Journal of the European Observatory on Health Systems and Policies

EUROHEALTH

RESEARCH • DEBATE • POLICY • NEWS

European Health Forum Gastein 2024

› Shifting sands of health: Democracy, demographics, digitalisation

- Democracy and health at the crossroads of Europe's future
- How Wales is tackling health inequalities
- Creating an inclusive and trustworthy European Health Data Space
- Women in Global Health: Accelerating leadership through mentoring
- Advancing gender equality in health
- Rethinking social contracts in a risk society
- Realising food democracy
- Future health priorities for the EU

:: Special Issue ::
Volume 30 | Number 2 | 2024

European Observatory on Health Systems and Policies
a partnership hosted by WHO

EUROHEALTH

Journal of the
European Observatory on Health Systems and Policies
Eurostation
Place Victor Horta/Victor Hortaplein, 40/30
1060 Brussels, Belgium
T: +32 2 524 9240
F: +32 2 525 0936
Email: contact@obs.who.int
http://www.healthobservatory.eu

Eurohealth is a journal that provides a forum for researchers, experts and policymakers to express their views on health policy issues and so contribute to a constructive debate in Europe and beyond.

The views expressed in *Eurohealth* are those of the authors alone and not necessarily those of the European Observatory on Health Systems and Policies, WHO or any of its partners or sponsors. Articles are independently commissioned by the editors or submitted by authors for consideration.

The Observatory is a partnership, hosted by the WHO Regional Office for Europe, which includes other international organizations (the European Commission); national and regional governments (Austria, Belgium, Finland, Ireland, the Kingdom of the Netherlands, Norway, Slovenia, Spain, Sweden, Switzerland, the United Kingdom and the Veneto Region of Italy (with Agenas)); other health system organizations (the French National Union of Health Insurance Funds (UNCAM), the Health Foundation); and academia (the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM)). The Observatory has a secretariat in Brussels and it has hubs in London at LSE and LSHTM and at the Berlin University of Technology.

Design and Production: Steve Still

ISSN 1356–1030

Cover illustration: Daniel Triendl, https://danieltriendl.com/

Eurohealth is available online and in hard-copy format. If you want to be alerted when a new publication goes online, please sign up to the Observatory e-bulletin.

To subscribe to receive hard copies of *Eurohealth*, please send your request and contact details to: contact@obs.who.int

Back issues of *Eurohealth* are available at: https://www.lse.ac.uk/lse-health/publications/eurohealth

CONTENTS

Gastein Special Issue

Plenary

Democracy, demographics, digitalisation

Cover illustration: Daniel Triendl, https://danieltriendl.com/

FOREWORD

Shifting sands of health – Democracy, demographics, digitalisation.

With more than half of the world's population going to the polls this year, democratic values are once again under threat around the globe, as far-right movements gain momentum. While some nations have already cast their votes, many elections, such as the national election in Austria, remain to be held. These elections will profoundly shape the societies we will live in for the coming years – whether we will live in a fortress Europe or in an open society in which human rights apply to all its members.

Strong democracies are not only the pillars of our political systems, but also the guarantors of social justice and, therefore, functioning welfare and healthcare systems. As political decision-makers and stakeholders, we need to understand that health policies are ultimately social policies. Receiving the best healthcare possible can never be a question of socioeconomic status, nationality, religious background, or gender but should be available to everyone. Health must not be a privilege but a fundamental right for every individual.

At the same time, our societies are experiencing vast demographic changes, as the world's baby boomer generation is growing older and reaching retirement age. With increasing life expectancy thanks to groundbreaking medical research in the past decades, it is now our responsibility, not only as policymakers but as society, to ensure that our older citizens receive the best care possible. This puts immense pressure on our healthcare systems, as the shortage of skilled workers, especially in the health and care sector, still prevails.

Offering attractive working conditions for people working in the health and care sector is key. In Austria, we passed three reform packages ensuring higher wages, scholarships for care students as well as the academisation of the care profession. However, it must be clear that no European country will be able to meet the demand of care workers needed in the coming decades through individual efforts alone. We need to work together to ethically attract talent from all around the world, welcoming qualified care and nursing workers not only to our labour markets but also into our societies.

To ensure high-quality access to health for all, decision-makers and stakeholders need to acknowledge the need for fundamental changes within our healthcare systems due to digitalisation and innovation, as well as changed expectations and needs from both patients and healthcare workers. Over the next five years, we are investing a total of €14 billion in structural reforms in the Austrian healthcare system, relieving pressure on our hospital systems and strengthening the outpatient sector.

This is only feasible through simultaneous investments in digitalisation. By using modern technologies now available to us, we will significantly increase the efficiency and quality of care, reduce the burden on healthcare workers, and offer patients easy access to all of their health data. Telemedicine, electronic patient records, and artificial intelligence (AI)-based diagnostic systems are just a few examples of the possibilities available to us nowadays. However, these innovations can only be successful when strict data privacy is ensured at all times.

The past few years have taught us that access to high-quality healthcare for all requires continuous, strong international cooperation. Pandemics, the climate crisis, and other large-scale threats to our health systems know no borders and require global solutions and solidarity. By working together, we can overcome many of the challenges facing our health systems, ensuring better health for all and stronger societies.

Johannes Rauch,
Federal Minister of Social Affairs, Health, Care and Consumer Protection, Austria

Cite this as:
Eurohealth 2024; 30(2).

GUEST EDITORIAL

The discussions at this year's European Health Forum Gastein (EHFG) will focus on the ever-changing health landscape in Europe, driven by the complex "3D" interplay of democracy, demographics, and digitalisation. Most notably, the demographic shift and rapid developments in digitalisation are having wide-ranging implications for the health of our societies and healthcare systems.

Furthermore, 2024 marks the largest election year in human history, with over 50% of the global population being called to the polls. Data shows that democracy is under threat like never before, as it is perceived to be failing in addressing key issues such as the climate crisis, conflict, migration, and secure employment.

In his opinion piece on the "3Ds" of democracy, demographics, and digitalisation, EHFG President Clemens Martin Auer offers possible solutions to pressing challenges currently facing healthcare. These include establishing a new social contract based on mission-oriented financing; shifting the perception of healthcare work to address demographic challenges; and making smart use of data while protecting citizens' rights and privacy.

Eluned Morgan, First Minister of Wales, showcases health policies focused on future generations, which the Welsh government has adopted to address health disparities in Wales, where the population tends to be older, poorer, and sicker than those in neighbouring countries. A prime example is the Well-being of Future Generations (Wales) Act 2015. Tackling health inequalities has been made a policy priority, and a Memorandum of Understanding (MoU) was signed with the World Health Organization Regional Office for Europe.

Rapid digital developments promise to address many of Europe's health challenges by offering effective diagnosis and treatment. The European Health Data Space (EHDS), a groundbreaking agreement, provides clear rules for the use of health data to improve healthcare delivery, research, innovation, and policymaking. Its overarching aim is to improve individual care and to facilitate data reuse for broader societal benefits within a more inclusive healthcare environment. However, Milana Trucl also highlights the potential pitfalls, noting that success will depend on trust, digital literacy, effective governance, and harmonised implementation across EU Member States.

In her article on inclusive digitalisation, Sabine Ludwig points to the gender equality gap in digitalisation. She calls for more women to be included in the development of digital tools and applications and emphasises the need for women to obtain knowledge and skills to use these tools. By providing tools that are designed for their needs, FemTech and inclusive digitalisation can improve women's access to healthcare worldwide. Furthermore, gender-sensitive data collection and analysis are crucial for developing algorithms that adequately consider gender perspectives.

Women make up 70% of the global health and care workforce, yet they remain significantly underrepresented in leadership positions, which hinders progress towards Sustainable Development Goal 5, which calls for full female participation in leadership and decision-making. Authors Theresa Oatridge and Mari Pollari point to the value of mentoring, such as creating supportive environments by fostering connections and providing guidance as a recognised strategy to empower women to ascend to leadership roles. In 2024, the Austrian chapter

of Women in Global Health, hosted by the EHFG, launched a pilot mentoring programme to address this gap.

Marisol Touraine observes that the values underpinning Europe's health systems are being challenged by rising populism. Targeted investments in structural reforms are needed to address major challenges, such as ageing populations, shortages of health and care workers, and adapting to new technologies. European funds for are available for Member States, but the funding landscape is often too complex for policymakers to navigate. To counter inequalities and streamline access to these funds, an EU Health Hub providing tailored support is being considered – which will ultimately improve health outcomes and help counter populism.

One of the significant burdens European health systems face is the high prevalence of non-communicable diseases (NCDs). Daša Kokole et al. criticise the slow implementation of effective prevention policies. Their article examines the strategies that the unhealthy commodity industries (with a focus on tobacco, nutrition, and alcohol) use to shape public policies and showcases concrete examples of these practices in EU policymaking.

In his opinion piece, Stefan Woxström discusses the mounting pressure NCDs place on Europe's health systems. He also highlights the potential vicious circle between the impact of climate change on health and healthcare's contribution to the increasing greenhouse gas emissions. He advocates for a shift from reactive 'sick care' models to proactive prevention and explores public-private partnerships to increase healthcare efficiency and reduce its environmental impact.

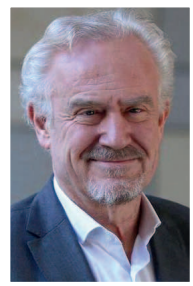
Ilona Kickbusch argues that it is time to rethink our social contracts, many of which were devised over 150 years ago. We are witnessing a major social transformation influenced by globalisation, rising inequities, and modernity. Current social contracts no longer reflect the real-life experiences of people today or how younger generations want to work and live. Kickbusch urges us to revisit the social contract and to be bolder in our calls for change.

In their article, Samuele Tonello and Anant Jani discuss the gap between strategy development and implementation, referencing the end of the EU's Farm to Fork policy. They argue for alternative forms of food system governance based on food democracy, with more power in the hands of the populace to address Europe's unhealthy and unjust food systems.

Democracy, demographics, and digitalisation were central to the findings from a public debate on the future health priorities of the EU. In their article, Nicole Mauer et al. emphasise the importance of stakeholder involvement in shaping the EU's health agenda. The outcomes highlighted the need for transformative health systems, intersectoral collaboration, and responsible digital health use, offering valuable insights for the health policy agenda of the future.

We hope you enjoy diving more deeply into these topics in the respective articles! We look forward to the solution-oriented discussions on these and other topics at the EHFG 2024. The Forum will not only strive to keep health high on the policy agendas of the future Commission and new European Parliament but will also serve as a platform for the Gastein community to contribute to a mission letter to the newly elected leadership.

Dorli Kahr-Gottlieb,
Secretary General,
European Health Forum
Gastein



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

Cite this as: *Eurohealth* 2024; 30(2).

DEMOCRACY AND HEALTH AT THE CROSSROADS OF EUROPE'S FUTURE

By: Clemens Martin Auer

OPINION PIECE

Summary: How are the crisis of democracy, rising populism, enormous demographic changes from ageing, migration and urbanisation, along with digitalisation, transforming the prevailing conditions for health systems in Europe into *shifting sands?* And what can health sector stakeholders do to stave off these detrimental effects? The challenges are threefold: 1) securing a mission-oriented financial basis of healthcare by establishing a new social contract; 2) championing the healthcare sector as a source of employment to address demographic change; 3) optimising use of digital healthcare data for procedures and research in ways that protect privacy and uphold patients' rights.

Keywords: *Democracy, Demographics, Digitalisation, Social Contract*

> **#EHFG2024 – Plenary 1:** Democracy and Health at the crossroads of Europe's future.

Clemens Martin Auer is President, European Health Forum Gastein; former Director General and Special Envoy of Health for the Austrian Ministry of Health, Vienna, Austria; former Vice-Chair of the Executive Board of the World Health Organization, Geneva, Switzerland. Email: clemens.auer@ehfg.org

Introduction

Democratic countries in Europe are going through difficult times characterised by challenges all too familiar to us: new wars on the continent for reasons we thought were long behind us, environmental crises involving natural disasters, clearly perceptible climatic changes, and the mounting pressure of migration movements reminiscent of the great migrations of earlier eras. Added to all this is the decline of traditionally centrist political parties, that contributed to the creation of the modern welfare state and the social market economy. Or the rise of fake news and misinformation about certain policy measures to combat COVID-19, such as vaccines, which has led to much scepticism about science and experts.

All of these factors trigger a creeping sense of alienation among some segments of the population, undermine acceptance of democratic institutions of self-government, and contribute to the rise of unappealing forms of nationalistic populism.

What do these trends have to do with healthcare policy? Why do negative developments in society set off alarm bells in healthcare policy circles? For one very simple and pragmatic reason: a well-functioning public healthcare system needs strong leadership and an adequate portion of public funding from the government, which in turn must be raised by taxing a society's economic output. Since public healthcare systems in OECD countries account for about one tenth of GDP, they represent one of the largest funding responsibilities of democratic

governments. The actual amount of healthcare expenditure always depends on the democratically legitimised political decisions, which are by their very nature changeable and reversible.

A new social contract is needed to ensure sufficient funding for health systems

Budgetary competition exists for healthcare spending because resources must also be raised for other sectors. For education and other public services, to fund wars or military armament, to finance measures to overcome environmental crises, to cover repair costs for natural disasters and negative climatic change, and for social welfare.

There is a reason the alarm bells are sounding: the budgetary competition for these governmental funds could result in a reduction in public budgets for healthcare. This reduction would diminish the quality of healthcare services, which in turn would give rise to dissatisfaction among the populace. This dissatisfaction would further undermine the legitimacy of decisions made by democratic institutions and give another boost to populist policymakers who thrive on the failure of centrists parties.

> “deliver workable solutions to problems arising from demographic change

In unstable political times, healthcare policymakers must therefore demand a new and binding social contract that guarantees public funding for healthcare and prevention is not reduced. This is paramount for the stability of democratic governments. This political debate is an urgent priority for national parliaments and must rest on a solid financial and economic foundation within the European Union. The basic political thrust of such a new social contract must be clear to all: it must involve mission-oriented public financing. This means that governments and legislators must cover the costs of precisely targeted healthcare, innovations and related expenses in a participatory manner.*

In a new social contract of this type, it is also imperative that the elephants in the room be addressed, namely the factors causing high costs that threaten to push the system to the brink of bankruptcy. These factors are, first, the pharmaceutical and medical technology industry. For new and expensive forms of therapy, a paradigm change is needed that prioritises the public good over the pursuit of exorbitant profits for shareholders.

This social contract must also cover the food and agricultural sectors. Both must acknowledge their responsibility for substantially endangering healthy lives and the natural basis of human existence, and they must make fundamental changes in food production. “One Health” must evolve from a mere slogan of political rhetoric into codified legal regulations essential for reducing the burgeoning costs of the healthcare system. Or put another way: anyone who endangers life and nature through their economic behaviour (whether in production, use of resources, marketing, or other activities) must also bear the societal costs of this endangerment. These costs can be imposed through taxes or import duties until the potential for endangerment is sufficiently reduced.

The health and care sector presents employment opportunities for immigrants, women and young people

The healthcare sector can play an enormously important role of its own in countering the insidious delegitimisation of democratic institutions. The goal must be to deliver workable solutions to problems arising from demographic change in European societies. Ageing, immigration and loneliness are the prime challenges in this context. Put simply, if centrist politics and policy in a democracy can no longer amass the personnel and financial resources to guarantee the care of its ageing populations, this unresolved issue will become a gateway for populism. The health and care sector can contribute by creating working conditions so attractive that people will happily take jobs in these areas and remain in these careers for lengthy periods of time. The health and care sector in all countries is a major employer and provides an opportunity to promote inclusive economic growth and reduce unemployment, especially for women and young people. Recruiting, retaining and fairly remunerating the health and care workforce should therefore be viewed as an opportunity in European immigration societies, not as a negative burden and danger. Presently, national healthcare policy discussions fail to consider approaches involving creative solutions that can only be developed in a way that covers all generations. The World Health Organization Regional Office for Europe began these discussions, but the political responsibility lies with the constitutional levels of political responsibility.

Smarter regulation is needed to reap full benefits from digital health technologies and big data

Digitalisation is one of the key drivers of radical change in the health and care sector. Medical progress in laboratory medicine, imaging diagnostics, and surgery would not be where they are today were it not for digitalisation. Till now, however, democratic legislation has definitely applied brakes when it comes to the comprehensive use of personal health information. Data privacy and regulations on data security were central in 2010 during the first wave of legal regulations governing the use, sharing, and exchange of health data among different healthcare institutions and patients.

This approach often prevented data from being passed on during a patient’s treatment (primary use) and even slowed down the full use of the top view of comparable data in clinical and therapeutic research (secondary use). A justifiable political question in this context would

* Mazzucato M. *Mission Economy: A Moonshot Guide to Changing Capitalism*. London: Allen Lane, 2021.

be: was national and European legislation in fact working against the interests of citizens by not allowing the development of the full use of health data?

> healthcare policy involves constant change management

A paradigm shift in democratic policy did occur, at least at the level of European legislation, allowing the use of personal data both in connection with the direct treatment of a patient and with the use of this data for research purposes. Democratic progress in the current EU Regulation on the European Health Data Space is evident in the fact that the rules on data protection and data security have been expanded to include the patient's right to make both primary use of the personal data and secondary use. This example shows that democratic institutions are indeed capable of acting in the interest of citizens.

In other words, the prevailing conditions for successful healthcare need not become shifting sands. We can prevent that from happening. It is a question of facing reality and taking the initiative. Healthcare policy involves constant change management. There is no other way.

European support for improving global health systems and policies

Edited By: SL Greer, N Mauer, H Jarman, O Rockwell, M Falkenbach, I Kickbusch, D Panteli, M Wismar

Policy Brief 57

Published by: World Health Organization, 2024 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Number of pages: 56, **ISBN:** 1997-8073

Freely available for download: https://iris.who.int/bitstream/handle/10665/376756/Policy-brief-57-1997-8073-eng.pdf?sequence=1

The European Union has a significant influence on global health due to its role as a major market, aid donor, healthcare innovator, and trading power. Its impact on global health is both direct and indirect, through explicit health policies and the broader effects of its other policies. Recognising the need for a more cohesive approach, the EU has developed the 2022 Global Health Strategy and the 2024 Council conclusions, which emphasise principles like better health across the life course, stronger health systems, and combating health threats.

This policy brief also looks at ways the EU can enhance global health by, for example, aligning its diverse policy instruments, coordinating across EU agencies, consensus-building with national governments, and strategic management of global health tools.

HOW WALES IS TACKLING HEALTH INEQUALITIES FOR FUTURE GENERATIONS

By: Eluned Morgan

Summary: The population in Wales tends to be older, poorer, and sicker than those in neighbouring countries. To address these health inequalities, future generations-focused health policies have been embraced, and support is being provided for health and wellbeing projects aimed at addressing these disparities. A prime example is the Well-being of Future Generations (Wales) Act 2015. Additionally, close collaboration with the World Health Organization Regional Office for Europe has been established, and a Memorandum of Understanding (MoU) has been signed with a focus on health equity.

Keywords: *Future Generations, Health Inequalities, Demographic Transition, Wales*

> #EHFG2024 – PLENARY 2:
Democracy and the demographic transition.

Eluned Morgan is First Minister of Wales, and previously held the post of Cabinet Secretary for Health and Social Care, Wales, United Kingdom. Email: Correspondence:Eluned.Morgan@gov.wales

Introduction

In Wales, we face a number of challenges, both environmental and demographic, to the health of the population. These include the cost-of-living crisis, climate change and stubborn and persistent inequalities, which are seen across the country.

Our population, on average, is older, poorer and sicker than some of our neighbouring countries. This was highlighted during the COVID-19 pandemic, where the oldest people, those living in the most deprived parts of the country and people from minority ethnic backgrounds were often the most severely affected. These disparities are something we take seriously and take into consideration whenever we make policy decisions about healthcare and health policy.

According to the latest mid-year estimates of the population (mid-2022), more than one in five people living in Wales is aged 65 years or older (21.5%).[1] Wales has the highest proportion of people aged 65 years or older in all the constituent countries of the United Kingdom[2] – this trend is projected to continue. According to the latest interim national population projections, by mid-2031, just under a quarter of the population of Wales is projected to be aged 65 years or older (23.9%).[3]

We also have worrying health inequalities in Wales. Women who live in the wealthiest (least deprived) areas of Wales live, on average, six years longer than women who live in the poorest (most deprived) areas. They also have 17 more years of good health (healthy life expectancy). For men in Wales, the difference in healthy life expectancy between those in the least and most deprived areas is just over 13 years.[4]

These figures make it clear that where a person lives, and their wealth has a direct impact on their life expectancy and their long-term health. People with ill health are more likely to be unemployed or to have poor-quality jobs with fewer opportunities for advancement. This is also likely to have an impact on their children.[5] This self-perpetuating cycle shows the importance of tackling the root causes of inequalities, so we can protect future generations from the cycle of poverty and poor health.

The way government works in the United Kingdom means that many of the tax and welfare powers to address these deep-seated issues rests with the United Kingdom Government in London. But while the Welsh Government does not have all of the levers, we will use the powers we do have to make the best future for people in Wales and work closely with the United Kingdom Government wherever we can.

Policies and the legislative landscape

Health inequalities are a direct consequence of inequalities across society. We can reduce health inequalities and prevent them from getting worse by targeting their root causes. This means reducing poverty, racism, discrimination, making health and care services easier to use, and improving the places where we live, work, play and learn.[6]

> need to look beyond Wales to address our health inequalities

We know this is something that can't be achieved overnight but is something that must be taken into consideration when making decisions that will affect generations to come.

Figure 1: Wellbeing goals

Source: [8]
Note: © Crown copyright.

We have taken a comprehensive view of the factors that improve and affect the wellbeing of the citizens of Wales, with foundational legislation that underpins this approach.

The Well-being of Future Generations (Wales) Act 2015 provides a legislative framework to improve the health and wellbeing of people living in Wales and future generations.[7] Wales is the first country in the world to make such a law, which places sustainable development as the central organising principle of the public sector.

It sets out seven ambitious goals (**see Figure 1**) for a prosperous, resilient, healthier, more equal and globally responsible Wales, with a vibrant culture and thriving Welsh language. The Act also sets out 50 national indicators which assist in measuring whether progress is being made towards the achievement of the seven wellbeing goals.

We also recognise how connected human health is with the health of our planet. Climate change will harm health and wellbeing, impact the delivery of health and care services and put already vulnerable people at further risk.

Our Chief Medical Officer for Wales has warned about how climate change poses a 'serious health risk'[9] to the most vulnerable people in Wales, putting it on a par with the impact and response to the pandemic, as well as Wales's ageing population.

In 2019, we declared a Climate Emergency for Wales,[10] to help trigger more focus and greater action to meet the challenges

presented by the climate crisis. Wales has a legally binding target to deliver the goal of net-zero emissions by 2050 as set out in The Environment Act 2016.[11] This is alongside an ambition for the public sector in Wales to be collectively net zero carbon by 2030 as set out in The Net Zero Wales Carbon Budget 2.[12]

We also have strong enabling legislation through the Social Services and Wellbeing (Wales) Act, the Planning (Wales) Act, the Environment (Wales) Act, the Public Health (Wales) Act and Socio-economic Duty.

Health and wellbeing projects

It's not just through policies and legislation that we will address health inequalities, but we also have projects and programmes in place which are having real life impacts.

Whether these are run by the National Health Service (NHS) and stakeholders or partnerships where we can share learning with the World Health Organization (WHO), we need to ensure we are all working together to tackle the issues that affect our healthcare system and the wellbeing of our citizens.

We understand we need to look beyond Wales to address our health inequalities and we have been working closely with the WHO Regional Office for Europe to achieve this, where we are helping to build, promote and progress wellbeing economies.

Wellbeing societies are those that prioritise the wellbeing of their citizens over economic growth and profit. According to the WHO,[13] wellbeing is a positive state experienced by individuals and societies, determined by social, economic, and environmental conditions. It encompasses quality of life and the ability of people and societies to contribute to the world with a sense of meaning and purpose.

This collaboration is enabled by a Memorandum of Understanding (MoU) between the Welsh Government and the WHO Regional Office for Europe which has a focus on health equity.[14] Our work with the WHO has helped us to consider the health and care system's role in delivering an economy designed to serve people and the planet.

We understand the intrinsic link between health and wellbeing when it comes to the public health of citizens. There is a role for the health service, as providers of care, as anchor institutions, and as an advocate for health in driving a wellbeing economy. It cannot be underestimated the impact the NHS can play in this. As an anchor institution, NHS Wales has a profound influence on the health and wellbeing of communities. More than half of the Welsh Government's budget is spent on health and social services with the NHS being Wales's biggest employer with close to 80,000 employees. But by choosing to invest in and work with others locally and responsibly, health systems can have an even greater impact on the wider factors that make us healthy.

Access to health

Improving access to NHS Wales is imperative in addressing health inequalities. Examples of action within my portfolio to reduce the inequities in accessing healthcare include free prescriptions and the Common Ailments Service, which provides free access to evidence-based treatments for a range of minor conditions, through local pharmacies.

Free patient transport is available to all those who qualify. Our Non-Emergency Patient Transport Service makes around 700,000 journeys every year between people's homes and hospitals, taking people to and from hospital appointments. For those who can drive, car parking is free at all hospital sites for patients, visitors and NHS staff.

These initiatives help to improve access to NHS care for all – supporting the most vulnerable, especially during a cost-of-living crisis.

We know that in the current economic climate, as all public services have to do more within their budgets, we need to make efficiencies wherever possible. NHS Wales has embedded the principles of the Foundational Economy into its procurement contracts. The results of this work have seen a shift in spend with more than £53 million (about €63 million) of new contracts awarded in the past two years to Welsh businesses – previously these contracts may have been awarded out of Wales and away from our local economies

The percentage of spend on goods and services with Welsh businesses has increased from 26% in 2018–19 to 36% in 2022–23.

> regulations will promote a broader consideration of socioeconomic factors

We are currently consulting on Health Impact Assessment regulations that would make it a requirement for certain public bodies in specified circumstances. These regulations will promote a broader consideration of socioeconomic factors, so that positive health impacts can be maximised, and potential negative effects eliminated, reduced, or mitigated. I am proud that Wales will become one of the first countries in the world to place Health Impact Assessments on a statutory footing.

In January 2024, we launched a national framework for social prescribing, a person-centred approach to connecting people to local communities' assets. This can help empower individuals to recognise their own needs, strengths, and personal assets and to connect with their own communities for support with their health and wellbeing.[15]

Future outlook

It is clear how the demographics of Wales exacerbate health inequalities, impacting on the quality of life and life expectancy

of our citizens. However, the development of future-generations focussed policies and the willingness to look beyond Wales to support the building of 'wellbeing societies' shows what can be done to have a positive impact on the lives of citizens.

When those in the most deprived areas of Wales have the shortest life expectancies, it's clear that the poorest and most vulnerable need additional support. Improving their access to treatment, whether that's medication, transport, parking or self-prescribing, are all measures that can help improve their health and give them the tools to improve their lives.

We know that tackling these solutions isn't easy and more than half of the Welsh Government budget already goes towards health and social services, but if we put the lives of future generations at the heart of decision making then together, we can address the health inequalities we face.

References

1 Mid-year estimates of the population: 2022. https://www.gov.wales/mid-year-estimates-population-2022

2 Statistics Wales Demography newsletter, March 2023. https://www.gov.wales/sites/default/files/pdf-versions/2023/4/2/1680616035/statistics-wales-demography-newsletter-march-2023.pdf

3 National population projections: 2021-based. https://www.gov.wales/national-population-projections-2021-based-interim-data

4 Wellbeing of Wales, 2023: a healthier Wales. https://www.gov.wales/wellbeing-wales-2023-healthier-wales-html#129697

5 A review of evidence on socio-economic disadvantage and inequalities of outcome, October 2021. https://www.gov.wales/review-evidence-socio-economic-disadvantage-and-inequalities-outcome-summary-html

6 Marmot M, Allen J, Goldblatt P et al. Fair Society, Healthy Lives The Marmot Review. 2010. https://www.parliament.uk/globalassets/documents/fair-society-healthy-lives-full-report.pdf

7 Welsh Government. Well-being of Future Generations (Wales) Act 2015: the essentials. 2024. https://www.gov.wales/well-being-future-generations-act-essentials-html

8 Welsh Government. Well-being of Future Generations (Wales) Act 2015: the essentials. 2015. https://www.gov.wales/well-being-future-generations-act-essentials-html

9 Chief Medical Officer warns climate change poses a 'serious health risk' to the most vulnerable in Wales in annual report, June 2022. https://www.gov.wales/review-evidence-socio-economic-disadvantage-and-inequalities-outcome-summary-html

10 Welsh Government makes climate emergency declaration, April 2019. https://www.gov.wales/welsh-government-makes-climate-emergency-declaration

11 Environment (Wales) Act 2016: overview. https://www.gov.wales/environment-wales-act-2016-overview

12 Welsh Government. Net Zero Wales Carbon Budget 2 (2021–2025). https://www.gov.wales/sites/default/files/publications/2021-10/net-zero-wales-carbon-budget-2-2021-25.pdf

13 World Health Organization. Promoting wellbeing. 2024. https://www.who.int/activities/promoting-well-being

14 World Health Organization and Welsh Government commit to achieve better health for all, November 2020. https://www.gov.wales/world-health-organization-and-welsh-government-commit-achieve-better-health-all

15 National framework for social prescribing, January 2024. https://www.gov.wales/national-framework-social-prescribing-html

EMBRACING DEMOCRATIC HEALTHCARE – CREATING AN INCLUSIVE AND TRUSTWORTHY **EUROPEAN HEALTH DATA SPACE**

By: Milana Trucl

Summary: The European Health Data Space (EHDS) aims to transform health data management across the European Union (EU), with the overarching aim of improving individual care and facilitating data reuse for broader societal benefits. By fostering transparency, participation, and empowerment, the EHDS seeks to create a more inclusive and equitable healthcare environment. However, its success will depend on trust, digital literacy, effective governance, and harmonised implementation across EU Member States, among others. This article explores how the EHDS can promote more democratic healthcare and outlines what is needed to ensure that it serves all EU citizens.

Keywords: *European Health Data Space, Patient, Digital Health Literacy, Empowerment, Trust*

> #EHFG2024 – Plenary 3:
Democracy at work – the European Health Data Space from concept to reality.

Milana Trucl is Policy Officer for Digital Health & Data Saves Lives at the European Patients' Forum, and Member of the Young Forum Gastein, Brussels, Belgium.
Email: milana.trucl@eu-patient.eu

EHDS in a nutshell

Despite the widespread availability of various online services and the ease with which citizens can access electronic data, the accessibility and portability of health data lag significantly behind. This inability to easily access and manage crucial information about our health not only undermines patients' autonomy and the fundamental right to health but also poses significant challenges for researchers, regulators, and innovators, who rely on accurate and comprehensive data to advance innovative therapies and improve healthcare systems and patient care.

Although the digitalisation of healthcare and health data has been on political agendas for decades, the COVID-19 pandemic served as a catalyst by highlighting the critical need for timely access to electronic health data for patient care, including in cross-border scenarios. It also exposed the challenges that governments and healthcare systems face in accessing such data in a timely manner, underscoring a crucial need for improvement.

In response to these challenges, in May 2022 the European Commission proposed the regulation to establish the EHDS framework.[1] Through a set of common standards and practices,

interoperable infrastructures, and a governance framework, the EHDS is expected to overcome many of the existing obstacles in the EU's ability to exploit health data for better patient outcomes, research, policymaking, and innovation.

Improved accessibility

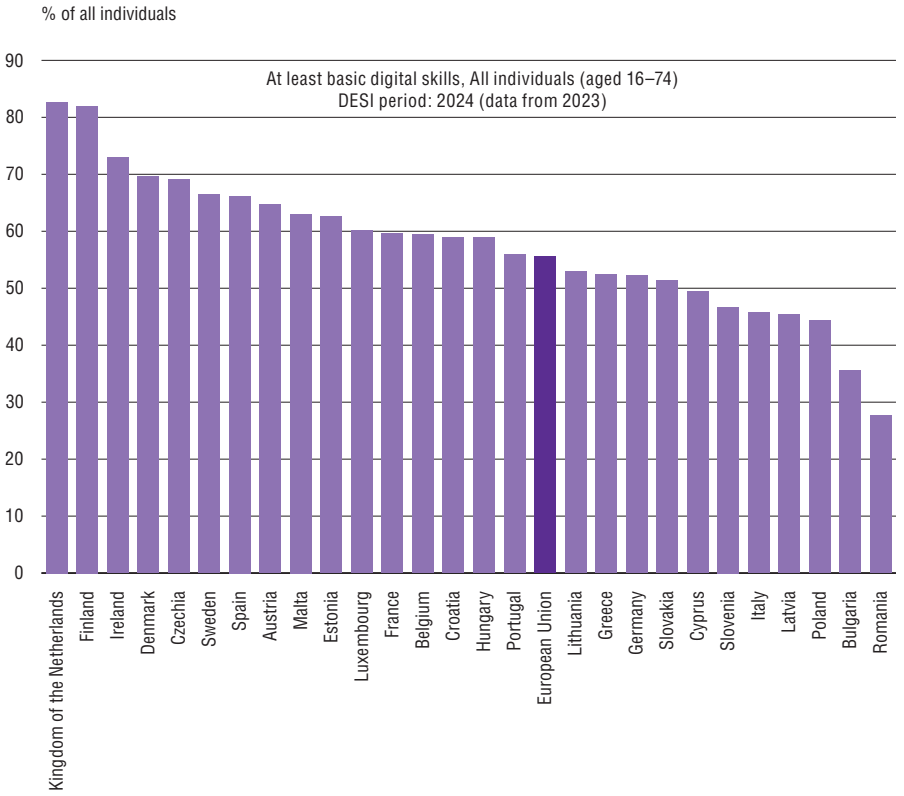
With regards to direct care, patients will have guaranteed access to their health data in electronic health records (EHRs), be able to see and control who can access their data, and request deletion, changes, and integration of incorrect or incomplete data. This is also defined as the *primary use* of health data. Given that EHRs are not yet a reality for many patients across the EU, the improved accessibility to health data planned under the EHDS would enhance patient autonomy but also improve the quality of care, as healthcare providers will be able to obtain comprehensive health records that support better-informed and faster clinical decisions.[3]

Moreover, the already existing, although not widely used, cross-border digital EU infrastructure MyHealth@EU, will ensure the interoperability of EU countries' health systems and their ability to communicate and share data safely and securely, ensuring that patient information is easily accessible across borders.[2] As Europeans move, travel, or seek healthcare in a different EU country, the EHDS would help ensure that their health data travels with them, enabling uninterrupted care and reducing the need for unnecessary tests.

Mind the Gap

The potential of EHDS to improve patients' autonomy over health data nevertheless faces a number of challenges, including insufficient digital literacy among the EU population. Recent data reveal that only 55.6% of the EU's population has at least basic digital skills,[4] as shown in **Figure 1**. This suggests that, despite improved access to health data, individuals with low digital literacy may find it challenging to navigate EHRs, understand the information therein, or be able to fully exercise their rights to restrict access and request rectification of wrong or incomplete data.

Figure 1: DESI 2024 report on digital literacy among EU citizens



Source: [9]
Notes: Eurostat data from 2023.

> the EHDS must be designed with inclusivity in mind

Low levels of literacy could also hinder both patients' ability to integrate the data they generate into EHRs and healthcare professionals' ability and willingness to review and acknowledge such data. It is therefore crucial to ensure that data introduced by a patient is properly marked and verified to maintain the quality of care and prevent potential harm.[5] This requires comprehensive education and support for patients in managing their health data, as well as enhanced digital health literacy across the entire EU population, including among healthcare professionals and hospital staff.

Some 88% of the EU population believe that public authorities should provide sufficient support to help citizens navigate the impacts of digital transformation, including in healthcare.[6] With this in mind, EU institutions and Member States must prioritise and provide sufficient funding for initiatives aimed at improving digital literacy for their citizens. It should also be highlighted that addressing health literacy is essential not only in the context of the EHDS but should be seen as the crucial prerequisite for all informed decisions about health.[7]

Moreover, the EHDS risks unintentionally disadvantaging those without access to the necessary technology, who may find themselves excluded altogether. To address such disparities, the EHDS must be accompanied by policies and initiatives that not only promote digital health literacy but also ensure that digital tools

are accessible to all citizens, including people with disabilities and older people, regardless of their socio-economic status or geographic location. This effort must involve investments in infrastructure, connectivity, and skills, to support the necessary changes across all EU Member States.[8] The EHDS must be designed with inclusivity in mind and the commitment to universal access to digital tools, including user-centric EHRs.

By building on the 2016 General Data Protection Regulation (GDPR), the EHDS also aims to facilitate the reuse of data for purposes other than direct patient care, such as research, innovation, and policymaking. This is also referred to as *secondary use* of data. By enabling the secure and ethical reuse of anonymised or pseudonymised health data through the HealthData@EU platform,[10] the EHDS can support groundbreaking research, such as developing new treatments and diagnostics. Regulators and policymakers will benefit from having easier access to health data allowing for swift and coordinated responses across Member States and more informed policymaking tailored to public health needs.[11] For patients, this could translate into more personalised medicine, faster development of therapies, and improvement of treatment outcomes, among others. However, due to low levels of literacy, patients and citizens may not understand the implications of the use of health data for secondary use or be able to exercise their right to opt-out from data sharing.

Apart from widespread investment in digital health literacy, and access to digital tools, governments should address confusion around the differences between primary and secondary uses of data, explain potential benefits and risks, and provide examples and good practices of responsible data sharing in lay language. To create more effective and relatable educational materials that resonate with patients and citizens, governments and the European Commission should build on the work of initiatives such as Data Saves Lives (https://datasaveslives.eu/), which aims to raise public awareness about the importance of health data and to improve understanding of how data are used. Involving patients and patient organisations in the design and implementation of these campaigns could not only enhance their credibility and effectiveness but also foster a sense of ownership and trust among the public.

> “it is crucial that patients feel comfortable sharing their data

Upholding Patient Trust

To ensure the widespread acceptance and success of the EHDS, it is crucial that patients feel comfortable sharing their data. Citizens expect stakeholders to adhere to ethical principles that align with their values.[13] For instance, many citizens may feel that any reuse of patient data should prioritise collective welfare by enhancing access to treatments and medical devices, making healthcare more affordable across the EU. This approach not only serves the interests of individual data subjects but also benefits society as a whole and increases trust among the public.

Moreover, public services and companies that use and store health data must be accountable to citizens and patients by upholding high standards of data security, protection, transparency, and accountability. This involves clearly communicating compliance with regulatory standards and guidelines, along with implementing robust safeguards against data breaches and misuse. Penalties for violations and poor data management and effective access to justice for patients in cases of data breaches must be respected to maintain trust.

However, despite efforts to build trust and improve transparency and accountability, some patients and citizens may still feel uneasy about sharing their data for purposes beyond direct care. Therefore, it is essential to offer a clear and transparent opt-out mechanism, allowing individuals to control their data through accessible and understandable consent process. Providing patients with straightforward options to object to the secondary use of their data is crucial for fostering confidence in the system and empowering patients in decision-making.[13] Such a mechanism, however, needs to be coupled with clear and easily understandable information about the benefits and possible disadvantages when exercising this right, as well as any foreseen exceptions, such as for public interest purposes.

Governance and Stakeholder Engagement

Despite decreasing trust in traditional institutions and political figures, individuals continue to actively engage in the public sphere, and digital technologies and frameworks have opened new channels for this engagement.[14] The healthcare sector should not be an exception to this. Governments must ensure effective EHDS governance and stakeholder engagement. This latter can be enhanced by actively engaging citizens and healthcare professionals throughout the different stages of implementation of the EHDS, through public consultations, surveys, and forums. This would allow policymakers to understand the real impact of the EHDS on diverse groups of patients, as well as on the literacy levels and access to digital tools. Moreover, patient organisations should play a vital role in this process by being meaningfully involved in the governance and decision-making structures of the EHDS, including representation on the EHDS Board and in national digital health authorities and health data access bodies. Such involvement is crucial for transparency, building trust, and ensuring that the needs and perspectives of patients are taken into account.[15]

Conclusion

For the EHDS to work, it will have to be more than a large-scale flagship European project. It must reach patients and citizens, be accepted by them, respond to their needs, and ultimately ensure that health data and the digital transformation of health and care will help deliver better care and increase quality of life. Digitalisation

of healthcare, with EHDS at its heart, should be seen not as an end in itself, but rather as a means to ensure a mentally and physically healthier society, increased autonomy and empowerment of citizens and patients, and more personalised and affordable healthcare.

References

1 European Commission, Proposal for a REGULATION OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the European Health Data Space, 2022. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52022PC0197

2 E-HEALTH Ireland, Introduction to MyHealth@EU. https://www.ehealthireland.ie/technology-and-transformation-functions/standards-and-shared-care-records-sscr/myhealth-eu/introduction-to-myhealth-eu/

3 European Patients' Forum, Public consultation on Digital health data and services – the European Health Data Space, 2021. https://www.eu-patient.eu/globalassets/0.-epf-consultation-response-ehdsfinal.pdf

4 European Commission, 2024 State of the Digital Decade report, 2024. https://ec.europa.eu/commission/presscorner/detail/en/IP_24_3602

5 Fåhraeus D, Reichel J, Slokenberga S. The European Health Data Space: Challenges and Opportunities, 2024. https://www.sieps.se/globalassets/publikationer/2024/2024_2epa.pdf?

6 European Commission, 2024 State of the Digital Decade report, 2024. https://ec.europa.eu/commission/presscorner/detail/en/IP_24_3602

7 European Patients' Forum, EPF's position on establishing an opt-out system for the secondary use of health data, 2023. https://www.eu-patient.eu/globalassets/policy/ehds---opt-out-statment-1.pdf

8 European Patients' Forum, Public consultation on Digital health data and services – the European Health Data Space, 2021. https://www.eu-patient.eu/globalassets/0.-epf-consultation-response-ehdsfinal.pdf

9 Eurostat. *Database.* 2024. https://ec.europa.eu/eurostat/web/health/overview

10 HealthData@EU Pilot, Piloting an infrastructure for the secondary use of health data. https://ehds2pilot.eu/

11 European Commission, Questions and Answers on the European Health Data Space. https://ec.europa.eu/commission/presscorner/detail/en/QANDA_24_2251

12 Data Saves Lives. *Toolkit.* N.d. https://datasaveslives.eu/toolkit

13 TEHDAS, Qualitative study to assess citizens' perception of sharing health data for secondary use and recommendations on how to engage citizens in the EHDS, 2023. https://tehdas.eu/tehdas1/app/uploads/2023/03/tehdas-study-to-assess-citizens-perception-of-sharing-health-data-for-secondary-use.pdf

14 Council of Europe, Study on the impact of digital transformation on democracy and good governance, 2021. https://rm.coe.int/study-on-the-impact-of-digital-transformation-on-democracy-and-good-go/1680a3b9f9

15 European Patients' Forum, EPF's recommendations on the European Health Data Space (EHDS), 2022. https://www.eu-patient.eu/contentassets/6d8824eb20224dcb893c12fbc233ec2e/epf-statement-ehds---final.pdf

ADVANCING GENDER EQUALITY IN HEALTH THROUGH FEMTECH AND INCLUSIVE DIGITALISATION

By: Sabine Ludwig

Summary: There is a gender equality gap in healthcare, but also in digitalisation. Femtech and more inclusive digitalisation can improve women's access to healthcare by providing tools that are designed for their needs. For this, they need to be included in conception and design, and have adequate access, knowledge and skills to use digital tools and applications. More women should be educated and trained to work in the information and communications technology sector and be promoted to leadership positions. Sex and gender-sensitive data collection and analysis are crucial to develop algorithms that adequately take the gender perspective into account.

Keywords: *Gender equality, Inclusive digitalisation, Women's Health, Female Technology*

Introduction

Healthcare systems are facing major challenges due to demographic change, the increase in chronic diseases and multimorbidity, rising costs of healthcare services and the shortage of healthcare professionals. Certain population groups face barriers in access to healthcare services including women and girls, contributing to a gender health gap. Artificial intelligence (AI) including inclusive digitalisation, the generation of big data and improved computing capacities are seen as a solution to many of these problems. Inclusive digitalisation is supposed to focus on the needs of different population groups and to apply a diversity perspective taking account of age, sex, gender, cultural background, disabilities and socioeconomic status when developing new innovative digital tools.

A recent scoping peer-review by the World Health Organization Regional Office for Europe shows that digital health technologies can contribute to improving maternal health, mental health and reproductive health, as well as improving access to health information and health literacy, self-care and self-monitoring.[1] Digital tools can also contribute to removing barriers to the access of healthcare services and support women in participating in household decisions. This article presents how inclusive digitalisation and female technologies (femtech) can enhance women's access to healthcare and information and thus contribute to better health outcomes, support their work-life balance and professional roles in healthcare, and empower their participation in household decisions.

> #EHFG2024 – Session 1:
Cracking the code for gender health equity. Advancing inclusive digital transformations in FemTech.

Sabine Ludwig is Professor for Diversity in Medicine and Director of the Institute for Diversity in Medicine, Medical University Innsbruck, Austria.
Email: sabine.ludwig@i-med.ac.at

Gender equality gap in healthcare

Globally we see major deficits in women's health. There are 800 pregnancy-related deaths every day, 73 million abortions per year with 50% of them unsafe, 270 million women have an unmet need for contraception, and one in six people suffer infertility in their lifetime.[2] Reliable and accessible information on sexuality and reproductive health is therefore needed as well as the protection from harmful practices like female genital mutilation. There are also sex and gender-based differences in the prevention, pathogenesis, diagnosis and treatment of diseases. For example, the prevalence of depression and suicide attempts is higher in women than men, as well as autoimmune diseases, such as rheumatoid arthritis. Globally, cardiovascular diseases, are the main cause for mortality for women and men, the risk is often underestimated by women. Women are also brought to intensive care units later than men and receive more medications, especially psychotropic medications. Furthermore, they are also underrepresented in pharmaceutical trials. An important number of medications are therefore not adequately tested on women and can lead to side effects with serious health consequences. In addition, women spend more of their lifetime in poor health than men.[3] [4] According to a new report by the World Economic Forum, closing the gender health gap could add almost €1 trillion to the global economy by 2040,[5] funding in women's health and research as well as investment in female technologies should therefore be increased.

Due to out-of-pocket payments for health 381 million people were pushed or further pushed into extreme poverty in 2019 leading to limited access to healthcare.[2] This is especially true for women, as their incomes and pensions are lower than those of men. Globally and in Europe we see a gender pay gap as well as a pension gap. The average gender pay gap in Europe is 13.0%, with the highest in Latvia (22.3%) and the lowest in Luxemburg (0.7%).[6] The gender pay gap as well as the gender pension gap can limit the access to women to healthcare services and thus have a negative impact on their health outcomes.[3]

Table 1: Digitalisation, gender equality, women's health and the Sustainable Development Goals

SDG 1 No Poverty	**Target 1.4:** By 2030, ensure that ***all men and women***, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, ***appropriate new technology*** and financial services, including microfinance.
SDG 4 Quality Education	**Target 4.b:** By 2020, substantially expand globally the number of scholarships available to developing countries, in particular least developed countries, small island developing States and African countries for enrolment in higher education, ***including vocational training and information and communications technology***, technical, engineering, and scientific programmes, in developed countries and other developing countries.
SDG 5 Gender Equality	**Target 5.b:** ***Enhance the use of enabling technology***, in particular information and communications technology, to promote the empowerment of women.
SDG 8 Decent Work and Economic Growth	**Target 8.2:** Achieve higher levels of economic productivity through diversification, **technological upgrading and innovation**, including through a focus on high value-added and labour-intensive sectors.
SDG 9 Industry, Innovation and Infrastructure	**Target 9.a:** Facilitate sustainable and resilient infrastructure development in developing countries through enhanced financial, **technological and technical support** to African countries, least developed countries, landlocked developing countries and small island developing States. **Target 9.b: Support domestic technology development**, research and innovation in developing countries, including by ensuring a conducive policy environment for, inter alia, industrial diversification and value addition to commodities. **Target 9.c:** Significantly **increase access to information and communications technology** and strive to provide universal and affordable access to the internet in least developed countries by 2020.
SDG 16 Peace, Justice and strong institutions	**Target 16.7:** Ensure responsive, **inclusive**, participatory and representative decision-making at all levels. **Target 16.10: Ensure public access to information and protect fundamental freedoms**, in accordance with national legislation and international agreements.
SDG 17 Partnerships for the goals	**Target 17.8: Fully operationalise the technology bank and science**, technology and innovation capacity-building mechanism for least developed countries by 2017 and **enhance the use of enabling technology**, in particular information and communications technology.

Source: [2]

Digitalisation and the Sustainable Development Goal 5 on Gender Equality

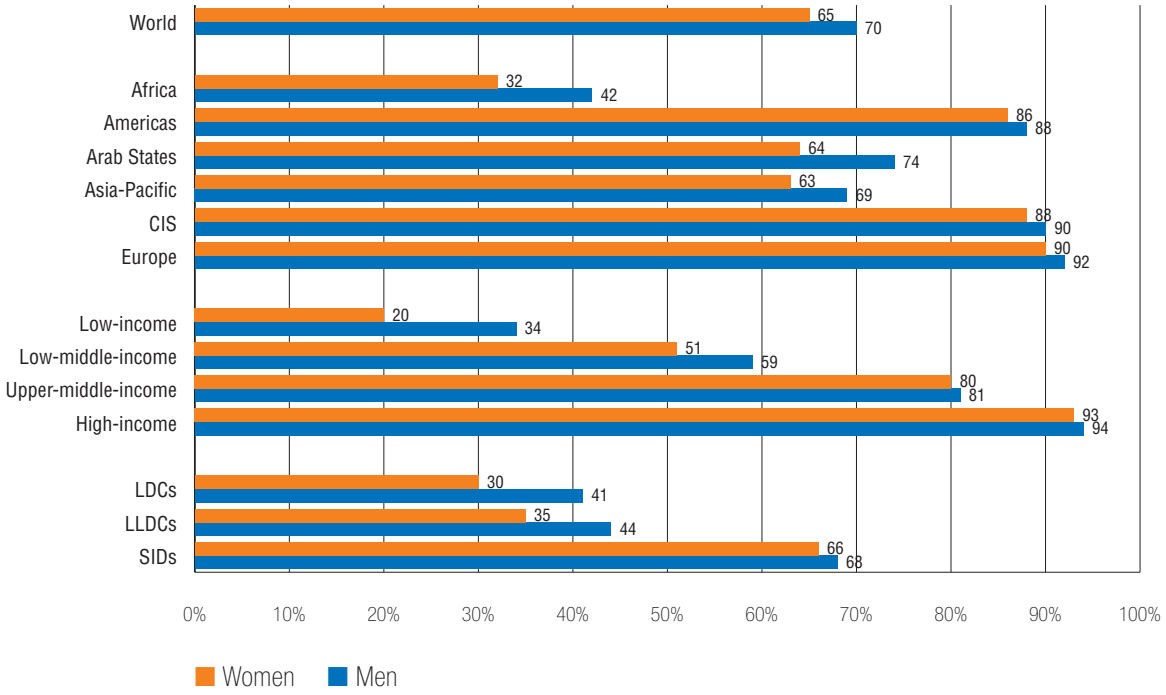
Information and Communications Technology (ICT) and digitalisation are mentioned in several Sustainable Development Goals (SDGs) including SDG 5 on Achieve gender equality and empower all women and girls, specifically target 5.b (**see Table 1**) and are thus part of the Agenda 2030 of the United Nations. **Table 1** lists the SDGs related to digitalisation, gender equality and women's health.

The global community has therefore committed itself to 1) improving access to ICT and 2) designing digital tools and applications that specifically consider the needs of women and thus contribute to the empowerment of women, advance gender equality and reduce the gender health gap.[2]

Female Technologies (femtech)

Femtech provides an opportunity to contribute to improving women's health and reducing health inequities. Although we face major digital gaps between regions and related to gender, 65% of women globally use the internet (**see Figure 1**); there is thus potential for digital solutions to reach a high number of women.[7]

Figure 1: Percentage of the population using the internet by sex/gender 2023



Source: [3]

CIS: Commonwealth of Independent States; LDCs= least developed countries; LLDCs=Landlocked Developing Countries; SIDS= Small Island Developing States.

> women spend around 30% per capita more on healthcare than men

Femtech covers different segments of women's health and offers digital solutions for issues related to prevention and health promotion (e.g. on lifestyle), to diagnosis and treatment. It includes mobile health, telehealth, and wearable devices. Cell phones, tablets and other electronic devices can be used to support health, healthcare delivery, and health education and health literacy. It facilitates the communication between: 1) individuals and health services such as health service helplines; 2) communication between health services and individuals, such as reminders to take medication; 3) communication between healthcare professionals; 4) access to information for the population and healthcare professionals.

Existing apps and high tech services include reproductive health issues, such as menstruation tracking and digital-driven fertility, maternity care, postpartum, and menopause. Some companies are focusing on prevention, early detection and diagnosis, and management of chronic diseases such as heart disease or cancer. Virtual clinics are also being established and provide services for both women's health and family health and well-being.[8]

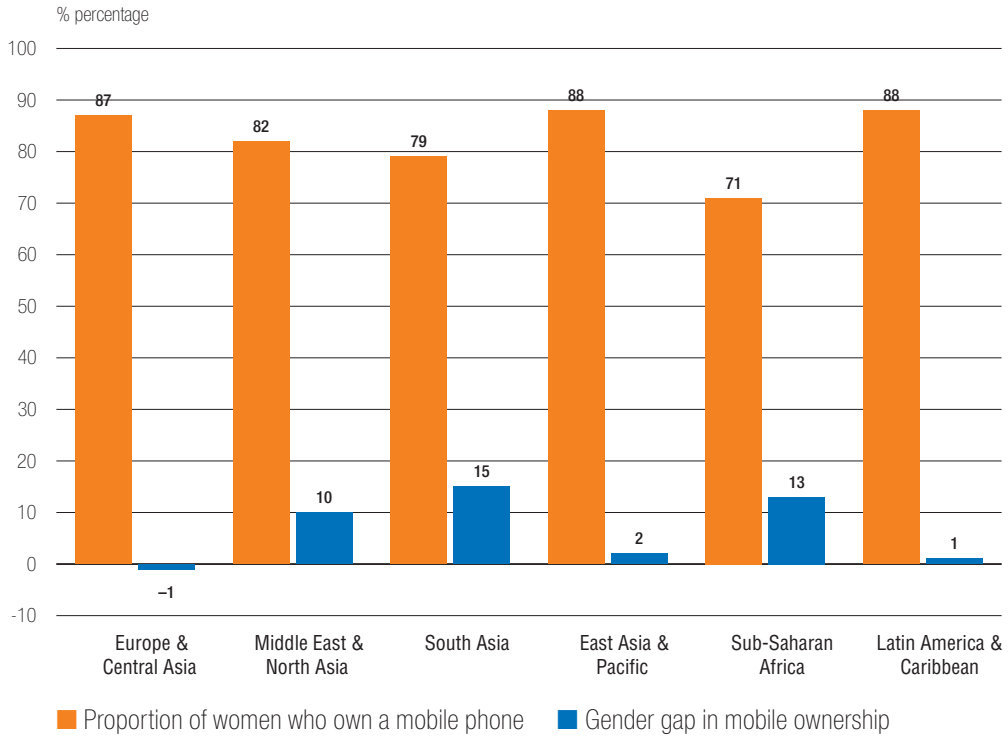
As women spend around 30% per capita more on healthcare than men and make approximately 80% of decisions on family health, femtech is a significant, but until now underappreciated market.[8] Femtech can contribute to a reduction of costs in healthcare, improve healthcare standards and the quality of life for women and thus contribute to achieving SDG 5 and SDG 3 on Good health and Well-being.[5]

Gender equality gap in digitalisation

In order to use digitalisation and femtech to overcome the gender health gap we have to face the gender equality gap regarding access to the internet and the use of digital tools (**see Figure 2**).[1]

Globally we face a "digital divide" and inequalities in the access to computers, the internet and mobile phones. The global internet penetration rate (the percentage of people in a given location who have consistent, reiable access to the internet) is 67.1%, with Northern Europe having the highest rate (97.4%) and Eastern Africa the lowest rate (26.8%).[9] According to data of the International Telecommunications Union (ITU), in 2023 only 20% of women from low-income countries used

Figure 2: Gender gap in mobile ownership in low and middle income countries, by region, total adult population*



Source: [10]

* The gender gap refers to how much less likely a woman is to own a mobile than a man. Mobile ownership is defined as having sole or main use of a SIM card (or a mobile phone that does not require a SIM) and using it at least once a month. Based on survey results and modelled data for adults aged 18+.

the internet compared to 93% women in high-income countries (compared to 34% and 94% of men, respectively).[7]

In low and middle income countries women are 8% less likely than men to own a mobile phone and 15% less likely to use mobile internet, that results in 265 million fewer women than men using mobile internet.[10] In South Asia, the gender gap in mobile ownership is the highest among all regions and amounts to 15% compared to 1% in Latin America and the Caribbean (**see Figure 2**). The number of women who do not own a mobile phone is 135 million in this region compared to 30 million in Latin America and the Caribbean.[10]

Some barriers to owning or using mobile phones are technical in nature, such as lack of phone charging facilities or internet coverage. Other barriers are social, economic or political in nature. In a recent report by GSMA it is stated that in most of the countries surveyed, affordability is the main reason for not owning a mobile phone, followed by illiteracy, low literal skills or the lack of digital skills.[10] This is especially true for women. Women are also more often concerned making mistakes when using a mobile phone and lack confidence in independently improving their digital skills. Safety and security concerns are stated as a third access barrier, especially in Latin America, but also in Africa. Around one fifth of women not using a mobile phone in South Africa state that the reasons are safety concerns. Relevance is also reported to be an important barrier in low and middle income countries. Ownership of a mobile phone is not considered as improving one's life and thus prevent them from buying one.[10]

Patriarchal structures are also considered a barrier, with men fearing that women might neglect their work in the household and caring for the family as a result. Further concerns include the opinion that information is available on the internet that is not appropriate for women.[11] Lack of family approval, in some countries, also prevents some women from owning a mobile phone. For example, around 30% of women in Pakistan cite family disapproval as the main reason for not owning a mobile phone (compared to only 4% of men).[10]

In addition, there is a lack of entrepreneurship opportunities and employment of women in the fields of science, technology, engineering, and mathematics (STEM), especially in leadership positions, resulting in a gender divide in the ICT sector and a gender bias in the design of new technologies and digital applications.[12]

Conclusions and recommended actions for inclusive digitalisation

Inclusive digitalisation and femtech including digital tools and applications, telemedicine, telemonitoring services or e-prescriptions can improve women's access to health information and healthcare services and thus contribute

to reducing the gender health gap. It can also improve the compatibility of family and work and give women the possibility to participate more in different household decisions.

> improve women's access to health information and healthcare services

For inclusive digitalisation and to reduce the gender health gap, the following actions are recommended:

1) Applications need to be adapted to the specific needs of women. Women should therefore be involved in the development and design process of new digital tools and applications. This can be achieved by more women working in the STEM professions, especially in leadership positions.
2) Women and girls must have adequate skills in the use of and access to ICT. Especially in middle and low-income countries, this can help them to improve their health, escape the poverty spiral and prepare them for the labour market.
3) When designing studies, collecting, analysing and presenting data a gender and diversity lens needs to be applied over the whole research cycle. Women need to be sufficiently integrated into clinical trials. Data need to be representative and reflect the diversity of the population and thus allow conclusions for different subgroups of, e.g., women, with the ultimate goal of having more sex/gender specific data on diseases, health behaviour and access to health services to develop sex/gender sensitive algorithms.
4) Finally, gender and further diversity aspects need to be taken into account at all levels and in all stages of the policy planning process.

In this way, digitalisation can contribute to improve gender equality and women's empowerment, to close the gender health gap and thus to achieve the Sustainable Development Goals.

References

1 World Health Organization Regional Office for Europe. *The role of digital health technologies in women's health, empowerment and gender equality*. Project report. Copenhagen: WHO Regional Office for Europe, 2024. https://www.who.int/europe/publications/i/item/WHO-EURO-2024-9293-49065-73153

2 Statista. *Global internet penetration rate as of April 2024, by region*. 2024. https://www.statista.com/statistics/269329/penetration-rate-of-the-internet-by-region/

3 International Telecommunications Union. *The gender digital divide*. Geneva, 2023. https://www.itu.int/itu-d/reports/statistics/2023/10/10/ff23-the-gender-digital-divide/

4 United Nations. *The Sustainable Development Goals Report*. New York: United Nations, 2024. https://unstats.un.org/sdgs/report/2024/

5 European Statistical Office. *Gender Pay Gap in Europe*. 2022. https://ec.europa.eu/eurostat

6 Robert Koch-Institute (ed.) Gesundheitliche Lage der Frauen in Deutschland. Gesundheitsberichterstattung des Bundes [Health situation of women in Germany. Federal health reporting]. RKI, Berlin. 2020. https://www.rki.de/DE/Content/Gesundheitsmonitoring/Gesundheitsberichterstattung/GBEDownloadsB/Gesundheitliche_Lage_der_Frauen_2020.html

7 Legato MJ (ed.). *Principles of Gender-Specific Medicine*. 4th edition. London:Elsevier, 2023.

8 World Economic Forum. *Closing the Women's Health Gap*. World Economic Forum, 2024. https://www3.weforum.org/docs/WEF_Closing_the_Women's_Health_Gap_2024.pdf

9 Wiederhold BK. Femtech: Digital Help for Women's Health Care Across the Life Span. *Cyperpsychology, behavior, and social networking* 2021;24(11):2021.

10 GSMA. *Connected Women*. The Mobile Gender Gap Report. 2024. https://www.gsma.com/r/wp-content/uploads/2024/05/The-Mobile-Gender-Gap-Report-2024.pdf

11 Ludwig S. *Frauen in der globalen Gesundheit – Digitalisierung und Karrieregerechtigkeit* [women in global health – digitalization and career equity] In: Aulenkamp J, Thun S, Heinemann S (eds.). *Frauen in der digitalen Zukunft der Medizin und Gesundheitswirtschaft: Karrieregerechtigkeit, Gendermedizin, (She)Health, Diversity* [Women in the digital future of medicine and the healthcare industry: career equality, gender medicine, (she)health, diversity]. Heidelberg: medhochzwei Publishing house Ltd. 2021 S.277–302.

12 United Nations Development Programme (UNDP). *Gender Equality in digitalization. Key issues for programming*. Istanbul: UNDP, Instanbul Regional Hub, Regional Bureau for Europe and the CIS, 2021. https://www.undp.org/eurasia/publications/gender-equality-digitalization

WOMEN IN GLOBAL HEALTH: ACCELERATING LEADERSHIP THROUGH MENTORING

By: Theresa Oatridge and Mari Pollari

Summary: Women make up 70% of the health and care workforce but are underrepresented in leadership. This hinders Sustainable Development Goal 5, which seeks full female participation in leadership and decision-making. Creating supportive environments for women to ascend to leadership roles by fostering connections and providing guidance is a recognised strategy, reflecting components of mentoring. In 2024, the Austrian chapter of Women in Global Health, hosted by the European Health Forum Gastein, launched a pilot mentoring programme to address this gap. This article explores the role of mentoring in leadership development, sharing observations from the programme.

Keywords: *Leadership, Mentoring, Gender Equity, Empowerment, Capacity Building*

Theresa Oatridge is Project Officer and **Mari Pollari** is Project Manager, European Health Forum Gastein, Bad Hofgastein, Austria.
Email: theresa.oatridge@ehfg.org

Introduction

A stark global health gender paradox exists. While women make up 70% of health and care workers, only 25% hold leadership positions.[1] This disparity extends to pay with women earning approximately 20% less per hour than men within the health sector.[2] The European Union (EU) gender overall earnings gap sits at 12.7%, and Austria exemplifies this problem with the second highest hourly rate difference within the EU at 18.4%.[3] Even in leadership roles within Austria's top 200 companies, women only hold 11% of managing director positions, distinctly falling below the EU average of 21%.[4]

Whilst specific policies exist to combat gender inequality across Europe, progress is slow. Reports suggest key indicators for Sustainable Development Goal (SDG) 5, dedicated to gender equity, will not be met by 2030.[5] Leadership shortfalls were apparent at this year's World Health Assembly with just 30% of member state delegations headed by women.

Women in Global Health and the mentoring initiative

Women in Global Health (WGH), a movement dedicated to challenging systemic barriers to improve gender equity in health, has active networks across 52 countries globally. WGH identified 'Mentoring and Networking' as one of five priorities to improve female leadership representation and this was recognised by WGH Austria as an important initiative to offer for its members. The concept of the WGH Austria mentoring programme was born from its members' desire to foster

professional growth, share knowledge and experiences, and create a supportive community. The initiative reflects the WGH Austria objectives of boosting female leadership and promoting gender equity in health-related professions.

With strong links to personal growth and development, increased career opportunities and job satisfaction, mentoring is widely accepted as an effective leadership intervention. Originating from Greek mythology, Homer's character 'Mentor' in *The Odyssey* served as a role model, an educator, and leader to the 'mentee', as seen in traditional mentoring relationships.[6] As the structure of mentorship is constantly evolving, the programme embraced contemporary partnerships that accommodate both the classic senior-to-junior relationships, but also reciprocal or peer-to-peer collaborations, tailored to individual preferences.

The WGH Austria mentoring programme in action

After opening a call for mentee and mentor applications, followed by a matchmaking process, the mentoring programme of the WGH Austrian chapter kickstarted in February 2024 (**see Box 1**). The programme comprises of eighteen pairs, with varying health sector expertise, ranging from fresh Master's degree graduates to highly experienced leaders. Their backgrounds include academia, public sector, international organisations and the wider healthcare industry. The participants' expertise spanned a broad spectrum, from clinical practitioners to policy advisors and individuals holding directorial positions.

Participants met both online and/or in-person

While spanning different sectors, applicants were ultimately matched based on aligned mentoring objectives and ambitions. Mentoring goals are often orientated around psychosocial support or career objectives,[7] a concept observed across the group through their applications. Motivations such as development of personal impact and growth in confidence were common, as were leadership skills, networking, and career guidance.

> "fosters a culture built on mutual respect, trust, and honesty

Designed to run for eight months, the pilot encouraged participants to meet monthly with clear agendas set by the pairs themselves. To establish a common ground for mentoring, the pairs formalised their mentoring relationship by amending and signing a mentoring agreement for the duration of the programme. Meeting formats were left to participants' preferences, with options for online, in-person, or a hybrid approach.

To further enrich the experience, the programme offered an online kick-off session, an onsite leadership workshop and an interactive mid-way reflection session for the entire cohort. The programme will culminate with an event at the European Health Forum Gastein 2024 in September, providing a platform for reflection and celebration.

Mentoring experience: "The feel-good factor"

Successful mentoring requires dedication from both the mentors and mentees. Mentors prioritise meeting mentees, often during their free time, despite busy workloads and external responsibilities. This commitment sits outside of organisational silos and focuses on another person's development. It fosters a culture built on mutual respect, trust, and honesty.

While the benefits of mentorship for career progression and skills development are widely recognised, there are deeper motivations at play.

Crucial benefits for both mentors and mentees are the development of leadership skills, the building of social capital, and personal networks. Reflecting on the benefits, a member of the cohort explained, "through the exchange of perspectives, shared experiences, and collaborative problem-solving, mentors and mentees gain valuable insights that contribute significantly to their leadership journeys."

Box 1: Key facts of the WGH Austria mentoring programme

- 36 participants (18 pairs) were selected
- 13 pairs opted for traditional mentoring; 5 pairs opted for reciprocal mentoring
- Pilot duration from February to September 2024
- Pairs committed to six meetings/ sessions.

Mentees: Seeing the path ahead

For a mentee, especially a woman seeking a leadership role, interacting with a role model in a leadership position is invaluable. Seeing women in leadership makes those positions more tangible and achievable. The fact that another professional, external to their organisation, is willing to dedicate time is viewed as a privilege. Mentorship provides a safe and trusted space where one can ask for help, confident that they will be seen and heard, fostering personal and professional development. The sharing of experiences, the exchange of perspectives, and the validation of personal and professional challenges leads to a sense of belonging and empowerment. As one mentee aptly stated, "In the safe space our WGH mentoring cohort provided, I was able to learn a lot, not only about myself and leadership, but also how to properly reflect upon it as well as being inspired by our mentors and fellow mentees".

Mentors: Paying it forward

For mentors, the motivations connect to altruism, the desire to give back and

contribute to another women's journey to success. One participant explained, "I want to nurture and inspire the next generation of female leaders, while also keenly learning about the aspirations of our young colleagues and what hurdles they are encountering on their career path".

Mentoring also hones listening skills and challenges and motivates others to recognise their own potential. Mentors who hold leadership positions often find the dialogues with their mentees paramount as they gain deeper understanding on the issues that women with leadership aspirations go through. Mentors can then advance their leadership performance by transferring this knowledge into their daily work by creating conditions that empower others with similar goals.

> relevance of shared lived experience

The gendered leadership paradox

This may be a good opportunity to outline that WGH Austria membership is open to everyone, regardless of gender identity. Its objectives lie in improving gender equity, and the network actively seeks allies who support this mission. However, the pilot mentoring programme only included women, resulting in a 'femtoring' programme, which raises an interesting question: To what extent do we need gender specific mentoring programmes?

Successful mentoring thrives on shared challenges and experiences. Yet caution is required to ensure such programmes within systems do not reinforce narratives of a privileged or elite group. This poses the question of whether mentoring relationships should prioritise diverse backgrounds over gender.[8] The relevance of shared lived experience should also be carefully considered in mentoring programme design.

The WGH Austria mentoring programme mitigated this concern by matching professionals across the health sector, with varying experience levels and mentoring goals. Placing a strong focus on the one-to-one partnership itself is also crucial. Participants were advised to define personal mentoring goals beforehand, prepare for meetings, and utilise self-reflection tools and resources. Regardless of gender, achieving these requires commitment, dedication, and effective self-reflection – all components of self-leadership.

Proponents argue that with women still underrepresented in leadership positions, gender specific programmes offer a safe space for women to share experiences and find relatable role models, something potentially lacking in general programmes.

Interestingly, despite having access to internal organisational mentoring programmes, some participants actively sought an external opportunity within WGH Austria. This could be seen as a form of social capital development, fostering a sense of belonging, participation, and social inclusion. Regardless of whether it is specifically female social capital or not, the resulting expansion of social networks increases the resources available to the cohort, ultimately supporting leadership development.

Conclusion

In a world of imbalance, with persistent pay gaps, global goals targeting gender equity are crucial.

Fulfilling the objective of developing a mentoring programme within WGH Austria ensures that network members can access a place for learning and personal development. Leveraging community assets, such as experienced health leaders as mentors, is an essential aspect of this service design, contributing to community building.

Local mentoring programmes, like the one established by WGH Austria, have the potential to foster the development of female health leaders, playing a crucial role in promoting gender equity in leadership within countries. Successful mentoring can significantly impact an individual's career and life decisions. But the impact expands far beyond. Empowering women and creating supportive networks can have a ripple effect, making a significant impact in local and national settings. By fostering international exchange, this programme aims to spread the benefits of mentoring more broadly and to contribute to gender equity on a larger scale – one woman at time.

References

1 Dhatt R, Keeling A. Delivered by women, led by women: The future of global health leadership. *Leader to Leader* 2021;100:43–7.

2 International Labour Organization. The gender pay gap in the health and care sector: A global analysis in the time of COVID-19, 2022. https://www.ilo.org/publications/gender-pay-gap-health-and-care-sector-global-analysis-time-covid-19

3 European Commission. The gender pay gap situation in the EU, 2022. https://commission.europa.eu/strategy-and-policy/policies/justice-and-fundamental-rights/gender-equality/equal-pay/gender-pay-gap-situation-eu_en

4 Vienna Chamber of Labour. Women Management Report, 2023 (in German). https://emedien.arbeiterkammer.at/viewer/image/AC16789040/3/

5 Beloskar VD, Haldar A, Gupta A. Gender equality and women's empowerment: A bibliometric review of the literature on SDG 5 through the management lens. *Journal of Business Research* 2024;172:114442.

6 Early SL. Relational Leadership Reconsidered: The Mentor–Protégé Connection. *Journal of Leadership Studies* 2020;13(4):57–61.

7 Block BA, Tietjen-Smith T. The Case for Women Mentoring Women. *Quest* 2016;68(3):306–15.

8 Meschitti V, Smith HL. Does Mentoring Make a Difference for Women Academics? Evidence from the Literature and a Guide for Future Research. *Journal of Research in Gender Studies* 2017;7:166–99.

SECURING THE FOUNDATIONS AS WE BUILD A EUROPEAN HEALTH UNION: **AN EU HEALTH INVESTMENT HUB** FOR THE ERA OF SHIFTING SANDS

By: Marisol Touraine

Summary: The values underpinning Europe's health systems are challenged by rising populism. Policymakers must urgently answer key structural challenges health systems face: ageing populations, shortages of health and care workers, and adapting to new technologies. This means making the right investments in reforms and transformation. While an array of European Union (EU) instruments could contribute to health investments, the funding landscape is complex for national officials to navigate. Creating an EU Health investment Hub is proposed to streamline access to these mechanisms, provide tailored support for national reforms and foster collaboration. This initiative would improve health outcomes and help counter populism.

Keywords: *Investment Hub, Technical Support Instrument, Structural Challenges, Populism*

> #EHFG2024 – Session 2:
Unlocking EU investment potential for health. A resources hub for sustainable investment in health.

Marisol Touraine is Former French Minister for Health and Social Affairs and Senior Advisor/Lead expert for the *"EU Resources hub for sustainable investing in health"* project, Expertise France.

Introduction

Europe's health systems, like the societies they serve, are built on common values. Until recently, it was easy to believe these foundations were rock solid. Our common European values of universality, access to good quality healthcare, equity, and solidarity [1] were so well established – so widely shared – they seemed unshakeable. However, the economic, societal and geo-political shocks of the past few years as well as the long-lasting impact of the COVID-19 pandemic have had a profoundly destabilising effect on all our societies, contributing to the rise of populism in the European Union (EU) and the growing mistrust of public policies.

Our health systems now also have to face structural challenges. These are well expressed in the title of this year's edition of the European Health Forum Gastein: "demographics, digitalisation and the shifting of the sands under Europe's democracies". It is easy enough to make the connection between these factors and the need for health sector reform.

The ageing of populations across the EU means we have an increasing number of people living with chronic diseases, often coupled with shortages of health and care workers. To meet this challenge, we need to focus more on prevention rather than on treatments, and develop primary health care systems that enable all Europeans to access high-quality, patient-centred care near to where they live. Strategic investments in digitalisation can help health authorities deliver these reforms. But it is a double-edged sword: advances in technology may help us achieve a step-change in health system productivity, but they can create a digital divide and exclude certain groups. This in turn leads to disruption and division, which can be exploited by anti-European and anti-democratic forces in our societies. We need to address such new challenges through innovative public policies, grounded in common values, that can reassure European people who are both anxious and distrustful.

> “start reinforcing the foundations of our health systems

This is why, seeing the sands starting to shift all around us, now is a good time to start reinforcing the foundations of our health systems. And a key part of this is making the right investments in health system reform and transformation. But how can the EU support the Member States in addressing these challenges? There is certainly, at the European level, a will to do so and funds and instruments to support reforms in the Member States. In January 2020, the European Commission created a Directorate-General for Structural Reform Support (DG REFORM) to help EU countries design and implement reforms, in particular through the EU Technical Support Instrument (TSI).[2] In 2021, the EU further created a Recovery and Resilience Facility (RRF) with €648 billion to invest in supporting reform projects as part of its strategy to help the Union emerge stronger and more resilient from the COVID-19 pandemic.[3] Indeed, as demonstrated by the European Observatory on Health Systems and Policies (the Observatory) in its recent report on EU resources for investing in and strengthening health systems,[4] there are in fact many EU funds and instruments that can be used to support health reforms. But, as the Observatory’s report highlights, the EU funding landscape is complex and difficult to navigate for health authorities preparing reforms and looking for funding.

Box 1: Extract from *Council conclusions on the Future of the European Health Union: A Europe that cares, prepares and protect*

Adopted by EPSCO Council meeting in Luxembourg on 21 June 2024, in the section on “Implementation tools”:

Invites the European Commission to: ESTABLISH an EU Health investment Hub in consultation with Member States and taking into consideration the lessons learned from the Technical Support Instrument project “EU Resources Hub for sustainable investing in health”, to provide on-demand, tailored and fit-for-purpose support to Member States in accessing and using existing EU funds delegated to Member States for the planning, financing and implementation of national health projects of high interest and impact and within the context of national health reforms and health care transformation processes, as well as identifying opportunities from different EU programmes for projects with objectives that span across multiple EU funding instruments and their priorities.

Source: [8]

An EU investment Hub could optimise results from reforms

The idea of creating a service to help Member State health authorities access EU funding was first raised by the Council of the European Union under the Slovenian Presidency in November 2021.[5] In 2022, the European Commission’s DG REFORM agreed to finance a multi-country project to create a pilot *“EU Resources hub for sustainable investing in health”* *. Funded from the TSI and overseen by DG REFORM, the project involved a team of experts managed by Expertise France and the Observatory supporting health reform initiatives in Austria, Belgium and Slovenia.[6,7] Under the Belgian EU Presidency in the first half of 2024, Member States decided in the June 2024 Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) Council † to call on the Commission to create a permanent EU Hub, based on experience from the TSI funded project (**see Box 1**).

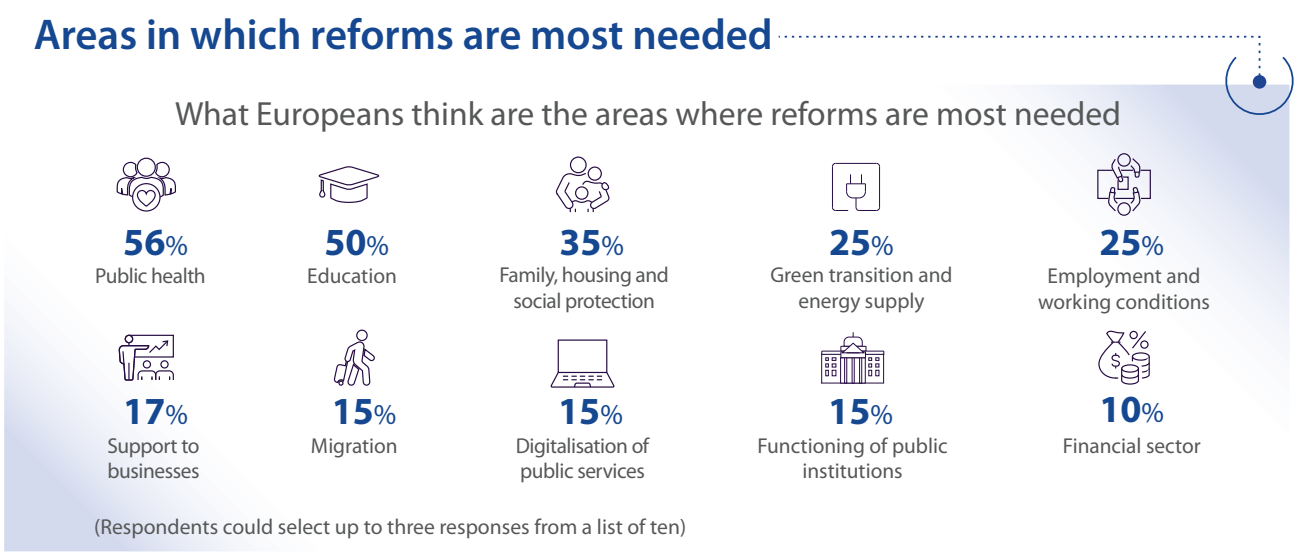
Though this might seem like a technical project, its positive socio-political impact should not be underestimated. This Hub can support EU Member States – both individually and collectively – to implement strategic, high-quality and sustainable health system reform by sharing innovation and expertise across national borders and collaborating on joint projects where this makes sense. This networking of Europe’s strategic knowledge, experience and, when agreed, resources can help Member States achieve optimum results from their health reforms. It can help pave the way for new funding models that encourage a holistic approach. In our complex environment, and with shifting sands all around us, Member States’ decision-makers need tools such as this proposed Hub to make the health system reform journey simpler and easier.

Put more precisely, the EU Health investment Hub called for by the EPSCO

* For project information, see https://reform-support.ec.europa.eu/what-we-do/health-and-long-term-care/resources-hub-sustainable-investing-health_en

† The Employment, Social Policy, Health and Consumer Affairs Council brings together ministers from all EU Member States who are responsible for employment, social protection, consumer protection, health, and equal opportunities.

Figure 1: EU citizens' top concerns



Source: [9]

Council in June would offer Member States support throughout the health system reform process, from the initial planning to implementation, offering user-friendly, easy-to access services. Its aim would be to make the path to reform and transformation less daunting for national officials and policymakers by supporting them in identifying the right investments. Its ultimate mission would be to foster more effective reform in Member States, helping to ensure health systems better meet the needs of EU citizens.

An EU investment hub should tailor support according to context

We have already identified some clear lessons from the TSI project that can inform the proposed EU Hub. Foremost among these is the need for flexibility. The countries that participated in the TSI funded Hub pilot project had very different capacities, needs and contexts when it came to developing investment cases and designing health system reforms. The initiatives they identified for EU funding were at different levels of maturity and reflected each country's differing needs and priorities. This meant the pilot Hub had to provide a bespoke advice and support service for each country, rather than developing standard packages. In two countries (Belgium and Slovenia), the pilot Hub helped with the reform concept and strategy, then helped design projects to achieve the strategy – all before helping the health authority apply for EU funding. This flexible adaptation to the needs of each country was key in helping them prepare their reforms efficiently and effectively and simplifying access to the EU funds and instruments to finance them.

Based on this model of tailored and specific support, the partners in the TSI project have developed a set of core principles that they propose should govern the future EU Health investment Hub. These include inclusivity, respect for national ownership, dissemination of appropriate information to all Member States and openness to innovation (**see Box 1**).

> supporting them in identifying the right investments

The key principles governing the services provide by the future Hub should be ease of access, flexibility and adaptability. Applying these, we see the need for a more pragmatic and flexible project identification processes than those that exists for most EU programmes and services. Each country would decide internally who can present a proposal for Hub support. The best way to ensure broad access and flexibility is to allow all kinds of requests to be presented. The scope of the reforms for which Member States could ask for support would not be defined in advance by the EU but correspond to strategic national needs and priorities.

This role for the EU as the facilitator of country-specific change based on common values is one that can take out some of the angst – and maybe some of the controversy – from the transformations Europe's health systems need to go through in the coming years. By doing so, it would strengthen our democracies.

Conclusion

Safeguarding the future of democracy in Europe is a "whole-of-society" challenge. Equally, even though, public health consistently appears as one EU citizens' top concerns in Europe-wide surveys, they also see it as one of the sectors most in need of reform (**see Figure 1**).

If we collaboratively create successful models where Member State-led, EU supported reforms can lead to substantial health gains for citizens, and clearly communicate that these successes are based on EU cooperation and shared

values, we can help to counter populist and anti-European narratives. European democracy underpins our health systems and their values. At Gastein this year, it is crucial to recognise that European health systems also play a vital role in underpinning our democracies.

References

1 *Council Conclusions on Common values and principles in European Union Health Systems,* Official Journal of the European Union, 2006; C146/1.

2 European Commission. *Technical Support Instrument,* 2024. https://commission.europa.eu/funding-tenders/find-funding/eu-funding-programmes/technical-support-instrument/technical-support-instrument-tsi_en

3 European Commission. *The Recovery and Resilience Facility,* 2024. https://commission.europa.eu/business-economy-euro/economic-recovery/recovery-and-resilience-facility_en

4 *EU resources for investing in and strengthening health systems: Tailored options for Austria, Belgium and Slovenia,* 2024. Copenhagen: World Health Organization 2024 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies). https://eurohealthobservatory.who.int/publications/m/eu-resources-for-investing-in-and-strengthening-health-systems-tailored-options-for-austria-belgium-and-slovenia

5 *Council Conclusions on strengthening the European Health Union,* Official Journal of the European Union, 20 December 2021; C 512 I/02.

6 Mauer N, Durvy B, Forman R, et al. Building capacity and identifying appropriate support: how can the EU contribute to securing resources for health systems? *Eurohealth* 2023;29(3):55–9. https://iris.who.int/handle/10665/375439

7 Rauch J. European Health Investment Hub. *Eurohealth* 2023;9(3):13. https://iris.who.int/handle/10665/375423

8 Draft Council conclusions on the Future of the European Health Union: A Europe that cares, prepares and protects, 29 May 2024. https://data.consilium.europa.eu/doc/document/ST-9900-2024-INIT/en/pdf

9 European Commission. *Understanding Europeans' views on reform needs,* April 2023. https://europa.eu/eurobarometer/surveys/detail/3054

The **"EU Health Resources Hub for Sustainable Investing in Health"** project – a collaborative initiative to benefit all EU Member States

By: Béatrice Durvy, Rebecca Forman, Nicole Mauer, Christina Amrhein, Ilana Ventura, Stefan Eichwalder, Paolo Fornaroli, Ann Marie Borg, Laurence Ballieux, Anne Swaluë, Mircha Poldrugovac, Dušan Jošar, Vesna Kerstin Petrič and Dimitra Panteli

In response to ongoing and future health challenges, countries across Europe are seeking to conduct needed transformations of their health systems by investing in strengthening the healthcare workforce, improving primary care services, enhancing digitalisation, or tackling climate change's causes and consequences. In 2022, Austria, Belgium, and Slovenia joined forces on a common project, supported by the European Commission, to make more strategic and effective use of European Union (EU) funding available for improving health systems' resilience and to explore the establishment of an 'EU Health Resources Hub for Sustainable Investing in Health'.[1] This two-year project is funded by the EU via the Technical Support Instrument (TSI) and is implemented by Expertise France in collaboration with the European Observatory on Health Systems and Policies (the Observatory). It is one of the more than 50 health reform projects supported by the European Commission across the EU. It has contributed to:

- Building capacity in the three Member States to make a stronger case for strategic public investments at the national and international levels to support health systems' resilience and sustainability; and
- Exploring approaches to optimise the use of available EU resources for undertaking key health investments and health systems reforms.

An exercise conducted by the Observatory in an effort to achieve the first objective showed that, while data and evidence can inform and incentivise public decision-making on investments, when making the case for better investment in health, political will, engagement, cooperation, communication, transparency, accountability, and trust are key drivers for a successful business case.[2,3] The Member States participating in the project piloted relevant tools that fit their current policy goals. A policy brief is currently in preparation by SEO Amsterdam economics, which aims to distil lessons learned.

As part of efforts to support Member States in strengthening their capacity to identify, combine, and secure EU funding for health investments, pilots in Austria (on greening), Belgium (on digitalisation to support integrated care), and Slovenia

(on primary healthcare) were conducted. A mapping of the existing EU instruments to support these initiatives depicted a wide range of possible resources that Health Ministries, seeking financial and/or technical assistance to undertake key health reforms, could access.[2,4] However, it also demonstrated that these instruments vary widely in terms of budget size, management types, timing, application, focus area, and eligibility criteria and that their access is often not a straightforward exercise.[5,6,7] Hence, the 'testing on the go' approach of the pilots helped participating Member States to navigate the complexities of identifying relevant instruments, assess their suitability regarding both countries' needs and priorities and instruments' characteristics and requirements, and explore combination possibilities between selected instruments.

Overall, the project has supported the participating Member States to strengthen their approach to securing funding for priority reform areas in different ways. In particular:

- In Austria, the TSI project supported several Austrian hospitals in their application to the LIFE programme in an effort to secure funding for green investments. Furthermore, it supported the creation of a new department at the Ministry of Social Affairs, Health, Care and Consumer Protection dedicated to Health Financing that will involve a stronger engagement with tools and methods to make the case for investing in health. The department will also act as a national counterpart for a future EU Health Resources hub.
- In Belgium, the project has supported not only the preparation of the implementation of the country's inter-federal Population Health Management (PHM) strategy but also the development of a digital dashboard to support PHM, which will be elaborated further through the country's Recovery and Resilience Facility funds.
- In Slovenia, the project has provided decisive inputs to the development of a new primary healthcare strategy and support in navigating EU instruments that can assist in the implementation of the reform. Furthermore, it provided training and tools for making the case for investment in health, aimed at civil servants and other stakeholders, who are not experts in economics and financing.

This TSI project comes to an end in November 2024, when several reports, including a final report and action plan on the suggested design of a future EU Health Resources Hub, will be finalised. Nevertheless, preliminary outcomes have already showcased that there is untapped potential to optimise and find synergies across existing EU resources for health to fund reform initiatives for transformative change.[8] Through the pilots in the three participating Member States, the concept of an EU Health Resources Hub as an advisory support instrument was tested and elaborated on further as a promising mechanism to help all EU Member States unlock future health investment opportunities. A Health Hub concept, including the potential scope and services it could provide to public authorities on demand, has already been drawn up in consultation with experts involved in the TSI project and could inform the design of a broader framework, which is expected to benefit all EU Member States in the near future.

Building on the successful experience of this unique yet scalable project, DG REFORM presented the EU Health Hub flagship among the '2025 TSI call for requests for technical support' proposals, indicating its readiness to further test the Pilot Hub with other Member States. This transitionary approach considers the recent lessons learnt and ensures continuity while the establishment of a more permanent Health Hub is under discussion.

References

1 European Commission. *Resources hub for sustainable investing in health, Reform Support*. https://reform-support.ec.europa.eu/what-we-do/health-and-long-term-care/resources-hub-sustainable-investing-health_en

2 Mauer N, Durvy B, Forman R, et al. Building capacity and identifying appropriate support: how can the EU contribute to securing resources for health systems? *Eurohealth* 2023;29(3):55–9. https://iris.who.int/handle/10665/375439

3 Forman R, Feil C, Cylus J. *A mapping exercise: making the case for public investment in health*. World Health Organization, 2024 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies). https://eurohealthobservatory.who.int/publications/m/a-mapping-exercise-making-the-case-for-public-investment-in-health

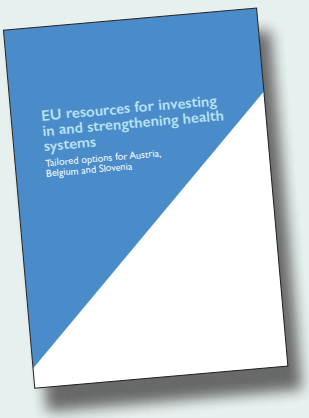
4 Mauer N, Durvy B, Panteli D. *EU resources for investing in and strengthening health systems: Tailored options for Austria, Belgium and Slovenia*. World Health Organization, 2024 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies). https://eurohealthobservatory.who.int/publications/m/eu-resources-for-investing-in-and-strengthening-health-systems-tailored-options-for-austria-belgium-and-slovenia

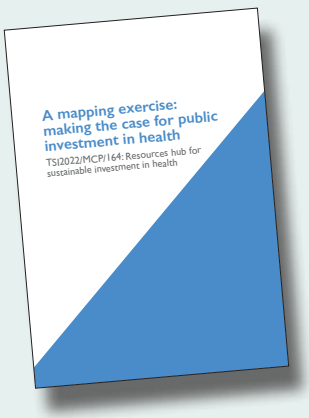
5 Fahy N, Mauer N, Panteli D. *European support for improving health and care systems*. Policy Brief 43. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2021. https://eurohealthobservatory.who.int/publications/i/european-support-for-improving-health-and-care-systems

6 Mauer N, Panteli D, Fahy D, De La Mata I. European Union support for health systems in the pandemic and beyond. *Eurohealth* 2022;28(1):46–50. https://iris.who.int/handle/10665/351084

7 Mauer N, Panteli D, Eichwalder S. Investment in health: supporting countries with implementing health system reforms. *Eurohealth* 2022;28(3):35–9. https://iris.who.int/handle/10665/362205

8 Rauch J. European Health Investment Hub. *Eurohealth* 2023:29(3):13. https://iris.who.int/handle/10665/375423





CORPORATE POLITICAL ACTIVITY IN EU POLICYMAKING: AN OBSTACLE TO ACHIEVING NONCOMMUNICABLE DISEASE TARGETS?

By: Daša Kokole, Catherine Paradis, Maria Neufeld, Kathrin Hetz, Sumudu Kasturiarachchi, Angela Ciobanu, Carina Ferreira-Borges, Kremlin Wickramasinghe and Gauden Galea

Summary: Europe faces a high burden of noncommunicable diseases (NCDs), yet implementation of effective prevention policies remains slow. Many countries are not on track to reach targets before the 2025 4th United Nations' High-level meeting on the Prevention and Control of NCDs. One reason for delayed policy implementation is corporate political activity. This article examines strategies of the unhealthy commodity industries (focused on tobacco, nutrition and alcohol) to shape public policies in ways that further corporate interests, and discusses examples of these practices in European Union policymaking – both historically and in recent developments such as Europe's Beating Cancer Plan.

Keywords: *Corporate Political Activity, Commercial Determinants, Tobacco, Nutrition, Alcohol*

> #EHFG2024 – Session 7:
An unhealthy profit – tackling obstacles to achieving the NCD targets. Is democratic policymaking being undermined by the political practices of commercial actors?

Daša Kokole is Consultant, **Catherine Paradis** is Technical Officer, **Maria Neufeld** is Technical Officer, **Carina Ferreira-Borges** is Regional Adviser, Alcohol, Illicit Drugs and Prison Health, Special initiative on NCDs and Innovation, WHO Regional Office for Europe, Copenhagen, Denmark; **Kathrin Hetz** is Consultant, **Sumudu Kasturiarachchi** is Consultant, **Kremlin Wickramasinghe** is Regional Adviser, Nutrition, Physical Activity and Obesity, Special initiative on NCDs and Innovation, WHO Regional Office for Europe, Copenhagen, Denmark; **Angela Ciobanu** is Technical Officer, Tobacco, Special initiative on NCDs and Innovation, WHO Regional Office for Europe, Copenhagen, Denmark; **Gauden Galea** is Strategic Adviser to the Regional Director, Special Initiative on NCDs and Innovation, WHO Regional Office for Europe, Copenhagen, Denmark.
Email: kokoled@who.int

Delayed progress in achieving noncommunicable diseases targets

In the World Health Organization (WHO) European Region, noncommunicable diseases (NCDs) such as cancer, cardiovascular disease, diabetes and respiratory disease account for approximately 90% of deaths and 85% of disability-adjusted life years.[1,2] A large proportion of these deaths is attributable to preventable and modifiable risk factors such as unhealthy diet, insufficient physical activity as well as tobacco and alcohol consumption.[3]

The year 2025 will mark the 4th High-level meeting of the United Nations (UN) General Assembly on the Prevention and Control of NCDs, following the previous meetings in 2011, 2014 and 2018. This meeting will provide an opportunity to evaluate the existing progress in achieving NCD-related targets as well as to adopt a new political declaration on NCDs towards 2050 that will serve as an

important framework to accelerate the global NCD response from 2025.[4] This action is urgently needed in light of the aforementioned burden of disease and the slow progress on achieving those voluntary targets.[5]

There are multiple reasons behind this lack of progress, including one which is gaining increased attention: the role played by the unhealthy commodity industries (UCIs) in policymaking.[6] Corporate political activities are defined as *"Practices to secure preferential treatment and/or prevent, shape, circumvent or undermine public policies in ways that further corporate interests"*.[7] They are closely related to the broader concept of the commercial determinants of health that was recently spotlighted in the commissioned Lancet series [8] as well as in the new report on the Commercial Determinants of NCDs in the WHO European Region,[9] as the *"the systems, practices and pathways through which commercial actors drive health and equity"*. This article will briefly outline the key strategies of the UCIs (with a focus on tobacco, alcohol and nutrition) contributing to interference in the regulation of their products, and discuss examples of how these practices have been visible in policymaking in the context of the European Union (EU), both historically and more recently with the progress of Europe's Beating Cancer Plan (EBCP).

Framing and action strategies of the unhealthy commodity industries

In a recent article, Ulucanlar and colleagues [7] developed a model and evidence-informed taxonomy of UCIs' corporate political activity based on mixed-methods synthesis and validation of existing taxonomies and evidence. The main identified action strategies are summarised in **Table 1**.[7]

It is important to note, however, that in addition to these activities, the authors find that corporate actors also promote the following narratives:[7]

- **Health problems are attributed to individual lifestyles and choices**, with health harms either not caused by the industry's products or being exaggerated. These harms are portrayed as arising from consumption patterns of atypical minorities and shift responsibility to individuals;
- **Focus on self-regulation and targeted individual interventions are portrayed as appropriate solutions**, thereby avoiding or delaying regulation to avoid disrupting businesses. Policies focusing on the whole population are deemed unnecessary and are argued to lead to losses for businesses, the economy and society;
- **Corporations frame themselves as playing a key role in the economy, society, policymaking, science and public health**, positioning themselves as part of the solution. They also question the skills and motives of policymakers and the public health community supporting unfavourable policies.[7]

These framing and action strategies are directed both towards short-term objectives aimed at solving specific policy 'problems' (such as diffusing attempts of product regulation) and long-term objectives directed at creating an enduring corporate-friendly policy environment, including through shaping the public discourse.[7]

Table 1: Taxonomy of action strategies of corporate actors

ACTION STRATEGIES	DESCRIPTION
Access and influence policymaking	accessing policymakers and policy spaces, attempting to influence policy processes and outcomes and managing policy venues
Using the law to obstruct policies	using or threatening legal challenges to policy and undermining the policymaking/public health community through legal means
Manufacture public support for corporate positions	coordinating and managing industry strategies, forming business alliances, securing support beyond business, fabricating allies, operating through third parties and maximising corporate favourable media content
Shape evidence to manufacture doubt	undermining and marginalising unfavourable research, while producing or sponsoring favourable research, blending the latter into public discourse
Displace and usurp public health	undermining the rationale for statutory policies on corporate practices, promoting individual-level interventions and harm reduction as a public health goal, delivering education and training to public health professionals and weakening the public health community
Manage reputations to corporate advantage	repairing and nurturing corporate reputations and discrediting public health community

Source: summarised from [7]

Policymaking in the EU and the role of the unhealthy commodity industries

Europe's Beating Cancer Plan (EBCP) has been a significant initiative by the European Commission to combat cancer across four pillars: i) prevention, ii) early detection, iii) diagnosis and treatment, and iv) quality of life of cancer patients and survivors.[10] The ambitious plan published in 2021 among other things pledged to *"help create a 'Tobacco Free Generation' by 2040"*, reach *"the interim goal of the WHO target of a 30% relative reduction in tobacco use by 2025 as compared to 2010"*, and *"achieve a relative reduction of at least 10% in the harmful use of alcohol by 2025"*. Some of the key initiatives were revision of the tobacco-related directives, which would review the excise taxes for tobacco and revisit whether more novel products (such as nicotine pouches) should be covered under Tobacco Products Directive's rules; propose mandatory front-of-pack nutrition labelling and mandatory labelling of ingredients and nutrition declaration on alcoholic beverage products as part of revising the Food Information to Consumers Regulation; develop proposal on health warnings on alcoholic beverage products, as well as review the EU legislation on taxation of alcoholic beverages, specifically on minimum

rates of duty on alcohol and alcoholic beverages which have not been reviewed since 1992.[11]

In a 2023 issue of Eurohealth, Lambert and colleagues looked at the progress of the legislative agenda of the NCD-related initiatives in EBCP in relation to alcohol, tobacco, and nutrition and concluded that the foreseen legal measures did not progress according to the initial timelines indicated in the Plan and the majority of the planned legal initiatives remained behind schedule.[12] In February 2024, the European Commission published an updated Implementation roadmap of EBCP [11] which lacked reference to concrete timelines for many of these proposals – indicating uncertainty about their future. Some of these changes may have been politically motivated, with controversial files being shelved before the European elections.[13] However, the influence of commercial actors in Brussels also deserves scrutiny. Investigations by academics, journalists, and civil society organisations, as presented below, show that representatives of UCIs have access to the European Commission both directly in Brussels and through national authorities of EU Member States.

Tobacco policies

Pre-EBCP initiatives to regulate tobacco at the EU-level have already been subjected to strong pressure by the economic operators. For example, the Tobacco Product Directive 2 (laying down rules on manufacture, presentation and sale of tobacco and similar products) was found to be one of the most highly lobbied pieces of legislation in the EU, with Philip Morris International spending €1.25 million and employing over 160 lobbyists on a campaign targeting the policymakers at various stages of the policymaking process, aiming to *"block, amend and delay"* the passage of the directive.[14] Some of those lobbyists were previously working as politicians or civil servants in the EU institutions. Furthermore, the lobbying strategies involved using a coalition of third parties focused on establishing political support from non-health commissioners.[14] The *"Smart Regulation"* mechanism facilitated meetings between tobacco companies and European Commission representatives, often undisclosed. The lobbying efforts had partial success, as plain packaging and point of sales display ban were removed from the proposal text during the during the proposal drafting stage".[14] [15]

Analysis of the tobacco industry's presence in the EU policymaking environment showed that in 2022 (the year with the last available data), the tobacco industry overall declared spending €19 million on lobbying activities – an increase of 28% compared to 2021.[16] The lack of transparency around meetings between the Commission and tobacco industry representatives was criticised by the European Ombudsman – more specifically, their inquiry concluded that the European Commission failed to ensure a comprehensive approach across all its departments.[16] The ombudsman also noted lack of systematic assessment across Directorate Generals whether such meetings are necessary in the first place [16] – in line with the WHO Framework Convention on Tobacco Control (FCTC) Article 5(3), whose guidelines stipulate that *"Parties should interact with the tobacco industry only when and to the extent strictly necessary to enable them to effectively regulate the tobacco industry and tobacco products"*.[17]

Nutrition policies

During the 2010 negotiations for food labelling regulations, the Confederation for the Food and Drink Industries of the EU invested €1 billion to counter proposals for front-of-pack traffic light labels. Instead, they advocated for a labelling system based on guideline daily amounts, a non-interpretive system that is considered to be more difficult for the consumers to understand. This industry-preferred approach was ultimately incorporated into Regulation 1169/2011, demonstrating the substantial impact of economic operators on EU nutritional policymaking.[18]

Over a decade later, EBCP plans for a mandatory EU-wide proposal on nutritional labelling have once more been stymied, and inquiries by civil society organisations requesting access to relevant documents have shown that the commercial actors had disproportionate access to the European Commission when compared to civil society organisations, and in their meetings (sometimes arranged through connections within Member States), the arguments used were echoing those from more than a decade ago, promoting own labelling schemes in place of the evidence-based ones.[19]

Alcohol policies

Alcohol as a public health issue has been a contentious topic since the beginning of discussions on how to reduce alcohol-related harm at the EU-level. The production of background documents for the EU alcohol strategy was subjected to intense lobbying,[20] and the final strategy in 2006 relied heavily on industry's self-regulation while ignoring other potentially high-impact measures such as price increase via taxation, or reducing availability.[21] The case of alcohol health warnings demonstrates a recurring pattern in EU policy-making.

> corporate political activities demonstrate large power asymmetry

In 2007, the health committee of the European Commission proposed a clause in the alcohol strategy motion that could have required health warnings on all alcoholic beverages across the EU. The clause stated: *"Health warnings on alcohol may require European harmonisation similar to health warnings on tobacco. Commission is asked to publish before 1 January 2010 either a legislative proposal to introduce health warnings on alcoholic beverages, or a communication to explain why, in contrast to health warnings on tobacco, the introduction or harmonisation of health warnings on alcohol is not necessary"*.[22] However, when the European Parliament adopted the resolution two months later, this clause

had been significantly altered, eliminating the possibility of mandatory health warnings.[22]

Fifteen years later, the Special Committee on Beating Cancer put forward the motion to adopt a version of the Resolution on the fight against cancer, which expressed support for *"the provision of better information to consumers by improving the labelling of alcoholic beverages to include health warning labels"*.[23] However, reference to health warning labels was removed from the final resolution and replaced with support for the *"moderate and responsible drinking information"*, and the same framing then appeared in the Report on NCDs of the Committee on the Environment, Public Health and Food Safety a year later.[24]

> necessitating continuous vigilance and strategic interventions to counter their influence

Seen from a health perspective, certain activities linked to the European Institutions seem counterintuitive. An example is the European Beer Group, which is owned by the Members of the European Parliament, while the technical support is provided by an association representing the beer producers.[22,25] The alcohol industry also appears to have disproportionate access to the European Commission when compared to civil society organisations.[26]

Conclusions and next steps

The examples presented above show that the representatives of UCIs engage in similar activities across different fields, employing well-established strategies beyond their involvement in EBCP. These representatives have disproportionate access to EU policymakers (as compared to other stakeholders such as civil society organisations), facilitated by their substantial lobbying budgets, extensive networks of lobbyists, and relationships. It is important to recognise that such access does not only happen at the EU-level but also nationally. Beyond access to policymakers, the examples presented above also show other action strategies of corporate actors mentioned in the key taxonomy presented in **Table 1**, such as operating through third parties, shaping narratives on the evidence, and nurturing corporate reputations.

Such corporate political activities demonstrate large power asymmetry and should not be considered as an ordinary phenomenon in participatory democracy, but rather as a corruption of democracy.[7] To confront this threat, Gilmore and Van der Akker[27] recommend drawing lessons from tobacco control, emphasising *"a deliberate focus on the tobacco industry as an object of public health inquiry and action"*, and recognising *"the inherent conflict between its interests and public health"*. This approach should extend also to other UCIs in order to diminish their influence and reconsider their involvement in policy discussions. However, they also warn that such an approach to protecting against industry influence is insufficient for securing long-term public health advances. Industries will adapt and find new ways to create profits, thus necessitating continuous vigilance and strategic interventions to counter their influence.[27]

Furthermore, looking at the corporate political activity as part of the commercial determinants of health of the NCDs more broadly, the new WHO/Europe report[9] emphasises the need to recognise and target the different levels that commercial influence is exercised on, and address the systems and the environment rather than focusing solely on individual behaviour or responsibility. The policymaking process should be safeguarded from commercial influence through requiring commercial actors to increase transparency and disclosing their contacts with policymakers, providing training for relevant stakeholders on how to recognise the commercial determinants and conflicts of interest, and the management of interactions with commercial actors, including establishment of mechanisms that exclude their engagement.[9]

Finally, the current political system often prioritises the interests of capital and powerful commercial actors over those of public health. Alternative economic models (the "wellbeing economy") are emerging that urge governments to prioritise health, wellbeing, and the environment over profit and productivity as metrics of development.[9]

Declaration of interest

None. CP, MN, AC, CFB, KW and GG are staff members of the World Health Organization; DK, KH and SK are WHO consultants. The authors alone are responsible for the views expressed here and these do not necessarily represent the decisions or the stated policy of WHO.

References

1 World Health Organization. *Global health estimates: Leading causes of death: Cause-specific mortality, 2000–2019*. Geneva: WHO, 2023.

2 World Health Organization. *Global health estimates: Leading causes of DALY: Disease burden, 2000–2019*. Geneva: WHO, 2023.

3 Global Burden of Disease Collaborative Network. VizHub – *GBD Compare*. 2023. https://vizhub.healthdata.org/gbd-compare

4 World Health Organization. *On the road to 2025. Preparatory process for the Fourth High-level Meeting of the UN General Assembly on the prevention and control of NCDs*. Geneva: WHO, 2024. https://www.who.int/teams/noncommunicable-diseases/on-the-road-to-2025

5 World Health Organization. Monitoring noncommunicable disease commitments in Europe 2021: are we on track to reach targets 10 years after the Moscow Declaration and First United Nations High-Level Meeting? Geneva: WHO, 2021. https://www.who.int/europe/publications/i/item/WHO-EURO-2021-4479-44242-62494

6 Pearce N, Ebrahim S, McKee M, *et al*. Global prevention and control of NCDs: Limitations of the standard approach. *J Public Health Policy* 2015;36:408.

7 Ulucanlar S, Lauber K, Fabbri A, *et al*. Corporate Political Activity: Taxonomies and Model of Corporate Influence on Public Policy. *Int J Health Policy Manag* 2023;12:1–22.

8 Gilmore AB, Fabbri A, Baum F, *et al*. Defining and conceptualising the commercial determinants of health. *The Lancet* 2023;401:1194–213.

9 World Health Organization Regional Office for Europe. *Commercial Determinants of Noncommunicable Diseases in the WHO European Region*. Copenhagen: WHO/Europe, 2024. https://iris.who.int/handle/10665/376957

10 Communication from the Commission to the European Parliament and the Council – Europe's Beating Cancer Plan. 2021. https://eur-lex.europa.eu/legal-content/en/TXT/?uri=COM%3A2021%3A44%3AFIN

11 European Commission. Europe's Beating Cancer Plan: Implementation Roadmap. 2024. https://health.ec.europa.eu/system/files/2022-01/2021-2025_cancer-roadmap1_en_0.pdf

12 Lambert J, Borg AM, Galea G, Wickramasinghe K, Costongs C. A renewed call to action: how can the European Union scale-up action on non-communicable disease prevention? *Eurohealth* 2023;29(3):34–9.

13 Andres A, Martuscelli C, Brzezinski B. EU chief quietly kills 'nanny-state' policies with eye on election – POLITICO. 19th February 2024. https://www.politico.eu/article/tactical-retreat-how-ursula-von-der-leyen-is-rowing-back-her-agenda-ahead-of-elections/

14 Peeters S, Costa H, Stuckler D, McKee M, Gilmore AB. The revision of the 2014 European tobacco products directive: an analysis of the tobacco industry's attempts to 'break the health silo'. *Tob Control* 2016;25:108–17.

15 Costa H, Gilmore AB, Peeters S, McKee M, Stuckler D. Quantifying the influence of the tobacco industry on EU governance: automated content analysis of the EU Tobacco Products Directive. Tob Control 2014;23:473–8.

16 Smoke Free Partnership. Tobacco Industry spent almost €20 million to influence EU policymakers, new report finds. https://www.smokefreepartnership.eu/news/tobacco-industry-spent-almost-%E2%82%AC20-million-to-influence-eu-policymakers-new-report-finds

17 Guidelines for implementation of Article 5.3. https://fctc.who.int/publications/m/item/guidelines-for-implementation-of-article-5.3

18 A red light for consumer information | Corporate Europe Observatory. https://corporateeurope.org/en/2010/06/red-light-consumer-information

19 Food Label Ambush: How intense industry lobbying halted EU plans–Consumer Corner. https://www.beuc.eu/blog/food-label-ambush-how-intense-industry-lobbying-halted-eu-plans/

20 Baumberg B, Anderson P. The European strategy on alcohol: a landmark and a lesson. *Alcohol and Alcoholism* 2007;42:1–2.

21 Gordon R, Anderson P. Science and alcohol policy: a case study of the EU Strategy on Alcohol. *Addiction* 2011;106:55–66.

22 Gornall J. Alcohol and public health. Europe under the influence. *BMJ* 2014;348:g1166.

23 REPORT on strengthening Europe in the fight against cancer – towards a comprehensive and coordinated strategy. https://www.europarl.europa.eu/doceo/document/A-9-2022-0001_EN.html

24 REPORT on non-communicable diseases (NCDs) | A9-0366/2023 | European Parliament. https://www.europarl.europa.eu/doceo/document/A-9-2023-0366_EN.html#_section1

25 About us | European Beer Group. https://beergroup.eu/about-the-european-beer-group/

26 Lobbying Hangover: How intense alcohol industry pressure put Commission labelling plans on the rocks–Consumer Corner. https://www.beuc.eu/blog/lobbying-hangover-how-intense-alcohol-industry-pressure-put-commission-labelling-plans-on-the-rocks/

27 Gilmore AB, van den Akker A. Protecting future generations from commercially driven health harms: lessons from tobacco control. *The Lancet* 2024. DOI:10.1016/S0140-6736(24)01128-0.

New Denmark HiT 2024

Edited By: HO Birk, K Vrangbæk, A Rudkjøbing, A Krasnik, A Eriksen, E Richardson, SS Jervelund

Published by: World Health Organization, 2024 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Number of pages: 186, **ISBN:** 1817-6119

Freely available for download:
https://eurohealthobservatory.who.int/publications/i/denmark-health-system-review-2024

Other country HiTs available at:
https://eurohealthobservatory.who.int/publications/health-systems-reviews

This analysis of the Danish health system reviews recent developments in organisation and governance, health financing, health care provision, health reforms and health system performance.

Denmark's health system offers a comprehensive range of services but requires co-payment for outpatient prescription drugs and adult dental care, leading to out-of-pocket expenses. The country's population health is strong, with life expectancy above the EU average, though it lags behind other Nordic nations. Over the past 15 years, Denmark has centralised its hospital sector, but there is a recent shift towards decentralisation to improve care quality in primary and local settings. Digital solutions are integral to the system, but ensuring healthcare availability across the country and addressing significant staffing challenges, especially among nurses, remain critical concerns. Sustaining the health workforce will require long-term policy efforts and changes in working conditions.

HEALTHY PATIENT, HEALTHY PLANET: HOW BETTER CHRONIC DISEASE MANAGEMENT BENEFITS BOTH HEALTH AND THE ENVIRONMENT

By: Stefan Woxström

OPINION PIECE

Summary: Mounting pressure from non-communicable diseases on Europe's health systems is being exacerbated by the impact of climate change, with greater healthcare resource utilisation increasing greenhouse gas emissions. This threatens to create a vicious cycle. We urgently need to shift from reactive 'sick care' models to a proactive approach emphasising prevention, early diagnosis and effective treatment. Public-private partnerships piloting innovative programmes to increase healthcare efficiency and reduce environmental impact have demonstrated initial success. Governments can work to integrate health, economic and environmental policies and scale up best practices to achieve the best outcomes for patients and the planet.

Keywords: *Sustainability, Greenhouse Gas Emissions, Non-communicable Diseases, Climate Change, Prevention and Early Intervention*

> #EHFG2024 – Session 16:
Healthier patient: greener patient. Decarbonising care pathways for people and planet.

Stefan Woxström is Senior Vice President, Europe and Canada, AstraZeneca, Zug, Switzerland.
Email: ava.lloyd@astrazeneca.com

Introduction

The evidence is undeniable: the climate crisis is also a health crisis, and Europe is paying the price. The unsustainable burden of non-communicable diseases (NCDs), responsible for 90% of deaths in Europe,[1] is compounding the effects of climate change. Increased utilisation of healthcare resources is driving up health systems' combined carbon footprint, which already accounts for approximately 4.6% of worldwide greenhouse gas (GHG) emissions. At the same time, climate change is escalating demand on health systems: heat-related deaths globally are expected to triple by 2050 if no action is taken, and at least 1.8 million people die prematurely each year due to air pollution from fossil fuels.[2] This in turn heightens the risk of chronic conditions, including respiratory, cardio-metabolic and neurological diseases, as well as cancers.[2]

This critical relationship between climate and healthcare remains under-appreciated despite recent advances in green and healthcare policies in Europe. By recognising and addressing this interconnectedness, it will be possible

to achieve dual benefits for health and the environment, and position Europe as a global leader in innovation, economic growth and stability.

Moving on from the 'sick care' model

Current models of healthcare delivery have been judiciously described as 'sick care'. A predominant focus on treating those who are already ill means that efforts and funding are deployed too late, when the human, economic and environmental costs are at their highest. As a result, an estimated €700 billion – 80% of healthcare costs – is spent per year on treating chronic disease in Europe.[3] This compares to only 2.7% of total health expenditure spent on prevention in OECD countries.[4]

> achieve dual benefits for health and the environment

Prevention, alongside earlier diagnosis followed by more effective, patient-centred treatment, may allow us to 'do more with less', preserving valuable healthcare resources. Healthy patients are less likely to require hospitalisation or outpatient care, resulting in lower GHG emissions and reducing pressures on already-stretched healthcare systems.[5]

Public-private partnerships: An incubator for policy solutions

Improving patient outcomes while reducing the economic and environmental impact of healthcare systems will require multi-stakeholder collaboration and political commitment. No single entity can achieve this alone. The World Health Organization (WHO) has made promising first steps [6] and the inaugural Health and Climate Day at COP28 highlighted the urgent need for change.[7] In Europe, the adoption of the Budapest declaration on environment and health signifies recognition of the problem.[8] We must now transform this recognition into practical, large-scale action integrated into healthcare systems.

Public-private partnerships (PPPs) can play a vital role in testing the best ideas in this space. At AstraZeneca, we are leveraging our research and clinical expertise to reduce the carbon impact of treatment pathways across a number of NCDs that significantly impact patients and the environment, in partnership with public bodies.

Strategic PPPs like the *Sustainable Markets Initiative Health Systems Task Force* are critical to scaling action and driving political will towards delivering net-zero health systems. This PPP brings together leaders from global life sciences, healthcare systems, multilateral and policy institutions, and academia, to accelerate the transition towards sustainable healthcare.

Heart failure: Meeting the challenge of timely diagnosis

More than 15 million people in Europe live with heart failure (HF), which is the leading cause of preventable hospitalisations in the European Union (EU) and accounts for approximately 2% of the total healthcare expenditure in developed countries.[9] [10] Late diagnosis often leads to acute hospital admission,[11] with associated personal burden, financial cost and environmental impact.
Early diagnosis is vital for improving outcomes and reducing pressure and costs to healthcare systems. Programmes like Project OPERA, a PPP between AstraZeneca and the National Health Service Greater Glasgow and Clyde, underline the potential to use artificial intelligence (AI) and digital tools to aid HF detection and management. The project used hand-held, AI-powered echocardiogram (ECG) machines to streamline ECG analyses, allowing primary care physicians to undertake initial triage and eliminating the bottleneck leading into secondary care. This reduced ECG waiting times from 12 months to 4 weeks and has meant faster diagnosis for the highest-risk patients and significantly less healthcare resource use. Project OPERA has contributed to an estimated annual reduction of approximately 8 kg of CO_2 emissions, largely a result of reduced hospitalisation. Following this initial success, the Project OPERA model is expanding across the United Kingdom and beyond.*

Chronic kidney disease: Late-stage disease is associated with greater environmental impact

Chronic kidney disease (CKD) affects one in ten adults in Europe and is often diagnosed late.[12] A quarter of a million Europeans rely on dialysis for survival, which can result in a direct annual cost of around €80,000 per patient.[12] CKD is also a major contributor to climate change: dialysis requires 160 billion litres of water per year and generates over 900,000 tonnes of mainly plastic waste.[12] Better screening, early detection and preventative care could minimise costs, both physical and financial, to patients and the planet. Real-world data highlights the need to prioritise prevention, with potential to inform future programmes to address CKD.

The IMPACT CKD study in the United Kingdom measured the consequences of CKD. This study predicted that in-centre haemodialysis will generate around 1.35 megatonnes of CO2-equivalent by 2032, highlighting the large impact that CKD could have on patients, economies and the environment.[13] Similar findings arose in Halland, a region in Sweden, where gaps in CKD care have been shown to cause excess GHG emissions. Early stages of kidney disease, where patients are not on dialysis, are associated with much lower GHG emissions per patient than in end-stage kidney disease.* The Newcastle-upon-Tyne Hospitals NHS Foundation Trust, the Sustainable Healthcare Coalition, and AstraZeneca partnered in the United Kingdom to develop an in-centre, open-access Haemodialysis Carbon Calculator.[14] This tool can be used in clinical centres, allowing clinicians to understand the environmental impacts of haemodialysis. It can help enable the development

* Estimates are based on AstraZeneca data on file, which have not yet been published.

of relevant sustainability initiatives, focused on early detection and secondary prevention of CKD.

Continuing momentum: from ideas to implementation

Often in the field of climate change we talk about 'trade-offs': reducing valuable activities to bring down energy consumption. In healthcare, on the other hand, we have the potential for a 'win-win' scenario. By coming together to transform and improve the healthcare sector with a focus on patients, we can reduce use of healthcare resources and lower carbon emissions simultaneously. For this to happen we need supportive policies in place to turn ideas into implementation.

The EU's Green Deal has begun to set the wider ambition for a competitive, sustainable EU economy. This vision has the potential to acknowledge the critical role of healthcare in achieving green transformation and build it into the plan's foundations. Healthcare is changing as rapidly as the green economy is growing, and we can only achieve the best results for patient and planet by considering the two holistically. We can learn from local and national initiatives – such as Greener NHS [15] in England – and apply current best practices from across the continent.

Digitalisation is a pivotal component to accelerate this transformation. The European Health Date Space (EHDS) [16] holds enormous potential to inform health research and unlock the power of digital healthcare tools to revolutionise care for NCDs. We must ensure that these crucial policy frameworks are established and implemented in a way that benefits the healthcare sector as a crucial part of the green economy.

Change for patients and the planet

Our patients, health systems and planet can't afford for us to delay. As the EU embarks upon a new five-year political cycle, we offer three principles to consider, to support a patient-focused green transition in healthcare:

1. Encourage prevention and early intervention

Europe's governments can prioritise the transition from 'sick care' to 'health care' by emphasising early detection and diagnosis. As seen in research in CKD and elsewhere, this is often incorporated into guidelines, but not always carried out in practice. One practical step is the promotion of co-created healthcare pathways and quality standards, encouraging widespread, 'ground-up' change. This can be achieved through targeted disease action plans underpinned by a common framework, especially in disease areas with a high burden on patients and the environment.

2. Embrace digital innovation in healthcare

Nurturing innovation is vital to Europe's future competitiveness and climate resilience. The Green Deal presents an opportunity to invest in technologies, like AI-powered solutions demonstrated in Project OPERA, which have the potential to reduce waiting times, lower healthcare resource use and improve outcomes. Policy must facilitate this technological transformation by prioritising data availability (as in the EHDS) and ensuring regulations are pragmatic and patient-focused.

3. Recognise the mutually reinforcing relationship between environment, economic and health policy

Health is a multisectoral concern. The EU needs to think across health, finance, environment, and climate policies, recognising their interconnections. Policymakers can lead the way in promoting 'joined-up thinking' between healthcare and the environment, focusing on decarbonising healthcare as an essential step to protecting the environment and promoting economic growth, both of which are beneficial to health.

A healthier patient is a greener patient. By taking bold action to stem the growing impact of NCDs, we can tackle the climate crisis, taking us one step closer to a healthier future for people, society, our economies, and the planet.

References

1 Vandenberghe D, Albrecht J. The financial burden of non-communicable diseases in the European Union: A systematic review. *Eur J Public Health* 2020;30(4):833–9.

2 Romanello M, Napoli C di, Green C, et al. The 2023 report of the Lancet Countdown on health and climate change: the imperative for a health-centred response in a world facing irreversible harms. *The Lancet* 2023;402(10419):2346–94.

3 Seychell M. Towards better prevention and management of chronic diseases. European Commission Public Health Newsletter, 2016. https://ec.europa.eu/health/newsletter/169/focus_newsletter_en.htm

4 OECD. *Health at a Glance* 2021. Paris: OECD publishing, 2021. https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2021_ae3016b9-en

5 Tomson C. Hospital Infrastructure: Reducing the carbon footprint of hospital-based care, 2015. https://www.supplychain.nhs.uk

6 World Health Organization. Alliance for Transformative Action on Climate and Health (ATACH). https://www.who.int/initiatives/alliance-for-transformative-action-on-climate-and-health

7 World Health Organization. *Health at COP28,* 2023. https://www.who.int/teams/environment-climate-change-and-health/climate-change-and-health/advocacy-partnerships/talks/health-at-cop28

8 WHO Regional Office for Europe. Budapest Declaration: Accelerating action for healthier people, a thriving planet, a sustainable future, 2023.

9 European Heart Network. Heart Failure and Cardiovascular Diseases, 2019. https://ehnheart.org/wp-content/uploads/2023/08/EHN-heart-failure-paper_final_180419.pdf

10 Luxembourg Institute of Health. Healing Europe's heart: a mission to conquer heart failure. https://www.lih.lu/en/article/healing-europes-heart-a-mission-to-conquer-heart-failure

11 British Heart Foundation. Rushed to hospital: when heart failure isn't diagnosed early enough, 2019. https://tinyurl.com/BHFLateHF

12 Economist Impact. Chronic Kidney Disease: Driving change to address the urgent and silent epidemic in Europe, 2023. https://impact.economist.com/perspectives/health/chronic-kidney-disease

13 Jose J, Sanchez G, Wheeler DC, et al. The growing burden of chronic kidney disease in the UK: An IMPACT CKD analysis, 2024. https://academic.oup.com/ndt/article/38/Supplement_1/gfad063c_4271/7196773

14 Sustainable Healthcare Coalition. ICHD Carbon Calculator, 2024. https://ichdcarbon.org/

15 NHS England. Greener NHS, 2023. https://www.england.nhs.uk/greenernhs/

16 European Health Data Space. https://health.ec.europa.eu/ehealth-digital-health-and-care/european-health-data-space_en

RETHINKING SOCIAL CONTRACTS IN A RISK SOCIETY

By: Ilona Kickbusch

Summary: Globalisation, major inequities and modernity are bringing about major social transformation, which "detraditionalizes" societies. In consequence, social contracts that have their origin over 150 years ago no longer reflect the real-life experiences of people today. In addition, the security offered by these contracts does not align with the preferences of new generations regarding how they want to work and how they want to live. The impact of new technologies, the continuing burden of risk on women, and the crisis of climate change make it worthwhile to revisit the social contract and to be bolder in our proposals for change.

Keywords: *Social Contract, Risk, Polycrisis, Social Protection, Wealth Redistribution*

> **#EHFG2024 – Session 19:** Renewing the social contract in Europe. Building new bridges for health and well-being.

Ilona Kickbusch is Founder and Chair, Global Health Centre, Graduate Institute Geneva, Switzerland. Email: kickbusch@bluewin.ch

Introduction

The polycrisis brings back the discussions on the risks we are exposed to as a consequence of globalisation, major inequities and modernity. Already twenty years ago the German sociologist Ulrich Beck maintained that we live in a risk society – a society where risk is at the centre of everyone's lives. Risk is the anticipation of the disaster *now*, and as risks mount so do the question about common responsibility and collective responses. Throughout Europe there is a debate about the social insecurity that ensues from different types of shocks, and the nature of social contracts that seem to no longer provide sufficient security. Problems transcend borders and new challenges emerge "at home" that redefine the role of governments, businesses and citizens and can threaten established systems of unity and solidarity. Trust in government, institutions, media and science has declined in many countries – and even in health systems which tend to rank high on trust.[1] Beck outlined the paradox that due to evolutions ("progress") in technology and science, risks are increasing, leading to what he has called "the world risk society".[2] Were he still alive today, he would find many of his concerns reflected in our discussions on the digital transformation and the risks of artificial intelligence (AI).

The challenge we face

While longstanding issues such as social protection, access to healthcare and fighting poverty remain as critical as ever, challenges such as climate change, pandemic response and digitalisation have gained high relevance for collective action. They often seemed very abstract to the general public in terms of their impact on everyday life and ways of living. People rarely associate them with the long tradition of solidarity to counter risks and generally dissociate them from their own behaviours. But security seems less certain now that Europe has recently experienced a pandemic, floods, large numbers of migrants, restructuring of

industries and the rapid development of AI. Indeed, there often seems to be a new conflict between the classic "social" and the new "environmental" challenges not only in terms of budgetary allocations by governments but also in terms of societal narratives and who is "to blame". The same is true for what is expected of the state and what we expect from others (and ourselves). What is left and right in the political debate becomes less clear as societies discuss who and what will keep them safe, or who and what is a threat.[3] And most recently – with war raging in Europe – there is a conflict between spending for traditional military security and the needs of modern social security.

For many, it seems that the past was a safer time. Risks no longer remain *"over there"* in other parts of the world – they are *here* for us to deal with. The pandemic clearly played this out. It is also less easy to export European problems – such as the garbage, the plastics, the pollution and even people. The World Health Organization (WHO) states, "No one is safe unless everyone is safe". This cross-border narrative of solidarity and security calls for the support to "others" – like development assistance or integration of migrants. As Minouche Safik further states, *"social contracts shape every aspect of our lives, including how we raise our children and engage in education, what we expect from our employers, and how we experience sickness and old age. All of these activities require us to cooperate with others for mutual benefit, and the terms of that cooperation define the social contract in our society and the shape of our lives".*[4]

Many consider the existing social contracts to be broken, with some analysts judging this to be one of the reasons for the weakening of democracy and the increased political polarisation within Western societies.[5]

The origins of the social contract

For Europe, the idea of the social contract originates with philosophers in European Enlightenment – which is not to say that other cultures and parts of the world do not have their own understandings and traditions in relation to social contracts.[6] Originally the social contract was understood to be between the state and the citizens – the latter give up some of their freedoms and decision-making power in return for political and social order, security and the protection of rights. They in turn respect each other's life, liberty and property and thus contribute to the common good. Over time, a wide range of social issues – including health – were redefined as social rights, leading up to the declaration of health as a human right, as expressed in the WHO constitution and now considered as a central piece of any health solution, whether national or international.[7]

But rights alone are not sufficient – already in 1755, in his *Discourse on the Origin of Inequality* Jean-Jacques Rousseau, raised the issue of social inequality and its relation to private property. The path breaking work of the philosopher John Rawls, who in 1971 developed a highly influential theory of justice as fairness [8] outlined two principles of social justice of which especially the *difference principle* has had a powerful influence in defining the social contract for health, both nationally and globally. It states that actions on equity must not only be based on *conditions of fair equality of opportunity;* but that they must *"be to the greatest benefit of the least-advantaged members of society (the Difference Principle)".*[9] This principle of fairness has become central to all health discussions, first launched by the WHO through its 2008 seminal report on the Social Determinants of Health.[10]

The ideological conflict – the citizen and the state

This understanding of rights, equity and fairness goes far beyond what was originally considered the role of the state and its institutions, but it follows the trajectory set in the late 19th and early 20th century, mainly in Europe. With the rise of communism, the critique of capitalism and the increasing fear of social uprisings, the strength of the workers movements and social democracy as well as new challenges arising through radically different forms of work and social organisation, a new dimension of the social contract was introduced. The state would ensure that the social needs of citizens were met. In health one of the historical starting points was the model of social insurance for workers introduced by Fürst Bismarck maintaining that *"... those who are disabled from work by age and invalidity have a well-grounded claim to care from the state."* In Germany the "sickness" insurance was enacted in 1883, the workers' compensation program provided contributory retirement benefits and disability benefits established in 1884 and unemployment insurance was added in 1927. The state ruled participation to be mandatory and contributions were taken from the employee, the employer and the government. This led to a model of a comprehensive system of income security based on social insurance principles that has survived two world wars, fascism and radically different forms of government.[11]

> better rules around global taxation

These new components included in the contract between the state and the people led to redefinitions of the understanding of political and social order, security and the protection of rights throughout the 20th century – and enabled the expansion of the social contract. Now the claim to the state was for social protection, social security and the guarantee of not only individual but also social rights, and not only for men but also for women. The fight for women's suffrage is a significant part of this development. Early on, the Soviet State proclaimed just after the 1917 Russian Revolution that the protection of the people's health was the basic concern and duty of the Soviet state *"which is vitally interested in promoting people's health prolonging their lives and improving their wellbeing."* [12] A wide range of social protection measures were introduced as part of the social contract including many of the issues we today classify as the social determinants of health: housing, pensions, work compensation, paid maternity leave, nutrition and employment conditions and overseen by a range of state agencies in consultation with Narkomzdrav *(Commissariat for Public Health).*[13]

This expansion of the understanding of the social contract as providing social security in the widest sense became a defining feature of the competition between (political) health systems during the Cold War – with the USA firmly committed to individual rights (despite Franklin D. Roosevelt's New Deal in the 1930s), the Soviet Union and its allies to social and communal rights and Europe (and the United Nations) uneasily in the middle. Meanwhile the Nordic welfare states were expanding, and Britain had introduced the Beveridge system, creating a new "crown jewel" the National Health Service. Indeed, the welfare state determines and mediates the extent of inequalities in health through healthcare, social policy and public health as many studies show.[14] This scope of action is reflected in the WHO's constitution and the definition of health it provides, where physical and mental health were expanded to include "social health" as a code for the social determinants that the Soviet Union wanted to introduce.

What's the deal?

The contract of citizens with the state is one thing – the other is the contract between citizens, which in many cases is mediated by the state. If health is a human right and if such a right implies equity and fairness, then this must be reflected in equal access and fair means of financing. It should also be evident in everyday life and in our social interactions. In many of our societies, we have an implicit agreement – or at least we believe we do – where we raise children, pay taxes or health and social insurance fees according to our means, and expect to be cared for when we are ill or when we grow old. There is a strong element of redistribution in our "welfare" contracts, but if we contribute to the common good then we expect a return when we are in need. Minouche Safik maintains that this is no longer the case: existing social contracts *"no longer deliver on people's expectations for both security and opportunity,"*[4] and we might also add fairness, as stipulated by John Rawls. A new approach is needed, as public services, health services and the social safety net fail to provide what are life essentials for many parts of the population. This issue is particularly acute for women, whose right to their bodies, including reproductive rights, are consistently challenged.

But how would we deliver security under conditions of uncertainty? How can we share risks, especially if so many of them are related to factors that no single government can control on its own? Or provide security and rights to people that are not recognised as citizens? Or are particularly vulnerable? The new social contract – says Safik – depends on three pillars: *security, shared risk, and opportunity* – it is about fundamentally reordering and equalising how opportunity and security are distributed across society, between generations, and between men and women.[4] As in Bismarck's time we face new challenges arising through radically different forms of work – especially women having entered the labour market – and different forms of social organisation, such as the relationship between men and women, new family structures with a high number of one parent families, and the significant increase of older people. Adding to this are the increasing risks from climate change, global financial markets, and advancements in digital technology and AI. The challenges posed by these factors require a new social logic around which social contracts are constructed. Beck proposes that our societies will need to consider not only wealth distribution but risk distribution; as in both, burdens are not shared equally. Once more, women in most societies bear a higher burden of risk.

We face digital worlds that divide us, a consumer society prone to individualisation, identity groups fighting for their rights, ideological and religious differences stemming from migration, and wars that need to be financed. New groups expect traditional rights – like being able to marry – but gaining rights can also not be enough. Women are still not safe in our societies; they are subject to femicide, earn less and are, on average, poorer than men when old. They also provide most informal care. Safik proposes new models to share risks around childcare, health, work, and old age that cause so much anxiety, but she underestimates the differentiation principle. She includes taxation and proposes minimum income and higher investments in education and healthcare, which would result in higher productivity at the national level. At the international level, she envisages better rules around global taxation so that companies pay taxes where economic activity takes place for the benefit of the people where those companies operate.

> bolder in our proposals for change

But something much larger needs to be considered. Following Ulrich Beck, we are witnessing a major social transformation which "detraditionalizes" societies. As a result, social contracts that have their origin over 150 years ago no longer hold for the real-life experiences of people, and for new generations the security provided does not relate to how they want to work or how they want to live. When Beck put forward his theory of the global risk society, he was heavily criticised.[15] But the discussion today on the limits of our existing social contracts, the impact of new technologies, the continuing risk burden of women, and the crisis of climate change make it worthwhile to revisit his ideas, and in consequence, to be bolder in our proposals for change.

References

1 Eurofound. Trust in national institutions is falling: Data behind the decline. Eurofound, 2022. https://www.eurofound.europa.eu/en/blog/2022/trust-national-institutions-falling-data-behind-decline

2 Wimmer J, Quandt T. Living in the risk society: An interview with Ulrich Beck. *Journalism Studies* 2006;7(2):336–47.

3 Kaukiainen K, Kurikka K, Mäkelä, H, et al. Narratives of Fear and Safety. Tampere, Finland: Tampere University Press, 2020. https://library.oapen.org/handle/20.500.12657/41530

4 International Monetary Fund. What we owe each other: A new social contract. *Finance & Development,* 2021. https://www.imf.org/external/pubs/ft/fandd/2021/04/what-we-owe-each-other-book-minouche-shafik.htm

5 McCoy J, Press B. What Happens When Democracies Become Perniciously Polarized? Carnegie Endowment for International Peace, 2022. https://carnegieendowment.org/research/2022/01/what-happens-when-democracies-become-perniciously-polarized?lang=en

6 Youvan D. *The Social Contract: Origins, Evolution, and Contemporary Implications*. 2023.

7 WHO. Constitution of the World Health Organization. Geneva: World Health Organization, 2020. https://www.who.int/about/governance/constitution

8 Rawls J. *A Theory of Justice: Original Edition*. Cambridge, MA: Harvard University Press, 1971.

9 Orji CP. The social contract from the lens of John Rawls' veil of ignorance: A philosophical analysis. *IGWEBUIKE: An African Journal of Arts and Humanities* 2023;9(4):314–30.

10 WHO. Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva: World Health Organization, 2008. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1

11 ILO. From Bismarck to Beveridge: Social security for all. Geneva: International Labour Organization, 2009. https://www.ilo.org/publications/bismarck-beveridge-social-security-all

12 Vinogradov, N. *Health Protection in the Soviet Union*. Moscow: Foreign Languages Publishing House, 1956.

13 Birn A, Krementsov N. 'Socialising' primary care? The Soviet Union, WHO and the 1978 Alma-Ata Conference. *BMJ Global Health* 2018;3:e000992.

14 Pförtner TK, Pfaff H, Elgar FJ. The Role of Welfare State Characteristics for Health and Inequalities in Health from a Cross-National Perspective: A Critical Research Synthesis. *KZfSS Kölner Zeitschrift für Soziologie und Sozialpsychologie* 2019;71:465–89.

15 Jarvis DSL. Ulrich Beck, Globalization and the rise of the risk society: A critical exegetic analysis. Lee Kuan Yew School of Public Policy Research Paper No. LKYSPP08-003, 2008. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1162662

Health system summaries

Edited By: A Maresso (series editor)

Published by: World Health Organization, 2024 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Number of pages: 186, **ISBN:** 1817-6119

Freely available for download: https://eurohealthobservatory.who.int/publications/HiT-summaries

Health System Summaries are stand-alone, concise documents summarising the main elements of a country's health system in an engaging, policy-relevant way. They analyse core evidence and data on the organisation, financing and delivery of health care. They also provide insights into key reforms and the varied challenges of testing the performance of the health system.

The information is taken from the most recently published Health Systems in Transition (HiT) review on that country and will be updated every two years, starting from 2022. All newly published HiTs will be accompanied by a new Health System Summary. Like HiTs, Health System Summaries follow a common template and allow comparisons across countries. This new series of Health System Summaries is being compiled gradually and aims to be a complementary resource to HiTs, enhancing the Observatory's country monitoring activities and supporting rapid access to country evidence.

REALISING FOOD DEMOCRACY BY TACKLING "FEAR OF THE MASSES" IN PUBLIC DEBATES

By: Samuele Tonello and Anant Jani

Summary: The unsuccessful end of the European Union's Farm to Fork policy is another example of what seems to be an insurmountable gap between the development of 'good' strategies and their implementation. This gap necessitates a search for alternative forms of food system governance. Several voices are now calling for governance based on food democracy, with more power in the hands of the populace. However, this call is often jeopardised by a dominant ochlophobia, the fear of the masses, in the public debate. This article explores the importance of overcoming ochlophobia in food system governance and advocates for addressing wealth power as a crucial step forward.

Keywords: *Farm to Fork Strategy, Food Democracy, Ochlophobia, Wealth Power, Food Policy*

> #EHFG2024 – Session 23: Europe's unhealthy and unjust food systems. New policies to promote better food environment.

Samuele Tonello is EuroHealthNet Senior Research Coordinator, Brussels, Belgium; **Anant Jani** is Research fellow at the Heidelberg Institute of Global Health, Germany and University of Oxford, UK and coordinator of the Horizon project FEAST. Email: s.tonello@eurohealthnet.eu

The gap between policy strategies and policy implementation

At the beginning of 2020, the European Commission launched Farm to Fork (F2F) [1] a strategy at the heart of the European Union (EU) Green Deal,[2] which aimed to make European food systems more just, healthy, and environmentally friendly. The approach of F2F was quite 'new', as it moved beyond a narrow focus only on food production to consider all parts of the food value chain, including production, processing, distribution, retail, consumption, and waste management.

As outlined online* and defined by the Food and Agricultural Organisation (FAO), food systems "encompass the entire range of actors and their interlinked value-adding activities involved in the production, aggregation, processing, distribution, consumption and disposal of food products that originate from agriculture, forestry or fisheries, and parts of the broader economic, societal and natural environments in which they are embedded." [3] This comprehensive perspective was finally placed at the forefront of the EU food policy agenda with F2F.

The political debate surrounding F2F in the following years was intense, especially with respect to the implementation of the legislative framework for sustainable food systems (FSFS),[4] the flagship initiative of F2F. FSFS was supposed to be implemented by the European

* See Global Food System Map at: https://image.slidesharecdn.com/shiftnglobalfoodsystemmaps-160114131223/75/Global-Food-System-Map-2-2048.jpg

Commission by the end of 2023, but eventually, almost all the policies foreseen by F2F have been paused or dismissed.[5] What started as a strategy promising to finally implement a systemic view for EU food system governance eventually became another example of a good strategy that was watered down before its implementation.

The reasons for this failure are multiple and complex but a key factor was the significant power inequality among the different food value chain stakeholders in their ability to influence EU food system policymaking. In particular, and in line with what was highlighted by recent literature on the Commercial Determinants of Health (CDoH) [6] (World Health Organization, 2024), a key issue was the disproportionate influence corporate lobbies have on the policy process, and especially on food system governance.

The strategies used by the agri-food corporations are similar to those used by tobacco, alcohol and fossil fuel corporations. Lobbying is the most documented activity,[7] but there are several other ways large food corporations influence governance. These include influencing the political economy framework to favour neoliberal economic policies,[8] limiting corporate liability,[9] and creating doubts about the value and legitimacy of opposition from academics and civil society organisations.[10]

Currently, it is difficult to pinpoint causal linkages between these different activities and their influence on policymaking and governance, but some instances of the impact of corporate lobbying are well documented. For example, the implementation of the mandatory Front of Package Labelling [11] and the legislation on the reduction of chemical pesticides were heavily influenced by corporate lobbying (see article by Kokole et al., in this issue).

Given the importance of the EU's food systems, a fundamental question is not *if* but *how* we can prevent this type of interference from occurring again in the future.

Table 1: Approaches to food system governance that empower the populace

APPROACH	KEY FEATURES
Food Sovereignty	This is the right of individuals, peoples, communities, and countries to define their own food policies which are ecologically, socially, economically and culturally appropriate to their unique circumstances. This paradigm focuses on developing forms of collective autonomy across the food value chain, from production to waste, at a local level, so that control over the food system remains in the hands of farmers, for whom farming is both a way of life and a means of producing food.
Food citizenship	Centres on the competencies and skills that individuals need so they can act as food citizens, namely actors that are not involved only as consumers in the food system, but as participants who shape it. Stressing this division between consumers and citizens helps to explain that individuals must be better aware of how the food system works, more involved in the decision-making process, better educated about the processes structuring current decisions. Moving from consumers to citizens, individuals can thus increase their willingness to create a just and sustainable food system.
Food as commons	Aims to deconstruct food as a commodity and treat it instead as, what Ostrom called, a 'commons' – namely a resource that is rivalrous and non-excludable. In other words, the use of the resource by one person reduces availability to others and it is difficult to prevent access to the resource by others. A key aspect of this paradigm is that problems of the food system are based on the commodification of food, which is structural to prioritising economic profit over other values. To change this, it is necessary that food system governance is based on food as a commons, which will allow more just and equal forms of management of the commons.
Food Democracy	This is the paradigm that focuses most on food governance, since it focuses on the structures and social processes that are necessary to make sure that people – and not just a few technocrats – are more involved in the control of the food system. In this way then, it can be conceived as the discussion on which institutions, processes and structures are needed to realise food citizenship and food sovereignty.

Source: authors' own

The problem of ochlophobia in current forms of governance

Over the last few decades, there have been several attempts to develop alternative approaches to the neoliberal paradigm that has dominated recent food system governance (**see Table 1**). These approaches include paradigms such as Food Sovereignty,[12] Food Citizenship,[13] Food Democracy [14] and Food as Commons.[15]

Though differing in their approaches, a commonality across these paradigms is the need to move beyond commoditised food systems managed primary for the profit of large corporations, towards empowering the populace in decision-making.

However, following the dominant rhetoric of the political debate in recent years, one might question whether this is really the solution we should pursue. Given the occurrence of events like the election of Donald Trump in the United States, Brexit in the United Kingdom, the rise of demagogic governments in several European Member States, and the shift of several political parties towards more right-wing positions, are we sure that giving more power to the people is the solution to fix the current problems of the EU's food system governance?

The authors believe the answer to this question is 'yes'. Furthermore, we believe that a core element that will help to underscore the importance of giving more power to the people lies within a concept that may be unfamiliar to many but is essential for understanding current political events: *ochlophobia*.

In standard dictionaries, ochlophobia is defined as the 'extreme or irrational fear or dislike of the crowds'. In politics, this term reflects the fear that masses (due to their perceived irrationality, and uncontrollable behaviour) may jeopardise the stability and overall functioning of a state. The

dominant political rhetoric that followed the aforementioned events is based on this fear. However, this rhetoric is wrong.

First of all, while it is not possible to present here all the evidence to deconstruct the biases exposed by recent political literature, citizens are not as ignorant, irrational and racist as the political debate is depicting them.[16] To take just one example, many seem to have forgotten that in 1975 the United Kingdom already had a popular referendum to determine whether to remain in the European Community. The 'remain side' won by a large margin, despite the fact that racism and anti-immigrant rhetoric were endemic issues of the 60s and 70s United Kingdom politics. Hence, it would be wrong to maintain that Brexit occurred because United Kingdom citizens are now much more racist and ignorant than before.[17]

Furthermore, aforementioned events did not occur as a result of a popular revolt by the masses. On the contrary, these events followed standard democratic procedures, where demagogic parties are able to exploit fallacies in the system [18] and to convey popular discontent into a successful political agenda. This distinction is crucial because the difference between "political engineering" and "mass revolt" goes beyond semantics; it reflects different targets in addressing what we perceive as issues within a democratic system. The former entails that demagogues are exploiting a rigged system for their own interests, while the latter entails a spontaneous action by crowds who, driven by intrinsic biases, end up threatening the well-functioning of society.

As already pointed out centuries ago by Machiavelli in the *Discourses,* the story of democracy and other republics has always been connected to the question of who is the best "guardian of liberty": the many (the population) or the few (the wealthy elites)? It follows that the main political concern becomes who must control the other side.[19]

The ochlophobic view is concerned with the tyranny of the many, and thus relies on technocratic governments to control this threat. Democratic republicanism, the opposite view, has wealth power as the biggest threat posed to common liberty. By relying on the latter, the goal becomes to control wealth power to prevent it from using common institutions to favour their own interests at the expense of societal wellbeing. It is important to stress here that politicians are theoretically external to this duality and are the "object" the two sides compete for. Therefore, the problem is not that policymakers are always on the side of the 'few', but that if the 'many' do not democratically control, or have the opportunity to control, wealth power, then wealth power will be used by the few to sway governments to work for their wealth accumulation rather than the people's and society's wellbeing.

This change in perspective is essential to address the problems of the current European food system. The impact of CDoH has resulted in situations where 'food billionaires' have increased their wealth by $382 billion over the last two years, leading to 62 new food billionaires since the outbreak of the COVID-19 pandemic.[20] Based on this alone, there are strong grounds to maintain that food system governance should be based on democratic republicanism for which concentrated wealth, and not the tyranny of the majority, is the main concern to be tamed.

The solution: A food democratic republicanism

A shift of power towards the many is the basic concept of food democracy. A summary of the literature identified four general types of power in our societies, which are also important for governance: [21]

- Power over (ability to influence or coerce)
- Power to (organise and change existing hierarchies)
- Power with (power from collective action)
- Power within (power from individual consciousness)

All four of these must be tackled if we are to realise a food democratic republicanism.

A practical example of a fairer distribution of 'power over' and 'power to' is the creation of food citizens' panels [22] at EU level, which several voices would now like to see as a permanent practice.[23] While these bodies have proven to be effective for specific issues (e.g., food waste in the case of the European Commission panels), unless they specifically target the influence of wealth power over food system governance, they are unlikely to lead to a more just, healthy, and sustainable European food system. For this change to happen, popular participation must be intertwined with systemic regulations targeting CDoH. Examples of systemic regulations that could create more balanced 'power over' and 'power to' are described in **Table 2**.

These are just some of the actions required to improve European food system governance. Food systems are a complex network involving actors, relationships, and legislation across multiple sectors. Mentioning the need to change food systems is akin to saying that we must change our societies; and in a way, there is truth in this.

In addition to creating a better balance of the distribution of the 'power over' and 'power to', more opportunities for the manifestation of the 'power with' and 'power within' are essential so that decisions about food systems are devolved, shaped and taken at more local levels. There are promising examples of this happening with cooperative movements in food systems, such as Morgenrot in Austria (which engages with all key stakeholders in the regional food system [producers, direct marketers, food processors, transporters, stores, online stores] to ensure that producers are producing food sustainably, consumers have access to healthier and more sustainable regional and seasonal products and that both are tied through fair pricing) but more needs to be done to realise a true food democratic republicanism.

Conclusion

The narrow concentration of wealth power has negatively affected our societies for centuries. Food systems are just one area where the commodification of a

commons has led to dynamics focused on maximising corporate profit at the expense of the people's health and Europe's sustainability. A food democracy republicanism can be achieved only if power inequalities are addressed at all levels of society, manifested as the power over, power to, power with and power within. Recent developments in the Economy of Wellbeing [25] point in this direction and they highlight that we can only achieve an equitable, just and well functioning economic system if we set people's wellbeing as a societal goal. A more just, healthier and more sustainable food system is a central piece in this bigger puzzle.

This article proposes two initial steps towards achieving these goals. First, food democracy institutions must genuinely engage citizens in the governance of the system, granting them decision-making power over outcomes rather than involving them merely to gather opinions in consultation processes.

Second, wealth power must be recognised as a major threat and policies should specifically target CDoH to ensure that there is a more balanced distribution of the 'power over' and 'power to'. History demonstrates that societies function better when wealth power is effectively regulated. EU policies have missed this target for too long, and as a result, there is now overwhelming evidence that European food systems are unjust, unhealthy and unsustainable.

If we aim for European food systems to prioritise health as an absolute value rather than a negotiable one deprioritised for economic profit, it is necessary to control the influence wealth power has over food system governance. Only in this way will it be possible to bridge the gap between strategy and implementation.

"This project has received funding from the European Union's Horizon Europe research and innovation programme under grant agreement No. 101060536 and by Innovate UK [grant number 10041509]. CS was supported by the Swiss State Secretariat for Education, Research and Innovation (SERI) under contract number 22.00156."

Table 2: Creating more balanced power in food systems

FOOD SYSTEM POLICY GOAL	EXAMPLES
Fairness & transparency	***Across the food value chain:*** • Implement transparency disclosure requirements and stricter conflict of interest standards • Develop norms to regulate Corporate Social Responsibility practices and their interference in Public Health policies • Protect scientific publications from corporate influence, focusing especially on clear funding and Conflict of Interest disclosures
Level playing field	***Across the food value chain:*** • Especially at EU level, address the inequality in access to institutions between industries and civil society organisations [24] • Prevent "revolving doors" between big corporations and important governmental positions • Focus on mandatory regulations versus self-regulatory approaches favoured by the industry
Preventing wealth capture	***Across the food value chain:*** • Regulate tax havens, tax evasion, profit repatriation and implement progressive corporate taxation
Protecting population health	***Producers and Retailers:*** • Implement taxes on foods high in sugar, salt and fat (HFSS) • Regulate predatory marketing, especially targeted to children, on all media and especially in digital platforms

Source: authors' own

References

1 European Commission. *Farm to Fork strategy*. https://food.ec.europa.eu/horizontal-topics/farm-fork-strategy_en

2 European Commission. The European Green Deal. https://commission.europa.eu/strategy-and-policy/priorities-2019-2024/european-green-deal_en

3 FAO. Sustainable food systems Concept and framework, 2018. https://openknowledge.fao.org/server/api/core/bitstreams/b620989c-407b-4caf-a152-f790f55fec71/content

4 European Commission. Legislative framework for sustainable food systems. https://food.ec.europa.eu/horizontal-topics/farm-fork-strategy/legislative-framework_en

5 EU 'farm to fork' strategy: State of play, 2024. https://www.europarl.europa.eu/thinktank/en/document/EPRS_ATA(2021)690622#:~:text=The%20'farm%20to%20fork'%20strategy,on%20its%20objectives%20and%20priorities

6 World Health Organization Regional Office for Europe. *Commercial Determinants of Noncommunicable Diseases in the WHO European Region*. Copenhagen: WHO/Europe, 2024. https://www.who.int/europe/publications/i/item/9789289061162

7 Moodie R, Stuckler D, Monteiro C, et al. Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. *Lancet* 2013;381(9867):670–9.

8 Battams S, Townsend B. Power asymmetries, policy incoherence and noncommunicable disease control – a qualitative study of policy actor views. *Crit Public Health* 2019;29(5):596–609.

9 Schrempf J. A social connection approach to corporate responsibility: The case of the fast-food industry and obesity. *Business & Society* 2014;53(2):300–32.

10 Collin J, Hill SE, Eltanani MK, Plotnikova E, Ralston R, Smith KE. Can public health reconcile profits and pandemics? An analysis of attitudes to commercial sector engagement in health policy and research. *PLoS One*. 2017;12(9):13.

11 Food label ambush: industry lobbying halted EU plans, 2023. https://www.socialeurope.eu/food-label-ambush-industry-lobbying-halted-eu-plans

12 Wittman H. Food sovereignty: a new rights framework for food and nature? *Environment and Society* 2011;2(1):87–105.

13 De Tavernier J. Food Citizenship: Is There a Duty for Responsible Consumption? *J Agric Environ Ethics* 2012;25:895–907. https://doi.org/10.1007/s10806-011-9366-7

[14] Lang T. Food control or food democracy? Re-engaging nutrition with society and the environment. *Public Health Nutr* 2005;8(6A):730–7.

[15] Vivero-Pol JL. Food as commons or commodity? Exploring the links between normative valuations and agency in food transition. *Sustainability* 2017;9(3):442.

[16] Fuller R. *In defence of democracy*. John Wiley & Sons, 2019.

[17] Britain's most racist election: the story of Smethwick, 50 years on. *The Guardian* 15 Oct 2014. https://www.theguardian.com/world/2014/oct/15/britains-most-racist-election-smethwick-50-years-on

[18] See for example the issue of gerrymandering in the US elections: These maps show how Republicans are blatantly rigging elections. *The Guardian* 12 Nov 2021. https://www.theguardian.com/us-news/ng-interactive/2021/nov/12/gerrymander-redistricting-map-republicans-democrats-visual

[19] McCormick JP. *Machiavellian Democracy*. Cambridge: *Cambridge University Press,* 2011.

[20] Oxfam. Profiting from Pain: The urgency of taxing the rich amid a surge in billionaire wealth and a global cost-of-living crisis. *Oxfam Media Release,* 2022.

[21] Luttrell C, Quiroz S, Scrutton C, Bird K. Understanding and Operationalising Empowerment. Paper prepared by the Overseas Development Institute (ODI) for the Poverty-Wellbeing Platform, 2007. https://odi.cdn.ngo/media/documents/5500.pdf

[22] Conference on the Future of Europe follow-up: Commission hosts first European Citizens' Panel on food waste reduction, December 2022. https://ec.europa.eu/commission/presscorner/detail/en/ip_22_7734

[23] European politicians want citizen panels to be used at EU level, 2022. https://www.euractiv.com/section/future-eu/news/european-politicians-want-citizen-panels-to-be-used-at-eu-level/

[24] BusinessEurope: the death star of corporate lobbying, 2023. https://corporateeurope.org/en/2023/09/businesseurope-death-star-corporate-lobbying

[25] European Union. The Economy of Wellbeing: going beyond GDP, 2018. https://www.consilium.europa.eu/en/infographics/economy-wellbeing/

[26] Winters JA. *Oligarchy*. Cambridge: Cambridge University Press, 2011.

FUTURE HEALTH PRIORITIES FOR THE EU: KEY INSIGHTS FROM THE PUBLIC DEBATE

By: Nicole Mauer, Giada Scarpetti, Dorli Kahr-Gottlieb and Matthias Wismar

Summary: Key findings from a public debate on the future health priorities of the European Union (EU) underscore the importance of stakeholder involvement in shaping the EU's health agenda. Participants showed strong support for developing the European Health Union and enhancing the EU's role and mandate in health. Democracy, demographics, and digitalisation (the 3Ds) were central to the debate, aligning with the themes of the 2024 European Health Forum Gastein. The discussion emphasised the need for transformative health systems, intersectoral collaboration, and responsible digital health use, offering valuable insights for the incoming Health Commissioner as the EU shapes its health policy agenda.

Keywords: *EU Health Priorities, Democracy, Demographics, Digitalisation, Stakeholder Involvement, Health Governance*

Nicole Mauer is Technical Officer, **Matthias Wismar** is Programme Manager, European Observatory on Health Systems and Policies, Brussels, Belgium; **Giada Scarpetti** is Research Fellow, Berlin University of Technology and European Observatory on Health Systems and Policies, Berlin, Germany; **Dorli Kahr-Gottlieb** is Secretary General, European Health Forum Gastein, Bad Hofgastein, Austria. Email: wismarm@obs.who.int

Introduction

In the lead up to the 2024 European elections, the European Observatory on Health Systems and Policies (Observatory) ran a public debate on the future health priorities of the European Union (EU). It served to take stock of the EU's health actions over the past five years and the legacy of a mandate impacted by a global pandemic, economic instability, and conflict. At the same time, the public debate aimed to empower participants to reflect on future needs, to gather their insights, expectations, and perspectives, and to inform future EU action and priorities in the area of health.

The public debate was launched during the 2023 European Health Forum Gastein (EHFG) [1] and, over eight months, delivered a series of events that engaged a broad and diverse audience (**see Box 1**). Now, a year later, the outcomes of these events can help to inform and feed into this year's EHFG debate centred around three conference tracks – democracy, demographics, and digitalisation (the 3Ds) – and with it, the future of the European Health Union. This article presents key findings from the debate, reflecting on the critical issues discussed by different constituencies and evaluating how the inputs collected chime with this year's conference themes.

Although the Observatory used a framework centred around nine priority topics (**see Box 1**) to structure the debate, its results present clear parallels and synergies with the EHFG debate on the 3Ds (democracy, demographics,

Box 1: Putting the public debate into context

The public debate was delivered in agreement with the European Commission's Directorate General for Health and Food Safety (DG SANTE) over the course of eight months (September 2023 – April 2024). It followed three different formats:

- sessions and workshops at leading public health and health policy conferences (EHFG, European Public Health (EPH) Conference);
- an interactive webinar series; and
- an online stakeholder survey.

A discussion framework highlighting nine key topics was used to streamline and frame the debate across all three formats and focused on the themes of: 1) health security, 2) health determinants, 3) health system transformation, 4) health workforce, 5) universal health coverage, 6) digital solutions and artificial intelligence (AI), 7) health system performance and resilience, 8) long-term challenges such as climate change and ageing, and 9) the EU's global role in health.

Different types of data were collected through the three formats: opinion polls, group discussions, and an online survey featuring a mix of multiple-choice and open questions. Both quantitative and qualitative methods were employed to analyse debate inputs.

Over 500 people participated in the opinion polls held during conference events, around 500 joined the webinar series and over 300 survey replies were collected from respondents across 48 countries.

For further information please refer to the Observatory's summary report "A public debate on the future health priorities of the European Union: Outcomes, insights and ideas for action".[2]

and digitalisation) and the European Health Union. The following subsections briefly outline key inputs collected from participants along the 3Ds tracks.

DEMOCRACY – A call for more intersectorality and participation in policymaking processes

"Addressing the determinants of health through Health in and for all Policies" (HiAP and H4AP) was singled out as a top priority by various groups in the debate (**see Figure 1**). Calls for stronger intersectoral policy and decision-making to address different types of health determinants emerged consistently in group discussions and survey responses. Participants emphasised the need to prioritise health across other sectors to address the structural, social, and commercial factors negatively impacting European citizens' health. Additionally, poor health and social conditions were linked to rising populist and nationalist sentiments. Political stability, democratic processes, and the rule of law were seen as closely intertwined with health and health systems. This connection was evident in discussions on conflict and peace, where participants reflected on current geopolitical events and the need for health systems to prepare for and safeguard health during crises.

Co-creation, foresight exercises, and stakeholder engagement, involving health professionals, patient organisations and citizens (including marginalised and vulnerable communities), were further cross-cutting themes. The role of civil society and the need to ensure adequate representation in decision-making were similarly emphasised.

Further, several participatory sessions and initiatives are planned at this year's EHFG and are briefly outlined in **Box 2**.

DEMOGRAPHICS – From acute care to integrated systems

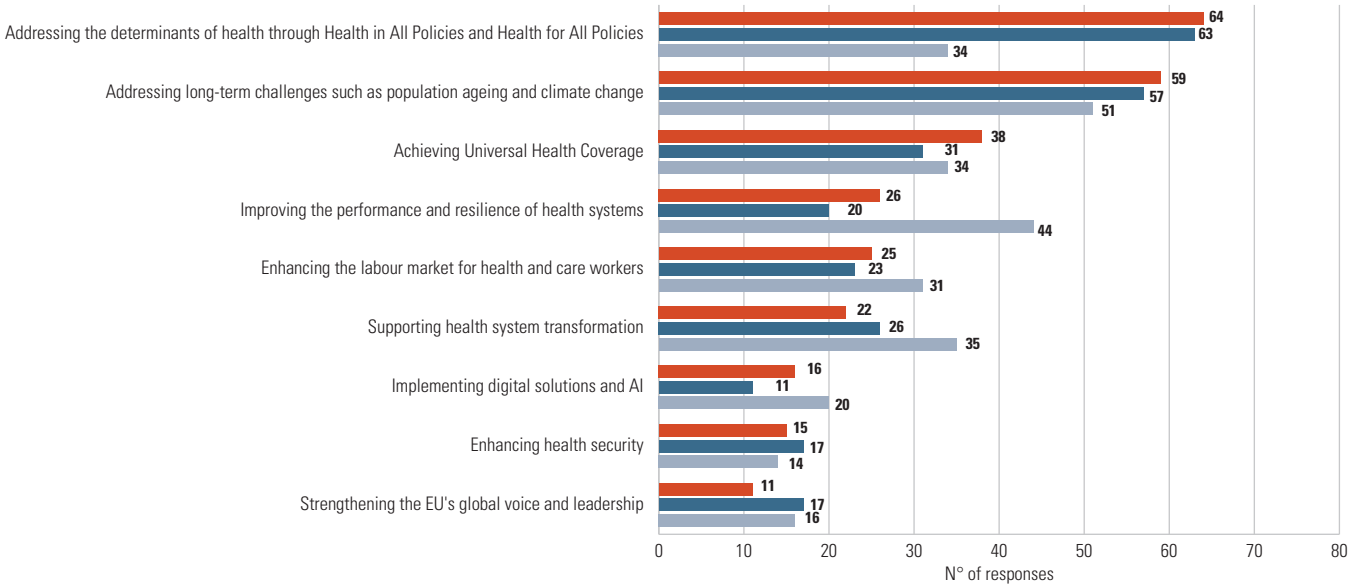
Addressing long-term challenges such as population ageing and climate change was a highly ranked priority across all opinion polls (**see Figure 1**), including the 2023 EHFG audience, which placed it first among the nine topics in the framework. Discussions in the webinars and survey responses emphasised the need to transition healthcare systems from hospital-centric models to primary care and integrated care models that link health, long-term, and social care. Additionally, there was an emphasis on strengthening health promotion, public health, and preventive services to meet shifting health needs and the challenges posed by ageing, a rise in non-communicable diseases (NCDs) and multimorbidity. Intergenerational support systems and community-based initiatives to strengthen social cohesion were also suggested as potential solutions in the context of shifting demographic trends and needs.

DIGITALISATION – An opportunity to address pressing health system challenges?

"Digital solutions and AI" was one of the priority topics in the discussion framework but received surprisingly low rankings in the opinion polls across different constituencies (**see Figure 1**). This could be attributed to the cross-cutting nature of digital health solutions, which participants may have viewed as tools to achieving other health system goals included in the framework. Additionally, participants seemed well-informed about ongoing EU actions and policies, aware of the considerable EU investment in digital transition projects, such as those through the Recovery and Resilience Facility, and the prioritisation of digital goals initiatives such as the European Health Data Space. This awareness may have led to some complacency and stronger support for issues which have attracted less policy attention in recent years.

Nevertheless, participants were very vocal around the challenges and opportunities of digital health during the open webinar discussions and in the survey, converging

Figure 1: Opinion poll results across different conference sessions



Source: authors' own.

Box 2: Fostering meaningful participation at the EHFG 2024 Conference

- The European Health Forum Gastein (EHFG) has long been a key platform for fostering European debate on health policy, more recently in advancing the vision of a **European Health Union**. By bringing together a diverse range of stakeholders, including policymakers, civil society, science and academia, and industry representatives, the EHFG creates a collaborative space to shape the future of health in Europe.
- Central to this goal, the EHFG also facilitates the European Health Union initiative, which calls for a strong European Health Union where no one is left behind, solidarity and security for all Europeans is strengthened, and environmental sustainability ensured.
- With the new European Commission preparing to take office in autumn 2024, this year's EHFG presents a timely opportunity for the European health community to come together to agree up **key health priorities** for the upcoming term, based on prior consultations and work like the public debate conducted by the European Observatory on Health Systems and Policies, showcased in this article.
- The **EHFG2024** will include a **crowd harvest and a consultative session**, entitled "Co-creating an EHFG community mission letter". These are designed to explore not only what the health priorities should be but also **how to effectively advance them and to define concrete action points**. The insights gathered here, along with feedback from previous consultations and wider stakeholder input, will be compiled into an **EHFG Community Mission Letter**. This document will be presented to the new European Commission and Parliament, outlining clear and actionable recommendations for shaping future European health policy.

on a few common issues. Key topics explored included implementation barriers, with a focus on regulation, safety, privacy, and trust in digital technologies. Participants emphasised the importance of fostering participation, ownership, inclusion, and digital literacy as central to the successful implementation of digital solutions in health. Innovation and technology were regarded as an opportunity for health systems to address pressing challenges, including overcoming health workforce issues facing many European health systems and achieving better health service delivery (including delivery of preventive services).

Beyond the topics included in the discussion framework, participants raised several other issues in which they felt the EU could play a more prominent role. **Box 3** summarises some of the cross-cutting themes emerging from the debate discussions.

Notably, the actions the EU could pursue moving forward were fairly consistent across different fora and topics discussed (**see Box 4**). Many proposed initiatives aligned with the Commission's ongoing work and mandate, including generating and sharing knowledge or creating funding and investment opportunities. However,

other initiatives would require stronger EU involvement, as indicated by calls for standardisation and common monitoring and evaluation initiatives.

Our findings from the public debate on the EU's future health priorities strongly resonate with the themes highlighted in several recent publications.[3–5] These include the importance of stakeholder involvement and a more proactive role for the EU in health,[3–5] as echoed in the public debate's call for greater intersectoral collaboration and the integration of citizen voices in shaping health policies. Further, the emphasis on digital health solutions and health system transformation [3,5] aligns with the opportunities identified in the public debate, underscoring a shared vision for advancing the European Health Union in ways that are responsive to the evolving health landscape and the needs of its citizens.

These findings reveal the public's interests and priorities, offering the incoming Health Commissioner important insights to consider.

Conclusion

Democracy, demographics and digitalisation emerged as central elements of discussion over the course of the public debate, drawing clear parallels to the themes and events planned within the scope of the upcoming EHFG conference. Participants recognised the links between political polarisation, conflict, and health. They discussed the need to transform health systems to adapt to changing population health needs against a backdrop of profound demographic and environmental changes. They acknowledged the opportunities afforded by digital health, while demanding answers to issues related to safety, privacy, regulation, and trust in emerging technologies. Stakeholders highlighted a collective interest in expanding and strengthening the EU's role in health. The analysis reveals a desire among participants to see the EU play a more supportive and proactive role, particularly in advancing the 3Ds – democracy, demographics, and digitalisation – as key pillars of future health policy.

Box 3: Beyond the 3Ds, participants also cared about other priorities

- Climate change preparedness, adaptation, and health sector decarbonisation
- One Health and Antimicrobial Resistance
- Equity, inclusion and (health) inequalities
- Health workforce challenges
- Non-communicable diseases, including cancer, cardiovascular disease, mental health, and rare diseases
- Commercial determinants of health
- Public health, prevention, and health promotion
- Health services and provision to address the needs of patients

Box 4: What people want the EU to do more of:

- Develop and strengthen the implementation of existing **legal frameworks and EU** instruments that safeguard health
- Foster **cooperation and coordination** across policy areas to promote synergies, both within the Commission and in working with Member States and other actors
- Raise **awareness** and strengthen **communication**
- Provide **funding and investment**
- Encourage **standardisation**, as well as develop common methodologies and indicators
- Offer **technical frameworks and guidance**
- Generate and share **(research) knowledge and best practices**
- Build health **leadership** and **stakeholder participation**
- Play a leadership role in **(global) governance**
- **Monitor**, **evaluate** and provide **feedback**
- Stimulate **innovation** and support **implementation**

Participatory approaches such as this one, and the events planned at the 2024 EHFG, can give the public a voice and inform policymakers of citizens' wishes, needs and expectations.

Participants have formulated innovative, constructive, and concrete ideas for the impending political cycle, demonstrating an appetite to help policymakers identify unmet health needs in Europe and to build on EU health policy achievements to secure a healthier, more sustainable, and more equitable future.

Looking ahead to the EHFG 2024, the conference theme "Shifting sands of health – Democracy, demographics, digitalisation" offers a timely opportunity to translate public priorities into concrete policy actions. By fostering meaningful participation and engaging stakeholders,

the EHFG can play an important role in ensuring that the European Health Union aligns with the needs and aspirations of its citizens.

References

1 Mauer N, Wismar M. Launching a public debate on the European Union's future health priorities: how do we keep health on the political agenda beyond 2024? *Eurohealth* 2023;29(2):19–22. https://iris.who.int/handle/10665/373851

2 Mauer N, Scarpetti G, Wismar M. *A public debate on the future health priorities of the European Union: Outcomes, insights and ideas for action*. World Health Organization, 2024 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies). https://eurohealthobservatory.who.int/publications/m/a-public-debate-on-the-future-health-priorities-of-the-european-union-outcomes-insights-and-ideas-for-action

3 Council of the European Union. *Council conclusions on the future of the European Health Union: A Europe that cares, prepares and protects* (Document ST 9900/24), 2024. https://data.consilium.europa.eu/doc/document/ST-9900-2024-INIT/en/pdf

4 Alsamara I, Brand H. Public Opinion on a European Health Union. In: Andriukaitis VP, Cerniauskas G (eds.) *A European Health Union: A Blueprint for Generations. Foundation for European Progressive Studies & the European Parliament,* 2023:83–102.

5 EuroHealthNet. The future of public health: Foresight report summary, 2023. https://eurohealthnet.eu/wp-content/uploads/publications/2023/2403_foresightreportsummary_thefutureofpublichealth.pdf

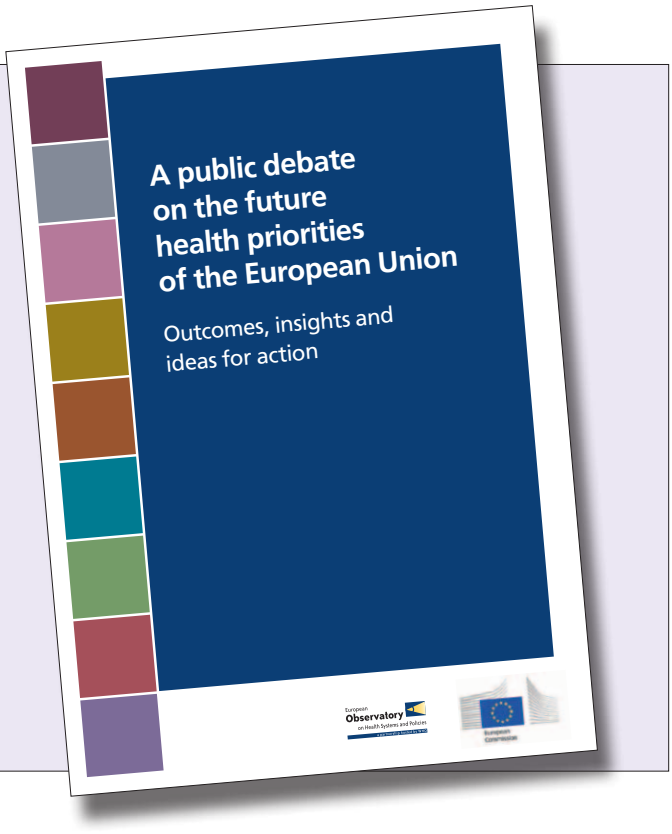
A public debate on the future health priorities of the European Union: Outcomes, insights and ideas for action

By: N Mauer, G Scarpetti, M Wismar

Published by: World Health Organization, 2024 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

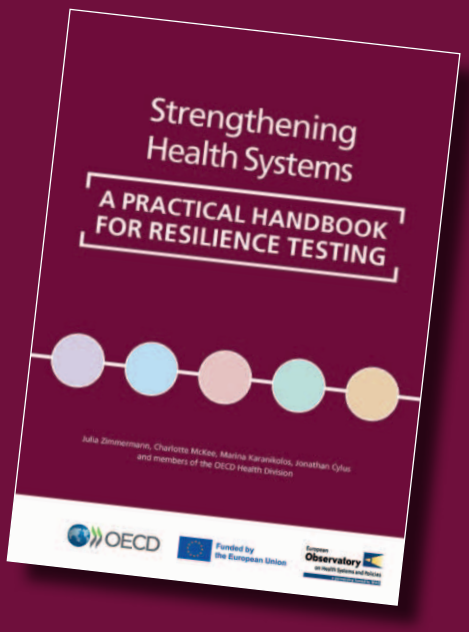
Number of pages: 137

Freely available for download: https://eurohealthobservatory.who.int/publications/m/a-public-debate-on-the-future-health-priorities-of-the-european-union-outcomes-insights-and-ideas-for-action



In an era marked by pandemics, natural disasters and geopolitical tensions, the resilience of health systems has never been more crucial.

This handbook is a comprehensive toolkit designed for health system leaders, managers, policymakers and planners ready to fortify their systems against any shock. It contains the strategies and insights needed to assess vulnerabilities, develop robust responses, and safeguard population health.



At its core, the handbook describes a pioneering resilience testing methodology — a structured, collaborative approach inspired by stress tests used in other sectors, scenario planning and health system performance evaluations.

Strengthening Health Systems: A Practical Handbook for Resilience Testing is organised into three distinct sections and serves as a comprehensive companion:

- Section 1 is a hands-on guide, explaining each step of the resilience testing process.
- Section 2 gives an outline of the foundational concepts driving resilience testing.
- Section 3 is a carefully curated collection of example shock scenarios that can be adapted for use in diverse country contexts.

Freely available to download: https://iris.who.int/bitstream/handle/10665/376809/9789289059596-eng.pdf?sequence=

OECD

Funded by the European Union

European Observatory on Health Systems and Policies
a partnership hosted by WHO