare challenges becomes ever more important.

The objective of the workshop was to use the European Health Forum Gastein 2012 as an opportunity to showcase a number of projects committed to running activities contributing towards the target deliverables of each specific action.

Action plan on finding innovative ways to ensure that patients follow their prescriptions and treatments

[Stefano Vettorazzi](#), APSS Trento, Italy

Hospital care systems, primary care systems and personal health record systems integrated into a three stage eHealth system. All patient records are freely accessible to all citizens upon request. This system can be used to monitor chronic conditions such as diabetes remotely in older patients. The creators of the (fully operational) software are offering to give it away for free to

those countries within the partnership through a system of mutual sharing of experiences.

Action plan on finding innovative solutions to better manage our own health and prevent falls

[Teresa Moreno-Casbas](#), Nursing and Healthcare Research Unit, Institute of Health Carlos III, Spain

Falls are the main cause of injury amongst older people leading to physical disability and fatal injury. This action plan aims to bring together the world of research, ICT and health care providers and thus get promising solutions implemented.

The three groups of activity in this action plan are the collection of data on risk factors, incidence and costs of falls. The plan details models and tools such as implementation of guidelines, ICT and education and the outlining of service care path models and offering ICT and technological support. At present eight care centres have implemented best practice guidelines related to fall prevention and the monitoring and evaluation of health outcomes. These models and tools have proved transferable as the project is part of an international collaboration using mobile apps, guidelines and outcome indicators.

Action plan on helping to prevent function decline and frailty

[Miriam Vollenbroek-Hutten](#), Roessingh Research and Development BV, The Netherlands

Old people who remain healthy live independently and incur fewer health and social care related costs. Frailty and functional decline are a problem in all areas of physical, cognitive and mental functioning. The action plan has received the commitment of thirty different institutes focusing on extramural diagnosis, monitoring, coaching and treatment of frailty. The draft action objectives focus on the development and implementation of sustainable multimodal interventions for the prevention and comprehensive management of frailty and functional decline.



George Crooks, Director, Scottish Centre for Telehealth and Telecare; Teresa Moreno-Casbas, Institute of Health, Carlos III, Spain; Marjon Vollenbroek-Hutten, Roessingh Research and Development BV, The Netherlands; John Dalli, former EU Commissioner for Health and Consumer Policy, European Commission; Joan Martin, Louth County Council, Ireland; Stefano Vettorazzi, APSS, Trento, Italy; Andy Hull, Director of Stakeholder Engagement, Liverpool Primary Care Trust; and Robert Madelin, Director General, DG CONNECT, European Commission

Action plan on promoting integrated care models for chronic diseases, including the use of remote monitoring

George Crooks, Director of the Scottish Centre for Telehealth & Telecare, Scotland, UK

This action plan was pushed by the desire for safe, effective, person-centred care. The action group are determined to continue delivery against real targets. The long-term focus is to secure commitment and encourage new participants – scaling up across Europe. The action group applies key tests to all collaborative activities and will lead to the development of a repository of best practice to help dissemination. The aim is to provide incentives to industry to invest in the EIP agenda – as true partners. The focus is on the implementation of electronic case records and teleservices. There is a need for change management, workforce training and stratification of risk factors.

Action plan on deploying ICT solutions to help older people stay independent and more active for longer

Andy Hull, Director of Stakeholder Engagement, Liverpool Primary Care Trust, UK

Use empowerment to support people at home to lead active, healthy and independent lives by deploying interoperable independent living

solutions. Improve knowledge, confidence and use of life enhancing technology to put people in control of their care and health. For example Liverpool One is a smart house where one can try equipment with health trainers on hand who can show how it works. Standards, guidelines and reference platforms developed between 5000+ users in 5+ countries focused on creating a practical and sharable tool kit.

Action plan on promoting innovation for age-friendly and accessible buildings, cities and environments

Joan Martin, Louth County Council, Ireland

A cross-cutting action plan involving regions and cities implementing age-friendly practices. It is built on research and evidence for spatial context and smart environments encompassing buildings and outdoor spaces, transport, housing, healthcare, social participation, communication and social inclusion. The focus of similar strategies should be on the importance of engaging older persons – asking them what they want and need.



Find out more about this session at www.ehfg.org/923.html?eid=16

New science and future healthcare

By Maria Chiara Orlandi

The main topic of this workshop session was the link between new science, current healthcare systems and patient benefits, in order to underline the way science is changing. New ways of collaborating in scientific research are revolutionising results and outcomes. New findings are leading to a reclassification of diseases, which is consequently changing the way patients are treated and healthcare is delivered.

The workshop was moderated by [Trevor Jones](#), Director of Allgeran Inc., who opened the debate by asking how scientific progress could actually lead to patient benefits.

Is the contract between society and the pharmaceutical industry up for renewal?

[Michel Goldman](#), Executive Director at the Innovative Medicines Initiative (IMI) showed the rationale behind the creation of IMI: public-private partnerships like a solution for the connection between new science and health systems. It allows “non-competitive” collaborative research for European Federation of Pharmaceutical Industries and Associations (EFPIA) companies, with data sharing and wide dissemination of results. The principal objective is to better involve patients and facilitate growth, in order to create concrete patient benefits from science.

The role of the UK National Institute for Health and Clinical Excellence (NICE), was presented by [Carole Longson](#), Director of the Centre for Health Technology Evaluation, NICE, describing its aim in sharing good practice as well as evaluating cost-effectiveness for medicines that have recently been or will soon be authorised in the UK. She stressed the debate about the definition of “value”, based on a consultation process between academics, patients and industries. The NICE challenge is to achieve a cost-effective approach, assuring systems sustainability and maintaining an environment friendly towards industry.

[Jim Attridge](#), Research Fellow at Imperial College, UK highlighted the issue related to

European weaknesses to incentivise industrial innovation, showing some concrete examples. Innovation is a long-term incremental process while, especially in the current economic and health systems funding crisis, European markets favour short-term results. He underlined three aspects that could improve the situation in Europe and promote innovation: increase research findings, reduce development expenses and adapt 27 Member States regulations towards innovation.

[Sascha Marschang](#), Policy Coordinator for Health Systems, introduced the European Public Health Alliance (EPHA), a network representing the public health community with the vision of “...a Europe whose policies and practices contribute to health, both within and beyond its borders.” He stated that innovation is driven by profit for pharmaceuticals, including public-private partnerships, but it is necessary to develop a more sustainable, socially responsible and innovative model that allows for the concrete involvement of patients and an increasing public interest. He proposed that an initiative like *Horizon 2020* could help in achieving the objective. There was a very interesting debate on problems related to innovation and possible ways to improve its sustainability, with active audience involvement. It was noted that in the context of the transparency directive, all pharmaceutical data will have to be accessible to patients and industry needs to continue working towards the increased involvement of patients.



Sascha Marschang, Policy Coordinator for Health Systems, EPHA

Discussion and conclusion

The necessity of a new global research agenda was underlined, together with collaborative efforts at a global level to develop more cost-effective medicines and healthcare systems. Goldman pointed out that the IMI allows close cooperation and shared experience between institutions and stakeholders.

The debate moved to pharmaceutical costs and a member of the audience argued that if medicines were cheaper, volumes would increase and the pharmaceutical industry would not see its revenue decreased, nor would manufacturing plants be relocated to India and China. Attridge answered that a lot of money and jobs moved to generic industry since 80% of drug consumption comes from generics with Indian and Chinese manufacturers.

Other topics discussed related to the length of time patients were required to wait to receive the benefits from innovation and the need for risk sharing and data sharing as a means of improving capacity for innovation.

The session was eventually closed by Jones who pointed out that in order to improve innovation in the pharmaceutical sector we need to establish priorities. In the current age of austerity the focus should not be addressing the value of innovation, and the way it can be assessed, the key topic is rather to allow society to fund and afford innovation.



Find out more about this session at www.ehfg.org/923.html?eid=17

Health and wealth

By Alexander Geissler

The current financial, economic and social crises have resulted in substantial cuts to some European healthcare budgets. These remarkable budget constraints are likely to impact on innovation in healthcare as well as increasing health inequalities and threatening well-being. New models and new business approaches for investing in health are required to support economic growth and Europe-based research.

The aim of this workshop session was to reflect on the current situation and to sketch out concrete future perspectives which will help improve citizens' health, ensure equity and protect Europe's innovation and competition capacity. The workshop focused on how new business models can stimulate investment and growth and how equity, patients' rights and responsibilities can be balanced.

Investing in health, increasing equity and wealth

The experienced panel was chaired by [Tamsin Rose](#), an Independent EU Health Advocate. After a short introduction round [Josep Figueras](#), Director of the European Observatory on Health

Systems and Policies, set the scene by defining and contrasting the terms sustainability, innovation and equity in relation to health systems. He pointed out that following the recent work of Paul Krugman, Professor at Princeton University, larger welfare states (for example, Sweden or Germany) might be better performers in times of economic crisis which means that investments in particular in health strengthen the economic power of countries. Moreover cutting health expenditure may lead to increasing health inequalities and can be a source of dissatisfaction and precipitate a deterioration in the social climate.

Health systems undoubtedly create wealth. This becomes apparent by the economic size of the health sector (10% of GDP within EU) or labour market effects of healthcare (6% of all workers in the EU). Additionally the R&D and innovation driven pharmaceutical and medical technology sector is constantly growing in the EU (~1.2 million jobs). However innovations in both sectors have to show their cost-effectiveness and should be accessible for all social classes. Otherwise the acceptance of the need for innovations decreases. Additionally new



John F Ryan, Head of Unit, DG SANCO, European Commission; Tamsin Rose, Independent Health Activist; Nicola Bedlington, Director, EPF; Anders Olafsson, President, EPF; and Claude Perol, Sanofi

business models have to be established to ensure that pharmaceutical R&D also generates solutions for rare diseases which are often considered as less profitable from a manufacturer's perspective.

Panos Kanavos, Reader at the London School of Economics, discussed some reflections on the sustainability of health systems financing. He showed results from a survey in which the respondents (N=366) would prefer more restrictive purchasing of medical technology and an increase in sin taxes in order to achieve more sustainable healthcare financing.

Representing the European Commission, **John F Ryan** summarised that times of crisis often present a good opportunity for breaking up existing patterns. Crisis should therefore not only be seen as negative. When discussing new ways of providing healthcare, patient needs should be incorporated more than ever. This means that the empowerment of patients including initiatives to increase patient literacy should be strengthened.

Moreover prevention (for example, early cancer screening, vaccination campaigns) should play a more important role. Currently in Europe just 3% of GDP is spent on prevention and 10% on healthcare. In order to avoid hospital stays and physician visits, budgets might be rebalanced from healthcare to prevention taking also other policies (for example, education, environment) into account.

Ryan announced that in the future the European Commission will make use of the European semester in order to review national health

policies and budgets. By doing this, the Commission wants to sensitise member states to consider upgrading their health systems instead of investing in e.g. infrastructure projects.

Claude Perol, SANOFI Vice President for Central and Eastern Europe, advocated a change of mindset, arguing industry is part of the solution and should be more incorporated in decisions and discussions. As health is not a cost but rather an investment in the community, national governments and the European Commission might think about an industry policy for the life science sector. For example international reference prices can help to face the price problems which lead to inequalities and inefficient cross border circulation of drugs within the EU.

The discussion at the end of the workshop showed that health expenditures should not be seen as costs but as investments and when considering decreasing, restricting or at least stabilising budgets for health we have to redesign our thinking, taking into account shifting budgets towards prevention and other sectors like education. Furthermore new business models have to be invented in order to make relatively cheap solutions profitable and to incentivise industry to develop products for rare diseases.



Find out more about this session at www.ehfg.org/923.html?eid=18

Healthcare financing

By Sabrina Montante

While the discipline of health economics provides a growing body of evidence on what should be done in health policy, it sometimes takes decades for a country's healthcare system to adopt these findings. Numerous obstacles lie on the road from science to practice, and many of these can be found in the political processes.

The aim of this workshop session was to exchange experiences gained in various countries that have undergone major reform or are in the process of doing so. Presentations focused on examples and lessons learned in this field. Participants from Austria, The Netherlands, Norway and Poland presented examples from their home countries and analysed the relevant factors, with the OECD providing an outline of the bigger picture.

Getting health reform done

The workshop started with an introduction to the common challenges for healthcare systems across Europe. In contrast to former years, when reforms proposed by stakeholders mainly addressed only changes in the "other side's" jurisdiction, empty coffers and continuous efforts by health economists seem to have brought about a change towards more holistic reform approaches. The chance for profound healthcare reform has probably never been better than today. Nevertheless, the stakeholder landscape is problematic.

Austria

Peter Brosch, Head of Department, Federal Ministry of Health: Despite its small size of only eight million people, Austria has numerous players in its healthcare system with both federal and provincial levels holding legislative powers in this area.

The para-fiscal bodies mirror the federalistic organisation of the country, with 19 sickness funds and their federal association. Professional bodies, first and foremost the Chamber of Physicians, have a strong influence on politics as well. Only by understanding all these factors

does it become obvious why it is hard to get health reform done in Austria.

Health economists in Austria have for a long time demanded considerable structural change in order to make the country's healthcare system fit for the imminent demographic changes. Despite scientific evidence, most money is spent on hospital care that is poorly integrated with other areas. Specialist care is provided dually in hospital departments and in the outpatient sector, with fragmentation in financing.

The Netherlands

Ilaria Mosca, Professor at the Institute of Health Policy and Management, Erasmus University Rotterdam: The Netherlands on the other hand has introduced a new system of healthcare insurance based on risk equalisation through a risk equalisation pool. In this way, a compulsory insurance package is available to all citizens at affordable cost without the need for the insured to be assessed for risk by the insurance company. Furthermore, health insurers are now willing to take on high risk individuals because they receive compensation for the higher risks.

The 2006 Dutch healthcare reforms were the product of nearly two decades of discussion in response to a number of problems that many healthcare systems in Europe are very familiar with: a two-tier system of private health insurance for the rich and state coverage for the rest; inefficient and complex bureaucracy; lengthy waiting lists and a lack of patient-focus.

The health insurance reform in The Netherlands is a rather fascinating example of cross-country policy learning. Some key features of the Dutch reform such as the introduction of a universal health insurance system, mandatory coverage for the entire population, tax-financed premium subsidies for low-income consumers and voluntary deductibles can also be found in the Swiss health insurance system. Evidence of the impact of the Dutch healthcare reforms is still not clear, although the introduction of a single health insurance system has certainly provided

consumers with more transparency. The rather arbitrary past separation between social health insurance and private health insurance has been abolished. The distinction between public health insurers and private health insurers has disappeared. As a consequence, all consumers are able to choose between all insurance companies on the market. The new health insurance scheme is compulsory for all inhabitants of The Netherlands although there is no control mechanism to seek out individuals who fail to take out health insurance.

Norway

Tor Am, Director General, Ministry of Health and Care Services: Integration policy has been high on the agenda for Norwegian health authorities during the last decade and despite the numerous challenges major national policy initiatives concerning cooperation have been promoted.

In June 2009 the Coordination Reform was passed by the Norwegian Parliament. This reform represents a shift in perspective away from the operational to the administrative level and appeals for the need for economic or organisational reforms. It pointed at the consequences of demographic changes for health care utilisation and proposed major structural reforms to reduce the demand for hospital services.

Key features of the Coordination Reform are two well-known strategies put forward in many health systems: (1) more patients should be taken care of in primary health and long-term care instead of being referred to hospital for treatment; and (2) discharge from acute hospitals should take place earlier.

Poland

Cezary Włodarczyk, Head of Health Policy and Management Department, Jagiellonian University discussed the recent healthcare reforms in Poland. On 14 October 2010 the Polish government approved two key pieces of its healthcare reform package: the Healthcare Provision Act and the Reimbursement Act. The former is among other things intended to




Cezary Włodarczyk, Head of Department, Jagiellonian University, Poland

strengthen incentives for the commercialisation of public healthcare entities, while the latter controversially introduces fixed mark-ups and prices for reimbursed medicines.

International perspective

The last presentation from the OECD Head of Health Division, **Mark Pearson** provided the bigger picture and summarised the factors that commonly lead to healthcare reforms. The process of reform design and implementation in a health system should start with an evaluation of the performance of the health system, trying to identify the gaps and needs for structural change. Data are often lacking at all levels of government and political discontinuity does not help the reform process which is normally slowed by political turnovers. Incentives play a massive role in getting reforms agreed. Despite the financial constraints health reforms don't happen in recessions.

In line with factors highlighted by Pearson at the end of the workshop an attempt was made together with the audience to draw conclusions from these experiences that might be relevant and transferable to other countries.

 Find out more about this session at www.ehfg.org/923.html?eid=19

Public-Private Partnership

By Andras Borsi

This session of the European Health Forum Gastein 2012 summed up topics we have heard about in other workshops: public procurement from the private sector and austerity and health service Innovation. Public-private partnership (PPP) is a new topic that can bring solutions to the problems discussed.

The economic crisis, the health sector and why you should be worried

In the future, funding by governments, including for health systems, will be restricted. Austerity is arguably not the answer, but few seem to have a better idea of how to best respond. We need to define “the economic crisis” and estimate how long it is going to last, so that the health sector can respond to measures of austerity. The crisis in 2009 has gone deeper than the crisis of 1929. At a global level the situation is improving but if you look at the West it endures and there have been huge costs associated with it. There is no consensus from economists about the roots of the crisis, but there are some common themes:

Inbalances: Some countries (eastern countries and emerging countries) had big surpluses. They export more than they import. This capital was not used productively, but went into housing, for example in the importing countries. At this moment in time the imbalances still remain.

High public and private debt: public debt is great and is still increasing. Private debts have risen even higher and have gone into bad investments and income. Countries with public and private debts have lower economic growth.

The retirement of the baby-boomers.

We should probably look at a mixture of reasons.

What do new generation PPP-models need to deliver?

All definitions have in common that they include risk-sharing between public and private partners. Features include: private finance, bundling, pay for performance and long term contracts (25–50 years). New models of PPP need to be: flexible, able to embrace and stimulate innovation,

efficiently allocate risk between private and public organisations, have contract completeness.

We can conclude that:

- PPP is here to stay, because there is a need for investment in healthcare infrastructure. Insurance companies, pension funds and sovereign wealth funds need stable and long-term investment and PPP can bring governments desirable public policy outcomes.
- There has been limited evaluation of PPP models. More analysis is needed.
- Decision-makers need better understanding of elements of effective PPP design.
- It is possible to expand PPP from infrastructure to healthcare services.

Financing future health infrastructures

The European need for infrastructure investment will be €1.5–2.0 trillion from now to 2020. The financing of infrastructure projects has been done with long-term bank loans. The ‘Basel III framework’ outlines that banks need to have more capital. To reach that, banks need to sell assets. The concepts of long-term financing and long-term lending have almost vanished.

In the Europe 2020 project bonds initiative, bonds are launched for the financing of infrastructure projects in the transportation, ICT and energy sectors. The European Commission will be sharing the risk. Insurance and pension funds have €8.73 trillion to invest and need to invest in stable and long-term bonds. This initiative will be operational in 2014. The EU project bonds initiative does not include the healthcare sector. If €50 billion were invested, it would be able to realise new investments of about €800 billion. It could be of interest to the EU and its citizens to get the healthcare sector into the EU Project Bonds Initiative.

The European Directive Solvency II framework will start in 2013. The aim of the framework is to ensure financial stability by insuring transactions, and it will allocate capital to each risk activity.

Modern health service delivery and innovation

Everywhere in Europe hospitals are moving into private forms of management in order to improve performance, confront patient demands, reduce costs and respond to demographic pressures, improve technology, and in response to pressure from different stakeholders.

If we can find a way to combine robust financing with the efficiency we see in the private sector, gains will be bigger. There is space for the private sector, if European governments provide the right regulation. The public sector should continue to provide personal care and population services but should not be the only one to do so.

There are theoretical problems inherent in PPP but there are bigger problems in the public sector because of a lack of incentives, outdated models of care and irrational ways of working. It is as yet unknown how to resolve these problems.

Conclusions

There has been a certain chain of reasoning presented in this session. It does not need to be a shared one. It gives an insight into the future and possible solutions.

The crisis is going to last for a long time and the Member States are not going to be able to fund normal operations in the health sector. PPP models are used to get private sectors to deliver services. It appears that wider models that bundle more services seem to be more efficient. Before we are able to make widespread use of them, we need to realise new payment models and move from banks to institutional investors that can support capital investment.

Health services across Europe can be more efficient. In the state controlled sector of healthcare we need to look at an appropriate and desirable use of the private sector. We do need stewardship and governance procedures.

Questions and remarks

Do we need private financing and private delivery of care? Public financing should be preferential and/or in the majority to guarantee solidarity, equity and be social. But there is no reason for it to be exclusively public. The private sector knows how to solve problems.

What is private? It can be for profit or not for profit. Both seem to work. Depending on the objectives, issues at stake and the values of the

society you should look at the range of options.

When PPP goes wrong, public money pulls out of the project not private money. There are unacceptable examples. Though private sector tools may be able to do more with less there is no reason why the health sector should not use this knowledge.

PPP is a tool not a target in itself.

PPPs are automatically linked to financing but should be linked to efficiency. To be able to realise the gains needed you need to link financing to efficiency.

PPP is discussed from a public not private view.

We have 30 years of experience of PPP, why do we still not know what works? Public sectors have not been monitoring what goes in and what comes out. We do know what mechanisms have an impact but not always how or exactly in which way. We need more robust evaluation.

In many countries PPP is used as hidden privatisation.

Some areas of the health care sector have already been monopolised by private companies.

Final remarks

- We need to have more discussions on PPP so we understand the different aspects of it.
- We should be looking for the opportunities of PPP.
- The health sector needs to get out more! It is too self-focused. When talking about the future it is done only from a health sector perspective.
- We need to understand the limits of our system and look at other systems like the American system.
- We need to talk more about the private sector financing the healthcare sector from within.
- External driving factors bring about changes to public health. Over the last 20 years there was no crisis or catastrophe, so there has been no change. Now we have a crisis and change can happen.



Find out more about this session at www.ehfg.org/923.html?eid=37

Governance

By Lucia Kossarova

All presenters and stakeholders agreed that good governance is essential for ensuring a high quality and efficient health system, especially during a time of financial crisis, the main topic of the conference. The conundrum between sustainability, innovation, quality and solidarity cannot be solved unless elements of good governance are in place, as simply cutting costs without a vision may have disastrous consequences. Accountability and transparency also came high on the agenda thanks to the financial crisis so it can and should be seen as an opportunity.

But what exactly does governance mean? Is it the same as stewardship?

The chair of the session, [Hans Kluge](#), Director, Health Systems and Public Health Division, WHO Regional Office for Europe suggested that instead of focusing on the terms only, it is more important to discuss the elements and specifics of effective steering and governing.

Does governance contribute to a sustainable health system?

Speakers from the World Health Organization – [Juan Tello](#), Programme Manager, Health System Governance, Health Systems and Public Health Division; [Alejandra Gonzalez Rossetti](#), Senior Advisor, Health System Governance, Health Systems and Public Health Division and [Josep Figueras](#), Director of the European Observatory

on Health Systems and Policies, presented their current work on health system governance with a focus on health system strengthening.

They argued that only by strengthening governance will it be possible for those in charge to deal with the increasing pressures to sustain depth, breadth and width of coverage within tighter fiscal boundaries and the increasing demands and needs of the population. At the same time, there is an opportunity to seek efficiency gains through innovation and healthcare reorganisation as cutting costs with easy to implement measures (for example, cost sharing through user fees, limiting benefits) is not sustainable.

Aligning the proposed three functions of health system governance – priority setting and policy development, organisation and management, accountability and performance monitoring and evaluation – is essential for success. Each of these three functions consists of a number of processes that lead to concrete outcomes.

Speakers also stressed the importance of strong stewards (i.e. Ministries of Health) and a level playing field. Findings from a number of country case studies looking at governance for patient safety were also presented. Health safety should be considered a system issue, not only the problem of an individual provider – we should learn lessons from other sectors (for example, the aviation industry).



Alejandra Gonzalez Rossetti, Senior Advisor, Health Systems and Public Health Division, WHO/Europe

The case studies provided useful recommendations for countries on how to best align existing institutions, skill sets and functions to ensure better coordination, implementation and overall governance of health safety. The studies also showed that countries have different cultural and institutional set ups which provide for different tools and mechanisms of governance. While comparability is limited, all countries have a range of old and new instruments to carry out effective governance.

Ludovica Banfi, Programme Manager from the European Union Agency for Fundamental Rights, presented the results of a patient survey on “equality in quality” where users and patients belonging to a minority group (for example, ethnicity, disability etc.) were interviewed about access to and quality of healthcare services.

The study identified a range of barriers to access (for example, unequal entitlements, language and communication, financial, lack of information about entitlements, organisational and accessibility, supply side barriers, cultural and psychological barriers) as well as forms of unfair treatment and direct discrimination (delay in treatment, refusal of treatment, lack of dignity and stereotyping, malpractice and poor quality of care, lack of informed consent and harassment).

Finally, the study looked at the causes of underreporting including lack of knowledge, lack of belief in the effectiveness of the system, fear of victimisation, complicated systems, lack of access, negative attitudes towards complaints, time and effort involved. Actions needs to be taken to improve access and quality of care provided to these minority groups.

Conclusion

Firstly, the importance of an appropriate skillset and institutional capacity to achieve effective governance was discussed. It was noted by one of the speakers that skills are becoming less and less generic and much more is needed than particular qualifications to carry out a job effectively. It is essential that highly qualified

people are hired but also retained in the public sector. Continued integration of qualifications, diplomas and other standards at the EU level are important to help countries move towards effective governance.

Trust in Ministries of Health was also the subject of a heated debate, especially as we live in a general climate where there is a lack of trust in the democratic process and governments. How do you make governments part of the solution again, not part of the problem? How do we convince people that governments matter? As ministries are the impersonation of a mandate by their voters, there is no shortcut and we must invest in institutional capacity to allow them to operate to their best potential. It is essential that a culture of integrity and transparency is built where the public is listened to and also feels that their voices are heard.

Finally, the patient should be part of the solution and not the problem. He or she should be the steward of the system, not the victim. Patients and citizens should be put in the centre of the debate. But how can we best achieve that? We need agents for the patient such as improved involvement of patient organisations. When prioritising, cutting costs or implementing other important changes, we need to ask for the opinions of those who are affected. Then perhaps the right changes can be made and those services are cut that the patient can happily live without.

The session ended on a positive note. We should learn from the many excellent country examples that exist. Investment in institutions does have a tangible impact on efficiency gains and sustainability and should therefore be high on the agenda. And last but not least, let's allow patients to make the best policy choices.



Find out more about this session at
www.ehfg.org/923.html?eid=13

Vaccination and the role of social media

By Amanda Saliba

Childhood vaccination is the basis of public health medicine. However, last year there were 30,000 cases of measles, which is a vaccine preventable disease. For example, the HPV vaccine is a very safe vaccine for girls but its rate of uptake is still low and we need to investigate why this is the case. Complacency, convenience and confidence are three barriers to vaccination. The first two can be dealt with by using social media.

Pros of using social media

- Social media can play a role in reaching vulnerable populations and influencing the public.
- The capabilities of social media include distribution and re-distribution of information, peer-to-peer contact, speed of distribution of information and a wide range of coverage. It offers an immediate means of communication rather than the lengthy processes involved when using traditional means of communication, such as issuing a press release.
- Posting and blogging on social media is cheap and therefore ideal for use during a time of financial crisis.

Cons of using social media

- People trust the information they find on the internet and they don't differentiate between information that is evidence-based and information that is not.
- There are limited ways as to how one can retract and control the information that is released.
- For publishers, posting research findings on social media does not create much direct income, therefore their interest in this area might be limited.

What needs to be done?

Training of public officers to enable them to be more proactive and engage in debates on social

media, rather than hiding behind previously released official statements.

Training of the team that is using social media, to enable understanding and participation on social platforms. Employees should be given the freedom to try these social platforms and interact with the target group, using a no-blame policy during a formal training period.

Creating accounts with the different social networks and updating them regularly to make it interesting for the target population to sign-in and visit these accounts often.

Points to bear in mind when using social media to promote vaccination

- Understand the dynamics of social networks and social behaviour. Remember that scientific facts mean nothing when perception rules.
- Map all influencers - find out who are the people delivering the wrong messages to your target audience. Know who is behind these messages to understand how to deal with them and be willing to agree to disagree. Carry out communication and dialogue profiling of the target audience to find out where the gate keepers and agents of change lie within the target community.
- Use analytic tools to do real time monitoring of all the vaccination campaign related messages which are being featured on social media. This will enable you to do your research and know the facts before the public starts approaching you with queries.
- When blogging, enter and engage into a conversation, don't just provide information if you want to gain the user's trust.
- Take advantage of the fact that mainstream media pick-up messages from social media to create the peer-to-peer effect, therefore, ask people who have been vaccinated to react to messages in the media and share their experience.



Marc Sprenger, Director, ECDC, opening the lunch workshop session

- Understand the language being used by your target audience.

Future projects

Vaccination tracker – plug-in gender, age and location and the user will have an immunisation calendar on his smart phone or tablet, to keep records of his/her children's immunisation.

Online Vaccine Rumours by country – an ongoing project. A programme that traces online rumours related to vaccines according to the country of origin. Results so far show that the USA and UK are the leading sources of these rumours.

Conclusion

30% of the EU population don't have access to social media. Therefore, a mix of tools is needed to reach everyone. Social media should compliment not replace traditional media. We need a good business case to ask policy makers to invest more money in social media at the regional and national level, during a time of austerity. This could be done by presenting policy makers with the advantages and benefits of using social media and with examples that have worked, such as the use of social media to promote HPV vaccination in the Netherlands.



Find out more about this session at www.ehfg.org/923.html?eid=14

Innovation and sustainability

By Maria Chiara Orlandi

The key topic of this lunch workshop session was to highlight the way healthcare systems could ensure access to financially sustainable innovations. Such access could be improved through the adoption of a mechanism like differential pricing. The issue has been discussed from the point of view of different stakeholders, including academics, regulatory authorities and patient organisations in order to provide a complete overview.

Pavos Kanavos from London School of Economics showed the theoretical and empirical implications of differential pricing for prescription medicines, underlining the point that the key challenge is to balance different needs within Europe, including:

Governments to control pharmaceutical expenditure.

Patients to get an equitable and rapid access to medicines throughout the EU.

Industry to be rewarded for innovation and to foster R&D, in order to have a competitive and dynamic market in Europe.

The economic principle is the third degree (multi-market) price discrimination, linked directly to consumers' willingness and ability to pay for a good or service. It means that the prices charged may bear little or no relation to the cost of production. Ramsey-Boiteux pricing consists of maximising the total welfare under the condition of non-negative profit, that is, zero profit.

As per policy implications, the issue for Europe is a balance between static efficiency, which seeks to maximise welfare by attaining the highest health gain from today's expenditure at the lowest possible cost, and dynamic efficiency, that stands for incentivising R&D through reasonable returns with a view to seeking treatments and eradicating disease in the future. Currently greater attention is given to static than dynamic efficiency and re-balancing that focus means exploring further price differentiation options.

Reconciling innovation and sustainable healthcare systems – what next for Europe?

Differential pricing, generated from the dualism between innovation and sustainability, was discussed by **David Taylor**, University College, London School of Pharmacy, with a presentation about the case for Ramsey-Boiteux pricing in the context of intellectual property (IP) protected pharmaceutical products, taking into consideration medicines' costs, values and prices.

Medicines are considered to be unique high technology products, difficult and risky to develop and easy to copy; they normally have high fixed development costs and low marginal production costs and can be regarded as specialised global "public utility goods". For such products, IP law grants temporary monopolies to protect public interests in research investment, taking into account the amount temporary monopolies should charge for new medicines.

In this context, Ramsey-Boiteux pricing theory provides a logical case for differential pricing, with poor markets being supplied at marginal production costs while the affluent are charged at the maximum level they will bear. The underlying objective is therefore to maximise present collective welfare while incentivising innovation for the future. Differential pricing has a potentially important part to play in the twenty-first century global pharmaceutical market, nevertheless optimising its contribution will require a more mature and better natured public policy debate than has to date been achieved.

Innovation sustainability was illustrated from the point of view of a patient organisation by **Nicola Bedlington** from the European Patients Forum (EPF), which is the umbrella organisation of pan-European patient organisations active in the field of European public health and health advocacy, acting in the interest of over 150 patients with chronic diseases.



Nicola Bedlington, Director, European Patients' Forum

Among other EPF initiatives, Bedlington highlighted a recent conference on health inequalities in the new EU member states, entitled "Policy makers and patients – creating the change", that took place on the 20–21 September 2012 in Sofia, with representatives from Eastern European countries in attendance.

The objective of this conference was to create an opportunity for patients and policy makers to discuss needs and gaps in national healthcare systems, through patient experience and exchange of best practice.

In order to curb health inequalities in the EU, innovation should go hand in hand with solidarity. The application of External Reference Pricing should be objective and transparent, in order to provide opportunities for assessing its effects, make decision-makers accountable, reduce uncertainty for the pharmaceutical industry and diminish the risk of discrimination and corruption (as also reported in the WHO-HAI Report 2011).

Pricing pharmaceuticals by GDP/capita could encourage fairer and swifter access to innovations across Europe and bring forward a reduction in significant and growing health inequalities. To achieve the objective an essential requirement is a commitment to transparency; there is indeed a requirement for both a culture of solidarity and trust across countries and

among stakeholders.

Differential pricing issues were eventually analysed from a Competent Authority perspective by [Stanislav Primožič](#), representative of the Agency for Medicinal Products and Medical Devices of the Republic of Slovenia.

There are some weaknesses to take into consideration since it is a model not yet tested in an EU pharmacy environment with an unclear level of political consensus. Moreover, there is a wide diversity of EU pricing and reimbursement regulation and practices, in addition to the adoption of the HTA model still under development.

Making the differential pricing idea fully functional requires removing loopholes of External Reference Pricing, ensuring transparency of price determination, establishing a scientific theoretical basis and approaching health technology products in a selective way. The expected benefits are many, from enabling access to innovation to increasing the absolute size and volume of the market.



Find out more about this session at www.ehfg.org/923.html?eid=35

Dialogue, transparency, trust. What part do they play in aligning the pharmaceutical industry with social needs?

By Claudia Fischer

The key topic in this session was the role of Corporate Social Responsibility (CSR) in the current context of financial crisis and constrained healthcare budgets.

Is CSR an opportunity or an additional cost? In general, CSR can be defined as a corporate initiative to assess and take responsibility for the company's effects on the environment and its impact on social welfare. The term generally applies to company efforts that go beyond what may be required by regulators or environmental protection groups.

Key challenges

Lack of transparency and trust – “The lack of transparency and trust is a never ending story in health care”

This is true between all kind of stakeholders, but especially between public authorities and the industry. Therefore, the European Commission launched special work on CSR in 2010. Different workstreams cover for instance ethics and transparency. Participating stakeholders are the industry, health care professionals and Member States (e.g. Belgium, Netherlands, and United Kingdom). The aim is to exchange information and potentially achieve a common understanding in terms of best practice when it comes to access to medicines. A lack of trust is currently hampering innovation to a large extent.

Polypharmacy and co-morbidity – “The end of blockbusters”

The current dynamics of the healthcare industry can be summarised as a one size fits all approach, since developing more medicines for a smaller audience seems to be less profitable. In the future, diagnoses and treatment will be based on biology. Patients will play a more dominant role, therefore they will need to understand the concepts of: healthy lifestyle, genetic predisposition, lifelong management of



John Bowis, President, Health First Europe

risk, self-monitoring. But how should we work with patients to ensure they become better informed? It must be understood that an informed patient is a very cost effective patient. The key challenge is how to communicate scientific ideas to a non-scientific audience. Finally, the EFPIA code of practice should be utilised more by patients. The pharmaceutical industry will be shaped by the extent to which it can be a part of the data flows; however its role is limited by trust issues.

The quality of information

New infrastructure needs to be built to navigate the significant amount of information available. Further, the relationship between the industry and health care professionals needs to be improved; standards need to be set, together with all stakeholders. On the one hand quality data should be available, on the other hand this raises concerns that raw data is presented without any further adaptation or explanation. The information is therefore open to interpretation, which can lead to confusion, uncertainty and fear.



Find out more about this session at
www.ehfg.org/923.html?eid=36

Wake up to the real solutions!

By Edita Nagyova

On the second day of the conference we woke up to an optimistic early morning breakfast session presenting real solutions.

Karen Kovach, Chief Scientific Officer of Weight Watchers International, presented evidence that tackling obesity in a proper and systematic way can reduce the burden of chronic diseases and deliver substantial cost savings to struggling European healthcare systems. She highlighted certain facts and threats supported by the results of a range of different studies and research:

- More than half of the EU population is overweight or obese.
- 40% of the European population above the age of 15 have a chronic disease.
- Chronic diseases currently account for over 86% of deaths in the EU.
- 70–80% of European healthcare costs are for chronic care (€700 billion in the EU).

There is now good evidence to show that adult obesity is associated with a wide range of health problems. It is estimated that adult obesity and overweight are responsible for up to 6% of healthcare expenditure in the European region and costs spent on chronic diseases in EU countries appear to be out of control.

There is a growing need for effective solutions that prevent and treat chronic diseases, which are affordable and scalable. Weight loss treatment is one solution. Lifestyle interventions that deliver medically significant weight loss have been shown to lead to multiple clinical benefits. The population don't have to achieve an "ideal" weight to realise significant benefits. As an example, Kovach presented the results of the *Diabetes Prevention Programme*, (DPP) (www.cdc.gov/diabetes/news/docs/dpp.htm) a major multicentre clinical research study. It indicates that millions of high-risk people can delay or avoid developing type 2 diabetes by losing weight through regular physical activity and a diet low in fat and calories. In addition to health benefits, preventing or delaying the onset of type 2 diabetes also brings the positive impact of cost savings to healthcare systems.




Gillian Merron, former Minister of State for Public Health, UK and Karin Miller-Kovach, Chief Scientist Officer, Weight Watchers International, Inc.

Some solutions presented by Kovach were:

- To focus on the major recognised risk factors for chronic diseases by using *specific "weight management" solutions*, i.e. surgeries, medical devices, medications, lifestyle modifications.
- Tackling obesity through *lifestyle modification programmes* that meet best practice.

New and innovative partnerships between healthcare and industry have been proven to be scalable, effective and affordable.

Gillian Merron, former UK Minister of State for Public Health, underlined the importance of community based programmes such as Weight Watchers, a unique programme which successfully tackles obesity, based on up-to-date science and tried and tested over the years by real people with many success stories. She called for more binding actions to be developed by policy-makers to change legislation and prepare regulations. Policies to support the prevention of chronic diseases need to change quickly – but there is no need to “re-invent the wheel”, she said. There are already scalable, effective and affordable solutions available. Cooperation and dialogue with the private sector are very important as well.

 Find out more about this session at www.ehfg.org/923.html?eid=9

Health literacy – the cornerstone in future health

By Claudia Fischer

In times of demographic change, with the rise of chronic diseases and increasing competition from other markets, health has become a key asset for Europe in meeting its objectives for the 2020 strategy. In addition, new health technologies such as personalised medicines, eHealth and increased knowledge of healthy lifestyles are promising developments that contribute towards reaching the ambitious 2020 goals. A lot of resources have already been invested in community empowerment, however the “right people”, have not yet been reached.

Healthy ageing is one of the key challenges, the success lies also in the literacy skills of doctors.

Vaccinations: communicating scientifically valid information to patients is challenging. It also asks for communication on a national level (not just internationally through the European Commission), because patients and the public search for information nationally.

Tobacco: misleading labelling needs to be worked on. Terms like “light”, “low” can be misleading to the public.

How can national policies make a difference?

Take the example of Austria, who defined health literacy as a health target in the Health Ministry. Political commitment and leadership needs to be embedded in the action plan *Health 2020*.


Further, more research is needed, for example, Patient University (Barcelona/Spain).

The results of the first *European Health Literacy Survey* led by the University of Maastricht and supported by the European Commission, unveiled inconvenient facts:

- Europe moves at different speeds.
- Health literacy levels vary considerably between different Member States (Austria shows high rates of health literacy, whereas for instance in The Netherlands the rates are lower and age is not a determining factor. Perhaps the Dutch health care system is more easily accessible?).

Health literacy needs to be tackled in the education system– so far no educational book exists. What shall we do then? Health literacy seems to be a key concept and a critical element for fostering healthy choices, supporting healthy lifestyles or – in case of illness – improving health outcomes and healthcare efficiency.

Eventually, improving health literacy means empowering citizens to take control over their own lives – the latter being a critical element for better health. In this context employers can also play a role.

 Find out more about this session at www.ehfg.org/923.html?eid=34



Speakers and panellists: Jürgen Pelikan, Ludwig Boltzmann Institute for Health Promotion, Austria; Helmut Brand, Professor, Head of Department, Maastricht University; Kristine Sorensen, The European Health Literacy Project, Maastricht University; David Boyd, Director European Government and Public Policy, GE Healthcare; Judith delle Grazie, Head of Unit, Ministry of Health, Austria; Christine Neumann, CSR Europe; Nicola Bedlington, Director, European Patients' Forum; Karin Kadenbach, MEP, Austria; Birgit Beger, Secretary General, Standing Committee of European Doctors; and John F Ryan, Head of Unit, DG SANCO, European Commission

The Young Forum Gastein Initiative – new ideas, enthusiasm and new European contacts

By EW Maarseveen, Ministry of Health, Welfare and Sports, The Netherlands, Alumni 2011

For me the Young Forum Gastein Initiative means new ideas, enthusiasm and new European contacts. It is quite special to have an international group of bright young researchers and young policy-makers together in a beautiful setting like Gastein. This setting provides excellent opportunities for Young Gasteiners to get introduced to the topics that senior-level decision-makers are working on. And, vice versa, it's a good opportunity for these senior decision-makers to get in touch with a younger generation and discuss their ideas and opinions.

The informal meetings in 2011 with, among others, former EU Commissioner John Dalli, Paola Testori Coggi (DG SANCO), Robert Madelin (DG CONNECT) and Zsuzsanna Jakab (WHO Regional Director for Europe), are great examples of how easy it is for young Gasteiners to interact with high level decision-makers. I believe that the Young Forum Gastein Initiative has the potential to become a strong network of EU health policy advocates, also outside of the Gastein congress week.

The Young Forum Gastein Scholarship was established by the EHFG with the support of the European Commission, DG Health and

Consumers and DG Research and Innovation, on the occasion of the EHFG's 10th anniversary. The project aims to bring promising young researchers and policy-makers to the conference in Gastein for learning and networking towards future activities in the sphere of health.

In 2012, young researchers and officials working in the field of health from EU Member States were once again invited to attend the 15th EHFG conference. In addition, the WHO Regional Office for Europe contributed to the initiative, supporting several Young Gastein Scholars from Eastern Europe and Central Asia.

Apart from actively participating in the general programme, specific Young Forum Gastein meetings and working groups took place, with meetings between the scholars and former EU Commissioner John Dalli, Director General Paola Testori Coggi, Director General Robert Madelin and WHO Regional Director for Europe Zsuzsanna Jakab.

The EHFG and the European Commission are pleased to have created this important initiative and are looking forward to the continuation and development of the Young Forum Gastein project.



Young Gasteiners: Michael West, Edwin Maarserveen, Ana Raquel Nunes and Daniela Negri

The European Health Award 2012 goes to the European Health Literacy Project

Health literacy is identified as a critical empowerment strategy which constitutes the ability to make sound health decisions in the context of everyday life. With the global emergence of the health literacy field, it became clear that the European region was lacking an evidence base on health literacy.

The European Health Literacy Project (HLS-EU) was established from 2009–2012 with financial support from the European Commission. Its objective was to demonstrate the manifestation of health literacy in various European countries, to address its overall cultural, social and political impact, and to ensure the implementation of working structures and the formulation of policy measures. Accordingly a consortium of nine European partners coordinated the European Health Literacy Survey in eight countries, and established the international network 'Health Literacy Europe' and national advisory boards on health literacy in eight countries.

The European Health Award is awarded annually in connection with the European Health Forum Gastein. The prize honours projects and

initiatives that contribute towards improving health care systems in Europe. Important criteria are that several countries have to participate in a given project; the project concept has to be transferable to additional countries; and a significant portion of the population must benefit from it.

The short list of projects nominated for the European Health Award 2012 were as follows:

- Breast Health Day – Prevention and early detection of Breast Cancer
- EB-CLINET of EB centres and EB experts (EB = Epidermolysis bullosa)
- EUBIROD – European Best Information through Regional Outcomes in Diabetes
- HLS-EU – The European Health Literacy Project
- Paediatric Nutrition in Practice – Extensive e-learning programme
- Tob Tax – Making Tobacco Tax Trendy



Antonyia Parvanova, MEP, Moderation; Wolfgang Tüchler, Representative FOPI, Sponsor; Gerardine Doyle and Kristine Sorensen, EHA Winner 2012, HLS-EU Project; and Günther Leiner, Honorary President of the EHFGE

Organiser International Forum Gastein

Coorganiser Federal Ministry for Health, Austria

Supported by and in collaboration with

European Commission, CONNECT DG
European Commission, Health and Consumers DG
European Commission, Research and Innovation DG
Federal Ministry of Health, Austria
Land Salzburg
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Supporting Organisations

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