20TH
European Health Forum
Gastein

Health in All Politics – a better future for Europe

Conference Report

EHFG 2017 report

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As a long-standing board member, I have witnessed the development of the EHFG towards a place of dialogue, best practice, big ideas and balanced debates. As the newly elected president of the association, my vision is to see the Forum become even more of a largescale forum for policy dialogue, with the goal of transforming ideas into reality, of closing the gap between experts and policy-makers. Based on its strength of providing a platform for exchange between different stakeholders and policy-makers, I would like the EHFG to give more weight to this knowledge-translation process.
Gastein is the place to have candid (and possibly controversial) but fair debates which involve players from all the four EHFG pillars – public sector, civil society, private sector and science & academia.

I would like to take this opportunity to thank our partners and session organisers as well as all our Board and Advisory Committee Members for their support and contribution to this years' edition and I am delighted to present you this report of the 20th European Health Forum Gastein conference.

Clemens Martin Auer
President, European Health Forum Gastein

EUROPEAN HEALTH FORUM
GASTEIN

Twenty Years

20TH ANNIVERSARY
1998 - 2017

With the help of many of our friends and colleagues, who have supported and accompanied us over the past years, we have put together a special **Twenty Years** publication. It takes you back to the beginnings of the Forum, and marks its 20th anniversary by portraying its development, by paying tribute to its pioneers and supporters, and by highlighting what makes the European Health Forum Gastein unique.

On behalf of the entire Board and all the people behind the Forum, we want to thank you – our participants, session organisers and contributors – because it is you who make the EHFG so special. Thank you!

Your EHFG Team

This anniversary edition of the 20th European Health Forum Gastein conference took place under the patronage of:

Alexander van der Bellen, President of the Republic of Austria

About us

European Health Forum Gastein

The European Health Forum Gastein (EHFG) is the leading annual health policy event in the European Union. With its wide-ranging three-day programme, the Forum offers an unparalleled platform for decision-makers in various fields of public health and healthcare.

The European Health Forum Gastein was founded in 1998 as a European health policy conference with the aim of providing a platform for discussion for the various stakeholders in the field of public health and healthcare.

Since then the EHFG has developed into a key annual event, bringing together, politicians, senior decision-makers, representatives of interest groups, and experts coming from government and administration, business and industry, civil society and science and academia. These four groups of stakeholders with their perspectives constitute the four pillars of the European Health Forum Gastein.

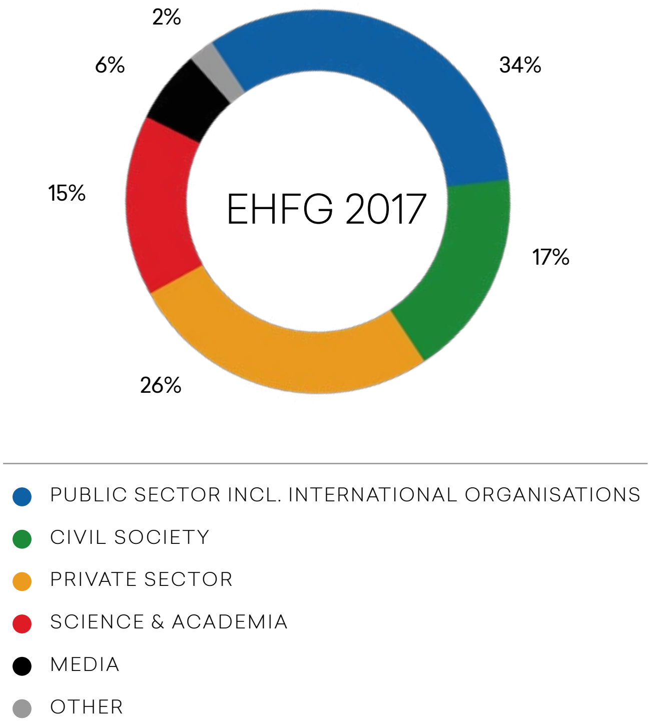
The EHFG further considers the vertical organisation of societies and the EU by integrating regional, national, European and international levels and thus facilitating the exchange of views and experience amongst key actors and experts from the 28 EU members and the EEA countries, but also from the rest of the 52 countries of the WHO European region. Launched with major financial support from the European Commission, subsequent events have grown with the continued and extended co-operation of EC services. In that regard the Forum can be considered as a pilot project and benchmark for any Commission civil society consultation process.

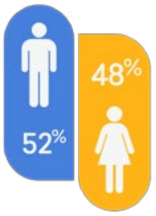
EUROPEAN
HEALTH FORUM
GASTEIN

EHFG 2017 in numbers

Gastein brings together the worlds of politics, academia, private sector, and civil society in assessing where everyone is equal. Over 500 leading experts participate in the annual conference - the unparalleled mix of participants is especially critical to the success of our event.

Participants' structure





Our initiatives

The EHFG Health Futures Project

Scenarios for health in 2037

The Health Futures Project forms part of the EHFG's celebration of its 20th anniversary - what better way to mark the passing of time than to look ahead to imagine what the future might hold for the health of European people?

Project stages

Background research, centred around a set of semi-structured interviews with expert contributors of a wide range of different backgrounds, with the aim to identify the factors that are likely to have greatest influence on the health of people in the EU. The outputs from the interviews and supplementary research were summarised in a series of mind maps.
We then highlighted three glimpses of what the future of health might look like, based around four areas of unsustainability: health systems, environment, disjointed investment in health technology and inequalities in health and wealth.

A workshop that brought together a different set of experts - the scenario builders, whose task it was to draw on their own experience and judgement to expand and refine each glimpse into a fuller picture of health in 20 years' time, exploring how their scenario might affect different interest groups.

Partners

The project was carried out by the European Health Forum Gastein in collaboration with the realisation collaborative and acumen public affairs.
We thank all involved experts for their valuable input!

Report & project results

First results of the project were presented at the European Health Forum Gastein 2017 during a forum session on Health Futures in a post-truth world.

In some of the more recent election campaigns in EU Member States, health has taken centre-stage as a bargaining tool to win over voters. What has often been neglected in this context are the aspirations to either comprehensiveness or correctness of the information provided.

In this particular forum session, we aimed to explore the perceived status quo of our post-truth reality. To help us move forward, we introduced the audience to three alternative scenarios for health in 2037, the outcomes of our Health Futures Project. These visions are neither predictions nor recommendations for the future of health in Europe, but shall help us assess the policy choices we make today against a longer-term horizon. We invite you to lend your stakeholder and personal perspectives to each of the EHFG "health future" scenarios, to test ideas on how our roles and the choices we will have to make might change over time.

> *We cannot know what the future holds, but now is the time to put in place the foundations to shape that future.*
>
> *Clemens Martin Auer, EHFG President*

European Health Award

The European Health Award honours initiatives aiming to improve public health or healthcare in Europe. It was established to promote cross-border cooperation, multi-country working and the development of sustainable, innovative and transferable initiatives which address current challenges such as disparities in health status, access to services and the provision of treatment within Europe.

Award sponsors 2017

The award of prize money of €10,000 is supported by the Austrian Federal Ministry of Health and Women's Affairs and by Austrian Research-based Industry Association (FOPI), which brings together Austria's research-based pharmaceutical and biotechnology companies.

MINISTERIUM
FRAUEN
GESUNDHEIT

Forum der forschenden
pharmazeutischen Industrie
in Österreich
FOPI

Shortlisted projects 2017

Education Against Tobacco (EAT)
EUropean Refugees - HUman Movement and Advisory Network (EUR-HUMAN)
Focus IN CD Project - Innovative patient centred health care services – advantages of establishing a close CE network in coeliac disease patient healthcare
Gen-Equip Project - Equipping European Primary Care Health Professionals to Deal with Genetics
EU SHIPSAN ACT Project - The impact on maritime transport of health threats due to biological, chemical and radiological agents including communicable diseases

Selection criteria

Initiatives & projects must comply with the following criteria to be eligible for consideration:

- It must already be in its implementation phase, although it does not have to be completed at the time of application.
- Applicants should be able to provide some initial results from their initiative.
- It must be implemented in at least two European countries.
- Should focus on public health or health care delivery and address an important threat to the health of the population in terms of prevention or health promotion, improving quality of care or access to care or through increased efficiency or cost-effectiveness
- Should be innovative and/or demonstrate how it has added an innovative dimension to similar projects.
- Should be sustainable and have the potential to be transferable to other countries.

Jury members 2017

The jury panel includes representatives of the European Health Forum Gastein Board, EHA Sponsors - currently FOPI and Austrian Ministry of Health and Woman's Affairs and European representatives from our four pillars: civil society, science & academia, private and public sectors.

Peter Brosch, Ministry of Health and Women's Affairs, Austria • Martin McKee, London School of Hygiene & Tropical Medicine • Terje Peetso, DG CONNECT, European Commission • Manuel Reiberg, Austrian Research-based Industry Association (FOPI) • Albert van der Zeijden, European Health Forum Gastein


Peter Brosch


Martin McKee


Terje Peetso


Manuel Reiberg


Albert van der Zeijden

Cartoon portraits by Floris Oudshoorn / ComicHouse

Christian Marihart (FOPI), Leigh Jackson (Gen-Equip project), Günther Leiner (EHFG) and Peter Brosch (MoH Austria)

Winner 2017

The Gen-Equip Project: Equipping European Primary Care Health Professionals to Deal with Genetics.

The Gen-Equip project is a European initiative to provide free, online education in genetics to health professionals, particularly general practitioners, nurses and midwives providing primary care.

The main aim is to improve healthcare of patients who have or are at risk of a condition with an underlying genetic cause.

GEN-EQUIP
GENETICS EDUCATION FOR PRIMARY CARE

PRESS RELEASE

> *Receiving such a prestigious award is a valued acknowledgement of the hard work that has been required to develop the learning resources over the past three years. Our project has already reached many thousands of health professionals and this award raises the profile of genetic healthcare and will help us to maintain the website and continue to update our materials to help more patients in future.*
>
> *Heather Skirton, Gen-Equip Project manager (EHA Winner 2017)*

Over the past **eleven** *years we have received* **1,022** *applications and were able to award* **737** *scholarships. Our YFG network currently counts* **409** *members. The application rate stays at about 100 per year, but two major peeks of interest can be noticed – in 2010 & 2017 – when it rose by 50% compared to the previous years.*

Young Forum Gastein

This EHFG initiative brings together promising young health professionals from different backgrounds and with diverse professional experience, to participate in learning and networking activities in the sphere of health.

About

In the framework of engaging and stimulating dedicated programme, the Young Forum Gastein scholarship offers a unique opportunity to:

- Learn about the latest health developments in Europe and across the world;
- Develop important public health competencies such as the ability to build alliances and partnerships, learn advocacy and persuasion skills and develop presentation and communication skills;
- Network and make new contacts with an enthusiastic young international, inter-cultural and inter-professional peer group as well as senior experts in the sphere of health;
- Have privileged access to senior policy-makers and academics in special closed workshop sessions;
- Participate in tasks related to the EHFG, such as undertaking interviews, writing session reports, social media activities, compiling the Gastein Outcomes or acting as a speaker or session rapporteur.

Scholarship 2017

The number of scholarships has grown year by year, with 70 Young Forum Gastein scholars participating in the EHFG 2017. The entire Network counts currently over 420 members.

Over the years the Young Gasteiners have played an increasingly visible role in the EHFG conference – undertaking tasks as rapporteurs, interviewing delegates, tweeting and blogging, compiling the Gastein Outcomes, attending specific Young Forum Gastein workshops and meetings, and of course participating in the general conference programme with its plenary and parallel forum sessions, workshops and evening networking events. In addition the Young Forum Gastein has started increasing its activities outside the EHFG conference, with Network members meeting up at international conferences and summer schools, or participating in specially organised workshops hosted by the European Commission, World Health Organization and other partners.

This year's Young Forum Gastein was made possible by funding from the Robert Bosch Stiftung.

Robert Bosch Stiftung

Programme
EHFG 2017

Health in All Politics - a better future for Europe

Introduction

With the EHFG 2017 main theme of “Health in All Politics – a better future for Europe”, we aimed to take the concept of Health in All Policies to another level - the political level of policy implementation.
We have chosen to concentrate session topics around four main tracks this year.
Linked to our main theme, the Health in all policies (HiAP) track acknowledges that this concept has not yet become an integral part of political processes. It thus often stays where it is convenient, where it does not impact on budgets or staff resources – on paper. How can we change this?

The second thematic track is dedicated to health systems, increasingly under pressure across Europe and beyond. Several sessions will explore the directions of travel that European health systems need to take to become more equitable, more inclusive and more sustainable, and once again question how we can make the big issues a shared responsibility beyond the healthcare sector?

A bone of contention between different stakeholders within the healthcare sector has been the pricing of medicines.
In a quest to go beyond mutual recriminations, sessions in this third track will explore developments in the areas of legislation and regulation at both EU and Member State level. Where have we gone wrong, and how can we amend the shortcomings of the current system?

The fourth track concerns innovation, Big Data and ICT. Innovation is not only about the latest technology and data, it is also about methodological tools, concepts, processes. How can we create innovation cycles that allow health systems to become more flexible and quicker to respond, without creating a risk for current and future patients?
The rapid movement of data across borders, even across continents, is a subject that triggers fundamental fears in some and the vision of endless possibilities in others. What are the rules and regulations we need to protect individual privacy?

These sessions are complemented by three plenaries that will explore health policy-making from the local to the global level, with contributions ranging from city mayors, and discussion themes that will cut across our four thematic tracks and beyond.

Thank you for joining us for the 20th EHFG – and helping us take decisive steps into the future.

As discussed in Gastein...

EHFG 2017 Outcomes

No creativity without confrontation

The 20th edition of the Forum centred around the theme of Health in All Politics – a better future for Europe. One of its key insights was coined by newly elected EHFG President Clemens Martin Auer: There is no creativity without confrontation. Now more than ever, Gastein must remain an open forum for all health stakeholders to engage critically but constructively in key issues, from working out the specifics of IP rights for medical innovation to joint efforts to foster trust in public institutions on all levels, within and beyond the European health sector.

An important takeaway from the conference was the widely perceived urgency to unite against any attempts to close down health policy at EU level. Health is indisputably a core business of the EU and entrenched in the Treaties of the European Union. With 70% of Europeans favouring a greater role for the EU on health as a prerequisite to unlock the full potential of EU economic and social policies, its role and ambition should be BIG, not small.

Furthermore, the EHFG 2017 reiterated that facts are not enough to counteract negative health developments precipitated by post-truth rhetoric. Strong moral leadership and identification of common values are needed to give the facts a fighting chance. Travesties such as the recent avoidable measles deaths in the EU are a stark reminder not to forget the lessons history taught us - sessions covering a multitude of issues from vaccine scepticism to digital health illustrated how fake news and misinformation may prevent the soundest health system from realising its potential. “It is not possible to create trust from nothing, but we can build a mountain of trust if governments are open, transparent and make use of resources for the good of citizens”, stated Ain Aaviksoo, Secretary General for E-services and Innovation at the Estonian Ministry of Social Affairs.

We are pleased to share with you this executive summary - The EHFG 2017 Outcomes, followed by deatilled reports from each session on the next pages.

Track I - HiAP

Health in All Policies has to be a mutually beneficial relationship. Those who work on other policies need to converge with the health sector on agreed goals, but as health policy-makers we should also contribute to shared goals in other sectors. Clear political decisions are needed on what these common goals are and the courage to work towards them - even if this means rewriting current structures. One example for this is the food value chain, often dominated by incentives outside the best interests of public health. While educating consumers is crucial, we must not underestimate the power of the market to create artificial demand; empowering people to choose is important - but decision-makers also need to work towards making the right choices easily accessible for all.

When making the case for Health in All Policies, enhancing our research and research translation skills is crucial.
We need to make the interlinkages between health and environment, work, education and other areas more obvious, and communicate them better. And especially in politically challenging times we should never cease to emphasise that health is much more than the delivery of healthcare. It is about equity and social cohesion.

Track II - Health systems

How can we make European health systems more efficient, equitable, inclusive and sustainable? Many sessions echoed the mantra that putting patients at the centre, listening to them and focusing on their needs, experience and outcomes will lead to resources being targeted where it matters. Transdisciplinary and multi-stakeholder collaboration were also identified as crucial. The diversity of national contexts and individual needs means that there is no one-size-fits-all solution – a truly person-centred, adaptive health system requires a change of mind-set in numerous areas. There are many areas where we must do better e.g. when it comes to giving a voice to marginalised groups, and continuing education of both healthcare professionals and patients requires increased attention. All sides need to be open for solutions that possibly challenge current belief systems.

Sir Michael Marmot highlighted that “inequalities should not be seen as a footnote to the problems that we face, they are the problems that we face”. It is not enough to redistribute power, wealth and resources across sectors and societal groups for the sake of reducing health and other inequalities; we also have to reframe what health means: social, mental and physical well-being. We need to give space both to new actors coming into the health field, and for new roles for old actors. For example the possibilities of civil society organisations can be exploited far better by focusing on the opportunities flexible funding offers, the increased momentum brought about by engaging donors as advocacy partners, and the civil society sector’s special potential to join up silo thinking.

Track III - Access to medicines

It was no surprise to learn once more that new does not always equal better. Calls for stricter quality regulations for innovative drugs being released to the market were supported by many: these drugs must address unmet needs and represent therapeutic advances for patients. In addition, prevention measures require more investment and uptake, including screening and earlier diagnosis to capture the benefits of managing diseases at an early stage. Government research grants and other R&D finance instruments must be more efficient and effective, setting the tone for where public money is allocated, and taking time lag effects into consideration.

It was also suggested that the public sector must address the issue of R&D spending with the pharmaceutical industry too, to ensure conditionality and to consider some of the lessons learned from non-profit drug development initiatives in terms of sharing risks and costs. Among solutions discussed were differential pricing to support patient access in lower income EU countries, greater use of PPPs, and the possibility of crowd-funding R&D for therapies which may not provide a sufficient prospect of returns on investment for private biopharmaceutical companies.

Overall, better collaboration is required between everyone involved in the drug delivery process, including the end-user, to be solution-oriented and avoid blame and recriminations. In line with this year’s conference theme, it was concluded that there has never been a better opportunity to experiment with new models of inter-sectoral partnership to deliver the high-quality and affordable medicines that will meet patients’ needs on time.

Track IV - Innovation, Big Data & ICT

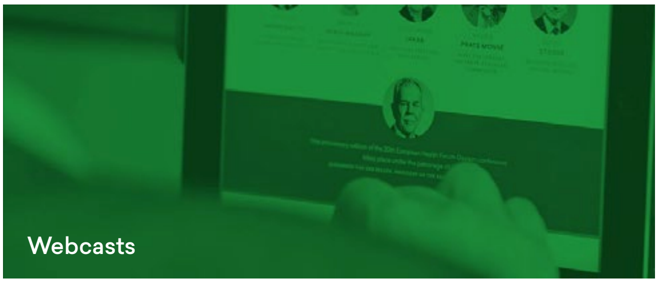
The two worlds of the health community and technology sector need to meet if progress is to be made in the area of innovation, participants recognised. Big Data, an ambiguous but ambitious tool, could have a tremendous influence on disease areas such as breast cancer and Alzheimer’s, by discovering new risk factors and new ways to diagnose and follow up patients. However, we have to ask ourselves which outcomes we need to look at – essentially, what is the best way to measure health? Also, with almost 80% of data still unstructured and disconnected to other data and therefore lacking contextual information, targeted investment in start-ups and other new initiatives is challenging.

All this means that new forms of education are needed to equip the health workforce with the right skillset to capture the benefits of using Big Data. At the same time, we need to engage with policy-makers on issues of data usage across sectors, and investment in research and its translation for policy. While it was recognised that the future of health[1] is both high-tech and high-touch, there were some concerns that we are not doing enough to counter the unintended consequences, like potentially worsening inequalities in health literacy due to the increased importance of eHealth.

Also, we need to openly reflect on the ethical dimensions of data usage, e.g. the thin line between personalisation and discrimination. There needs to be a new and clever form of data stewardship for patients, including societal consent based on trust in health data management. And what better way to accomplish this trust, it was posited, than to let the patients, with their knowledge and experience, advocate for innovation and progress?

Topic tracks video summary

EHFG 2017 at glance



Visions of a better future for Europe

Twenty years of the EHFG: From a remote destination to a laboratory of ideas

Organised by European Health Forum Gastein

Clemens Martin Auer, President of the European Health Forum Gastein welcomed all delegates to the Opening Plenary, and encouraged people to reflect on the last 20 years of the forum, reminding them that is a unique conference that has grown in size, bringing together representatives from a multitude of sectors, which include the public sector, industry, civil society and academia. It is also a conference which should allow ideas to be tested and the transformation of these ideas and dialogues into implementation and practice. This year's main theme Health in All Politics, and as Auer repeatedly emphasised, was chosen because health in all politics is fundamental to making progress. To achieve health in all politics we need to first overcome fragmentation and silo working to strengthen health in the realm of all political fields at the national and European level. He admitted that while it may require taking some risks, it is necessary as there is "no creativity without confrontation", and that we all cannot rest until health plays a central role in all politics.

Three scenarios for the future of health

Dorli Kahr-Gottlieb, Secretary General of the EHFG, then presented the findings of the EHFG Health Futures Project, which explored what leading figures in health policy thought would be the main challenges for health in Europe in 2037. 50 interviews were conducted and three major scenarios emerged:

Ain Aaviksoo, Francesca Colombo, Martin Seychell and Clemens Martin Auer

- The future of health is local,
- Your health, your responsibility and
- Technology delivers.

Francesca Colombo, Head of Health Unit, OECD, then provided a policy response to the scenarios, before joining a panel that discussed both the future scenarios and the EU Council Presidency Trio priorities. The other panellists consisted of Martin Seychell, Deputy Director General, DG SANTE, European Commission; Ain Aaviksoo, Ministry of Social Affairs, Estonia and Clemens Auer.

The future is local was the first scenario discussed, where health decision-making is more decentralised than today which involves less emphasis on choice and economic growth. Colombo raised some potential challenges however, including that a shift to such local decision-making is complex when current systems are so centralised and hospital centric. In addition, to ensure quality care is still delivered, scale is still needed so it remains unclear how that could work in a very decentralised health system. This was echoed by Auer, pointing out that there is a paradox where some things need to be organised locally and others at a national level. For example, the Information and Communication Technology (ICT) infrastructure can only be implemented at a national level, whereas social cohesion or pollution can only be organised locally. Aaviksoo added another example of alcohol harm, which he believes cannot be tackled by one nation alone but needs to happen collaboratively at the European level.

The second scenario, **Your health, your responsibility**, revolves around the state having the responsibility to equip people with information to manage their health, give them alternative healthy choices, and demonise unhealthy behaviours. Colombo raised some potential challenges however, most importantly the difficulty to demonstrate that public health and prevention are cost-effective and worth allocating the necessary resources to achieve them. This also requires investment in health literacy to help people make the right choices. That then begs the question if people are faced with so many choices, "how will they make the right choice?" This is only possible if the right choice is also the easiest and cheapest choice. Governments therefore need to play a greater role in making the healthier choice the easiest option. Auer also emphasised the role of governments at the national and European level to protect people, especially when people are not even given a choice, as is the case with processed foods.

The third scenario, **Technology delivers**, relates to how technology is expected to be a solution for almost everything in healthcare. Privacy in contrast is considered of negligible importance which may erode trust in governments. Emphasis remains on curative care and therefore greater social funds are needed to support insurance systems. Colombo responded first by saying that the opportunities for technology were huge when for example thinking of robots in diagnostics but it also raises some issues. If robots replace radiologists, what will the future be for radiologists? Data also facilitates decision-making and as such, more investment needs to go into data governance structures so that all data gathered can be used appropriately and linked to other datasets. This was echoed by both Aaviksoo and Seychell, who commented that it was easier for people to move across borders than data. This does come with challenges however, if we focus on technology we miss out on the human interaction and we therefore need to think about what workforce skills are needed to work in such a high technological and digital world.

Cooperation is crucial, technology only when it helps the patient

While across the three scenarios there are differences in terms of the delivery of healthcare and the main actors involved, the panellists agreed that they do illustrate the major developments that may contribute to improving health care. This does not only hold true for Europe, but also potentially on a global level.

Of these, first and foremost cooperation is considered crucial and a leitmotif that should pervade all approaches that seek to improve people's health. As much as there is a vision to consider health in all policies, all policies on health ought to consider cooperation as an essential instrument in helping measures for better health succeed. This holds true across all levels and sectors, i.e. from the highest political level, where, as Seychell put it, "the European Commission is a networker between the different areas that deal with health", to the national level, where according to Auer "the best friend of a Minister of Health should be the Minister of Finance", to those actually providing health services, i.e. in cross-border care.

Furthermore, monitoring is crucial to ensure transparency in healthcare as much as in other policy fields. The panellists underlined that every political action intending to improve healthcare can only be as good as the method of its evaluation, or in other words: without evaluation, political actions might fail to gain the political and public support they require to drive long-term, sustainable change. What gets measured gets done. Thus, every action, political or clinical, targeted at improving health needs to be monitored and evaluated to provide objective evidence of its quality.

Another lesson that the panellists derived is that in all three future scenarios of health, solutions to challenges of health systems and sustainable changes to people's lives can only be made at the local level. Think global, act local. Healthy cities are not merely the playground for new policies working on improving health, but set the framework in which most decisions regarding a healthy life are carried out and where the consequences become visible to the individual person. In parallel went Auer's proposal that "even if we master complexity, let's keep the basics in mind", implying that while ideas to improve health might start on an abstract, meta-level, actual changes only become visible when the individual is affected.

In this context, the panellists stressed that while planning for the future is relevant, we must not forget to look at our past battles which are coming back to "haunt us again" (Martin Seychell). For example the battle against the "old enemies" such as antimicrobial resistance, climate change and measles. To combat these once and for all we must think on a global scale, but then implement the measures at the local level.

As another key contributor to the delivery of future healthcare, one must always consider technology. The panellists made it clear that technology in the healthcare delivery process should not be implemented merely for the sake of using it, but only when it proves useful for delivering better healthcare. Somewhat surprisingly, this was explicitly stated by the representative of the highly digitally developed country of Estonia, Ain Aaviksoo. He further explained that technology is going to disrupt the traditional way of doing things, especially in health. Aaviksoo proposed that the role of governments should be to equip people with the right skills to be prepared for this shift towards more technology in their healthcare, while ensuring the use of technology, e-health and digital medicine only when it will actually deliver improved health for patients. Because after all, technology shares one crucial feature with all other developments: its use must improve healthcare for the individual person. This is essential to maintain the trust societies have in governments.

Health in all policies can contribute to freedom, equity and peace

This led to the panellists highlighting that trust is one of the crucial elements for robust societies, public institutions and health systems.

In a short video message, Alois Stöger, Federal Minister for Labour, Social Affairs and Consumer Protection, Austria, stated that trust and solidarity form the basis of a functioning health system, and that if this system leaves nobody behind, there are good chances that health can be provided as a fundamental right to people, which he considered "the most important factor for personal freedom".

As health significantly contributes to equity, social cohesion and securing peace within societies, its relevance can therefore not be overstated, playing a pivotal role for all people everywhere and hence in all policies.

Written by Bélène Podmore and Florian Tille

Speakers and panellists

Welcome address & opening
CLEMENS MARTIN AUER, President, European Health Forum Gastein

Health Futures Scenarios
DORLI KAHR-GOTTLIEB, Secretary General, European Health Forum Gastein

Video message
ALOIS STÖGER, Minister of Labour, Social Affairs and Consumer Protection, Austria

Inputs from & panel discussion with
MARTIN SEYCHELL, Deputy Director General, DG SANTE, European Commission
AIN AAVIKSOO, Secretary General for E-services & Innovation, Ministry of Social Affairs, Estonia
FRANCESCA COLOMBO, Directorate for Employment, Labour and Social Affairs, OECD
CLEMENS MARTIN AUER, Director General, Ministry of Health & Women's Affairs, Austria

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Local politics for health

Health is created at the local level, in the settings of everyday life

Organised by European Health Forum Gastein

Local politics and policy-making play crucial roles in both implementing policies that create healthier environments for all and adopting wider policy frameworks that are set at an aggregated level.

Particularly in times of populism and alternative truths, it is of utmost importance to bridge gaps - not only across different groups in society, but also across different policy areas to ensure comprehensive policies which follow shared goals for better health. Effective and efficient integrated policies should encompass values of equity and solidarity, and need to find their way into local policy implementation. Although the concept of Health in All Policies (which can be seen as a framework for coherent policy-making) is increasingly (in theory at least) considered by governments, different challenges remain for the various levels of policy-making.

At a local level, the political aspect for such local policy implementation becomes increasingly important – especially for health promotion. In the 2016 Healthy Cities Consensus, a local approach was advocated as crucial through the statement: “Health is created at local level, in the settings of everyday life”. City governments become responsible for constantly expanding populations as urbanisation continues

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Karolina Mackiewicz, Des Cahill, Furio Honsel and Matthias Wismar at a steady pace. Therefore, the Thursday Plenary focused on how Health in All Policies is dealt with in urban environments and what the role of local politics and leadership can fulfil.

The central aim for this session was to assess the particular challenges and specific opportunities for local urban politics in order to implement health-related policies. Furthermore, the question was raised as to what extent it would be easier to implement a HiAP approach on a local rather than an aggregated level.

Moderated by Matthias Wismar, Senior Health Policy Analyst, European Observatory on Health Systems and Policies, the session was set up as an interactive meeting in which the audience was invited to get actively involved and comment through social media platforms.

Three panellists were invited to provide their personal stories and react to these specific questions: Furio Honsell, Mayor of City of Udine, Italy, Des Cahill, Councillor, City of Cork, Ireland, and Karolina Mackiewicz, Acting Executive Director for the Baltic Region at the Healthy Cities Association.

Challenges

Long-term investments

Health-oriented policy-making is often a long-term investment, but not always yet regarded as such. Most politicians are only elected for relatively short periods, which are often shorter than the payback periods of such investments. This is a major limitation in planning interventions that are effective in the long term. Hence, it is usually hard for politicians to defend such policies and showcase their results as ‘achievements’ during upcoming elections. This is especially true when policies involve losses or sacrifices in the short term and only gains and improvements much later.

Where the action needs to happen

For many policies that are related to public health, the actual implementation needs to happen at a local or city level. Hence, health promotion often only becomes a reality when local politicians and civil servants take responsibility. For instance, the recent increased influx of refugees and demands regarding their health situation are often dealt with on a municipality level.

Communication

It is vital to communicate and actively share expectations with citizens in order to make the health-oriented political decisions more understandable and appreciated by the public. Especially when unpopular decisions must be made (e.g. road closures) that don´t always serve short-term economic goals, clear communication should point out the long-term benefits and educate the public on these.

Good alternatives should be provided

When one is expecting habitual change from the public, local policies to improve health are only truly effective when the right alternatives are provided. For instance, when a policy on improving air pollution is implemented through closing roads and making the city less attractive to cars, real change is only achieved when high-quality alternatives are in place that provide even quicker cross-city connections.

Opportunities

Immediate effects

Cities often deliver more direct services than national governments and the local population can more readily perceive changes. It is crucial therefore to implement the right instruments and policies at a local level so that their effects are felt immediately (e.g. the installation of good lightning in city parks increases the number of people practicing jogging, and therefore improves general health).

Marketing tool

The proposition of being a “healthy city” can be used as a valuable marketing tool, thus attracting investments and stimulating the local economy even in the short term. Many recommendations and tools of international organisations (i.e. WHO and EC) are in place to support investment decisions – for example, the online WHO tool showing how the increase in walk-ability and bike-ability of cities leads to citizens’ healthier lifestyles. This can easily be integrated into city marketing materials.

Measuring results

Rigorously measuring outcomes and risks related to health-oriented political decisions is the best way to plan and prioritise future interventions. Moreover, measuring is also important to better communicate policy decisions and inform others on best practices but also policy failures.

> *SDGs are only useful if we are able to transfer global goals to the local level.*
>
> *Ricardo Baptista Leite,*
> *Member of Parliament, Portugal*

Bridge gaps

A plea from the audience towards policymakers asked them to try living themselves in social housing, eating in school canteens and using public transport. Indeed, mayors and local policy-makers need to be citizens of their cities and experts in problems that trouble citizens. However, this responsibility works in two ways. Citizens also need to get involved in local politics to realise changes.

Learn from other cities

Actively sharing experiences regarding health-related policy-making is key to inform other governments about the mistakes made and the lessons learned. Joining networks, such as the Healthy Cities Associations, and twinning cities are very good opportunities for active exchange and learning.

Conclusions

Implementing Health in All Policies and Politics at the local level is not always an easy task. The panellists identified preconditions for running a city that is perceived to be “healthy”. Three main points were stressed: good measurement, transparency and communication to move from short-term to long-term goals and achievements. It is necessary to communicate with other policymakers and learn from their successes and mistakes, but simultaneously it is vital to properly communicate with citizens to make health-oriented political decisions more understandable and appreciated.

Written by Arjan van der Star and Iva Šimková

Speakers and panellists

Panel discussion with
FURIO HONSELL, Mayor of City of Udine, Italy
DES CAHILL, Councillior, Cork City, Ireland
KAROLINA MACKIEWICZ, Acting Executive Director, Baltic Region Healthy Cities Association

Moderation
MATTHIAS WISMAR, Senior Health Policy Analyst, European Observatory on Health Systems and Policies

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Global perspectives on Health in All Politics

Twenty years of the EHFG: Driving new ideas for health

Organised by European Health Forum Gastein

During the EHFG 2017, the discussions aimed to take the technocratic concept of Health in All Policies (HiAP) to the level of policy implementation – Health in All Politics.
In this Closing Plenary, Clemens Martin Auer, President of the European Health Forum Gastein, invited delegates to reflect on the importance of a solution-driven global health agenda.

Driving new ideas for health

In a short video message, Pamela Rendi-Wagner, Austrian Federal Minister of Health, sent her congratulations on the EHFG's 20th anniversary and commended the role the Forum has played over the years in furthering the health policy debate in Europe.

The EHFG has become a central marketplace for new ideas where stakeholders meet to exchange viewpoints and address complex health issues. Now more than ever, these conversations entail issues that go well beyond the borders of Europe such as non-communicable diseases , access and pricing of medicines, and antimicrobial resistance (AMR).

Civil society is key in bringing Health in All Politics forward

Robert Madelin, Chairman, FIPRA International, moderated the plenary and interviewed Vytenis Andriukaitis, EU Commissioner for Health and Food Safety, on the system-level challenges that are needed to achieve good health and well-being.

Piroska Östlin, Wanjiku Kamau, Agneta Karlsson and Vytenis Andriukaitis

Health is not only about the absence of disease but much more about sustaining people's health. It also relies on citizens' participation in achieving health for all.

Vytenis Andriukaitis, EU Commissioner for Health and Food Safety

In his address, Andriukaitis highlighted that "Health is not only about the absence of disease but much more about sustaining people's health. It also relies on citizens' participation in achieving health for all." He emphasised the need for cross-sectoral implementation, and insisted on the importance of civil society in ensuring the uptake of sustainable solutions for health. For instance, nutrition, which is reliant on individual lifestyle choices, is also associated with macro-level policy decisions in agriculture and trade. Andriukaitis also raised the issue of alcohol excise taxes, which still require - in contrast to tobacco policies - stricter and more coherent guidelines at national and EU level. He encouraged the audience to push for health-driven targets and outcomes and leverage for strong governance through action at local and national level.

Health in all Politics, to make sure that no one is left behind

Next, Agneta Karlsson, State Secretary to the Minister for Health and Social Affairs of Sweden, delivered a keynote speech on issues of global significance for health. Having participated in the World Health Assembly in Geneva earlier this year, Karlsson pointed out that there are obvious threats to health systems, but the SDGs constitute an opportunity to advance in a truly comprehensive manner.

She referred to cross-sectoral action plans that are being implemented worldwide to manage AMR as a national and global health security threat. She stressed that to succeed in reaching the SGDs, prevention is fundamental and no one should be left behind in attaining the highest possible standards of health.

Karlsson particularly called for greater emphasis on gender equality, women's health, and human rights.

Global health is rising on policy agendas worldwide

Interventions were followed by a high-level panel discussion on the interface between European and global health. Andriukaitis and Karlsson were joined in this discussion by Wanjiku Kamau, Executive Director of the Advocacy Accelerator in Kenya, Ilona Kickbusch, Director of the Global Health Centre at the Graduate Institute of International and Development Studies, and Piroska Östlin, Director of Policy and Governance for Health and Well-being at the WHO Regional Office for Europe.

The panel discussion began with Östlin putting forth the vision of the new WHO Director-General Tedros Adhanom Ghebreyesus vis-à-vis the global health reform agenda, in the context of the Health 2020 policy framework. Ghebreyesus' recent meetings with EU decision makers, as well as his participation at the G20 summit, reflect the direction to make the WHO more political in addition to its technical expertise. Östlin underscored the necessity of partnerships with prime ministers to ensure that health is an integral part of the global policy agenda.

Kickbusch further commented on the leading role of Germany that currently holds the G20 presidency in rallying governments and countries outside Europe (such as Argentina and Japan, the next holders of the G20 presidency) to move the global health agenda forward, for instance, on achieving universal health coverage.

Global challenges call for stronger civil societies and capacity building

Next, panellists discussed the need for capacity building in driving sustainable solutions for health. Wanjiku Kamau commented on the many similarities between the challenges in the Global North and the Global South regarding health advocacy. She brought up issues of trust in politicians, funding, and capacity building. In describing her work at the Advocacy Accelerator, she echoed Andriukaitis´ enthusiasm about the importance of civil society, and coordinated advocacy as a driving force for improvements in health and development. She also remarked on the importance of sound decision-making in Europe and asked delegates to reflect on the impact of different European policies on population health in other parts of the world.

On this topic, Andriukaitis recalled Article 168 of the Lisbon Treaty, which pledges that public health issues are in the hands of Member States but that the EU is responsible for the protection of human health. Andriukaitis pressed for the need to extend our cooperative mechanisms to countries outside Europe, and called for more synergy between European public policies, and the financial instruments that are used to achieve the SDGs.

Karlsson added that the lack of EU involvement in public health is at the cost of people's lives, and that we should also consider health inequalities within Europe. She agreed with Kamau and Andriukaitis on the importance of capacity building in a broad sense to achieve a better uptake of evidence-based policies, and optimal translation of knowledge into action.

Understanding the impact of financial investments on health is crucial

Next, Ilona Kickbusch raised the importance of financial investments given the global health challenges we face. With the rise of emerging economies, there are concurrent shifts in the balance of powers, also regarding access to medicines. Similarly, NCDs and the commercial determinants of health will create new conflicts of interests. She called on delegates to be more astute in better understanding capital flows and investments in equity, especially in relation to the profit of health data and consumer goods.

Kickbusch stressed that public health experts should be aware of, and advocate for more ethical and sustainable financial investments. She warned that new issues of solidarity and sustainability could emerge because our pensions are also ensured through unhealthy investments in fuel, alcohol and tobacco. Therefore, ethical investment processes need to be explored. She asked the health community to consider the role of the private sector in recalibrating micro-finance for better health, and creating a space for civil society to engage. On this topic, Kamau remarked that we also need to prevent the flight of capital, and ensure the independence of non-profit organisations through the availability of public funding.

Ilona Kickbusch

Cooperation with industry bears potential for public health

Finally, Andriukaitis addressed future areas for improvement in European and global health: stopping amenable and avoidable deaths, the demographic crisis, developing better welfare, reducing health inequalities and food waste, and recognising that poverty is a global issue, also in Europe. Andriukaitis reaffirmed the need for better coherence between our health goals, policies and financial instruments, and pointed out the potential of an open government approach that reinvests in civil society funding.

All panellists agreed that more exchange and debate between private sector companies and civil society on the sustainability aspects of policy decisions could steer cooperation between sectors and increase mutual trust. Ultimately, positive corporate action could facilitate actions in which industry contributes and is also responsible for education, the social and health sectors. At last, Madelin rounded up the discussion, by underlining that implementing health in all politics will require investing in new venues and mechanisms for better health.

First-outcomes of EHFG 2017

In his closing remarks, Auer asked delegates to consider the first outcomes of EHFG 2017.

He invited those gathered to reflect on how to bring innovation and Big Data to contribute to health on a global scale, and to be self-critical with regard to pricing and market regulations. He noted that the tide has turned from neoliberalism to a better understanding of the value of social cohesion for better health and the wealth of nations. As we look towards the future, we will have to think about how to implement broad and innovative solutions while keeping a strong sense of purpose and solidarity.
Building on the opening remarks of Francesca Colombo, Head of the Health Division at OECD, "The future will be high tech and high touch", and in the words of Auer, we should aim to equip people for the different kinds of futures that are ahead of us.

Written by Marie Delnord and Juliane Winkelmann

Clemens Martin Auer

Speakers and panellists

Conference round-up & first outcomes
CLEMENS MARTIN AUER, President, European Health Forum Gastein
DORLI KAHR-GOTTLIEB, Secretary General, European Health Forum Gastein

Interview with
VYTENIS ANDRIUKAITIS, Commissioner for Health and Food Safety, European Commission

Input speech: Issues of global significance on health
AGNETA KARLSSON, State Secretary to the Minister for Health and Social Affairs, Annika Strandhäll, Sweden

Inputs from & Panel discussion with
VYTENIS ANDRIUKAITIS, Commissioner for Health and Food Safety, European Commission
PIROSKA ÖSTLIN, Director, Policy and Governance for Health and Well-being, WHO Regional Office for Europe
ILONA KICKBUSCH, Director, Global Health Centre, Graduate Institute of International and Development Studies
WANJIKU KAMAU, Executive Director, Advocacy Accelerator, Kenya

Moderation
ROBERT MADELIN, Chairman, FIPRA International

Newsroom team
NINA RENSHAW, Secretary General, European Public Health Alliance (EPHA)
FRANCESCO FLORINDI, Engagement Officer, BBMRI-ERIC and a member of the Young Forum Gastein

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Track I
Health in All Policies

Giving a voice to the mentally ill

Mainstreaming mental health policies across sectors

Organised by European Health Forum Gastein with research from Economist Intelligence Unit Healthcare

Much is now known about what works in the prevention, care and treatment of mental health problems. And it is accepted that promoting mental health and well-being in policy areas other than health is a crucial way of addressing its multiple determinants. Yet, implementation remains challenging, both at EU and national levels.

Giving a voice to the mentally ill

Mental ill health is a major burden on societies in the WHO European Region: mental health problems affect one in four people at some point in their lives and 38% of EU residents experience mental health problems at some point during any given year. The overall aim of this session was to address how the European Commission, Member States and the wider community can focus efforts to finally make real progress in the area of mental health.

To put a spotlight on the urgency of mental health problems, this workshop began with the very personal and poignant story of Geraldine Niedersüß, a courageous mother who lost her two sons to severe mental illness. Niedersüß was interviewed by moderator Tania Dussey-Cavassini, Former Vice-Director General, Swiss Federal Office of Public Health and Former Ambassador for Global Health.

Niedersüß highlighted that while things have improved over

Tania Dussey-Cavassini and Geraldine Niedersüß the past 25 years in terms of how families are integrated into the therapeutic process, when her younger son was diagnosed with classical depression in early adolescence, the disease was not recognised by his doctor. He was eventually diagnosed with schizophrenia, and in 2005 at the age of 22 he committed suicide. His elder brother was heavily affected by his younger brother's mental health problems and subsequent death, and developed psychological problems that led to addiction. These addictions resulted in him suffering a fatal cardiac arrest in January 2017. For many years now, Geraldine Niedersüß has been part of a self-help group called AhA! In Salzburg, which offers support to family members of people with mental health problems. She highlighted how even relatively small things such as the provision of well-lit, appropriately-located and comfortable rooms for meetings can make a big difference for those with mental health problems and their families, and that it was key to try and integrate those suffering from mental health problems into the workforce either through voluntary or paid work to give them skills and focus in their lives.

EU knowledge & policies on prevention, care & treatment of mental illness

Heinz Katschnig, Emeritus Emeritus Professor of Psychiatry, Medical University Vienna, began by discussing the many different concepts and definitions in the area of mental health. He asked "Where does normal unhappiness end and where does a mental disorder start?" Mainstreaming mental health policies across sectors requires preventive and promotive activities as well as treatment and rehabilitation, and crucially involves people outside the health sector, especially from the sectors of education, work and housing. There should also be a wakeup call for educational institutions concerning mental health, he suggested. The educational setting is the most important arena outside the family for the development of children's mental health. A life cycle approach ought to be taken to further mental health in all policies, as childhood, adolescence, adulthood and ageing are each associated with different determinants like bullying, work-related stress, alcohol consumption and dementia as well as isolation, which may compound the issues.

At a European level the EU does not have competence on national health policies but can address mental health promotion. The European Commission first addressed the issue with a green paper in 2005. This was followed by the 2008 EU mental health conference which saw the launch of the European pact for mental health and well-being. Following the pact, the Joint Action (on) Mental health and Well-being was launched in 2013 which led to the European Framework for Action on Mental Health and Well-being which supports EU-countries to review their policies and share experiences in improving policy efficiency and effectiveness. Katschnig encouraged a comprehensive approach at the Member State level by tackling mental illness inter-sectorally and demanding that ministers look at how community design, social welfare, employment, criminal justice, NGO engagement and other areas shape the issue.

How are EU countries benchmarking?

Annie Pannelay, Healthcare Principal, Economist Intelligence Unit, discussed cross-country policy benchmarking that focused on mental health and integration. Driving trends for this 2014 research were deinstitutionalisation of mentally ill patients and shifting the focus to recovery rather than alleviation of symptoms. The Economist Intelligence Unit's study measured the degree of support within EU governments for integrating people with mental health problems into society, by looking at literature on possible policy interventions and having experts create a conceptual framework which had 18 indicators and four domains: 1) Environment 2) Access to Health Services 3) Creating Opportunities for Workplace Integration 4) Governance. Germany topped the ranking due to strong healthcare and generous provision of welfare benefits. An association between higher rank with GDP and % GDP spent on healthcare was detected. Overall there was a strong correlation between employment and mental health and a lot of room for improvement across all EU countries. A lack of consistent policies on deinstitutionalisation needs to be addressed and better data is required in order to enable policymakers to make evidence-based decisions, particularly around funding. Furthermore, funding for mental health needs to stop being seen as a "luxury good".

How is the OECD supporting Member States mental health?

According to Francesco Colombo, Head of Health Division, Directorate for Employment, Labour and Social Affairs, OECD, more people are now advocating for, speaking up about and consequently destigmatising mental health. A slide of champions for mental health was shown including famous faces such as Canadian Prime Minister Justin Trudeau and Prince William who stated "Mental Health is not a dirty word, we all have mental health like we do physical health."

The OECD tracks prevention activities, and Colombo highlighted that school-based interventions such as anti-bullying campaigns seem to be making an impact. Multidisciplinary approaches to treatment have also been shown to be successful. However most general practitioners in OECD countries are not adequately trained to address mental health, and 50% of depressions in Europe are undertreated. Colombo concluded that we have policies in place but there is an implementation gap in terms of transforming theory into practice.

John Bowis, OBE, Honorary President, Health First Europe, concluded the session by reminding the audience to acknowledge that politicians are human beings and we should hold them accountable by making the issue visible. As mental illness is a sensitive and complex issue, inter-sectoral action has thus far been neglected. Bowis also discussed the plague of unsustainable funding of pilot projects. The EU does have competence in Safety and Health at Work and this could be an avenue to force employers to publish their policies on mental health and create action, he suggested. We ought to disseminate good practice more, and we need to move beyond listening and gathering data and engage in solutions that make life worth living for those with mental health problems.

Written by Laryn McLernon

Speakers and panellists

Panel discussion with
HEINZ KATSCHNIG, Emeritus Professor of Psychiatry, Medical University Vienna, Austria
JOHN BOWIS, Honorary President, Health First Europe
FRANCESCA COLOMBO, Head of Health Division, Directorate for Employment, Labour and Social Affairs, OECD
GERALDINE NIEDERSÜSS, AhA! Angehörige helfen Angehörigen (Family members help family members), Salzburg
ANNIE PANNELAY, Healthcare Principal, Economist Intelligence Unit

Moderation
TANIA DUSSEY-CAVASSINI , former Ambassador for Global Health and former Vice-Director General of the Swiss Federal Office of Public Health, Federal Department of Home Affairs of Switzerland

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Social inclusion, work & health

Inclusive workplaces to avoid social exclusion

Organised by European Agency for Safety and Health at Work (EU-OSHA)

Inequalities surround us everywhere we look – the workplace is no exception. Amongst others. Legislation, policies, employers, and co-workers shape how workplaces affect our health. The workplace can definitively be a place of social inclusion: good practices from the past and present, and plans for the future were presented in this interactive workshop.

When asked "Given the amount of time you spend at work, how do you think work affects your health?", 70 % of the audience indicated that their work duration affected their health negatively, while 20 % quoted a positive effect. The answers obtained by employees with permanent contracts in the European Working Conditions Survey 2016 were 26% and 11% respectively. While the relationship between work and health is very complex, one thing seems clear: work can both make you sicker and healthier.

The European Union's role in work, health and social inclusion

In line with the principle of subsidiarity, the Member States have the primary competence to define their national policies, while the EU can support and complement the activities of the Member States. Silviya Obaydi, Legal Officer, DG EMPL talked about the role of the EU in the field of social policy:

In spring 2017, the European Commission adopted the European Pillar of Social Rights, a guiding document of principles and rights urging Member States to take the level of worker health and safety protection higher. Fair working conditions are one of the three main fields of the Social Pillar, the remaining two being equal opportunities and access to the labour market, and adequate and sustainable social protection. Among other priority areas of occupational safety and health (OSH) measures are stepping up the fight against

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Silviya Obaydi, Hannu Stålhammar, Irene Kloimueller and Marieke Kroezen occupational cancer and exposure to chemicals, and helping businesses, in particular smaller enterprises, to comply with OSH Rules by providing practical guidance for employers, boosting the availability and use of free e-tools and offering tools to address issues of growing concern, like psychosocial risks and ageing. The EC also works with Member States on updating current EU provisions to improve the quality of protection, compliance and enforcement of occupational safety and health policies.

The EU-OSHA's role in work, health and social inclusion

Katalin Sas, Project Manager, European Agency for Safety and Health at Work (EU-OSHA), elaborated on the close interconnections between employment, social exclusion and health equity. Employment is both critical for social inclusion and an important determinant of health – unemployment tends to lead to the worst outcomes in terms of physical as well as mental health. At the same time, certain aspects of work can pose risks to health and contribute to health inequalities.

When talking about work as a risk to health we need to acknowledge the fact that there are groups of workers that are more vulnerable, e.g. because of being overexposed to occupational risk factors or having a higher risk of exclusion from the labour market. This vulnerable group includes women, young people, older workers, workers with disabilities, migrants, as well as temporary and low-qualified workers. To address vulnerability, a new tool has been developed by the Canada Institute for Work & Health: The occupational health and safety Vulnerability Measure, which assesses OHS vulnerability in four areas: hazard exposure, workplace policies and procedures, awareness of hazards and OHS rights and responsibilities, and workers' empowerment to participate in injury and illness prevention.

A Ministry of Social Affairs and Health's role in work, health and social inclusion

Hannu Stålhammar, Special Adviser, Ministry of Social Affairs and Health, Finland, presented the several national development programmes such as the National Programme on Ageing Workers or the Socially Sustainable Finland 2020 strategy, a cross-ministry cooperation working on a strong foundation for welfare, universal access to welfare, and a healthy and safe living environment.

Stålhammar also talked about the ambitious Working Life 2020 project, which strives for Finland to have the best working life in Europe by 2020 (currently Finland is ranked third). As part of the project, Finland developed a working life brand with the aim to make a good working life a competitive factor for Finland. The project aims to support economic growth in the long term, helping the country succeed in international cooperation and to elevating its status as an example and inspiration for others.

Fit2Work, a B2B solution's role in work, health and social inclusion

Irene Kloimueller, Programme Manager, Fit2Work Business Consulting, presented the programme Fit2Work BB which includes more than 1,000 companies and is based on the Austrian Labour and Health Act (2011). The goal of the Act is to reduce early retirement due to health reasons, to reduce invalidity and prevent unemployment for health reasons at an early stage, as well as to reintegrate the work force into the labour market after longer periods of sick leave.

The programme helps to avoid absenteeism and presenteeism by organising occupational health and work health promotion activities for all workers, and medical and vocational rehabilitation for those on sick leave. Once these employees return, they can work fewer hours at the beginning and gradually increase to full working hours. Fit2Work BB sets up in-house integration management resources and also connects companies with external support and facilities. The programme is successfully reducing the length of sick leave, and companies taking part even use their inclusion in the programme for branding.

Recruitment and Retention of the Health Workforce in Europe

Marieke Kroezen, PhD, Erasmus University Rotterdam, presented her research on recruitment and retention in the health workforce. According to estimates, there will be a shortage of 1 million health workers by 2020, which is mainly due to both a maldistribution of health workers and health workers leaving their workplaces - i.e. in Belgium, one third of nurses are thinking about leaving.

The good practices for recruitment and retention filtered out in Kroezen's study were continuous professional development, task substitution, considerable wage raises, professional support tailored to the individual, and interventions that combine several or all of the mentioned practices. The latter requires multiple actors from multiple levels, i.e. employers, workers and policy-maker, as is already the case in some instances. One example described was the NHS Tayside Healthcare Academy, Scotland, that offers training to young people and people from deprived areas to be able to apply for a job in healthcare, many of which remain in the field throughout their careers. Another example is Tallaght Hospital Dublin, Ireland, which provides 'Returning to Nursing' practice courses, refresher courses, and financial incentives as well as personal support for nurses who have left their profession and experience difficulties returning.

Sas reminded us that poor health pushes people out of the labour market and into exclusion, with poor working conditions contributing to poor health. The session placed the issue of social exclusion in the context of the new European Pillar of Social Rights and addressed different ways in which cross-sectoral action is being taken to reduce exclusion at European and national levels.

Written by Cathrine Festersen and Matej Vinko

Speakers and panellists

Interventions from
IRENE KLOIMUELLER, Fit2Work Business Consulting
SILVIYA OBAYDI, DG EMPL, European Commission
KATALIN SAS, Project Manager, Prevention and Research Unit, European Agency for Safety and Health at Work (EU-OSHA)
HANNU STÅLHAMMAR, Ministry of Social Affairs and Health, Finland
MARIEKE KROEZEN, Project manager, Department of General Practice, Erasmus MC, University Medical Centre Rotterdam and member of the Young Forum Gastein

Moderation
TIM TREGENZA, European Agency for Safety and Health at Work (EU-OSHA)

Organised by European Agency for Occupational Safety and Health (EU-OSHA)

European Agency for Safety and Health at Work

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Environment & health

Building the evidence base for policy

Organised by DG Research and Innovation (DG RTD), European Commission

The importance of environment and health for our society brought together experts from administration, politics, civil society, academia and the private sector to discuss new approaches to the challenges we are facing with this regard. These will require re-thinking our current lifestyles as well as the roles of and relationships between scientists and policy-makers in order to achieve the main goal of ensuring better health and well-being in a sustainable environment.

The session started with the panellists giving examples of what research has done so far and what it can do in the future to improve the dialogue with policy-makers and to translate evidence into practice. The following discussions looked at which areas of research and dialogue will need future investment to create the right evidence base for policy-makers.

Elizabet Paunovic, Head of the European Centre for Environment and Health, WHO Regional Office for Europe, gave the first input by presenting some general results of a meeting organised with the Portuguese Ministry of Health earlier that year.
It was agreed that research on environment and health is of crucial importance for contemporary society, and that the diminishing public research budget is a serious issue also when it comes to translating evidence into policy. Important topics raised during the meeting were technology, increasing the role of the private sector, and the importance of actors

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Robert Barouki and Ybele Hoogeveen

from other areas - such as social scientists - in order to maximise societal benefits. Paunovic also pointed to other fields for action, like i.e. citizens' engagement, with a shift from information to involvement and ensuring that the voice of citizens can be heard.

Sofie Nørager, Scientific Officer, DG Research and Innovation, European Commission emphasised the importance of a real dialogue between scientists and policy makers. There has to be a mutual understanding of how research results can be used in policy making, and policy makers need to set priorities for questions and issues scientists should focus their research on. These changes are needed today in order to make our society sustainable. She highlighted that the main challenges with this regard are trust in science and understandable data to make the interplay between science and policy work.
Nørager also reminded the audience of the current drivers for EU Environment and Health Research, like the Sustainable Development Goals (2015-2020), the WHO Environment and Health Process (since 1998), the EU's 7th Environment Action Plan (2013-2020) or Horizon 2020 (2014-2020).

Eva Csobod, Director, Regional Environmental Center for Central and Eastern Europe, presented the ClairCity project funded by the European Union. The main goal of the project is to integrate and quantify citizens' behaviour and activities to enrich city, national and EU level policy-making, resulting in improved air quality, reduced carbon emissions, improved public health outcomes and greater citizen awareness
Csobod also pointed to major issues like the association between respiratory and heart diseases and environmental problems - living in a city with a higher exposure to chemicals and a lack of green and blue spaces can severely affect the daily life of citizens.

Brigit Staatsen, Senior Researcher, National Institute for Public Health and the Environment, The Netherlands, also underlined the health and well-being benefits of exposure to blue and green spaces. Today's Europe is lacking both quantity and quality of green space, resulting in an increasing disconnection with nature – this has to be changed. Furthermore, for healthier cities and a healthier environment it is necessary to keep an eye on chemical safety, moving towards a non-toxic environment.

Greet Schoeters, Programme Manager, Flemish Institute for Technological Research, elaborated on the importance of living well within the limits of our planet and on the importance of data in order to give policy makers easy and fast access to translatable results.
Robert Barouki, Head of Unit, French National Institute of Health and Medical Research, talked about the exposome as an important future concept related to health and environment issues, encompassing the totality of human environmental (i.e. non-genetic) exposures.

The presentations and ensuing discussions during this forum made clear that the environment and its interplay with health need to be addressed in a holistic manner. In the end, we might not need that much additional research, but rather make the evidence we have more accessible and correlate findings better. It is important to collaborate across sectors, to be transparent and to use resources efficiently.
Lacking trust in science is one of the challenges that need to be met, just like bridging the gaps between scientists and policy makers is, by producing simple, translatable and actionable findings.

Written by Juljana Nanaj

Speakers and panellists

Opening

Setting priorities for environment and health research
ELIZABET PAUNOVIC, WHO European Centre for Environment and Health

Environment and health research under Horizon 2020, the EU FP for Research and Innovation
SOFIE NØRAGER, Scientific Officer, Health Directorate, DG RTD, European Commission

Part 1 - EU Funded Research Underpinning the Ostrava Declaration and SDGs

Healthy cities - air quality, waste, water and urban planning & Chemical safety

Engaging citizens for future with clean air and lower carbon emissions
EVA CSOBOD, Regional Environment Centre, Hungary | Project partner in CLAIR-CITY

Harnessing benefits for health and wellbeing in cities from exposure to blue and green spaces
BRIGIT STAATSEN, National Institute for Public Health and the Environment (RIVM), The Netherlands | Project partner in BLUEHEALTH & INHERIT

Informing and evaluating policies for chemical safety – HBM4EU, the European Human Biomonitoring Initiative
GREET SCHOETERS, Flemish Institute for Technological Research (VITO), Belgium | Co-coordinator of HBM4EU

Part 2 - The Future

The Exposome concept and its future potential
ROBERT BAROUKI, INSERM - Unit on Toxicology, Pharmacology and Cell Signalling, France | Project partner in HEALS & HBM4EU

Evidence for policy
YBELE HOOGEVEEN, European Environment Agency

Moderation
ELIZABET PAUNOVIC, WHO European Centre for Environment and Health
Co-moderation
ALESSANDRA LAFRANCONI, Milano Bicocca University, Italy and member of the Young Forum Gastein

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Organised by DG Research and Innovation (DG RTD), European Commission

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The SDGs/Health 2020 roadmap and environment and health

Transformative approaches for equity and resilience – Harnessing the 2030 Agenda for health & well-being

Organised by World Health Organization Regional Office for Europe

There is an undeniable link between the environmental conditions in which we live and our health.

This session focussed on ways to improve environmental health under the framework of “Health 2020” in the WHO European Region, plus the “New Urban Agenda”, “Agenda 2030” of the United Nations and the Sustainable Development Goals (SDGs) from a global point of view.

Elizabet Paunovic, Head of the European Centre for Environment and Health, WHO Regional Office for Europe, opened the forum by addressing the link between the SDGs and Health 2020. Globally, the Agenda 2030 for the SDGs have set new goals for health and well-being for all. This builds a supportive basis for the Health 2020 Agenda in Europe. In order to reach the goals, consideration of health in all policies (and politics) is required. This should create whole-of-society and whole-of-government approaches.

New way of thinking through SDGs: prevention instead of curing illness

Chris Dye, Director of Strategy, Policy and Information, WHO, explained how the SDGs could transform human health. His concern was about the term transformative approaches. The ideas from the SDGs are indeed transformative. The true transformation is not in shaping the new goals and visions, but rather in developing an answer to how to reach the goals. There is a real shift from Millennium Development Goals

Eva Csobod, George Morris, Elizabet Paunovic, Chris Dye and Sebihana Skerendovska

(MDGs) to SDGs. The MDGs focussed on the major causes of illness and death in the developing world, whereas the SDGs look for more horizontal sustainable systems in all countries to accelerate health gains through treatment and especially prevention. Additionally, health has an undeniable link with all SDGs. Investing in health would result in benefits for the other SDGs as well. This has made health a top priority on the agenda of the UN and therefore the countries' leaders. With a little creativity, one could put health in the centre of the sustainable development goals and develop a national agenda.

Promoting environmental health is about change management

George Morris, Honorary Professor, European Centre for Environment and Human Health, University of Exeter Medical School, focused on environmental public health in Europe and opened his speech with the importance of change management. Two distinct but related categories of change continually shape and reshape the foundations of health. First category: large scale, long term changes at the societal level which act on the material, social and cultural determinants of health and well-being. Second category: an evolution of ideas determines our basic understanding of how health is created and destroyed. Environmental health has been confronted with the last one. It has shifted from a traditional vertical view focussing on epidemiology, energy or pollution towards an inequality-focus. He gave insights on significant implications: societies can no longer hope to deliver health without a radical rethink. Part of this must be a return to an environmental conceptualisation of the whole public health project. Public health must think and act on a vastly extended temporal and spatial scale. For that, we should invest in evidence, ethics, holistic issue-framing, infrastructure and governance, and give importance to the relationship between human health and ecological health.

In the panel discussion, the advantages of a "whole-of-society approach" for national policy developments were discussed. According to Morris, environmental health has been tackled in a very narrow way. We need to reach out to other sectors that are involved. International policy instruments tend to have a universal approach, which results in countries applying them in their own ways. It is good to have some flexibility for individual implementation, as "one size does not fit all".

WHO Sustainable Development Goals

Sebihana Skerendovska, Roma Information Centre, the former Yugoslav Republic of Macedonia, gave some visions from an NGO point of view. According to her, being the critical voice in a society is not always easy. It is very much about making partnerships which promote the social determinants of environmental health. Roma people attending segregated schools are not educated well and have a low level of literacy. We should include also the vulnerable populations when we target public health policies.

Eva Csobod, Regional Environmental Centre for Central and Eastern Europe, mentioned the importance of monitoring the health status of populations with reliable indicators. Ministries should make health risk assessments in their countries and oversee potential hazards. Generating evidence from all segments of societies should help to tackle inequalities.

There was some criticism from the participants regarding why the WHO did not mention the Canada-Europe Trade Agreement. Chris Dye agreed that the WHO has been reluctant to comment on the health consequences of trade agreements. However WHO has defined its priorities and cannot comment on or fight against everything, what is most important in this area is to establish a consistent analytical framework on the risks and hazards of cancer. Yet, WHO is competent in explaining the hazards or health risks in layman-terms to people and they can give advice in this manner.

There was also discussion about the impact of housing on health, that ill-structured and poorly-insulated homes have a negative influence on health and renovating them could offer a big chance to improve public health. Warm dry homes are at the centre of public health, much like sanitation and clean water, argued the panel. Unfortunately the housing agenda has suffered from fragmented approaches, and failure to think on a sufficiently large-scale. For example, in terms of addressing specific health issues like Tuberculosis, there are greater risk factors than housing, so other risk factors are focussed on in terms of TB control. However if all the small positive impacts were accumulated, it would arguably offer a greater improvement overall in terms of public health. Therefore risk frameworks need to include a more integrated way of thinking that bring in all the different and separate areas that benefit from warm, dry housing.

The session was concluded with the following statement: the SDGs are a platform at the international level with multi-sectoral and multi-level approaches, which give us the opportunity to address our public health problems on a national level. A collaboration within and between the countries is the key to successfully promote environmental health.

Written by Thijs van de Schoot and Tugce Schmitt

Speakers and panellists

Keynote presentations
CHRIS DYE, Director, Strategy, Policy and Information, World Health Organization
BETTINA MENNE, SDG Coordinator, WHO Regional Office for Europe
GEORGE MORRIS, Honorary Professor, European Centre for Environment and Human Health, University of Exeter Medical School

Panel discussion with
EVA CSOBOD, Regional Environmental Centre for Central and Eastern Europe
SEBIHANA SKERENDOVSKA, National Roma Centrum, Macedonia, The former Yugoslav Republic of Macedonia
CHRIS DYE, Director, Strategy, Policy and Information, World Health Organization
BETTINA MENNE, SDG Coordinator, WHO Regional Office for Europe
GEORGE MORRIS, Honorary Professor, European Centre for Environment and Human Health, University of Exeter Medical School

Moderation
ELIZABET PAUNOVIC, Head of the European Centre for Environment and Health, WHO Regional Office for Europe

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Addressing inequities through social policies and investments and economic determinants of health and health inequities

Transformative approaches for equity and resilience – Harnessing the 2030 Agenda for health & well-being

Organised by World Health Organization Regional Office for Europe

Recent studies have shown that societies that are focused on resilience and equity tend to be stronger than societies which purely focus on growth. The "leaving no-one behind" agenda comes into place when speaking about transformative approaches - tackling discrimination and making sure everyone has a voice. We need to bring different actors and stakeholders into the process, but at the same time we need to be careful of how this agenda is communicated to policymakers and society as a whole. Evidence shows that generally health is improving, but not fast enough for everyone.

Health inequalities in Europe's working populations

"Health inequalities challenge social justice", began Nico Dragano, Institute of Medical Sociology, Düsseldorf University Hospital, and he presented a set of studies, ranging from the 1970s to today, which show that health inequalities amongst the working population in Europe exist and are at risk of widening. Throughout the life course and across different areas of life, work is interlinked with health and well-being. Data from all over the world support the statement "The richer you are the older you'll become", asserted Dragano. Occupational class, quality of life, and education all influence health, with income being one of the major determinants of health. Dragano showed epidemiological data from the famous Whitehall Study which showed that employees with a lower occupational status have a much higher risk for coronary heart disease than the higher occupational status group (Marmot et al. 1978). Nothing has changed, Dragano said, with hundreds of studies in different

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Graham Randles, Nina Renshaw, Furio Honsel, Mariana Dyakova, Nico Dragano, Bettina Menne and Leo Williams settings pointing to the same conclusions, that those with the lowest occupational status suffer the worst health outcomes. Recent data from Sweden show that inequalities in the workforce are even widening, while in other countries such as Germany they persist.

So, what can be done? Policies focused on childcare, education, welfare, housing and effective taxation can help to reduce the combination of risks that individuals face over the life course. Labour policies such as fair wages and effective Active Labour Market Policies (ALMP), coupled with opportunities for Lifelong Learning and sound occupational safety and health (OSH) legislation can also play a positive role in narrowing inequalities, with the healthcare system also able to support and help to improve the situation.

In conclusion, Dragano argued that the associations between work and health inequalities are complex, with different mechanisms involved. This is why we need cross-cutting, inter-sectoral transformational policies, and the involvement of different levels from the company level to the societal level. Policies on their own, without governance mechanisms, won´t work. And within the EU we should aim for better policy coherence.

Basic income and the crisis in governance

A universal basic income (UBI) could be a powerful equaliser of health, human potential and social progress. Louise Haagh, Reader, University of York, discussed the case for such a policy, the evidence and the political and institutional challenges. As defined by the Basic Income Earth Network, a UBI is a periodic cash payment unconditionally delivered to all on an individual basis, without means test or work requirement. It should be lifelong and permanent. It is expected that it will bring positive well-being impacts for all, not least in terms of a permanent sense of security. A UBI is an old idea that started as early as the 1970s. In 2016 there was a breakthrough in political interest in the issue with a referendum in Switzerland. As of January 2017, a two-year experiment in establishing a UBI began in Finland and Holland. It can be seen as a democratic and humanist response to the crisis in governance and public services (the destabilised welfare state), in terms of a new form of delivering welfare, and can be achieved through institutional transformation. There are a range of alternative arguments for establishing a UBI, such as redistributive or equal justice arguments, however Haagh underlined that her support of the measure was not about it transforming the whole of the welfare state, but rather that it will make a small but very important change.

Haagh discussed both historical and more recent research that showed that UBI has a core constitutive effect between more permanent background security including how well individuals strategise and think about their overall motivations for doing things in life, and how well institutions can become more inclusive, both of which have well-being effects.

In conclusion Haagh argued that basic income was a pivotal reform on three levels: individual, institutional and systems, and helps to consolidate the post-war “public human development project”, which sees a protective state as a foundation for society and the market. It does this in three ways. At an individual level it helps stabilise the individual´s condition against all other things happening in their lives. It helps transform social relations with institutions and it potentially also enables better performance of other services and systems (ie education and health). Although potentially a small change it could have a huge impact.

The well-being of future generations

Mariana Dyakova, Policy, Research and International Development, Public Health Wales, UK, highlighted some global challenges which she then considered in the Welsh context. There are global risks and threats, such as national disasters, war, migration crises and communicable and non-communicable diseases: there are predicted to be 250,000 deaths globally by 2030 caused by climate change. The OECD has estimated that the economic, societal and environmental burden of ill health and inequity means that the total cost of healthcare will double by 2050. Doing business as usual is unsustainable with high costs to people, their families, cities and countries, she posited.

Dyakova then highlighted some of the challenges facing Wales, including high health inequalities amongst young people, many children living in poverty, a faster rate of ageing than other parts of the UK, and an obesity problem. To address these, Wales held a wide-ranging conversation in which over 70,000 people participated, entitled “The Wales we want”. It mirrored the process of formulating the Sustainable Development Goals and led to the “Well-being of Future Generations (Wales) Act" (2015) enacted in 2016, with a range of health indicators developed to measure progress. This has been a ground-breaking process and the resulting work offers a greater chance for sustainability because of the multi-stakeholder process through which it has been developed: it has become embedded in and across different stakeholders in society, who are taking ownership of the work.

In addition, Public Health Wales formulated an advocacy package, the main message of which was that investing in public health drives social, economic and environmental sustainability. An executive summary and eight infographics were developed which focus on different public health issues in Wales and reveal at a glance information on how investing in these areas pays off. These can be used by stakeholders to support their arguments and make the case for health.

Panel Discussion

One theme of the ensuing panel discussion was about how we create open systems for genuine participation for well-being and health. Leo Williams, European Anti-Poverty Network, highlighted the examples of a minimum income scheme that EAPN had helped to introduce in Portugal and the inclusive and responsive process by which the UN agreed the SDGs, especially the involvement of those most experiencing poverty and injustice. This led to more participatory space, a specific target on participation in the SDGs and key transformational policies in the SDG agenda – i.e. development as a global issue, and bringing sectors together that traditionally operated in their own silos. These examples showed that ongoing work within political and civil dialogue processes can work, and the sense of control and destiny of the people involved were also transformed. Nina Renshaw, Secretary General, European Public Health Alliance, added that policymakers need to be ready to receive a diversity of voices from civil society and not expect civil society to always speak with one voice. We need to keep getting better at participation and empowerment, to ensure diversity of voices and stakeholders in the content and design of services and decision-making processes around the distribution of resources needed to live a healthy life.

Moderator Christine Brown, WHO Venice Office, asked Graham Randles, New Economic Foundation, and Nina Renshaw what the health community could do to get the financial sector involved in this transformational work? Renshaw responded that a critical catalyst for the Paris Climate Agreement in 2015 was bringing in the private sector, World Bank and other financial institutions to look at climate bonds which brought in investment for renewable energy. Nowadays too ethical investment is a growth sector. She also cited a BMJ meta-study that showed a 14-1 return on investment for public health and prevention measures, suggesting this figure alone should unlock a new wave of investment in prevention. We know from the O'Neill Report that the costs of doing nothing in the area of AMR would be 10 million deaths by 2050 and a cost of 100 trillion to GDP. So the economics will stack up, let´s copy the methods of those working on climate change, suggested Renshaw.

In terms of governance and accountability, Christine Brown pointed to the lack of political advocacy tools around health equity and reported that in 2018 the WHO will launch a Health Equity Status Report as a political advocacy tool to monitor progress to implement policies important for health equity, introducing a scorecard around these drivers of health, looking at accountability, empowerment and participation. We need to look at how to use these tools with other approaches to achieve social well-being, equity and sustainability goals, she said. If we are really serious about this then we will do regular social, economic and environmental reporting on value. That is the basis for driving both change within our own practices as well as maximising resources.

Written by Vladana Stefanovic and Claudia Fischer

Speakers and panellists

Keynote presentations

Health inequalities in the working population: what causes them and what can inter-sectoral policies do against?
NICO DRAGANO, Institute of Medical Sociology, Düsseldorf University Hospital

The transformative impact of universal basic income – a powerful equaliser of health, human potential and social progress
LOUISE HAAGH, Reader, Department of Politics, University of York, UK

The Well-being of Future Generation (Wales) Act: a whole-of-government whole-of-society roadmap for creating a healthier, resilient, prosperous and more equal Wales
MARIANA DYAKOVA, Deputy Director, Policy Research and International Development, Public Health Wales and member of the Young Forum Gastein

Panel discussion: Acting to create healthier, more inclusive and sustainable societies

Building a new economy where people really take control. The tools to transform real lives, workplaces and communities
GRAHAM RANDLES, Managing Director, New Economic Foundation Consultancy

Political and civic dialogue processes – strengthening democratic processes for better lives and healthier people and societies
LEO WILLIAMS, Director, European Anti-Poverty Network

The Role of Cities in levelling up health and life opportunities: progress and lessons learned from creating health-enhancing systems for living and working. Illustrated by sustainable mobility, air quality and the Udine Declaration on Life Long Learning
FURIO HONSELL, Mayor of City of Udine, Italy

European advocacy, lobbying and constituency building for health - partnerships for the health and well-being of all Europeans
NINA RENSHAW, Secretary General, European Public Health Alliance

Moderation
CHRISTINE BROWN, Programme Manager Health Equity & Social Determinants & Coordinator, European Health Equity Status Report, WHO European Office for Investment for Health and Development

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Investing in healthier cities: “insuring” prevention

Organised by World Health Organization Global Coordination Mechanism on NCDs (GCM/NCD)

This session was already the fourth in a series of debates organised by the WHO Geneva Office in Gastein, addressing NCDs and ways of tackling them. This time, the focus was on health promotion and prevention on the local level, also taking into account the national insurers’ point of view.

Armin Fidler, immediate past President, European Health Management Association and former adviser to the World Bank, co-chair of the workshop, highlighted the unique composition of the panel, that gathered together not only representatives of local authorities, but for the first time also included the payer’s perspective. He also drew attention to the context specific differences of the healthy cities topic, with i.e. mega-cities, such as Mexico City or Beijing, facing a different calibre of problems than i.e. European capitals. However, the common challenge remains the same: bringing all relevant stakeholders on board.

The Austrian journey

Josef Probst, General Director, Main Association of Austrian Social Security Institutions, reflected on the Austrian “master-plan” for health promotion and prevention, the “Gesundheitsziele” (health targets), that successfully brought together both national and local level of government, as well as civil society and other relevant stakeholders. To strengthen and prolong health and healthy life years of the population, ten health targets were developed through various participatory projects.

Probst is particularly proud that nine out of ten goals target health determinants and work through a health-in-all-policies approach. In his opinion, the targets have been successfully established as a framework for orientation within the healthcare system - they are viewed as guiding principles for the ongoing health reform process.

Julia Tainijoki-Seyer, Josef Probst, Siegfried Walch, Armin Fidler, Kai Kolpatzik, Karolina Mackiewicz and Des Cahill

> *Ní neart go cur le chéile.*
> *There is no strength without unity.*
>
> *Des Cahill, Councillior, Cork City, Ireland*

He emphasised that changing the attitude towards organising care when reorganising the health system is crucial. The key component here is to strengthen the role of primary care. Drawing a link to the topic of the workshop – healthy cities and tackling NCDs – strong primary healthcare must, according to Probst, be a part of the community and city strategy for health: We can achieve the targets only by working with local communities.

A local example - the role of Cork's City Council

Local government has limited powers, but it is the local government that is closest to the population, said Des Cahill, Councillor of the city of Cork Ireland. The local council can actually see the people who will be affected by its actions and decisions – which is a unique opportunity to react timely to the needs of the city's population.

Cahill explained in more detail how local governance works in the city of Cork. He stressed that when passing the budget and overseeing the development plan for the next council term of five years, it is crucial to ensure all stakeholders agree collectively on a strategy. Only like this it can be guaranteed that - independent from election results - long-term plans can be implemented, with health and well-being of citizens playing a very important role. He sees the city hall as facilitator for all main stakeholders coming together and working as one unit, which is the key to success.

Promotion of healthy living and education are vital for tackling NCDs in the long-run, according to Cahill. Arguments for investing here go beyond health itself: the better the physical and mental state of the population, the more productive and successful it will become. In his view, the city hall should empower, allow the city to grow and citizens to participate.

A holistic approach – how physicians can make a change

Julia Tainijoki-Seyer, Medical Adviser, World Medical Association, asked the audience to reflect on their own personal experience of how difficult it is to change one's habits as an adult – which is why it is extremely important to develop healthy lifestyle early on.

Speaking from the health practitioner's point of view, cities play an increasingly important role for creating healthier citizens. Cities also have to face the problem of how to guarantee access to care for rapidly growing populations, while being affected by i.e. shortages in the health workforce. In her opinion, the role of a physician should not be limited to treatment. Physicians, as group that belongs to one of the most respected and trusted in society, should encourage people to be and live healthier – to focus on health promotion and prevention.

Tainijoki-Seyer mentioned a simple communication tool helping physicians to address NCDs. A simple "why?"– question addressed to the patient about the reason or motive behind his or her behaviour can shed some light and direct towards appropriate treatment.

She sees two roles a physician can play:

1) Being active in the city planning – by contributing their knowledge and expertise on the health impact of i.e. air pollution, traffic, mobilisation, physical activities, access to care, access to fresh water and tobacco free zones.

2) Through direct contact with patients – by encouraging them to change their life-style.

Tainijoki-Seyer acknowledges the challenges physicians are facing, such as the lack of time for a detailed exchange with patients given the average 5-7 minutes per consultation. She suggests looking at reimbursement systems and their adaptation to changing realities and the new requirements these demand from physicians.
She emphasised the importance of a collaborative approach and multi-stakeholder understanding when it comes to changing behaviours.

Health literacy – a German approach

Kai Kolpatzik, Physician and Public health expert, Head Department of Prevention, AOK - Federal Association of German Health Insurances, shared the German story of dealing with low levels of health literacy, and how insurances can contribute to solving the issue. He started out by explaining how the health insurance he represents decided to develop a tool for communicating medical information. The tool includes both easily accessible and understandable information, by using simple linguistic and visual ways of presentation, i.e. text boxes summarising benefits and risks of a medical procedure or a medication.
The AOK, together with different scientists, decided to develop a national plan to combat health literacy. The project started in May 2016 and will be completed in February 2018. It has so far produced around 15 recommendations on health systems, promotion and prevention, and chronic diseases. National coordination centres for health are being established to help implement these recommendations and get other players - like local governments - on board.

Healthy cities – a practical example from Finland

Karolina Mackiewicz, Acting Executive Director, Baltic Region Healthy Cities Association, began with acknowledging the shift in understanding health – from a very narrow view, i.e. visiting a doctor and taking medication, to a much broader one. This broader view is also reflected in the healthy cities platform. Health is approached in a way that includes the global ecosystem, natural and built environment, our activities, local economy, community and lifestyle – all this is interconnected and interdependent.

The healthy cities platform stands for cross-sectoral cooperation, equity, empowerment and sustainable development. Mackiewicz focussed especially on the empowerment aspect, as this, in urban health, means bringing communities to the centre, and giving citizens the opportunity to participate and co-create their environment and surroundings.
What does this mean in practice? Mackiewicz presented examples of youth organisations engagement in local health promotion from the Finnish city of Turku, giving young people the opportunity to create the city they want to live in. An online tool was created, allowing to submit suggestions, comments, ideas and to participate in the decision-making. There is also an active youth city council that decides on grants for youth projects - an initiative for self-made project funding. A group of a minimum of three teenagers can apply for funding between 100-500€ for any project to co-create their living space. Furthermore, in the area of physical activities the city cooperates with youth sports clubs, who offer and organise after school events.

Mackiewicz emphasised a considerable shift in action – from providing services to creating them together. This gives a great chance to establish something together, shaping the space where youngsters spend their time and teaching them responsibility for their environment.

Dialogue with the audience

During the discussion part audience touched upon various topics, from possible ways of cooperation with the private sector, the role of the healthy cities in the vaccination through the role and expected contribution form the civil society to the global coordination mechanism for NCDs.

Working with the private sector - tobacco & food

Josef Probst concentrated on the commercial determinants of health on the Austrian example (tobacco), where, regrettably, in his opinion, there is no real discussion about changing the rule of the games, the framework between private-public sector. The fact that on the political level different types of actors are involved, gives hope, but, as Probst said, to come to an agreement one have to have a common understanding, talk openly about the problems and be trough a common learning process.

Kai Kolzatzik presented German efforts on sugar reduction. AOK invited other parties, most notable the food market chain giant Lidl, and toghether announced a strategy to reduce sugar level in the product that Lidl produces and sells. He also mentioned joint efforts on the voluntary commitment on the EU level on the conduct on food marketing to children, where it was managed to engage with almost half of the industry representatives to implement the rules of the conduct.

Getting all on board

Julia Tainijoki-Seyer responded to the vaccination and health promotion question, presenting an example how World Medical Association engaged with journalists to get the message about the need of vaccination to the people and debunk harmful myths.

Karolina Mackiewicz mentioned, that sometimes we will find ourselves working with very unusual stakeholder on health promotion – in her case it was an involvement from a Catholic church in one of Polish cities, where a priest got on board to promote the health gains of a HPV vaccination for young girls.

Social insurances would welcome contribution form the public health community in form of knowledge transfer and support, and for the community to speak up and vocalise strongly outstanding issues and problems, to become a partner in lobbying for good change.

All gathered agreed on the need of multi-stakeholder approaches and policy coherence for better health promotion and prevention, to mobilise against NCDs.

Written by Maria Dziubinska

Speakers and panellists

Welcome
OLEG CHESTNOV, former Assistant Director-General for Noncommunicable Diseases and Mental Health, World Health Organization

Input from
JOSEF PROBST, General Director, Main Association of Austrian Social Security Institutions
DES CAHILL, Councillior, Cork City, Ireland
JULIA TAINIJOKI-SEYER, Medical Adviser, World Medical Association
KAI KOLPATZIK, Physician & Public health expert, Head Department of Prevention, AOK Federal Association, Germany
KAROLINA MACKIEWICZ, Acting Executive Director, Baltic Region Healthy Cities Association

Moderation & chair
ARMIN FIDLER, MCI Management Center Innsbruck, Austria /and: immediate past President, European Health Management Association
SIEGFRIED WALCH, Head of Department & Studies, MCI Management Center Innsbruck, Austria

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Global Coordination Mechanism on NCDs (GCM/NCD)

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Transforming food systems

Adding value for better health in Europe

Organised by Federal Ministry of Health and Woman's Affairs of Austria

Magdalena Arrouas, Director General, Public Health and Medical Affairs, Ministry of Health and Women's Affairs, Austria opened the session by presenting prevention and control of non-communicable diseases as the main strategic objective of the Austrian Ministry of Health. To achieve this goal Austrian policies purport the creation of health promoting environments that empower individuals, families and communities to make healthier lifestyle choices.

This brings us to the topic of the session: how to transform the current food systems in a way that stimulates a healthier diet. Arrouas explained that this contrasted with earlier policies that were targeting malnutrition leading to the production of many kinds of processed food. It is this type of food that is partially responsible for the alarming rate of overweight and obesity among EU citizens.

New more encompassing strategies and policies that target the entire food chain are therefore urgently needed to achieve a more diversified and sustainable diet. This call is also echoed by the EU Childhood Obesity Strategy and recent initiatives by the Dutch and Maltese EU Presidencies which challenged the food industry to take their responsibility and reform the food they are producing.

She concluded by emphasising that working together is key to achieve our goals in this complex area.

Session moderator Clive Needle, Senior Policy Advisor EuroHealthNet announced the first panel that was expected to address the most pressing questions regarding research in that field.

Corinna Hawkes, Karen Fabbri and Jo Jewell

Setting the scene - WHO priorities for actions

Jo Jewell, Technical Officer at the WHO Regional Office for Europe, strongly endorsed the initiative by the Austrian EU Presidency and is keen to work with Austria on behalf of the WHO to further develop the work done so far. Europe is the most affected by NCD's and has the highest rates of overweight and obesity in the world. The WHO set the goal to have zero increase of obesity and diabetes by 2025 in Europe. In addition, the WHO aims for a 30% reduction of sodium/salt intake by the same year.

Jewell highlighted the shockingly high incidence of childhood obesity. In some European countries one out of two children is currently overweight. One of the causes is the high amount of sugar in food; for example, in Turkey this can be as much as 40 out of 100 gr in certain food products. A transition is therefore urgently needed to make more healthy food options available. To tackle some of the most pressing issues, the WHO recommended Member States to reduce the exposure to children and introduce more consumer-friendly labelling. The implementation of these recommendations will require the cooperation of the entire food chain including the producers, processors, retailers and secondary manufacturers.

Jewell called for additional research and innovation in this field to create more evidence that could be used by politicians and policy-makers. He also confirmed Arrouas' call for better cooperation to tackle the many challenges within the European food system.

Developments and prospects in research related to food systems and health - inter-sectoral collaborations

Karen Fabbri, Head of Sector, FOOD 2030, DG Research and Innovation (DG RTD), European Commission presented a number of alarming statistics:

- Two billion people worldwide are overweight or obese.
- By 2050, the world population will rise to nine million people, which will lead to a 60% increase in demand for food.
- Currently, food production requires 70% of our drinking water, uses 30% of our energy and is responsible for 25% of the greenhouse gasses in the atmosphere.

On the basis of these statistics, Fabbri called for changes in food policy and additional innovation in this field. She pointed to a window of opportunity to act now following the modernisation of the CAP, the upcoming new Framework Programme (FP9) and commitments made by the EU/Europe regarding climate change. According to the FOOD 2030 strategy, the EU should prioritise the following objectives:

- Nutrition for sustainable and healthy diets;
- Climate, smart and environmentally sustainable food systems;
- Circulatory, resource efficient food systems;
- Innovation and empowerment of communities.

These priorities should be driven by investing in innovation, open science and improved international collaboration.

In terms of political support, the sector FOOD 2030 managed to bring together three EU Commissioners at different high-level events to discuss these issues, namely Carlos Moedas (Research and Innovation), Vytenis Andriukaitis (Health and Food Safety) and Phil Hogan (Agriculture & Rural Development).

In addition, a 2030 expert group was set up to generate advice on the future of EU food policy over the coming 12 months. Ideas for the future so far include bio-fertilisers, alternative proteins, rural growth and 3D printed food. Food 2030 will launch a 2030 food engagement platform in November.

In conclusion Fabbri made all participants aware of a second-high level conference on food systems and policies in June 2018 under the Bulgarian EU Presidency.

Latest knowledge on priorities for transforming food systems

Corinna Hawkes, Director of the Centre for Food Policy at City University of London, discussed potential changes that are needed to transform the current food system in Europe and appropriate tools and methods to implement them.

She posed the rhetoric question what we would want food systems to do in reference to the 2015 – 2020 European Food and Nutrition Action Plan of the WHO. To summarise the document, she stated that society needs to make vegetables, fruits and whole grains more available, affordable, acceptable and more appealing for ALL people. Referring to ALL people, she stressed that it should not be forgotten that food consumption is an issue of equity as the prevalence of overweight and obesity is disproportionate in deprived communities.

In many respects consumers' wishes have become reality as there is an amazing variety of food available in Europe. Supermarkets are a success story. So why are we not healthy, Hawkes asked the audience. The problem is that the food system is not well integrated due to insufficient inter- and cross-sectoral links with other areas.
Supply chains want to make a food product more appealing or add value but do not necessarily make the product healthier and hence follow a policy line that clashes with national health policies, for example.
At the same time, consumers are assumed to drive demand, yet this is influenced by income, skills, busy lives and a number of other factors. The question is whether the industry is steered by consumer demands or whether many unhealthy products are easier to produce.

There is sufficient evidence that food systems can be oriented towards diet related health with economic incentives, in contrary to the current situation, aligning with national health objectives.
Following this assumption, it is crucial to engage with the industry and together change the food system and make it more sustainable.

Panel discussion with the audience

Corinna Hawkes pointed to the fact that sugar is readily available, and that people generally like it, which is why the industry has little incentive to cut down. To the contrary, it seems to be a standard in the food industry now to include sugar in your product if you want to make a profit.

Jo Jewell stressed that research and policy are required to target manufacturers and the agriculture sector to identify where effective changes can be made.

Karen Fabbri highlighted the necessity to identify how our food systems work. The most important step towards any kind of solution is to bring together all the different actors.

Hawkes informed the audience that, although this issue may seem new, it has already been on the agenda for a while, yet change takes time in this area due to the complexity of the matter. One of the reasons why this problem has not been properly addressed is that we tend to run away from complexity.

Young Gasteiner Karl Kristian Bekeng enquired about the lack of incentives to take health into consideration. He mentioned that in Norway a partnership with the food chain in which 95% of the industry is participating has been established successfully. The industry partners pledge for more fruits and vegetables and wholegrains, as well as a reduction of the amount of sugar and salt in food over the coming five years.
A representative from the European Society of Cardiology (ESC) brought forward that the ESC has done a lot of work in this area and has accrued large amounts of data on effective/ineffective measures to change food patters in consumers. On behalf of ESC he expressed his interest in cooperation. At the moment, healthy food is still too expensive and not tasty enough.

Closing the panel discussion, Jewell referred to target setting by governments as an effective measure.
In her closing statement Fabbri explained that projects like the Norwegian example above are difficult to implement at the EU level as health is very much a national competence. There is no systemic approach for a European food policy at the moment; It would require for all food policy actors to

be gathered around a table. In many regions and cities best practice projects are being implemented whose outcomes should be shared.
Hawkes stressed the difficulty to provide incentives for the different actors to come together. Once both industry and governments are truly committed, they will find a way, but this is yet to happen.

Industry point of view - localisation along the food value chain, perspective and priorities

The second panel was composed of members representing industry-side interests. The speakers drew heavily on the theme of individual responsibility, with each speaker emphasising the importance of consumers informing and educating themselves about healthy eating and food labelling.

Javier Valle, Senior Policy Adviser at COPA & COGECA (European Farmers and European Agri-Cooperatives) highlighted the general downward trend in consumption of milk, some meats and fruit and vegetables, noting that fruit and vegetables were the most wasted products in households. He sees an opportunity to address health in all agri-food policies, but this must be met with educating consumers to understand more about evidence-based dietary recommendations and the relationship between food and farming. Valle suggested that consumers should be discouraged from only looking at foods' energy content, and there was a need to go beyond current labelling to differentiate different types of fats or natural versus artificial nutrients, for example.

Johann Marihart, President of the Food Industries of Austria (FIA), outlined the huge task of the last century to make food affordable, safe, and of high quality, whereas now the problem was over-nutrition. His view was that food is only part of the problem, and that greater emphasis should be placed on physical inactivity, excessive media consumption, and consumer education. Marihart argued that the food industry already provided reformulated products and information on labelling and portion size, but education was needed for consumers to make the healthier choices for themselves. He suggested that the younger generation had a role to play, and provided the example of Austrian schoolchildren learning to recycle waste, thereby educating their parents.

This prompted a question from the moderator, who queried the role of the food industry in education amid concerns about direct access to schools. Marihart agreed that education was important for awareness-raising and pointed out that the FIA acts in co-operation with the Ministries of Health, Agriculture, and Environment to publish school newsletters.

The role of retailers was described by Els Bedert, an advisor on Food and Non-Food policy at EuroCommerce. Retail is competition-driven, where retailers have a constant need to differentiate themselves by understanding what the consumer wants and when. Bedert outlined the challenges for retailers due to the major increase in e-commerce, and societal changes such as single-person households, less food preparation at home, and more people eating out. Consumers do not want to be told what to buy, but they expect high quality, affordability and choice, and are more vocal nowadays about transparency and sustainability. She highlighted that retailers provided a link between producers and consumers, and although the industry has an opportunity to inform, consumers must have a solid knowledge base to act upon; therefore, education is key.

Karin Schindler from the Ministry of Health and Women's Affairs, Austria wrapped the forum up by calling for support to develop and transform the food industry in Europe, noting that all actors must be included, or the goal will be missed.

Conclusions and key messages

- Commitment is needed from all sectors to focus on (1) doing what is most effective for health, (2) understanding what prevents things from working and (3) avoiding getting mired in ideological arguments.
- The food industry hides behind the mantra that the consumer has to choose, yet there is substantial evidence on the influential effects of marketing and advertising, particularly on children.
- A supply-chain dialogue is very important; farmers do not want to be told what to do by retailers, and consumers do not want to be dictated by retailers. The EU is seen as too distant to bring about real change and is more likely to happen at national level.

Written by Kelly Muireann and Mischa van Eimeren

Speakers and panellists

Setting the scene: WHO priorities for actions, interrelations between NCDs and lifestyle with a focus on nutrition
JO JEWELL, WHO Regional Office for Europe

Developments and prospects in research related to food systems and health, inter-sectoral collaborations
KAREN FABBRI, Head of Sector, FOOD 2030, DG Research and Innovation (DG RTD), European Commission

Latest knowledge on priorities for transforming food systems
CORINNA HAWKES, Professor of Food Policy, Director, Centre for Food Policy, City, University of London

Overview of the organisation, localisation along the food value chain, perspective and priorities
JAVIER VALLE, Senior Policy Advisor, COPA & COGECA (European Farmers & European Agri-Cooperatives)
JOHANN MARIHART, President, Food Industries Association of Austria
ELS BEDERT, Adviser, Food & Non-Food Product Safety, EuroCommerce

Moderation
CLIVE NEEDLE, Senior Policy Advisor, EuroHealthNet

Organised by Federal Ministry of Health and Woman’s Affairs of Austria

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Health literacy in all politics

Organised by Health Literacy Coalition and sponsored by MSD

This workshop discussed health literacy in various contexts and considered ways of improving it, particularly with the involvement of citizens and patients. With health literacy (HL) already being a recognised need, John Bowis, International Health Policy Advisor and moderator of the session, highlighted the urgency of now working towards better patient involvement, as this is "the missing link in enabling us to afford health."

Kristine Sørensen, Founder, Global Health Literacy Academy, introduced the topic by defining it as follows: "Health literacy is the capacity of people to meet the complex demands of health in a modern society [...], to understand which factors are influencing it and know how to address them." [1]
The need for improving health literacy levels is proven by research: An average of 1 in 2 people have problems with health literacy. However, there are differences between countries; when comparing the eight European countries of the 2012 European Health Literacy Study, health literacy levels are highest in the Netherlands, with only 1.8% of respondents being inadequately health literate and 26.9% being problematically health literate. Bulgaria ranked last in the survey, with 26.3% of the population being inadequately health literate and another 35.2% having a problematic level of health literacy.[2]
Furthermore, digital HL is a rising issue. Six out of ten people in Europe (EU28) use the internet to search for health-related information, but merely 60% of these would also say that the information they found came from a trustworthy source, while 39% reported that they would not trust the information online to make health-related decisions.[3] Hence, while people are better informed than before the age of "googling symptoms", decisions about health and well-being can still not be made without the help of a health professional.

Rutger Jan van der Gaag, Vice President, Standing Committee of European Medical Doctors, stressed the importance of doctors, nurses and other health professionals

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Kaisa Immonen, Rutger Jan van der Gaag, John Bowis, Deepak Khanna and Kristine Sørensen welcoming the development of having better informed patients and helping them to correctly evaluate the sources they base their decisions on. He summed up that e.g. quality vs. length of life decisions cannot be made based on online information, and that patients need tailored advice from professionals regarding what to focus their investment in health on.

Kaisa Immonen, Director of Policy, European Patients' Forum criticised that institutions, healthcare providers and professionals are not sufficiently communicating what qualifies as adequate evidence for taking decisions on health. Better transparency as well as health information provided by established and trusted institutions could lead to an improved understanding of scientific evidence by the public. It is therefore the responsibility of these institutions and researchers to communicate evidence in comprehensible language.

As treatments become more complex, as Deepak Khanna, Senior Vice President and Regional President EMEAC, MSD Oncology, illustrated on the example of cancer treatment, health literacy will become more important and is also high on companies' agendas, as it can serve as a tool for citizens to benefit from innovation.

When discussing inequalities and the ability of people to access health information, van der Gaag pointed out that - at least regarding health literacy and specifically digital health information - the problem of access is often exaggerated. The potential to inform and empower also hard to reach groups through smart technology should be explored further, which can then contribute to reducing health inequalities.

Conclusions

Throughout the session, several specific action points were collected. A priority seemed to be the improvement of communication between health providers and patients, that the competence of health professionals with regard to health literacy should be improved, and that the patient should be recognised as expert. Other action points concerned the need for early-life health literacy, to enable every person to be in charge of their own prevention. Health promotion should therefore already be on primary school curricula. At the same time, if the culture of managing one's own health is changing, it is important to not only target children in schools, and not only patients, but the entire population, so that everyone knows what level of help, be it the GP, the hospital or the pharmacy, they require if they ever become patients. Especially the competences of pharmacists should be harnessed more effectively, as they are often the first point of contact for patients. Finally, better leadership is required to develop strategic plans to improve health literacy and legitimise action on all levels - health literacy should be a government goal.

Health literacy is not only a topic that concerns all citizens and all health professionals, but it is one that everyone of us can affect, shape and develop in our own context, may that be in our role as researchers, policy-makers or simply as users of health services and systems. Health literacy improves the responsiveness of health systems. Although not all questions posed in this session could be sufficiently answered - especially the question on what policies exactly could lead to improved health literacy - it did become clear that, while political leadership is useful, all institutions and individuals within the health system have a role to play.

Written by Katrin Berkemeyer

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[1] Sørensen K, Van den Broucke S, Fullam J, Doyle G, Pelikan J, Slonska Z, et al. Health literacy and public health: A systematic review and integration of definitions and models. BMC Public Health. 2012 Dec 25;12(1):80.

[2] Sørensen K, Pelikan JM, Röthlin F, Ganahl K, Slonska Z, Doyle G, et al. Health literacy in Europe: Comparative results of the European health literacy survey (HLS-EU). Eur J Public Health. 2015;25(6):1053–8.

[3] Flash Eurobarometer 404, TNS Political & Social. E-Health Literacy - Volume A (Results per country). 2014.

Speakers and panellists

Interventions from
KRISTINE SØRENSEN, Founder, Global Health Literacy Academy
DEEPAK KHANNA, Senior Vice President and Regional President (EMEAC), MSD Oncology
KAISA IMMONEN, Director of Policy, European Patients' Forum (EPF)
RUTGER-JAN VAN DER GAAG, Vice President, Standing Committee of European Doctors (CPME)

Moderation
John Bowis OBE, International Health Policy Advisor and Honorary President, Health First Europe

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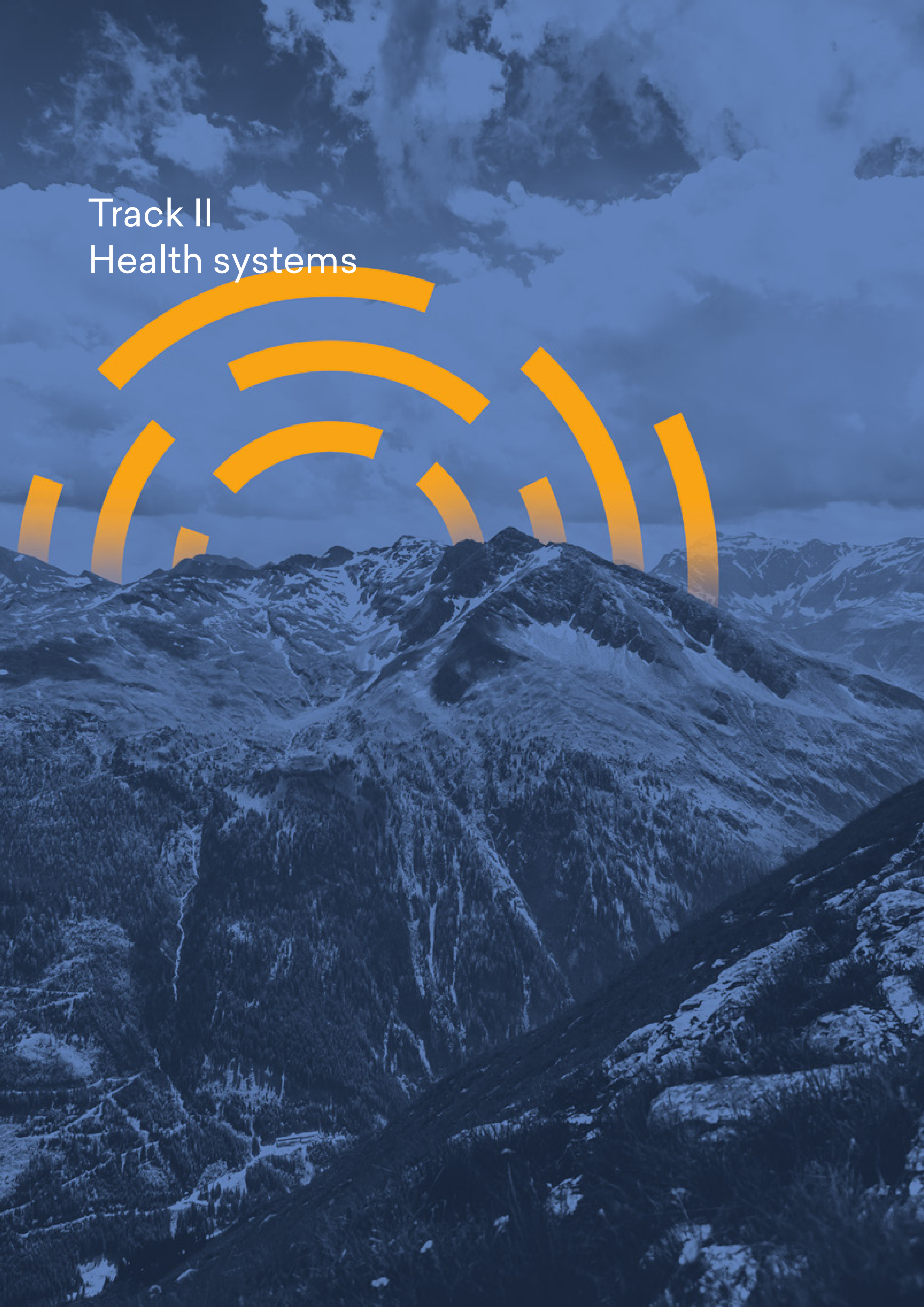

Josep Figueras, Dorli Kahr-Gottlieb, Vytenis Andriukaitis and Matthias Wismar

Better synergies for health - the role of civil society

Organised by European Health Forum Gastein in cooperation with European Observatory on Health Systems and Policies

The collaboration of governments with civil society organisations (CSOs) plays an essential role in the achievement of national and international health objectives. More than any other actor, CSOs can help to bring health to the political agenda by creating political momentum. Although the importance of civil society's contributions to health and health systems are undisputed, successful cooperation cannot always be taken for granted.

This session, chaired by Josep Figueras, Director, European Observatory on Health Systems and Policies, and Matthias Wismar, Senior Health Policy Analyst, European Observatory on Health Systems and Policies, explored how governments and civil society organisations can more effectively engage with each other and create better synergies for population health.

Figueras opened the session by highlighting the relevance of civil society in holding governments accountable for their decisions. Yet he also noted that there is still a considerable variation between countries with regard to the relationships between CSOs and their respective governments. Figueras further underlined that civil society organisations are one of the fundamental pillars of well-functioning health systems.

The introduction was followed by an impulse presentation by Vytenis Andriukaitis, Commissioner for Health and Food Safety, European Commission, who strongly emphasised that everyone is part of civil society – especially those elected to represent civil society in parliaments or other governing bodies. The Commissioner was critical of the fact that current discussions in public health focus mainly on diseases instead of well-being and prevention. To achieve a healthy society, we need to shift to an understanding of health as social, mental and physical well-being. Furthermore, a stronger emphasis on the health and well-being of children and adolescents is required if we aim for a sustainably healthy population.

This holistic understanding of health can only be accomplished through inter-sectoral collaboration in general and the cross-sectoral engagement of civil society organisations specifically. Platforms such as the European Health Forum Gastein can be used to break-up silo-working approaches by involving non-governmental organisations from the environmental, educational, agricultural or financial sector.

Breaking-up silo-working

Figueras encouraged the audience to reflect on Commissioner Andriukaitis's words and to scrutinise whether work in their own health communities is also taking place in silos. He stressed that CSOs are necessary to leverage arguments for public health, especially in the political sphere. While there are enough data available supporting the relevance of health and well-being, the message sent to the political arena needs to be reframed to gain more recognition.

During a discussion with the audience several difficulties that hinder successful collaboration between governments and CSOs were identified. Audience members then suggested solutions for how to address these issues to better support civil society organisations in their work. One problem raised was the general lack of financial support for CSOs and the need to be heard in different fora, including the powerful financial sector. Health in all policies is not only the obligation of DG SANTE but a responsibility of the European Commission as a whole. However, health still seems to be low on the agenda of other sectors as demonstrated, for example, by the lack of representation from other sectors or political areas at conferences such as the EHFG.

Andriukaitis echoed these difficulties by noting that "health is very high in our speeches but afterwards more people are interested in the economy and industry". The Commissioner further queried that it is often not understood that health is linked to the economy, as it is the condition for a productive workforce. He suggested to add health as one influencing factor in the national Gross Domestic Product formula to ensure that governments invest in human capital from different angles. Such an approach also includes that social, environmental, behavioural, economic and commercial determinants are taken into account when talking about health. Although the Sustainable Development Goals take such a multifaceted view, their successful implementation is still in doubt. Once again, the role of civil society comes into play as civil society organisations are "the only real instrument to implement health policies".

Matthias Wismar, who presented on the main findings of his co-edited book "Civil Society and Health – Contributions and Potential", gave the second talk of the session. While a negative definition of CSOs prevails in the literature, emphasising that civil society organisations are neither state nor market nor family, Wismar argued for a more positive view highlighting CSO characteristics such as autonomy and constituency. Besides the SDGs, the European health policy framework Health 2020 takes a whole-of-government approach stressing the importance of involving civil society. The main benefits of civil society organisations lie in their unique characteristics such as the empowerment of people, service delivery, commitment, flexibility, participation in policy-making, and credibility.

Barriers and facilitators for the work of civil society organisations

Representing CSOs, Wanjiku Kamau, Executive Director, Advocacy Accelerator, Kenya; Freek Spinnewijn, Director, European Federation of National Organisations Working with the Homeless (FEANTSA), and Wendy Yared Director, Association of European Cancer Leagues (ECL), reflected on their work through sharing first-hand experience of the facilitators and barriers related to the collaboration of civil society organisations with the political sector.

During the discussions, common drivers of success emerged, among them the recognition and use of windows of opportunity, flexible funding, the engagement of donors as advocacy partners, peer-support, the breaking-up of silo-working, and the active involvement of young people.

> *If you want to go somewhere fast, go alone.*
> *If you want to go somewhere far, go together.*
>
> *Wanjiku Kamau,*
> *Executive Director, Advocacy Accelerator, Kenya*

Significant shortcomings in the funding system were identified as a main barrier to the sustainability and effectiveness of civil society organisations. This relates not only to the overall availability of financial support. In fact, the specificities of some funding mechanisms impede innovative projects aiming to bring about change by encouraging the production of abstract results that mostly end up in reports. National and international politicians would need to walk the talk to change this limitation by going beyond making promises at a political level and ensuring that the administration follows through on those promises with new regulations.

Another major hurdle relates to the variations in the quality of collaborations. Following the reasoning "not every collaboration is a good one, not every platform is useful", civil society organisations need to be more strategic in choosing their partners to maximise their success.

Considering the added value of CSOs in a systemic way

Experiences shared during the session revealed incoherence on the political level with regard to the publicly stated importance of the involvement of CSOs and the actual support they receive. Further, as the impact of collaborations with CSOs is often hard to demonstrate in a quantitative manner, one should rather consider their added value in a systemic way – like complex social interventions – instead of focusing on the impact of single projects. Finally, effective partnerships between governments and CSOs require genuine collaboration and their strategic involvement.
In the end, it might be an African saying, brought forward by Wanjiku Kamau, that best describes the reason why a cross-sectoral collaboration of governments with civil society organisations is so important to achieve better health for all: "If you want to go somewhere fast, go alone. If you want to go somewhere far, go together."

Written by Ramona Ludolph

Speakers and panellists

The role of CSOs in health promotion, prevention and protection

VYTENIS ANDRIUKAITIS, Commissioner for Health and Food Safety

Keynote: What is civil society and what does it do for health and health systems?

MATTHIAS WISMAR, Senior Health Policy Analyst, European Observatory on Health Systems and Policies

Panel discussion round I - CSO stories

WANJIKU KAMAU, Executive Director, Advocacy Accelerator, Kenya
FREEK SPINNEWIJN, Director, European Federation of National Organisations Working with the Homeless (FEANTSA)
WENDY YARED, Director, Association of European Cancer Leagues (ECL)

Panel discussion round II - reflections from policy-makers

NATASHA AZZOPARDI-MUSCAT, Senior Lecturer, University of Malta /and: President, European Public Health Association (EUPHA)
VESNA-KERSTIN PETRIC, Division for health promotion and prevention of non-communicable diseases, Ministry of Health, Slovenia

Panel discussion round III - round-table discussion

NATASHA AZZOPARDI-MUSCAT, Senior Lecturer, University of Malta /and: President, European Public Health Association (EUPHA)
KAISA IMMONEN, Director of Policy, European Patients' Forum (EPF)
NICOLAE JELAMSCHI, Chair of Executive Committee, South Eastern European Health Network (Moldova)
KITI KAJANA PHILLIPS, Program Officer, Access to Medicines & Innovation, Public Health Program, Open Society Foundations (OSF)
WANJIKU KAMAU, Executive Director, Advocacy Accelerator, Kenya
VESNA-KERSTIN PETRIC, Division for health promotion and prevention of non-communicable diseases, Ministry of Health, Slovenia
SEBIHANA SKERENDOVSKA, National Roma Centrum, Macedonia, The former Yugoslav Republic of Macedonia
FREEK SPINNEWIJN, Director, European Federation of National Organisations Working with the Homeless (FEANTSA)
WENDY YARED, Director, Association of European Cancer Leagues (ECL)

Facilitation
JOSEP FIGUERAS, Director, European Observatory on Health Systems and Policies

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Nobody left behind

Improving access to healthcare for underserved people

Organised by MSD

There is a growing acknowledgment of the need to address health inequalities across different groups of underserved people, i.e. migrants, sex workers, lesbian, gay, bisexual, transgender/transsexual people (LGBT), people who inject drugs, prisoners, and the homeless subjects. Yet, at the same time, the design of our healthcare systems does not address their specific of this key populations. As a result, they often experience severe inequities in access to care and poorer health outcomes. The session was driven by the question on how to improve access to healthcare for underserved people with the purpose to reach consensus on a policy agenda.

The speakers in this session included: Alyna Smith, Platform for International Cooperation on Undocumented Migrants, Anastacia Ryan, International Committee on the rights of sex workers in Europe, George Kalamitsis, President of Prometheus, Hellenic Liver Patient Association, Greece, Eberhard Schatz, Correlation Network, Freek Spinnewijn, Director, European Federation of National Organisations Working with the Homeless, Andrej Kastelic, National Centre for the Treatment of Drug Addiction, Slovenia, Rachel Halford, Hepatitis C Trust, UK and Jeffrey Lazarus, International Health, Immunology & Microbiology Department, University of Copenhagen.

The session was moderated by Denis Onyango, Head of Programmes at the African Advocacy Foundation and Boris Azais, Director Public Policy, MSD Europe & Canada.

Jeffrey Lazarus

At first, the invited representatives and health policy experts provided a short overview of the purposes they serve and the challenges they face. Then, together with the participants, they discussed the main challenges and common needs in accessing healthcare for underserved people, and the policy responses at different policy-making levels and practical solutions to create a more inclusive, more effective health service design.

Similar challenges for different groups?

Certain challenges affect all underserved groups in the same way. The underserved people are at significantly higher risk of poorer health than the general population and have a substantially greater risk of contracting infectious diseases such as HIV, hepatitis C and tuberculosis. They are all fighting against stigmatisation and discrimination in society and in the healthcare system, even from health professionals. Access to education is limited for them, which has strong impact on their health literacy. Furthermore, these groups are disproportionally affected by all kind of health problems and often suffer from (mental) comorbidities. Therefore, their life expectancy is significantly lower than in the general population.

On the other hand, there are also group-specific challenges. Considering access to medical services, undocumented migrants live in constant fear to be discovered and to suffer of legal consequences like deportation. They mostly enter the EU on some kind of permit and then lose their status. Accepted migrants suffer disadvantages as well. Thirteen out of 49 countries do not provided treatment to migrants. Racism is still a huge problem within the healthcare sector and language problems negatively influence access to care. Confidentiality also plays a role, since migrants fear their personal information will be shared with the immigration department. For these people health in all politics is really an issue since there is a huge impact of migration policy on health status.

Sex workers are vulnerable because they are exposed to an increased risk of sexually transmitted diseases due to work. The main problem lies in the fact that their profession is not recognised, treated and regulated as work and therefore labour rights and preventive measures are not implemented. Another special group is the prison population - prison offers opportunities to healthcare. Access to physical and mental health is a fundamental human right – people in prison should have the same standard of medical care as people living in the community. However, a huge problem is the stigma and the lack of preventive facilities.

Some examples of good practice were presented like the “Ath Checkpoints” that were set up in Greece in order to test for HIV in men having sex with men. By broadcasting and advertising these services in special areas they now tested about 70,000 people for HIV. After positive testing direct linkage is provided to care or adequate counselling.

Another example are the harm reduction policies for people who inject drugs (PWID) that are implemented in Amsterdam, i.e. heroine programs and drugs consumption rooms. This is a very useful intervention to bring people out of the streets and increases public order.

At the end of the first part of the session Jeffrey Lazarus talked about health system design to promote universal access. He first referred to the WHO Health Systems Framework where six building blocks - leadership/governance, healthcare financing, health workforce, technologies, information and research, service delivery - of the health system help to reach overall goals as improved health, responsiveness, financial risk protection and improved efficiency. However, to leave no one behind, an advanced framework should be used that puts people in the centre and demonstrates the dynamic interaction between each of the six building blocks. Therefore, for the promotion of universal access for all people a people-centred health system approach is needed. But main questions remain: is the workforce able to address these populations? And do health systems have strategies to engage these populations? Lazarus argues that we must bring the medical services to the people to achieve people centeredness.

Where should we put our priorities?

After the short presentations participants were encouraged to discuss in world café groups:

- What are the main challenges and common needs in accessing healthcare for underserved people?
- The policy response at each level of policy-making, and practical solutions to help create a more inclusive, more effective health service design.

The challenges and needs were identified as discrimination and stigma, legal and regulatory barriers, awareness of rights, health literacy, perception of need, accessibility of services and inappropriate healthcare design.

The results of group discussions covered the following important challenges:

- sense that health systems systematically do not own responsibility for providing services for these vulnerable groups;
- lack of collaboration between the health sector and social care sector;
- no one is taking ownership and people from underserved groups visit a specialist after a specialist in the health system. Someone needs to take responsibility to take care for those people and health services should be provided more custom-made;
- the communities themselves should be more encouraged to become more involved;
- we should work together with underserved people instead of making decisions about them. Only by really involving them, we will be able to reach these groups and build their trust in the system;
- peer-to-peer support may be more effective in dealing with health literacy compared to top-down approaches. eHealth may have high potential to reach underserved groups.

Another main issue was identified as the lack of funding for early detection in primary care and funding for research - we need more knowledge on the needs of the underserved populations and how to address them. A final point made was that to reduce the amount of stigma - an open discussion is needed, also from the political side.

Conclusions and key messages

Many of the most marginalised and underserved people in Europe, including migrants, sex workers, prisoners, men who have sex with men (MSM), people who inject drugs (PWID), and the homeless are at a higher risk of infectious diseases, chronic diseases and violence, and yet face severe inequities in accessing healthcare.

The sessions concluded with a policy response at national level presented by Lee Baker which included the following four main points:

- **Service redesign**: This implies involving peers in service delivery and service design and therefore including more people centeredness, more trust to generate a greater continuum of health services and linkage of medicine and social care (more holistic view).
- **Training of the healthcare professionals**: In fact, the only way to effectively reduce stigma within the healthcare sector.
- **Communities involvement**: To be effective, health services for underserved people must be sited in community locations trusted by service users (such as harm reduction centres, drop-in community centres and homeless shelters) and should deliver person-centred, non-judgemental health promotion, prevention care, harm reduction, screening, treatment and rehabilitation, together with mental health and social services.
- **Improved funding**: by setting the right incentives. Participants called on national policy-makers to fund these programmes based on public health and human rights, and specifically to involve these communities in service design and delivery. The EU can support this paradigm shift through strategies and action plans, support for evidence-based policy (e.g. sharing of best practice), structural improvement at national level (e.g. European Structural Funds) and co-ordinated health surveillance.

At the EU level the following key solutions are proposed:

- Support evidence based policies and share best practices.
- Support structural funding,
- Provide disease surveillance, as a basis for evidence-based policy.

Written by Sandra van Oostrom and Stefanie Johner

Speakers and panellists

World café facilitators & moderators
ALYNA SMITH, Advocacy Officer, Platform for International Cooperation on Undocumented Migrants (PICUM)
ANASTACIA RYAN, Programme Officer, International Committee on the Rights of Sex Workers in Europe (ICRSE)
GEORGE KALAMITSIS, President of Prometheus, Hellenic Liver Patient Association, Greece
EBERHARD SCHATZ, Project Coordinator, Correlation Network
FREEK SPINNEWIJN, Director, European Federation of National Organisations Working with the Homeless (FEANTSA)
ANDREJ KASTELIC, Head of the National Centre for the Treatment of Drug Addiction, Ljubljana, Slovenia
RACHEL HALFORD, Deputy CEO, Hepatitis C Trust, UK
JEFFREY LAZARUS, Professor of International Health Systems, International Health, Immunology & Microbiology Department, University of Copenhagen

DENIS ONYANGO, Head of Programmes, African Advocacy Foundation
BORIS AZAIS, Director Public Policy, MSD Europe & Canada

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Re-imagining health systems with people at their centre

Organised by acumen public affairs

The session addressed the multifaceted question of how to make health systems more people focused. The moderator Andrea Feigl, Health Economist at the Organisation for Economic Cooperation and Development noted that the OECD has mapped more than 300 definitions for people-centred care. The concept of person-centred care encompasses various domains and involves different actors.

Delegates were split into six working groups focused on service integration, patient expectations, role of industry, role of government, healthy choices, and financing.
Each working group was led by a distinguished expert and was tasked to discuss three questions from the perspective of their respective domain:

- What defines a fully people centred health system, and what is it not?
- What are the current challenges in achieving people centred care?
- What are the three next steps towards achieving a people centred system?

The theme evoked lively discussions in the working groups. Following the group-work, the experts formed a panel to discuss the findings and the inter-linkages between them, as well as the ways forward.

Integrated care - Service integration and management

The working group on service integration, moderated by Axel Kaehne, Associate Director at the Institute for Public Policy and Professional Practice, Edge Hill University, UK, identified a broad range of elements and requirements for integrated

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Andrea Feigl, Alex Kaehne, Thomas Allvin, Ricardo Baptista Leite, Rachel Halford and Henry Ashworth

Making health systems more people focused requires a change of mindset on how health systems are conceived at different levels. Building and maintaining trust among all stakeholders remains of key importance.

services such as patients' capacity to access health data through inter alia developing data interface integration, education and health literacy; seeing the patient as an active citizen and creating the right fora for patient engagement; as well as ensuring the quality of in-person meetings, as it is in the end often the social interaction between the patient and the health care worker that creates value to the patient. Speaking a common language is central in building and maintaining trust and understanding. Putting the right incentives in place for the professionals and making sure that they have the skills for interaction are essential in making sure that services are built from the citizens' values.

Patient perspective/service delivery - Patients' expectations

Rachel Halford, Deputy CEO of the Hepatitis C Trust, UK, who led the working group on patient expectations, identified trust as a key ingredient for patient empowerment. Ensuring health literacy in an environment shaped by fast-developing technology sets new challenges for gaining and maintaining trust. Education of patients and professionals, making patients' expectations clear from the beginning, and including patient voices at each level were raised as key steps to address patient expectations. At the same time, the patient's voice is not the only voice to be heard. Health boards of citizens are practical examples of integrating patient voices and strengthening patient empowerment at different levels.

Medicine and technologies - How pharmaceutical sector can contribute?

The working group led by Thomas Allvin, Director Strategy and Healthcare Systems, European Federation of Pharmaceutical Industries and Associations, focused on the contribution of the pharmaceutical industry and pointed to access to medicine, including the industry's role in defining the price levels, as well as taking patients on board in R&D by understanding patients' views on quality of life and ensuring that they approve what they pay for, among others. The industry plays a major role in developing the use of data and personalised medicine as well as in ensuring transparency and patient access to neutral, high quality information on medicines and their effects.

Information - Nudges, health literacy and healthy choices

Henry Ashworth, President of the International Association for Responsible Drinking, moderated the group that focused on healthy choices. Ashworth underlined that an active, empowered patient is best equipped to make healthy choices, but empowerment requires departing from the individual's needs. The challenges lie in understanding each other's interests as well; patients need to know who to trust.

Governance - The role of the government

Ricardo Baptista Leite, Member of the Parliament of Portugal, underlined the central role of the government in ensuring that health systems include people who could be excluded from the macro level picture, and urged governments to look beyond health into well-being. The three steps for governments to achieve more people centred health systems were identified as defining a clear vision at the governance level; developing civic literacy, including among the elderly and the healthcare workforce; and breaking the silos.

Financing - Reducing waste & releasing resources

Andrea Feigl noted that in terms of financing, the tension between quality and efficiency challenges stakeholders to share values and goals that the health systems are to achieve. To focus people centredness on outcomes, patient' values should be better matched with the financial incentives. For instance, co-payments facilitate financial access to care for patients with multiple illnesses. The OECD Patient-Reported Indicators Survey (PaRIS) seeks to identify indicators valued by the patient.

Conclusions

In summary, the session recognised that in order to develop more people oriented health systems, there is a need for a common vision of what the patient wants. All stakeholders - patients, healthcare professionals, governments and governance at different levels, industry, and civil society have responsibilities to achieve this and will benefit from more people centred healthcare systems. The patient should be seen as an empowered, informed and active citizen whilst making sure that the more silent voices are heard as well. This in turn requires education of patients and of healthcare personnel, combined with a level of clarity and simplicity in language, quality in social interaction and incentivising the right people. The domains discussed in the workshop are intrinsically interlinked. For example, patient empowerment is more than health literacy, as it requires seeing the patient as an active citizen and understanding her or his values. This can require short-listing and framing the options available for the patient. Similarly, financial incentives that match the patients' values need to be put in place for better coordination and integration of services.

Finally, there is no one size fits all. Making health systems more people focused requires a change of mindset on how health systems are conceived at different levels. Building and maintaining trust among all stakeholders remains of key importance.

Written by Kaisa Lähdepuro

Speakers and panellists

Inputs from
THOMAS ALLVIN, Director Strategy and Healthcare Systems, European Federation of Pharmaceutical Industries and Associations (EFPIA)
HENRY ASHWORTH, President, International Alliance for Responsible Drinking (IARD)
RACHEL HALFORD, Deputy CEO, Hepatitis C Trust, UK
AXEL KAEHNE, Associate Director, Institute for Public Policy & Professional Practice, Edge Hill University, UK
ANDREA FEIGL, Health Economist, Organisation for Economic Cooperation and Development (OECD) and a member of the Young Forum Gastein
RICARDO BAPTISTA LEITE, Medical Doctor, Member of Parliament (Health Committee), Portugal

Moderation
ANDREA FEIGL, Health Economist, Organisation for Economic Cooperation and Development (OECD) and member of the Young Forum Gastein

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Better vaccine policies through coherent evidence

Exploring the needs and future developments of immunisation records in the EU

Organised by MSD

Outbreaks of measles and other vaccine-preventable diseases (VPDs) continue to challenge public health policy-makers at EU and national level. This forum brought together expertise from the policy level, academia, industry, the medical profession, and civil society to discuss how electronic immunisation records or vaccination registries could develop in future to help roll-back the incidence of vaccine-preventable diseases.
The session was moderated by Arnold Bosman, Public Health Consultant at Transmissible.

To open the debate Martin Seychell, Deputy Director General at DG SANTE; European Commission, presented how the resurgence of infectious diseases has prompted the European Commission to take specific action. On the one hand, there is need for a deeper analysis of the decline of vaccination coverage rates, to better identify the causalities and relative impact of factors such as increased costs, supply shortages, fragmented data collection, uncoordinated procurement and disinvestment by industry, but equally the lack of forecasting, planning and budgeting. In addition, important questions on data protection remain. Some of these technical, political, legal and cultural challenges will be addressed in the context of the Digital Single Market agenda and the forthcoming Joint Action on Vaccinations. Nonetheless, Seychell confirmed that electronic immunisation records would be an important support both to patients and public health.

Jean-Louis Koek, Antonio Gaudioso, Roumyana Petrova-Benedict and Laryn McLernon

"It ain't ignorance that does the harm, it is knowing things that are not true"

Next, Rutger Jan van der Gaag, Vice-President of the Standing Committee of European Doctors (CPME) shared the medical profession's point of view, opening with a reminder of the immense successes vaccinations have been in terms of reducing illness and death. Referring to the aphorism "it ain't ignorance that does the harm, it is knowing things that are not true", he reported on doctors' experience of vaccine hesitancy, which itself seems contagious, and occurs even among health professionals, contrary to all professional obligations to uphold evidence-based medicine. Van der Gaag underlined the need for transparency around communication on vaccinations and strongly advocated seeking a direct dialogue with patients and parents.

Immunisation record systems

Jean-Louis Koek, Founder of Mesvaccins.net, the French Electronic Immunisation Record System, presented an online tool, intended to provide clear vaccination recommendations and easy access to records. Based on the information on a patient's health status, recommendations are developed by experts according to protocols and patients are informed as well as reminded of their personalised schedules. The patient can consult the schedule and consent to giving access to health professionals, who in turn may also create new record entries. The use of the registry is voluntary, and it can be fully integrated with other databases. Koek described this initiative as a possible way to empower patients and help to fight false information. He believes it could be scaled to EU-level and make a significant contribution to combating VPDs.

Privacy vs. individuals' rights

In response, Antonio Gaudioso, Secretary General of Cittadinanzattiva, the Active Citizenship Network, picked up on the question of patients' rights, suggesting that this, rather than improved data collection, should be central to the debate. He drew attention to two frequently mentioned concerns: privacy and individuals' rights. He sees the discussion around privacy as a somewhat false debate, as he believes in most cases it is a question of patients using their own data for their own health benefits. The current data retention structures make reliance on own experience, i.e. "asking your mum", more reliable than official records. Second, he highlighted questions around individuals' rights, underlining the specificity of vaccination. He argued that a decision not to be vaccinated has a far greater impact on the general interest than other decisions on individual rights such as on end-of-life measures, for example. Therefore, the scope of individual self-determination as regards vaccination must be viewed more narrowly. In sum, Gaudioso called for stronger EU-level action on cross-border collaboration on data and patient empowerment.

The IOM guidance tools

Bringing the equity perspective to the debate, Roumyana Petrova-Benedict, Senior Regional Migration Health Advisor for the International Organisation for Migration (IOM), shared IOM's activities on vaccinations. She reported on general barriers migrants face in relation to access, some of which relate to legal entitlement to healthcare, especially preventive care, while others are of a practical nature, i.e. the lack of interpreters, but nonetheless important. One additional problem many migrants face is frequent relocation which leads to a fragmentation of their healthcare records. To improve the coherence of the records for the benefit of migrant patients and enable them to share this information with health professionals, IOM was commissioned by DG SANTE to develop a guidebook for health professionals as well as a health record template. Both projects are piloted in real-life settings and currently in implementation phase. These allow for better quality and continuity of care.

Health professionals' attitudes towards vaccination

The introductory statements were completed by Laryn McLernon, lecturer at the Management Center Innsbruck, and member of the Young Forum Gastein, who presented her comparative research on health professionals' attitudes towards vaccination in Austria and Canada. She highlighted the differences in approach in terms of policy and accessibility – i.e. the possibility of being vaccinated by a pharmacist under the Canadian system. She further elaborated on education and promotion, including the role of health workers as vaccine advocates, and the benefits of measurement and evaluation of interventions, i.e. through knowledge, attitude and practice surveys. Against this background, Canada is currently working towards a national network of vaccination registries governed by a national committee. McLernon lastly cited a case in which a nurse in a long-term care facility was sent on sick leave after co-workers and consequently patients spoke up about the infection risk, thus showing the effective impact comprehensive policies and evidence-based promotion campaigns can have.

Against this background, the panel was invited to reflect on the audience's comments on the debate, as well as an audience poll which found that most participants have only incomplete information on their own vaccination status. The experts considered the questions raised on different barriers to rolling out vaccination registries and pointed to diverse obstacles from the competition among data systems to the question of ownership of health data. The knock-on effects of low vaccination rates on hospitals' planning for emergency care capacities were also referred to. Vaccines have become a victim of their own success in this respect too, with the low incidence of disease leading to a lower priority in resource allocation. Overall, the need for further discussion around empowerment, access, the scope and potential of registries and governance issues was noted.

Results of the audience poll conducted during the session.

Pros and cons debate

To explore not only barriers but also solutions, Bosman invited participants to reflect on the pros and cons of the question of the benefits of an EU-level vaccine registry supported by all Member States which allows citizens real time access to their individual records. Some arguments raised in favour of such an approach included its relevance to patient empowerment, and the easier accessibility of data on coverage rates, broken down to regional or even street-level. In terms of concerns, the need to maintain data confidentiality was raised, as was the heterogeneity of existing systems, the need to establish patients' data ownership and the lack of political urgency to tackle the issue.

In this context ECDC reported on its recent activities supporting Member States in moving towards electronic registries. This includes on-going work on guidelines on the creation of registries, developed by an expert working group, as well as the provision of technical support to Member States with the help of on-site visits.

Lessons learnt

The discussion then turned to lessons learnt from existing policies and questions which remain to be solved. Petrova-Benedict explained that the IOM guidance tools are careful to address the concerns which have arisen in the past, i.e. by including consent forms for data transfer, and ensuring coherence and synergies with the policy environment such as the Directive 2011/24/EU on patients' rights in cross-border healthcare.

Van der Gaag shared the experience of national medical associations opposing a government order to breach patient confidentiality and transfer migrants' patient data without prior consent; the data was to be used in displacement proceedings. The idea of building of technical expertise in the area of public health informatics was raised. In terms of creating EU-level tasks and challenges, Seychell reaffirmed that the point of the departure must be the establishment of clear rules on data ownership and limits of data access. If patients were the owners of all their own health data, its use could be governed through delegated access rights to health professionals and authorities. A mapping of existing systems and interoperability challenges, as being coordinated by the eHealth Network, provides a framework for action. At the same time, he reported that the EU is building specific knowledge, i.e. in the cooperation with IOM and learning from the experience of the European Reference Networks as to technical cooperation on data sharing. The panel agreed that solutions must be accessible to all patients and demonstrate the benefit to the public.

To wrap up the debate, Bosman invited all to name the key recommendation for future policy debates on registries. McLernon proposed to use knowledge, attitude and practice surveys to better understand barriers in the roll-out of policies.
Petrova-Benedict named inclusiveness and the need for enabling policies as key tasks.
Gaudioso underlined the usefulness of the evaluation of interventions' effect on the community and stakeholder involvement in initiatives, which was supported by Koek who additionally called for the involvement of patients and healthcare professionals.
Van der Gaag reiterated the need to break the cycle of vaccines being a victim of their own success by motivating patients to follow vaccine recommendations.
Seychell concluded by recommending to explain the benefits to patients, and to find solutions to the interoperability challenge and the question of data ownership.

Written by Sarada Das and Damir Ivankovic

Speakers and panellists

Discussion starting points: Five panellists will provide starting points for discussion by delivering brief "impulse statements". The statements will provide different perspectives on the topic of immunisation registries.

Interventions from
MARTIN SEYCHELL, Deputy Director General, DG SANTE, European Commission
RUTGER-JAN VAN DER GAAG, Vice President, Standing Committee of European Doctors (CPME)
JEAN-LOUIS KOECK, Founder of Mesvaccins.net, French Electronic Immunisation Record System
ANTONIO GAUDIOSO, Secretary General, Cittadinanzattiva, Active Citizenship Network
ROUMYANA PETROVA-BENEDICT, Senior Regional Migration Health Advisor, International Organisation for Migration (IOM)
LARYN MCLERNON, Lecturer, Management Center Innsbruck, Austria and member of the Young Forum Gastein

Moderation
ARNOLD BOSMAN, Public Health Consultant, Transmissible, the Netherlands

Discussion promoted by
PIER LUIGI LOPALCO, Professor of Hygiene, University of Pisa

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Health Futures in a post-truth world

Scenarios for health in 2037

Organised by European Health Forum Gastein

“Half truth is more dangerous than a complete lie”

To open the session and frame the debate, Gerald Gartlehner, Head of Department for Evidence-based Medicine and Clinical Epidemiology, University of Krems, Austria, gave a presentation on “Post-truth in a world based on half-truths”.

Post-truth has become a catchphrase and the post-truth world is currently presenting some big challenges, but nevertheless the phenomenon is not new. “Post truth is relating to or denoting circumstances in which objective facts are less influential in shaping public opinion than appeals to emotion and personal belief”.
Gartlehner argued we are living in a world based on half-truths, because for example only half of all clinical trials are published, as the industry is often the funder and they might not want certain results to be published. In this way doctors will never be able to see the whole picture. “Half truth is more dangerous than a complete lie”.

We are experiencing endemic measles outbreaks again; the myths contained in Andrew Wakefield´s retracted study published in The Lancet that claimed a relationship between the MMR vaccination and autism live on, with 30 deaths from measles in Germany last year. People pick up on certain messages and give them a stage, like President Trump spreading untruths about vaccination. Social media allows such myths to perpetuate quickly and easily, with repetition of fake news lending credency to lies and half-truths and inhibiting contrasting viewpoints. So how can we try to refocus on facts? This is tricky, as it assumes that there is such thing as a single universal truth. We need to consider that evidence and statistics are not the only ways to create

Nina Renshaw, Boris Azais, Andrea Ammon, Tamsin Rose, Deborah Cohen and Gerald Gartlehner

> *The term "post-truth era" implies that there was a "truth era" before - is that the case?*
>
> *Tamsin Rose, Senior Fellow, Friends of Europe*

truth, because everyone has their own lived experience which, alongside facts, contribute to a personal and unique notion of "truth".

Deborah Cohen, Associate Editor, British Medical Journal, argued that health professionals and scientists don't do much to help citizens get clear, unbiased information. The "truth" is often obfuscated in spin and evidence overstated, with the public becoming often justifiably confused. Cohen has to process a wide range of health material on a daily basis, but still often struggles to get through the mountain of information to focus on the facts, so how should patients be expected to do that? Often only positive studies are promoted, so to create a well-balanced view is difficult for journalists. Anyone can easily set up a news site nowadays, paid for on the basis of how many clicks are received on articles. In addition, star rating systems are often understood as 'valid' mini peer review processes that influence decisions despite a lack of clarity behind the "reviewers" and their motivations in providing a certain score.

Andrea Ammon, Director, European Centre for Disease Prevention and Control (ECDC), discussed the ECDC-organised vaccine hesitancy lunch workshop held just before this forum session. She agreed that the health community must do better to present information that is independent, evidence-based, and appropriately tailored to the needs of different audiences. Regarding vaccine hesitancy, studies have shown that safety concerns (whether perceived or real) are the top influencing factor for those people who are deciding whether to vaccinate or not. Ammon cited an example from Denmark (where HPV vaccination rates are falling) where medical students have been recruited to assist with social media information campaigns to distribute information on and answer messages from concerned citizens about vaccine safety. What is certain is that old strategies are not working - we must leave our comfort zones and try something new to allay concerns around vaccination.

Boris Azais, Director Public Policy Europe Canada, MSD, agreed with some of the assertions made by other panellists that the so-called experts in the public health community have not always got things right – he referenced the safe sex advertisement campaigns from the 1980s picturing young teenagers holding hands that arose in response to the HIV and AIDS epidemic, as well as the fact that The Lancet published the Wakefield study in the first place. Increasing distrust of experts did not arise in a vacuum but perhaps because in some cases their expertise has been rightly questioned or discredited.

Nina Renshaw, Secretary General, European Public Health Alliance, raised the phenomenon of fake NGOs financed by commercial interests e.g. the tobacco industry, to influence research and ideas. She asserted "We need to immunise ourselves to bullshit information, to realise this we need to feel secure in our right of access to health." In public health it is important to look upstream at the "causes of the causes". We have reached a tipping point in inequalities, leading to extreme income inequality, which creates dissatisfaction and pessimism. We should focus on improving citizens´ general living standards and situation: a good level of public health, access to insurance and services which people experience as basic needs.

Scenarios for future health - the concept

Dorli Kahr-Gottlieb, Secretary General, European Health Forum Gastein presented the outcomes of the Gastein Forum's Health Futures Project 2017 - a qualitative study aimed to explore perceptions of what the future of health in Europe might look like in 2037. The resulting three scenarios explain what might lead us there, as well as the challenges and choices that may arise:

Scenario 1: The future is local
Achieving better quality of life is now more important than economic growth. A holistic approach is taken to health, and the commitment is to help Europeans achieve 'life satisfaction'. However, who will pay for this?

Scenario 2: Your health, your responsibility
Governments launch a 'health contract' between the state and individual, stipulating responsibilities for personal health. With the increased focus on prevention, one of the state's main tasks is to make reliable health information accessible; the individual is expected to self-monitor his or her health.

Scenario 3: Technology delivers
Governments have become more explicit about the health problems they want to address, and in response they are proactively shaping the health-tech market. Increased knowledge about people's genetic make-up and the proliferation of data analytics to predict and manage health have a profound effect on health system structures. People feel less responsible for their own health, because they rely on products and medicines as a solution.

Scenarios for future health - call for actions

Based on these scenarios, there was a discussion which lead to several suggested actions that government can pursue to contribute to the sustainability of healthcare systems:

- Improve communication and cooperation between different policy departments.
- Improve communication with the public.
- Simplify processes to assure decisions.
- Address health inequalities by taking measures to motivate health literacy and to ensure people understand the factors that influence their health.
- Policy-makers need to consider how they can enable people to understand the validity of information and how to provide them with appropriate resources.
- Facilitate dialogue between public stakeholders, patients, clinicians, academics and industry to develop products and services that are tailored to the public needs.

Young professionals' visions for the future health

Following this discussion, a panel of four Young Gasteiners representing different sectors discussed their thoughts about the future of health.
The Young Gastein panel consisted of Damir Ivankovic, Institute of Public Health, Croatia; Francesca Cattarin, BEUC - European Consumer Organisation; Saverio Bersani, University of Rome, Italy; Damiet Onderstal, Ministry of Health, Welfare and Sport, The Netherlands.

Francesca Cattarin and Saverio Bersani discussed how the status and uncontested authority of healthcare professionals has changed, partly because of technology and patient empowerment. For the future, healthcare professionals should think about their new role, engaging in greater dialogue with (hopefully more health literate and empowered) patients, including about new technologies to help them manage their health.

Damir Ivankovic likened old and new public health to the difference between a land-line and a smart phone A smart phone has a lot of new and different applications and everyone has to learn how to handle these new tools. This can be scary, for both patients and health professionals.
We should all remember that very stupid and very powerful people have the tendency not to form their opinions based on facts but to adjust facts based on their opinions, and we have to be mindful of this, he said.

Damiet Onderstal expressed some surprise at how quickly we are moving towards already implementing some elements of the scenarios, and that information and critical thinking on the downsides and challenges of progress is not always available and clear. Let's keep the discussion going and look at tools to connect people and get this information out there, she suggested.

Conclusions

Taking the pros and cons of the scenarios into account, we should move towards a system where we combine the different elements of each scenario: public health plays a central role, and we should have a person-centred system where quality of life is the focus and people can make use of technology when preferred.

Tamsin Rose summed up the discussion, asserting that we need to think about our roles in the future, prepare for it, explore the different possibilities and better understand and prepare to counteract the potential downsides. Our societies are unequal and the benefits of health are unequally shared, so as societies move forward and undergo rapid changes, let's not forget that these inequalities exist and make sure we have safeguards and policies in place to ensure people don't get left behind.

Written by Tanja Fruhmann and Damiet Onderstal

Speakers and panellists

Input speech - Post-Truth in an evidence-based world
GERALD GARTLEHNER, Head of Department for Evidence-based Medicine and Clinical Epidemiology, University of Krems, Austria

Panel discussion with
GERALD GARTLEHNER, Head of Department for Evidence-based Medicine and Clinical Epidemiology, University of Krems, Austria
NINA RENSHAW, Secretary General, European Public Health Alliance (EPHA)
ANDREA AMMON, Director, European Centre for Disease Prevention and Control (ECDC)
DEBORAH COHEN, Associate Editor, British Medical Journal (BMJ)
BORIS AZAIS, Director Public Policy Europe Canada, MSD

The future of health in Europe - Three visions for 2037
DORLI KAHR-GOTTLIEB, Secretary General, European Health Forum Gastein

Panel discussion - Young Forum Gastein - the future decision-makers
DAMIR IVANKOVIC, Institute of Public Health, Croatia
FRANCESCA CATTARIN, BEUC - European Consumer Organisation
DAMIET ONDERSTAL, Ministry of Health, Welfare and Sports, The Netherlands
SAVERIO BERSANI, University of Rome, Italy

Moderation
TAMSIN ROSE, Senior Fellow, Friends of Europe

Organised by European Health Forum Gastein

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The right health workforce – a matter of planning?

Organised by Gesundheit Österreich GmbH (GÖG) in cooperation with
European Observatory on Health Systems and Policies

This workshop brought together a diverse panel, including representatives of health professionals' associations, health service providers, and policy-makers.
The interactive meeting focused on health workforce planning and tackled a wide range of aspects: from horizon-scanning and health workforce capacities to the right skill-mix and data availability for planning purposes.

Discussing health workforce issues could not be more timely, given the overall context of health systems worldwide. In his keynote, Matthias Wismar, Senior Health Policy Analyst, European Observatory on Health Systems and Policies, summed up current challenges: We need to muster the right number of health professionals with the right skill-mix, bearing in mind factors such as geographical distribution, costs and productivity.

The main messages from the panellists were:

- Investment in health professionals supports and drives solid economic development;
- Technical progress provides better planning instruments, but this does not necessarily equal better healthcare – innovation has an unpredictable impact on the overall performance of health systems;
- Poor health workforce planning will negatively impact the availability of general practitioners in the decades to come;
- Unbalanced mobility of health professionals in the European Union is a threat to Member States' health systems' sustainability;
- Planning and training of health professionals are no longer national issues, but require coordination at European Union level.

Matthias Wismar, Anita Rabben Asbjørnsen, Bernhard Gibis, Aldo Lupo, Marius-Ionut Ungureanu and Herwig Ostermann

Moderator Claudia Habl, Head of Department, Gesundheit Österreich GmbH, then opened the floor to the audience, where the discussion returned to some of the issues touched upon earlier.

On the matter of health workforce planning, the workshop participants agreed that planning is still mostly carried out in single professional silos rather than in an integrated manner. One of the more recent developments that needs to be taken into consideration is the feminisation of the health workforce and its impact on planning. Currently, feminisation is observed in many professions, including doctors, nurses and social care workers. Bernhard Gibis, Head of Department, National Association of Statutory Health Insurance Physicians, Germany, shared some insights from his country: In Germany, about two thirds of medical students are female, a trend that has been favoured by the *numerus clausus* (restriction on university admissions).

There were different opinions in the room concerning what qualifies as an adequate time horizon for workforce planning. Participants agreed that in the end, this largely depends on the respective profession and the purpose of the planning exercise itself. However, regardless of the specific context, it is always crucial to set up health professionals' training in a way that conveys and nurtures the right work attitudes. Aldo Lupo, President, European Union of General Practitioners, seconded Wismar's view that health is a "people business", requiring a sound set of social skills that goes beyond medical knowledge. Anita Rabben Asbjørnsen, representing the International Council of Nursing, emphasised that health professionals face challenging, emotionally-demanding work environments that require resilience, and these professions are often made more demanding by current resource and time constraints.

Furthermore, determining the right number of health professionals is a significant component of any planning process. The majority of workshop participants agreed that over-capacity is necessary to preserve quality. However, over-capacity alone will not solve workforce problems, as both Herwig Ostermann, Executive Director, Gesundheit Österreich GmbH, and Marius-Ionut Ungureanu, Department of Public Health, Babes-Bolyai University, emphasised.
It needs to be put into perspective and considered together with other parameters that determine the quality of healthcare. Over-capacity comes with its own set of challenges, such as procuring excess resources in a targeted way that ensures there are no unmet needs. But one thing is certain: Educating doctors and other health professionals is an important societal investment.

Workshop participants identified skill-mix, age and structure of the actual health workforce as the parameters that have the largest impact on health workforce planning.
Regardless of the planning methodology, special attention should be paid to improving the attractiveness of health professions in general, and general practice in particular. This can be done by means of financial incentives, as well as more diverse employment options including cooperation opportunities across disciplines, limiting workload to adequate levels, or enabling flexible career paths.

Mirroring the theme of this year's EHFG, the workshop contributed to building the case around the inter-sectoral character of health workforce issues and planning, and highlighted the EU dimension of these topics. National health policies may have impacts beyond their own borders, meaning that we need a European strategy to address health workforce challenges.

Written by Marius-Ionut Ungureanu

Speakers and panellists

Keynote input
MATTHIAS WISMAR, Senior Health Policy Analyst, European Observatory on Health Systems and Policies

Panellists
BERNHARD GIBIS, Head of Provision and Structure of Health Care Services Department, KBV, Germany
ALDO LUPO, President, European Union of General Practitioners / Family Doctors
MARIUS-IONUT UNGUREANU, Department of Public Health, Babes-Bolyai University, Romania
ANITA RABBEN ASBJØRNSEN, International Council of Nursing (ICN)

Wrap-up
HERWIG OSTERMANN, Executive Director, Gesundheit Österreich GmbH (GÖG)

Facilitation
CLAUDIA HABL, Policy Officer, Head of Department, Gesundheit Österreich GmbH (GÖG)

Organised by Gesundheit Österreich GmbH (GÖG) in cooperation with European Observatory on Health Systems and Policies

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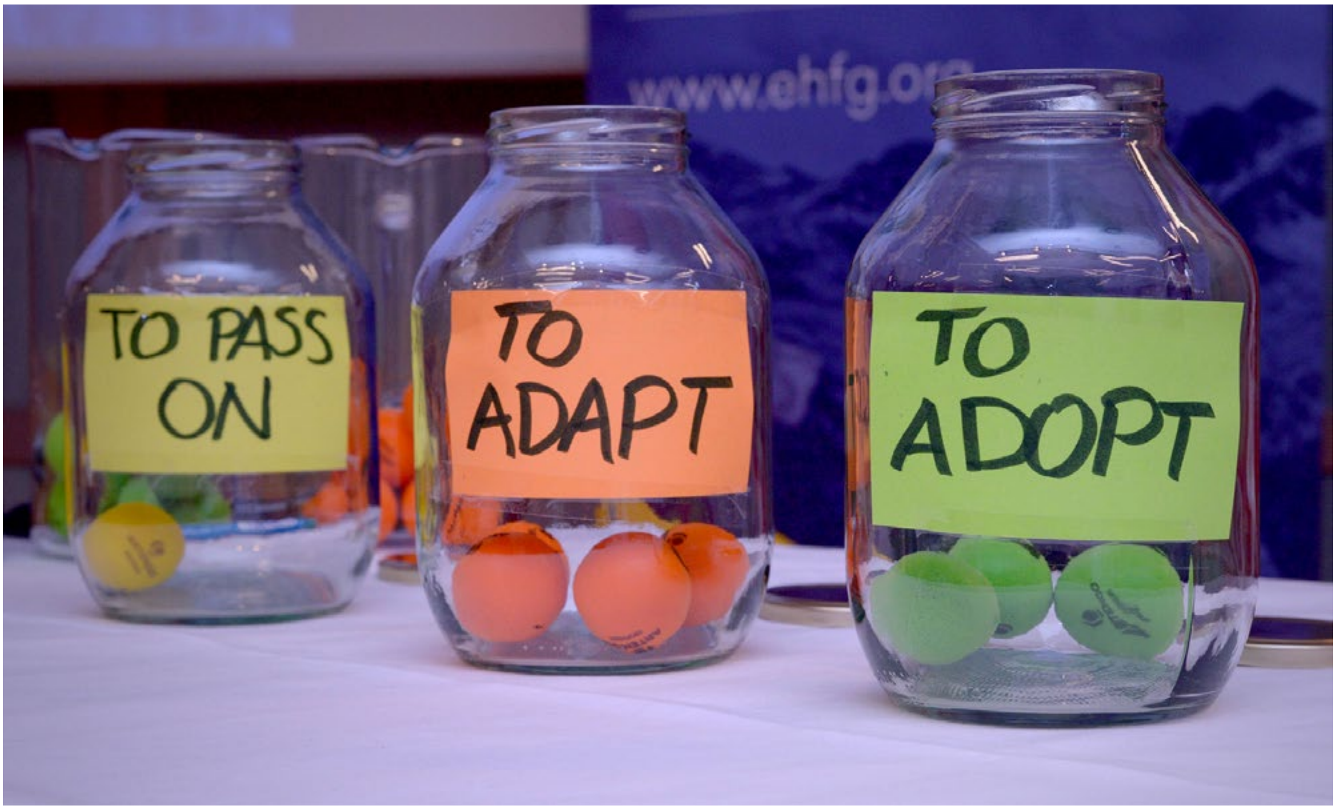

Person-centred care models

Changing mindsets for radical co-creation

Organised by Roche Diabetes Care

Health systems will face new challenges in the future, and meeting these challenges will require new ideas. In order to come up with such ideas, this workshop made use of co-creation, a strategy that involves bringing different parties together to jointly produce an outcome. In this instance, it meant bringing together international health stakeholders to crowd-source ideas for the healthcare system of Zealand, Denmark.

The workshop focussed on the challenges of locally implementing an ICT supported integrated care pathway for chronic diseases. Claus Rehfeld, Business Development Manager, Foundation for Innovation and Business Promotion, Zealand, described the Danish system and in particular the demographic challenges facing Zealand. He explained that due to resource constraints, the region needs to explore ways of improving services and health outcomes using the same level of resources.

One of the key focus areas is chronic diseases. For the workshop, diabetes was used as an example, due to its relevance to the Zealand region. At present, the region “pays for treatments, but not outcomes.” In order to drive efficiency, it is now exploring financial risk-sharing for reimbursing improved health outcomes. A second issue is silo working, which prevents managing diseases from a holistic and cross-sectoral perspective.

If we had the power and authority to pilot a new chronic disease management programme in Zealand, what is the one disruptive idea that we could do to improve health outcomes?
How can we action this idea?

Setting the scene

To set the scene for the co-creation exercise, several panellists engaged in a role-play, providing viewpoints from different actors in the health system.
The first input came from Dagmar Kownatka, Head of Professional Relations, Roche Diabetes Care, slipping into the shoes of a Danish diabetologist. She described how, despite a lot of innovation, the treatments she prescribes remain similar to those of 20 years ago, with a lot of patients still not reaching their treatment aims. In Europe, only 6.5% of type 2 diabetes patients meet their therapy targets for HbA1c, LDL cholesterol, and blood pressure at 12 months. The diabetologist would like to see access to electronic medical records (EMR) data for different disciplines to improve communication between providers and implement remote data monitoring strategies to better support and motivate patients in lifestyle changes. From her perspective, a key challenge to changing work processes is developing economic arguments that resonate with a hospital's General Manager.

The second viewpoint was provided by Bastian Hauck, Patient Advocate, #dedoc°, who played the role of a MedTech industry representative. He argued that the IT solutions the diabetologist referred to already exist, but that there are barriers to fully implementing them - particularly current public procurement strategies that do not incentivise data sharing. He saw Public-Private Partnerships as one way to overcome these barriers.

Nick Guldemond, Associate Professor Integrated Care & Technology, Erasmus University Institute of Health Policy & Management, portrayed the position of a diabetes nurse. He described both the tele-monitoring and home visits he delivers, highlighting the importance of social interactions and his role in guiding patients through the healthcare system. Yet, the strategic role of specialist nurses in optimal disease management is still underestimated; more should be done to involve nurses in the planning of patient-centred services.

Dario Pelizzola, Former Director, Internal Medicine Department and Diabetes Unit Az. USL Ferrara, played the role of a person with diabetes who finds it hard to live the lifestyle required to meet his treatment goals. This is partially due to a lack of immediate feedback on his health status. To improve adherence to therapy, he would like to have access to a mobile app that shows visually when he is deviating from his treatment goals.

Piloting a new chronic disease management programme - a co-creation exercise

The workshop participants were then grouped around five tables and given a scenario according to which they had to pilot a new chronic disease management programme in Zealand. They were each asked to come up with one disruptive idea for this pilot to improve health outcomes.

Group 1 proposed to create a platform that measures medical and patient-reported outcomes and enables interaction between all actors.
Group 2 proposed to create an open source IT management system around disease management to increase efficiency and improve health outcomes as well as patient and provider

satisfaction. A university would be commissioned to design the platform, informed by input from all relevant actors. With an open source architecture, each stakeholder could adapt the interface to their specific needs, or integrate new mobile applications.

Group 3 presented a “digital receipt” aiming to inform people’s dietary decisions. The proposal is to link patients’ supermarket receipt data to an app, which would then issue disease-tailored advice based on your purchases. For example, it would quantify a patient’s monthly sugar intake and provide recommendations. This data could also be shared with General Practitioners. The shops would have an incentive to fund and provide this service to attract customers and improve customer loyalty.

Group 4 wanted to launch an innovative electronic patient record. Using the EU’s ear-marked funding for an e-patient record as a basis, the group wanted to plug-in patient reported outcomes, both disease specific and on quality of life. This would allow to map treatment pathways and their efficacy – and stimulate reform. They also sought to add an encrypted communication platform to improve communication both between patients and providers, and among providers. The patient record would also include genomic and lifestyle data, creating a holistic resource. The added value to society in general would be the opt-in nature of the patient record for research needs.

Group 5 wanted to target continuity of care by ensuring every patient always sees the same healthcare provider – the same GP and ideally also the same specialist nurse - by increasing the number of healthcare providers and implementing retention strategies. To achieve this, the group proposed to focus on advocacy to win political support for more budget allocated to the training and retention of HCPs. The ensuing continuity of care would increase the trust between providers and patients, and ultimately trust in the healthcare system, which in turn will facilitate implementation of ICT solutions, including data-sharing.

Outcomes assessment

The ideas were then assessed by Claus Rehfeld in terms of their adaptability, adoptability and transferability. The first suggestion was considered adaptable, particularly given its current use in Taiwan. The second proposal was considered both adaptable and adoptable, with the patient data infrastructure that is already existing in Denmark – it was highlighted that Denmark is in a unique position to lead Europe in innovation in the healthcare system. The third group’s idea was considered adoptable, due to its corporate component and the potential for a Public-Private Partnership. The fourth group’s e-patient record was judged adaptable, adoptable and transferable – as a whole, it was considered an idea to be implemented on a national and European scale. The final group’s idea, which focussed on patient-healthcare provider retention, was considered adaptable but courageous, given the resource constraints for Zealand.

The session highlighted the added value of co-creation within a transdisciplinary international group, and all participants were invited to remain in contact to help with the implementation of the adoptable ideas within Zealand.

Written by Philip Hines

Speakers and panellists

Interventions from
CLAUS REHFELD, Business Development Manager, FIERS – Region Zealand, Denmark
NICK GULDEMOND, Associate Professor Integrated Care & Technology, Erasmus University Institute of Health Policy & Management, The Netherlands
DARIO PELIZZOLA, Former Director, Internal Medicine Department and Diabetes Unit Az. USL Ferrara (Local Health Authority), Italy
BASTIAN HAUCK, Patient Advocate, Diabetes Online Community #dedoc, Germany
DAGMAR KOWNATKA, Head of Professional Relations, Scientific and Strategic Affairs EMEA/LATAM, Roche Diabetes Care, Germany

Facilitation
TAMSIN ROSE, Senior Fellow, Friends of Europe

Organised by Roche Diabetes Care

Roche

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Health inequalities: threats and opportunities

Organised by Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C.
in cooperation with London School of Hygiene and Tropical Medicine

Many of today's public health issues – obesity, diabetes, cancer, cardiovascular disease – are strongly associated with health inequalities. Literature from across the world shows that gaps in income, employment, education and the socioeconomic gradient in health worsen health outcomes for disadvantaged populations.

Despite progress in life expectancy and health status, inequalities persist both across countries and across population groups within countries. What is behind the persistence of these harmful and avoidable inequalities? How can we increase equity through action on the social determinants of health? Where are there further opportunities for improvements? In this session speakers and audience explored these themes, with a particular focus on learning lessons from differences in approaches and responses.

A life course approach to reducing health inequalities

Martin McKee, Professor of European Public Health, London School of Hygiene & Tropical Medicine introduced the session and invited delegates to consider the implications of global health inequalities, he introduced the first speaker: Tung Liang-Chang, Professor of Public Health at the National Taiwan University.

Liang-Chang's key message was that from a life-course perspective, individuals matter as much as our social policies, and we must invest in children to safeguard our future. To illustrate this point, Liang-Chang provided delegates with compelling results from the Taiwan Birth Cohort study. In the population-based sample, low socioeconomic status (SES) was associated with lower housing quality, and unhealthy living practices which ultimately resulted in lower child

Clive Needle, Elodie Besnier and Nicola Bedlington

> *Greed is preventing the building of fair and equitable societies. Until we grasp the realities and fundamentals of tackling that, we are not going to build equitable societies.*
>
> *Clive Needle, Senior Policy Advisor, EuroHealthNet*

health status. He also referred to Barker's theory on the early origins of chronic disease, to explain that early life is a critical period of development, and that deprivations during this period can have strong inter-generational effects. Liang-Chang's presentation thereby set the tone to this session and paved the way forward: reducing systemic inequities in health begins with addressing childhood socioeconomic conditions and the social determinants of health.

Advocating for better health outcomes and committing to equity

Next ensued a conversation with Nicola Bedlington, Secretary General of the European Patients' Forum, and Clive Needle, Senior Policy Advisor at EuroHealthNet, on the contribution of NGOs to tackling health inequalities in Europe. The interview was moderated by Elodie Besnier, Young Gasteiner and International Health Policy Officer at Public Health Wales.

Bedlington and Needle agreed that the SDGs constitute an opportunity to increase political attention and put the focus on health at the core of public policies. Bedlington remarked that promoting multi-stakeholder dialogue is paramount to bypass the obstacles to sustainable health equity and development. Needle explained that public health professionals and policy-makers should address the determinants of health and examine the factors that prevent us from achieving equitable health outcomes. He insisted on balancing stakeholders' interests to foster a fair system, at the highest political level as well. Bedlington added that health needs to be prioritised differently and framed as an instrument to create the Europe we want. She forewarned that if we do not achieve SDG Goal 3 on health, we are sure to fail in the other SDGs. On this topic, Sir Michael Marmot, Director of the UCL Institute of Health Equity, agreed that we should ensure that we commit to equity. He added that this requires governments to be held accountable for reducing our net need for healthcare, and that non-governmental organisations have an important role to play in order to leverage this agenda.

Politics, Policies and regulatory instruments for better health equity: Reflections from the Pacific Rim

Sharon Friel, Professor of Health Equity, Regulation and Global Governance at the College of Asia and the Pacific, Australian University, reminded delegates that nations responsible for implementing the 17 goals of the SDGs have competing and often conflicting policy agendas and priorities. Nonetheless, there are many technical regulatory instruments that can be used to maintain the balance of power among stakeholders. She noted that the SDGs encourage the use of trade as a means of pursuing various development goals, citing the examples of important multilateral agreements for countries within the EU (GATT, TRIPs, etc.) as well as international investment agreements (Trans Pacific Partnership agreements). Friel explained that these legally binding agreements could affect economic growth, access to knowledge, social infrastructure, labour standards, but also our health systems, the lifestyle determinants of health, and our capacity to introduce health policy measures. For example, she asked delegates to reflect on the implications of the increased availability of sweetened beverages on a global scale. With this idea that all of the SDG areas matter for health, Friel made clear the need for more coherence across domains. She made a strong closing point by stating that decision-makers need to become more cognisant of public policies so that these do not contradict our trade rules, but at the same time we can also hope that trade policies can be shaped to include health clauses. She encouraged delegates to engage with economists and consider the political economy of health and the policy windows of opportunity.

Implementing evidence-based interventions in our communities

In the second half of the session, Katsunori Kondo, Professor of Epidemiology at Chiba University in Japan, presented the Health Equity Assessment and Response Tool developed in 2015 by the Japan Gerontological Evaluation Study project. The tool, which aimed to increase social participation and prevent cognitive decline in the elderly, was designed by mapping health status in specific areas and matching needs with resources available at the local level for senior citizens. Of note, residents were directly involved in the research and participated in the development of practical solutions such as a lunch club for the elderly living alone, and a mobile shop for more easy and accessible shopping. Konto et al's programme was a success and after five years, the rate of functional decline was halved in participant vs non-participants, and the incidence of dementia was reduced by 30%. The programme was subsequently scaled-up to other areas and results suggested that less educated individuals benefited the most from the programme. Comparative statistics were used to make health inequalities more visible, and benchmark targets for intervention. Kondo demonstrated that need-based participatory research could constitute a promising area for interventions that aim to promote health equity.

Perspectives from the Maltese presidency of the EU Council

Next, Martin McKee interviewed Natasha Azzopardi-Muscat, current EUPHA President and former Chief Medical Officer, Ministry of Health, Malta on the Maltese EU Council presidency perspectives on health inequity. Azzopardi-Muscat first focused on the key issue of access to medicines. She acknowledged that access varies widely across countries, not only based on size but also on the level of socioeconomic development and GDP, which constitutes an important challenge from a human rights perspective. During their presidency, Malta tackled this problem by setting up a round table discussion with industry, and a technical working group. Regional groupings of countries were also set up (Valetta Group Meeting) to improve knowledge sharing, with the particular intent of increasing the negotiation capacity of smaller countries and to iron out inequalities due to size.

Azzopardi-Muscat also discussed another important objective of the Maltese Presidency: to reduce childhood obesity in the EU. She noted that prevalence is especially marked by a social gradient, that the scale of the problem is large and as children grow fast, there is an urgent need to mobilise public and political support to drive this issue into the mainstream. She added that until politicians address the importance of a life-course approach to better health and economic outcomes, Europe will not succeed in reaching our development and public health targets. She concluded by pointing out that Europe is currently at a crossroads in terms of public health, and that we should all aim for a Europe that does more to ensure the legacy of our institutions.

Health equity at the global, national, and local level

In the last part of this forum, Sir Michael Marmot, Professor, Director of the International Institute for Society and Health, Epidemiology and Public Health, UCL Institute of Health Equity, UK reminded delegates that social injustice is killing people on a grand scale, and that policymakers should pay particular attention to the socioeconomic determinants of health. Globally, there are large differences in health outcomes by gender, ethnicity, and level of socioeconomic status (SES). For example, in Porto Allegre 45% of cardio-vascular disease-related deaths are due to socioeconomic inequality. More broadly, key population health indicators such as life expectancy, maternal mortality (from 2 to 235 per 100,000 in the WHO American region), and childhood mortality under 5 years vary widely across countries. In Europe also, there has been a slow-down in life expectancy increase, across countries, but most marked in the UK.

Despite these inequities, Marmot called on delegates to remain optimistic as differences highlight areas where improvements can be made. At the local level, he noted that doctors could be privileged partners to improve the social determinants of health. At the national and global level, he insisted on the role of the public sector. He added that in a world of post-fact politics it is our responsibility,

> *Poverty is not a destiny, we can break the link between poverty and poor health!*
>
> *Michael Marmot, UCL Institute of Health Equity*

as public health professionals, to strive for evidence-based interventions. He referred to "Fair Society, Healthy Lives: the Marmot Review: A Strategic Review of Health Inequalities in England Post-2010" that set out key policy objectives for better lives:

- Give every child the best start in life
- Enable all children, young people & adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

In his concluding remarks and to round-up this forum, Marmot invited delegates to reflect on the words of Martin Luther King: "I believe that unarmed truth and unconditional love will have the final word in reality. This is why right, temporarily defeated, is stronger than evil triumphant". He explained that if we truly want to reduce health inequalities, we should first and foremost ensure that those communities that have been left behind be given back their dignity and be empowered.

Written report by Sarah Czernin and Marie Delnord

Speakers and panellists

Health equity: global, national, local
MICHAEL MARMOT, Professor, Director of the International Institute for Society and Health, Epidemiology and Public Health, UCL Institute of Health Equity, UK

Health equity: early life and inter-generation
TUNG-LIANG CHIANG, Professor of Public Health, Health Behaviours & Community Sciences, National Taiwan University

NGO contributions to tackling health inequalities in Europe
NICOLA BEDLINGTON, Secretary General, European Patients Forum
CLIVE NEEDLE, Senior Policy Advisor, EuroHealthNet
Interviewed by ELODIE BESNIER, International Health Policy Officer, Public Health Wales and member of the Young Forum Gastein

Health Equity Assessment and Response Tool developed by Japan Gerontological Evaluation Study project
KATSUNORI KONDO, Professor of Social Epidemiology and Health Policy, Center for Preventive Medical Sciences, Chiba University, Japan /and: Head of Department of Gerontological Evaluation, Centre for Gerontology and Social Science, National Center for Geriatrics and Gerontology, Japan

Politics, policies and health equity: Reflections from the Pacific Rim
SHARON FRIEL, Professor of Health Equity, Regulation and Global Governance, College of Asia and the Pacific, Australian University

An EU Council Presidency perspective on tackling health inequalities
NATASHA AZZOPARDI-MUSCAT, Senior Lecturer, University of Malta /and: President, European Public Health Association (EUPHA)
Interviewed by MARTIN MCKEE, Professor, London School of Hygiene and Tropical Medicine

Panel discussion and summing-up
YIN-WEI WANG, Director-General, Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C.

Facilitated by
HARRY RUTTER, Senior Lecturer, London School of Hygiene and Tropical Medicine and
MARTIN MCKEE, Professor, London School of Hygiene and Tropical Medicine

Organised by Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C. in cooperation with London School of Hygiene and Tropical Medicine

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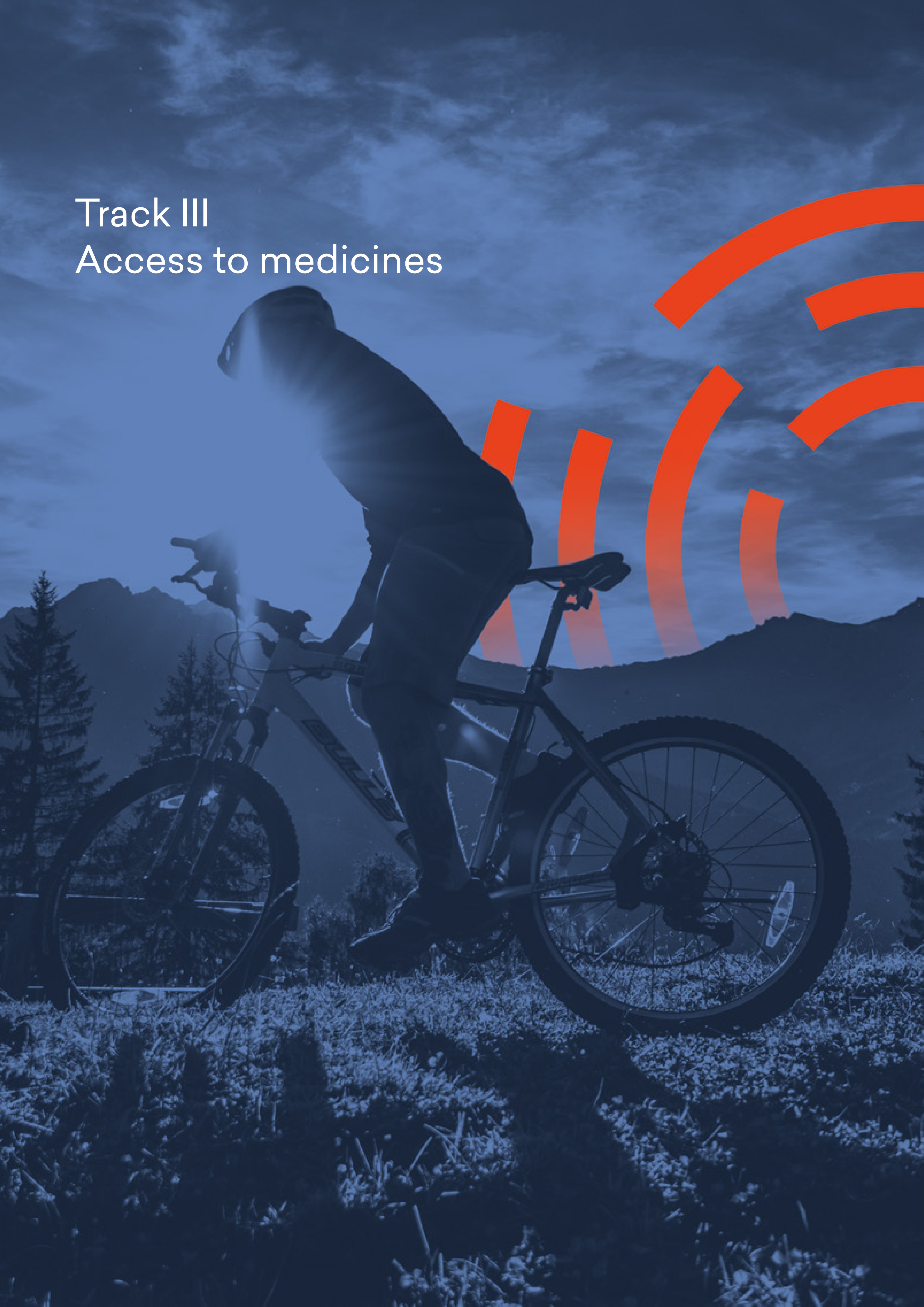
Track III
Access to medicines



Nathalie Moll, Ellen 't Hoen, Martin Seychell and Diarmaid McDonald

Access to vital and innovative medicines

Addressing challenges of intellectual property rights

Organised by Main Association of Austrian Social Security Institutions, National Institute of Health and Disability Insurance (NIHDI), Estonian Health Insurance Fund and Caisse nationale de l'assurance maladie des travailleurs salaries (CNAMTS) in cooperation with European Social Insurance Platform (ESIP)

The fact that several national insurance institutes jointly organised this session indicates the urgency of and interest in the topic of access to medicines and, while starting out early on the last day of the EHFG conference, there were no empty seats. Josef Probst, Director-General, Main Association of Austrian Social Security Institutions, opened the session by reflecting on his biggest worry: the pricing strategy of pharmaceutical companies for new and innovative drugs, with extraordinary price hikes in recent years. He emphasised the fact that few, extremely high-priced medicines account for one third of the Austrian expenditure on pharmaceuticals and that we are faced with a worldwide political complaint that the way pharmaceutical companies use monopolies destabilizes healthcare systems and excludes patients from necessary treatments.

The provision of access to affordable innovative and vital medicines is a key challenge to the sustainability of health and welfare systems. One increasingly debated aspect of this challenge is the mismatch between the market-driven model for pharmaceutical innovation and affordability, quality and access. The aim of this session was to foster the debate on the suitability of the current intellectual property (IP) system for developing innovative and affordable medicines.

What is wrong with today's IP rights?

The discussion started with a keynote speech by Ellen 't Hoen, Expert on Medicines Law and Policy. She provided an overview of the current IP schemes and of the various incentives progressively put in place by governments to support pharmaceutical companies in the development of

If an innovative product is not accessible, it is meaningless - it is no true innovation.

Ellen 't Hoen, Expert on Medicines Law and Policy

medicines. While acknowledging the good intentions behind these measures, 't Hoen illustrated the pitfalls of the system by providing evidence of the misuse and abuse of incentives in relation to the increasing prevalence of high-priced medicines. She ended her speech on a rather pragmatic note, calling on governments to review the current EU legislation - i.e. with regard to data exclusivity provisions - but also encouraging them to make better use of already existing tools, such as compulsory licensing.

As reaction to 't Hoen's keynote, Duane Schulthess, Managing Director, Vital Transformation, and Nathalie Moll, Director-General of the European Federation of Pharmaceutical Industries and Associations, approached the topic from a different angle. Dismissing the kinds of links between intellectual property and pricing t' Hoen had portrayed, they shifted the attention towards the challenges and risks that companies face in the process of drug development. In particular, they claimed a strong IP regime was necessary for attracting investors, preventing the capital flight towards more permissive countries and continuing to deliver innovative products.

The fourth intervention was that of Diarmaid McDonald, Lead Organiser, Just Treatment, a UK based patient's organisation. Disagreeing with the industry representatives, McDonald shared his experience in helping patients getting access to the medicines they need: availability of medicines was not the barrier, but excessive prices asked by manufactures. By reaffirming the link between high price and IP, the patient representative called on governments to question the current monopolies and use available flexibilities in relation to intellectual property, such as compulsory licensing, to solve the impasse created by companies.

The next input came from Martin Seychell, Deputy-Director General, DG SANTE. Building on his comprehensive knowledge of the sector, Seychell emphasised the need to look at the problem of access to medicines from a wider perspective, not only focussing on intellectual property. He highlighted that there are already regulatory tools available that can be used now to improve accessibility - before changing existing rules and regulations. Questioned on IP, Seychell acknowledged the need for investments to support the sector and foster innovation, but also said there might be room for improving the current patent system. In this context, Seychell also introduced the currently ongoing public consultation on Supplementary Protection Certificates (SPCs) and patent research exemptions as "a golden opportunity". He stressed the Commission's resolve to comprehensively evaluate the current system, and invited all actors to actively contribute and take responsibility during the process of the next months.

Producing workable solutions - Patents are not (the only) problem

Acknowledging the problem of increasing prices and decreasing affordability, Nathalie Moll opened the second part of the discussion by arguing that a change in IP law would not be the answer. Rather, she proposed regulatory solutions that address the reimbursement system, such as outcomes-based reimbursement models that some

healthcare systems (such as the UK on Hepatitis C) are already experimenting on, i.e. differentiating between responding and non-responding patients.
However, Moll added that the healthcare systems themselves are often inadequately equipped for using this kind of tools, i.e. due to lacking monitoring mechanisms that also ensure data is being collected in a uniform way; the health systems themselves need to be adapted for making these new reimbursement models work.

Reacting to Moll's input, Ellen 't Hoen said that while patents are part of the problem of affordability of medicines, they may indeed represent "the least of our worries". Acknowledging this part, however, is the way towards a solution. As example, 't Hoen referred to the Medicines Patent Pool: all HIV medicines producing companies are now licensing their products to this pool, and all the licensees can supply generics if countries issue a compulsory license. This huge progress could not have been foreseen 15 years ago, and could be applied to other areas as well. Furthermore, 't Hoen argued that governments need to set key principles for the innovation system: "If an innovative product is not accessible, it is meaningless - it is no true innovation", she claimed, and asked policy-makers to ensure that the pharmaceutical system is delivering in the public interest.

Raf Mertens, Director-General, Belgian Health Care Knowledge Centre argued that we do not have a problem with IP, but rather a problem with the link between intellectual property and price: "Buying a cancer treatment is not like buying a vacuum cleaner, where the inventor holding the patent can charge three times too much and that's OK - the consumer can simply choose not to buy it. As public payers responsible for our societies' well-being we do not have this freedom, but are forced to pay the pharmaceutical prices that are being asked for; healthcare is an imperfect market."

Value-based price versus affordable price: the inability not to pay

One issue arising in the discussions was value-based pricing. Ancel.la Santos Quintano, Senior Policy Advisor, Health Action International, emphasised that while medicines need to have value and provide meaningful innovation, value-based pricing does not guarantee affordability, and what value does a medicine have that is not affordable?

Mertens outlined three narratives relating to value-based pricing: Firstly, the "Sovaldi narrative", where a product is claimed to bring net benefit to the system, by rendering other interventions redundant. While it at first may seem legitimate to share the benefit with the inventor, Mertens reasoned that this argument ultimately fails, since companies would then also have to compensate negative benefits by setting a negative price.

The second narrative - the QALY narrative - looks at the value of a medicine in terms of quality of life. This would lead to excessive prices, whereby the patient is taken hostage and governments would have to pay the ransom. Such ransom would be set at the highest point governments are willing to pay, Mertens explained. Yet, with healthcare constituting an imperfect market this willingness to pay is rather an inability not to pay.

According to Mertens, the third narrative of value-based pricing would be the one of a lottery, picking up on a metaphor presented by Duane Schulthess earlier. Schulthess had compared the odds of successfully bringing a new drug compound to the market to those playing the lottery. Mertens suggested that government authorities and investors should learn “to play the lottery” together, sharing both the risks and the profits in a fair manner, increasing transparency of prices and at the same time guaranteeing the IP holder a fair return on their investment.

Adding to this comment, Ancel.la Santos Quintano reminded the audience that public funding contributes to a large share of research and development, and therefore governments should implement mechanisms to guarantee a public return on such investments.

Conclusion

In conclusion, panellists and audience could agree that while patents are part of the problem - as they make high prices possible by conceding monopoly power - they are not the only barrier to access and affordability. Several solutions were proposed, from alternative R&D models and de-linking price and R&D to patent pools and risk sharing. The different stakeholders concluded that rather than ‘talking in silos’ they should continue to sit together and discuss workable solutions guaranteeing fair returns on investment for both governments and industry.

Take away messages

- The panellists and audience agreed that ensuring access to medicines is a key challenge for health and welfare systems, even for European countries.
- Patents are not the only barrier to access, yet play a pivotal role in increasing prices
- Innovative medicines are meaningless if they are not accessible to the public.

Written by Francesca Cattarin and Katharina Hawlik

Speakers and panellists

Keynote: Historical overview and reflection on the key challenges
ELLEN 'T HOEN, Expert on Medicines Law & Policy

Panel discussion with
RAF MERTENS, Director-General, Belgian Health Care Knowledge Centre (KCE)
ANCEL.LA SANTOS QUINTANO, Senior Policy Advisor, Health Action International (HAI)
NATHALIE MOLL, Director-General, European Federation of Pharmaceutical Industries and Associations (EFPIA)
MARTIN SEYCHELL, Deputy-Director General, DG SANTE, European Commission
DUANE SCHULTHESS, Managing Director, Vital Transformation
DIARMAID MCDONALD, Lead organiser, Just Treatment, UK

Chair
DAVID ROSE, Director, LACS Training

Organised by Main Association of Austrian Social Security Institutions, National Institute of Health and Disability Insurance (NIHDI), Estonian Health Insurance Fund and Caisse nationale de l'assurance maladie des travailleurs salaries (CNAMTS) in cooperation with European Social Insurance Platform (ESIP)

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Medicines: new game, new rules

Pathways to better and affordable medicines

Organised by Open Society Foundations in cooperation with European Public Health Alliance (EPHA) and European Public Health Association (EUPHA)

Access to essential medicines is a health right according to the World Health Organization. However, innovation and affordability have become two of the main barriers to accessing new drugs, putting these issues high up on European health agendas over the last years. Patients, doctors, national governments and the EU Commission are amongst the stakeholders recognising that the current system is unsustainable.

The aim of the session, as Yannis Natsis, Policy Manager, European Public Health Alliance, outlined, was to foster a true and productive dialogue between all the stakeholders involved. Kiti Kajana Phillips, Programme Officer, Open Society Foundations emphasised: “Our goal is to build a world where everyone has equal and fair access to the medicines and treatments they need.” With this goal in mind, representatives of different stakeholder groups were gathered in the same room to discuss pathways to better and affordable medicines.

The session was divided into two panel discussions; the first one elaborated on the extent of the problem together with representatives from academia, clinical medicine and health economics. In the second part of the session, policy-makers, advocates and industry representatives discussed different solutions to improve access to new medicines.

Courtney Davis, Ajay Aggarwal and Deborah Cohen

> *Everything can be cost effective*
> *- it depends who does the calculation.*
>
> *Livio Garattini, Centre for Health Economics,*
> *Mario Negri Institute*

Do we get the medicines we need and can afford?

Courtney Davis, Department of Global Health and Social Medicine, Kings College London, presented the results of a newly published study which analysed cancer drugs approved by the European Medicines Agency (EMA) between 2009 and 2013. The authors found that for more than half of the studied drugs there was no evidence that they substantially improved quality of life or extended survival by the time they entered the market. An even lower proportion of the drugs showed clinically important benefits. This highlights the issues of innovation and regulation in the field of medicines. Davis emphasised the importance of raising regulatory standards to ensure that every drug which reaches the market is backed by strong evidence proving that it has clinically meaningful benefits for patients.

The discussion continued with Ajay Aggarwal, Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine, sharing his views as healthcare professional: clinicians like him need to decide what is the best treatment for their patients on a daily basis. Aggarwal claimed that there is yet a lot of room for innovation, to create new drugs and technologies that improve life, morbidity and mortality outcomes in cancer patients. However, he highlighted that “new does not always mean better”, and expressed frustration over the lack of data and evidence behind some of the new treatments.
Another issue that he perceived as problematic is the large amount of money spent on drugs labelled as “new and innovative”. Aggarwal explained that in public healthcare systems like the ones we have across Europe this kind of investment always implies an opportunity cost: If money is spent there, resources are not spent on other areas of the care pathway, like e.g. diagnostic imaging. Investing the resources here could, perhaps, have a bigger impact on morbidity and mortality than spending them on new drugs.

This clinical perspective was followed by Livio Garattini, Centre for Health Economics, Mario Negri Institute, discussing the issue from an economist’s point of view. He argued that it is very difficult to assess objectively whether a new medicine offers value for money. For him, the variables that form part of a Health Technology Assessment are often subjective. Factors like “cost” or “quality of life” may vary depending on the measurement techniques used, and are susceptible to bias. We need to take this into consideration when looking at the results of a cost-effectiveness analysis of a drug - the outcomes of such an analysis on the same drug may differ by context and responsible organisation.

Suerie Moon, Director of Research, the Global Health Centre, used an “elephant metaphor” to explain the existing problems related to medical innovation.
Moon said that in order to steer pharmaceutical activity (e.g. drug innovation) towards where it is really needed, we need to “remove the blindfold” and improve transparency. To tackle the issues related to access to affordable and effective medicines, stakeholders should know the price of manufacturing, the exact cost of R&D, as well as the data and evidence behind the drug’s effectiveness.
Moon finished her presentation by suggesting fundamentally new approaches to the development and pricing of new medicines. For example, investing public money on independent trials, learning from not-for-profit initiatives,

affordable validated value-based pricing. Lastly, she referred to the concept of fair profit margins – profit margins that are both fair to society but also ensure that companies get fair returns for the risks taken.

After the interventions from the speakers, the audience was invited to contribute. Wendy Yared, Director, European Cancer Leagues, asked whether price transparency is really key to improving access to new medicines. Moon argued that with this regard, we can learn something from the experience on vaccines: There has been more transparency around vaccines over the last years, which exposed the fact that, on some occasions, wealthier countries had better price deals than some poorer ones. Here, transparency could help to expose problems and find better solutions.

Another issue that was picked up on was how to put a price or a value on life. Although some agencies may feel that a drug which increases life expectancy by only a few months is not worth its price, patients may still wish for access to this medicine. Courtney Davis responded by arguing along Aggarwal's lines: We live in an environment with scarce resources. If money is spent on those drugs it means that it is not spent on other, (potentially) better treatments. She also pointed out that patients are not always given the correct information. Thus, they tend to systematically overestimate the benefits of new drugs and underestimate the harmful effects - for example, some drugs have severe toxic effects whilst achieving only minimum clinical benefits.
Suerie Moon also highlighted this asymmetry of information between stakeholders, including patients, governments and industry. According to her, the issue will only be tackled once more cooperation exists.

Members of the audience also asked the panel about pharmaceutical spending, mentioning the latest OECD numbers, which show that figures have fallen in recent years. There were concerns that this may mean that patients do not access life-saving treatments and medicines which could reduce complication rates or length of stay in hospital, which in turn could save money for healthcare systems.
Ajay Aggarwal followed up on his earlier intervention and Davis' line of thought, re-emphasising that investing in medicines is important but may not be the most efficient use of resources. For him, the key is to invest more in diagnostic and screening services to detect diseases at an early stage. He also reminded the audience that healthcare is only one of the factors that influence health. Wider determinants are the most influential factors on health and health inequalities, and action there is vital.

The access to medicines problems in Europe: What can governments do?

This part of the session kicked off by asking the audience whether they thought there was indeed a problem of access to medicines in Europe. All but one person had concerns, so everyone became more motivated to hear more about the assessment of the current situation and the solutions proposed by the panellists.

Clemens Martin Auer, Director General, Federal Ministry of Health and Women's Affairs, Austria, initiated the discussion with a self-reflection, admitting that public decision-makers had committed several policy failures in the context of drug development and access to medicines. He named a number of examples, such as insufficient regulatory standards for market authorisation, poor organisation of public R&D expenditures and inadequate innovation assessment. This self-criticism, Auer argued, is necessary to move forward, adding that a reorganisation of policies is required for

Public decision-makers should also be self-critical - this is necessary to move forward. Reorganisation of policies is required for improving quality of services and financial sustainability.

Clemens Martin Auer,
Ministry of Health and Women's Affairs, Austria

improving quality of services and financial sustainability.

According to Marcel van Raaij, Director, Ministry of Health, Welfare and Sport, The Netherlands, most aspects of the drug market are balanced. The main imbalance is caused by the rising prices of new products. He cited possible solutions for this issue, like aligning the appraisal of product value better, international collaboration, following medicines better in terms of proper and rational use, looking at new models of development, and the responsible balancing of private and public resources.

Martin Munte, President, Association of the Austrian Pharmaceutical Industry, explained that the industry, before bringing a new compound to the market, always seeks the scientific advice of the regulator: what kind of evidence regarding safety and efficacy is needed to get an approval? He admitted that maybe more questions should be asked early on in the process of drug development, arguing that there are also technical issues that need to be addressed, such as the fact that e.g. information on overall survival is unlikely to be available at an early time. As a second step, prices are set, and with different appraisal systems across Europe also here transparency is crucial for the industry to be able to estimate what price is justified in a given context. Munte wrapped up by saying that it is key to have a transparent, inclusive and clear discussion on what value means, paving the way for a price where demand and supply meet and that really captures the value of a drug.

Melanie Kennedy, Patient Advocate, Just Treatment, drew attention to the inequalities in quality of and access to health services within the UK. She said that the current system is broken, with patients not getting the diagnosis and care they need, and that fault for this lies on all sides. Having fought with cancer herself, she emphasised her conviction that speaking to patients and asking for their opinion could have a real impact – we need to remember that there are people behind the statistics. Kennedy advocated for more investment in a comprehensive cancer strategy, including e.g. investing in primary diagnosis. She emphasised that agencies really need to work together in order to make sure treatment reaches the end user.

Yannis Natsis then shortly referred back to the issue of quality of innovation. He re-emphasised the need for solid evidence rather than marketing hype, which can be achieved by the governments resetting the bar - asking the right questions via their regulatory bodies and sending the right signals to the market. Natsis made the case for pushing back on the deregulation agenda, while acknowledging the need to protect the competitiveness of the pharmaceutical sector as an important part of the European economy.

After the panellists' statements, the discussion was opened to the audience. Nathalie Moll, Director General, European Federation of Pharmaceutical Industries and Associations (EFPIA) warned that the real problem might be that current healthcare infrastructures are dysfunctional, with Munte adding later that there is the general need to prioritise and spot where there is wastage in our health systems. Moll also proposed to consider different pricing and reimbursement strategies for different types of drugs, for example anti-diabetics, Alzheimer's drugs or antibiotics.

On the issue of antibiotics, Auer also highlighted the need for improving antibiotic awareness and warned that there is currently only one antibiotic manufacturer within the EU. He argued for the authorisation of more pilots and not-for-profit drug development.

Van Raaij reminded the audience again that it is not possible to spend the entire healthcare budget on the pharmaceutical industry; there are many other important tasks that need to be financed, like prevention and primary care.
And there was a general agreement in the room about the need for monitoring public money spent on R&D better, applying conditionalities and reviewing the efficiency of incentives for innovation. At this moment in time, we are not aware of the results yielded by the significant amount of money spent on R&D in previous years. Moll expressed the will to plough savings resulting from medicinal treatment back into other drug therapies.

At the end of the session, all the panellists had the opportunity to share their one and most important solution to tackle the problem of access to medicines. Marcel van Raaij advocated for the restoration of balance in the system, Martin Munte called for checking R&D expenditure at universities. Clemens Martin Auer highlighted the need to address policy failures, Melanie Kennedy emphasised the importance of collaboration and the need for reaching end users with the treatment. Yannis Natsis called for incentives reviews and saw a big potential in cooperation examples, like the BENELUXA.

Written by Alberto Mateo and Judit Pako

Speakers and panellists

Welcome & introductory remarks
KITI KAJANA PHILLIPS, Program Officer, Access to Medicines & Innovation, Public Health Program, Open Society Foundations (OSF)

Panel I – Do we get the medicines we need and can afford?
SUERIE MOON, Director of Research at the Global Health Centre, Graduate Institute of International and Development Studies, Geneva; and Adjunct Lecturer on Global Health at the Harvard T.H. Chan School of Public Health
COURTNEY DAVIS, Director of the Masters in Medicine, Health and Public Policy, Department of Global Health and Social Medicine, Kings College London
AJAY AGGARWAL, Consultant clinical oncologist, Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine
LIVIO GARATTINI, Director, Angelo & Angela Valenti - Centre of Health Economics (CESAV), Mario Negri Institute, Italy

Moderation
DEBORAH COHEN, Associate Editor, British Medical Journal (BMJ)

Panel II - The access to medicines problems in Europe: What can governments do?
MARCEL VAN RAAIJ, Director Medicines & Medical Technology, Ministry of Health, Welfare and Sport, The Netherlands
CLEMENS MARTIN AUER, Director General, Federal Ministry of Health & Women's Affairs, Austria
MELANIE KENNEDY, Patient Advocate, Just Treatment, UK
MARTIN MUNTE, President, Pharmig - Association of the Austrian Pharmaceutical Industry; and Chief Executive Officer, Amgen
YANNIS NATSIS, Policy Manager, Universal Access & Affordable Medicines, European Public Health Alliance (EPHA)

Moderation
MARTIN MCKEE, Professor, London School of Hygiene and Tropical Medicine

Concluding remarks
YANNIS NATSIS, Policy Manager, Universal Access & Affordable Medicines, European Public Health Alliance (EPHA)

Organised by Open Society Foundations in cooperation with European Public Health Alliance (EPHA) and European Public Health Association (EUPHA)

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Martin Seychell, Jonas Sivelä, Lucia Pastore Celentano, Bolette Søborg and Jean-Baptiste Rouffet

Addressing vaccine hesitancy in challenging times

Organised by European Centre for Disease Prevention and Control (ECDC)

Vaccine hesitancy is a problem several countries are facing at this very moment. The workshop focused on background and causes of this problem - and looked at possible solutions.
Contributions came, amongst others, from DG SANTE, the European Centre for Disease Prevention and Control, and different EU Member States.

Vaccine hesitancy is nothing new: Anti-vaccinations lobbies can be traced back to the early smallpox immunisations in the 19th century, as Jonas Sivelä, Senior Researcher, Finish National Institute for Health and Welfare, explained. Another example is the now retracted 1998 study linking the MMR (measles, mumps, and rubella) vaccination to autism and bowel disease. It inspired hesitancy and mistrust towards governments and health authorities, which can still be felt to this day - even though the study was withdrawn and the medical doctor behind it lost his authorisation in the process.

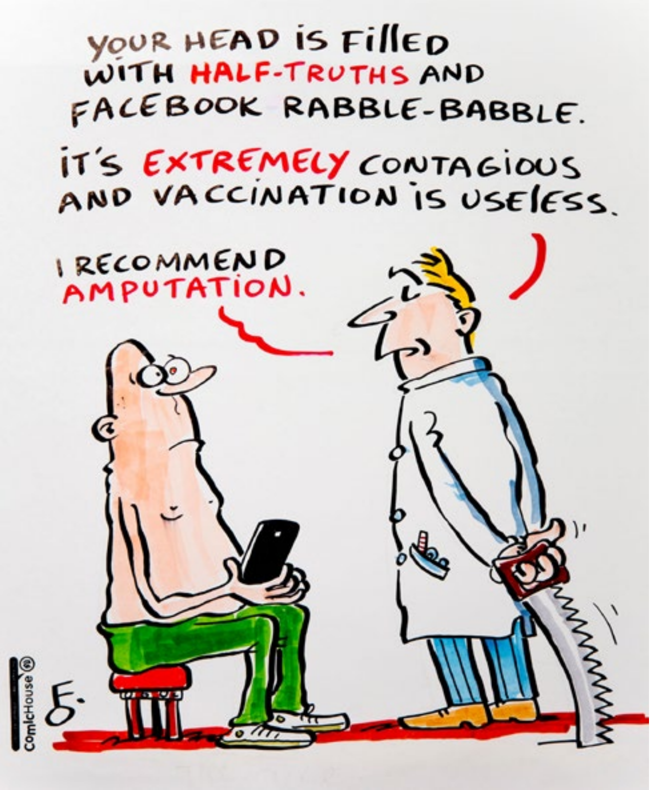
According to ECDC, the groups most hesitant towards vaccination are parents, teenagers, healthcare workers, pregnant women, some religious groups and underserved populations. Lucia Pastore Celentano, Head of ECDC's Vaccine-Preventable Diseases Programme, stated that one of the main reasons for this scepticism regarding vaccines is the success story of vaccination itself: Vaccine safety and coverage have increased over time, leading vaccine-preventable diseases to decrease or become eliminated. Therefore, the perceived risk of these diseases has also decreased, resulting in people being more hesitant and healthcare workers more reluctant to advocate vaccination.

Several of the speakers underlined that vaccination and hesitancy are context specific - immunisation programmes differ across countries regarding payment, access, mandatory vs. non-mandatory vaccinations and so on. Additionally, hesitancy is also related to the societal factor of overall trust towards experts and national governments.

During the session, it was also emphasised that today's world is post-factual, meaning that governments, countries and civil society have to deal with alternative facts and conspiracy theories. Wherever this challenge is combined with difficult topics such as science and vaccination it can create problems – like causing vaccination coverage to drop. Against this background it is important to be aware of the role social media plays by making the distribution of information across areas or even continents easy, partly in closed chat-rooms and groups with no interference from the outside world. Social media is therefore one of the factors enabling vaccine hesitancy to spread across borders, like a virus, making it a priority for all countries globally.

Vaccine hesitancy is seen in several countries in Europe today, where it is mainly related to concerns about safety. Bolette Søborg, Childhood Vaccination Programme, Danish Health Authority, shared her country's experience with the HPV vaccine, showing how fast a generally well-off nation with an on average highly educated population can suffer a massive drop in coverage in only a few years' time. This massive drop in coverage occurred after a documentary called "The Vaccinated Girls" was aired on a national broadcasting network. The documentary questioned the safety of the HPV vaccine and linked it to unspecific symptoms that the girls were experiencing. HPV vaccine coverage is just now starting to rise again, after a large, low intensity information campaign on Facebook. A homepage informing about the issue was launched in May this year. In the campaign, three big organisations stand together with the same message: the HPV vaccine is safe and young girls should get vaccinated.

In France, there is a growing concern related to vaccine safety, combined with a lack of trust in the efficiency of vaccines that arose after the 2009 influenza A(H1N1) pandemic. . The French immunisation programme consists of both mandatory and non-mandatory vaccinations. To increase vaccination coverage, the French government has decided to expand the number of mandatory vaccinations from three to eleven from January 2018 on. This is planned to go hand-in-hand with a large information campaign on vaccine-preventable diseases and vaccines safety. The topic of mandatory vaccination raised questions from the audience regarding sanctions in cases of non-compliance. Jean-Baptiste Rouffet, Policy Advisor, French Ministry of Health, underlined that parents are able to choose not to vaccinate their children, but in order to protect the other children the unvaccinated children cannot attend public institutions.



Ideas to challenge vaccine hesitancy in Europe

First of all, there is need for a change of culture in the public sector. National health authorities need to be more transparent regarding vaccines, vaccination and adverse events. Additionally, authorities should explain the evidence related to vaccines in an accessible and understandable way. Finally, communication must be tailored for each of the target groups respectively, and should always be based on dialogue.

Another point is that national authorities as well as industry, academia and civil society need to work together to raise awareness about vaccine-preventable diseases and the risks that parents take if they decide not to vaccinate their children – risks such as outbreaks of highly contagious and sometimes deadly diseases like we saw with the measles outbreaks in Romania, Germany and Italy. Also, these actors need to engage with the population via new and widely used channels, such as social media.

A third area of focus is the healthcare workers. They should be included in the conversation on vaccination, adverse events and vaccine-preventable diseases. Furthermore, healthcare workers should be supported in managing difficult talks with parents who struggle with the decision of whether to vaccinate their children. In that regard, national authorities can educate healthcare workers, and also develop tools for other professionals who might encounter similar situations.

The panellists also drew attention to the EU's Joint Action on Vaccination. The expected outcomes are, amongst others, a forum for knowledge exchange between Member State authorities, convergence of national policies on vaccine schedules, packing harmonisation, a plan for securing supplies and evaluation of vaccine policies' effectiveness.

In conclusion of the workshop, Andrea Ammon, Director, ECDC, stressed that there is no miracle cure against vaccine hesitancy. We need better cross-sectorial collaboration and to understand that we are all part of the solution - we need to really work together if we want to increase vaccination coverage and counteract vaccine hesitancy in a post-factual world.

Written by Nanna Grave Poulsen

Speakers and panellists

Inputs from
MARTIN SEYCHELL, Deputy Director General for Health, DG SANTE, European Commission
LUCIA PASTORE CELENTANO, Head of Vaccine-Preventable Diseases Programme, ECDC
BOLETTE SØBORG, National Manager of the Childhood Vaccination Programme, Danish Health Authority, Denmark
JONAS SIVELÄ, Senior Researcher, Infectious Disease Control and Vaccinations, National Institute for Health and Welfare, Finland
JEAN-BAPTISTE ROUFFET, Policy Advisor on European Affairs, Ministry of Health, France

Statement by KARIN KADENBACH, MEP (S&D, Austria), European Parliament and other key stakeholders

Moderation
ANDREA AMMON, Director, European Centre for Disease Prevention and Control (ECDC)

Organised by European Centre for Disease Prevention and Control (ECDC)

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Have a voice in the pricing debate

Medicines pricing simulation

Organised by Celgene and European Federation of Pharmaceutical Industries and Associations (EFPIA)

The workshop was opened by Nathalie Moll, Director General, European Federation of Pharmaceutical Industries and Associations, stating that the industry had proven on many occasions what kind of benefits it can offer to society by making new treatments available, for example in the field of biotechnology. She also portrayed the very specific nature of innovation in healthcare: costs are born upfront and on the medicines budget only, but impact and value are delivered over time and on a number of different budgets. This tension has put price at the centre of current discussions on access and sustainability of healthcare. So, how do companies set a price?

To answer this question and explore the relationship between pricing and future investments in research and development, the session was based on a simulation exercise developed by Celgene and facilitated by Kevin Loth, Celgene's VP for Corporate Affairs, Europe and International Markets.

In the exercise the audience was asked to put themselves in the shoes of a pharma CEO, making them experience the complexities and trade-offs of pricing decisions. The exercise was followed by a discussion on the sustainability of healthcare systems and the role of innovative medicines therein. Topics addressed in more detail were the value of new medicines, country-specific pricing decisions and the biopharmaceutical business model as reflected by both pricing and research investment decisions.

Nathalie Moll, Michael Schlander, Nicola Bedlington and Niklas Hedberg

The first set of questions during the exercise was about pricing:

- How do you value a drug?
- And how do you put a price on this value?
- Do you look at the life-expectancy of prospective patients, or their quality of life?

In this context, Michael Schlander, Professor of Health Economics, German Cancer Research Center (DKFZ), emphasised how complex the idea of value for money in healthcare is, saying that it goes way beyond quality vs. quantity of life. There are other key aspects that need to be taken into consideration, such as disease severity. From his perspective, two of the main challenges facing pharmaceutical companies today are transparency and a consistent manner of pricing.

Niklas Hedberg, Chief Pharmacist, Dental and Pharmaceutical Benefits Agency, Sweden, also stressed that doing the decision-making in this context is a balance between multiple factors, such as expectations from patients and politicians, media pressures, and the question of "what is the right thing to do" according to the science behind it all. He also explained that while many would probably have the tendency to want to help younger patients, possibly children, as a public payer you could never discriminate certain patient groups because of their age.

Nicola Bedlington, Secretary General, European Patients' Forum, added that it is challenging to measure and appraise quality of life because of the interconnectedness of health with other areas of life; for example, improving the quality of life of the individual can mean getting them back to work, which influences the economy by mitigating productivity losses. She also pointed to the need for adequately incorporating real world data, as we need to start getting a better understanding of the impact pricing of drugs has on patients.

When talking about country-specific pricing and lower prices for lower income contexts, Michael Schlander highlighted that in fact, a major determinant of the price of a drug is not the cost a company can expect to recoup on past investments, but what are the revenues it can count on for future investments in R&D.

Turning towards the topic of R&D, Moll explained that a company faced with different options for research investment has to not only identify medical gaps and unmet medical needs, but also decide considering which investment is likely to yield a return that is big enough to allow the company to stay afloat and later on invest in other research projects.

Qualifying Moll's line of thought, and slipping back into his payer perspective, Hedberg argued for the need to question the current R&D investment models and to look outside the box to find alternative paths to closing these medical gaps. Bedlington then also added that we have arrived at a point where investment in research and development, particularly in cases of unmet need, should be a collaborative venture between all stakeholders, i.e. within the framework of public-private partnerships.

Moll also agreed on this need for collaboration. She highlighted: "Everybody is expert in their own area, and often-times an agreement cannot be reached because of a lack of knowledge about the kinds of challenges other stakeholders are facing." It therefore seems crucial to not only work together on a specific question pursuing the respectively own viewpoint, but also seeing the bigger picture and understanding other perspectives.

Both panellists and audience agreed on the need for more transparency when it comes to the pricing of drugs, including to be able to compare prices between countries and providers. Furthermore, not only gains but also risks need to be shared, based on societal consensus. The secrecy of corporate decision making is perceived as a problem, and a more "cards on the table" type of approach should be introduced even for more generic discussions. Differing ability and willingness to pay as well as reaching a societally acceptable consensus for new drugs is among the main challenges, as well as the interplay between this expenditure and opportunity costs arising in other areas such as prevention.

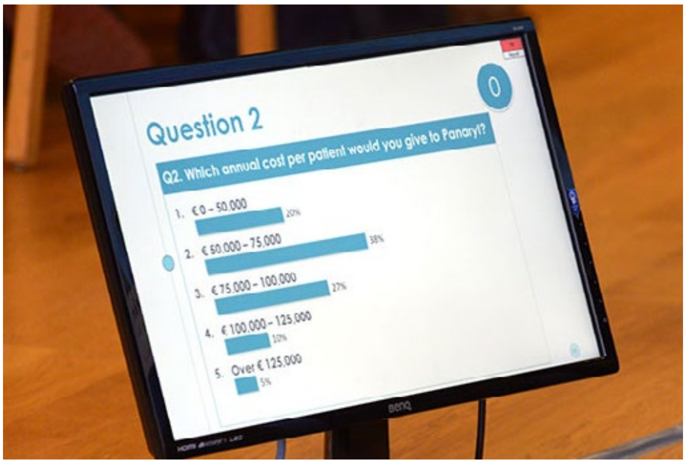
Overall, the session offered a critical perspective on the healthcare sustainability debate and encouraged a multi-stakeholder dialogue on solutions to support broad and timely access to innovative medicines and continued investment in R&D. It also enabled participants with several different backgrounds a glimpse into the challenges a pharmaceutical CEO is facing.

Main takeaway messages

- Biopharmaceutical pricing processes are centred on product value.
- R&D is high risk and expensive and expectations of how a product will be valued and priced are important when determining which new medicines to develop.
- Investment and pricing decisions are complex, multifactorial and interconnected.
- Pricing decisions directly affect the level of investment available to fund R&D in the future.
- New, more collaborative approaches should be considered to tackle areas of unmet need.

Moll wrapped up by reminding the participants that we need understand the complexity of the situation, that we need more evidence and new models of pricing as well as, most importantly, more creativity – encouraging everybody to be a little more creative goes a long way.

Written by Elaine Claire Lautier



Question 2

Q2. Which annual cost per patient would you give to Panaryl?

1. € 0 – 50,000 20%
2. € 50,000 – 75,000 38%
3. € 75,000 – 100,000 27%
4. € 100,000 – 125,000 10%
5. Over € 125,000 5%

Speakers and panellists

NICOLA BEDLINGTON, Secretary General, European Patients Forum (EPF)
NIKLAS HEDBERG, Chief Pharmacist, Dental and Pharmaceutical Benefits Agency (TLV, Sweden)
NATHALIE MOLL, Director General, EFPIA
MICHAEL SCHLANDER, Professor of Health Economics, German Cancer Research Center (DKFZ) and University of Heidelberg

Moderation
KEVIN LOTH, Vice-President, Corporate Affairs and Policy - Europe and International Markets, Celgene

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efpia European Federation of Pharmaceutical Industries and Associations

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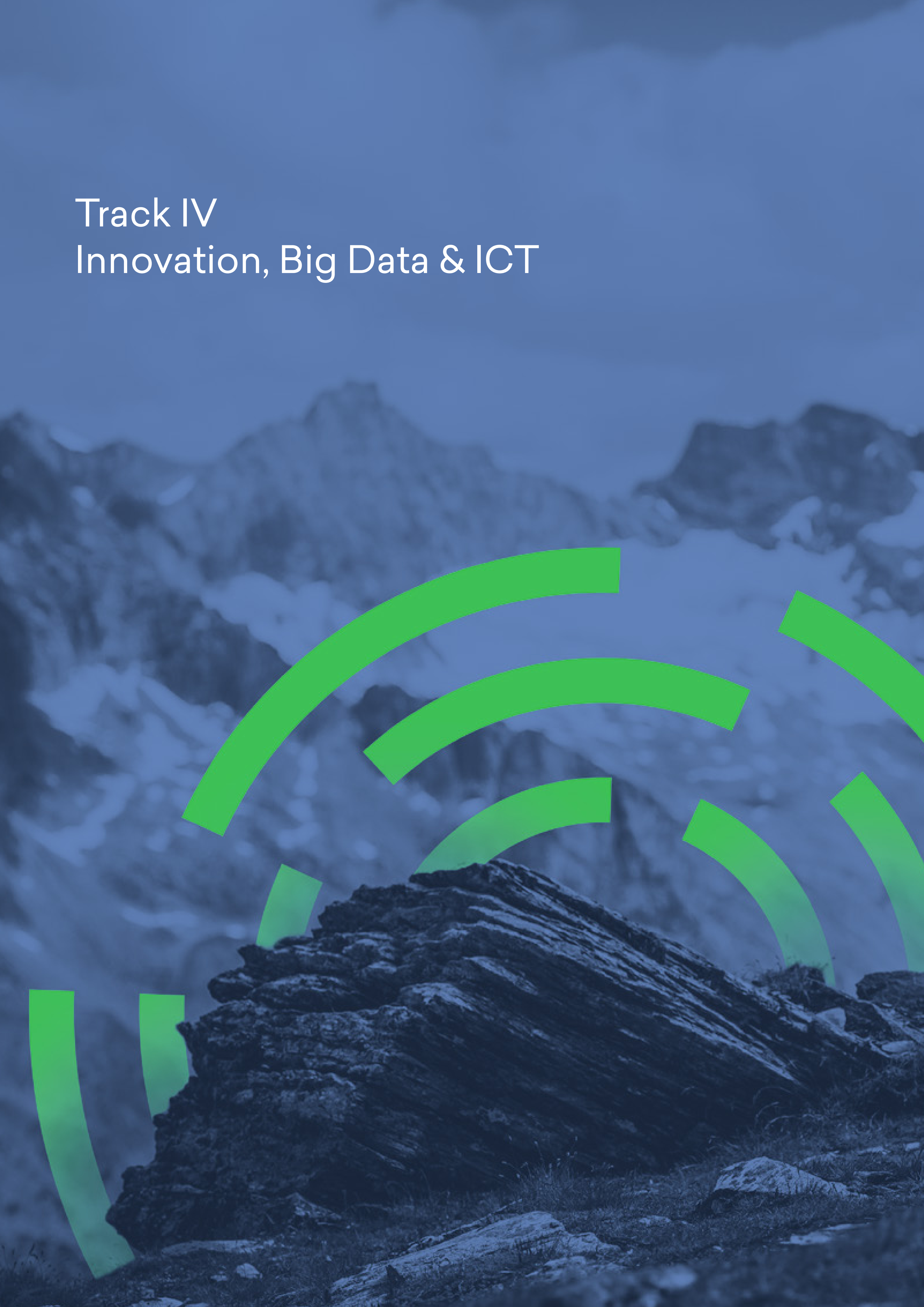
Track IV
Innovation, Big Data & ICT



Personalising healthcare

How rare diseases pave the way

Organised by DG Research and Innovation (DG RTD), European Commission

This workshop brought together different stakeholders to exchange knowledge and develop strategies, policies and guidance that help pave the way for personalised medicine in Europe.

The blurred boundary between clinical care and research in rare diseases makes them an excellent candidate for piloting integrated bench-to-bedside pipelines to ensure the rapid translation of research findings into clinical support for personalised medicine. Irene Norstedt, Head of Innovative and Personalised Medicine Unit, DG RTD, and moderator of the workshop, explained the goal of the session: to better understand how rare diseases could show a way forward for personalised medicine. She pointed out that there have been many investments in both rare diseases and personalised medicine, but that they are progressing in parallel and in different ways. Norstedt also explained that in this context, talking about personalised medicine means talking about the approach - i.e. using phenotype, genotype, and biomarkers to help improve prediction, prevention, treatment and care - and not personalised medicines, i.e. the pharmaceuticals. Currently, about 7% of the EU population suffers from a rare disease, which means that more than 30 million citizens are affected in total. With this number of patients, and because they mostly rely on a very patient-centred model of care, rare diseases can teach us a lot about personalised medicine in common diseases.

Olaf Riess, NeurOmics Project Coordinator, University of Tübingen, pointed out that with the development of “omics” (“omics” refers to a totality of some sort, e.g. genes or proteins) and similar tools, we find ourselves in a hopeful

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Páll Jónsson, Maurizio Scarpa, Vinciane Pirard, Olaf Riess, Ain Aaviksoo and Terje Peetso

> *More effort should be put into the shared EU projects, because, to be successful, we need to work at the EU level, while still providing country specific solutions.*
>
> *Ain Aaviksoo, Ministry of Social Affairs, Estonia*

situation: With the use of bioinformatics, we can work with thousands of genomes in a single lab to develop strategies for tackling different diseases. There are 15 million patients waiting to receive help, and now we can find the pathways, define biomarkers, stratify patient groups, do pre-clinical studies, and foresee other diseases that rare-disease patients might also acquire – all helping to manage the patient, and to learn more about how the disease develops over time.

Vinciane Pirard, Senior Director Public Affairs Specialty Care, Sanofi Genzyme, stated that rare diseases teach us that treatment should not only mean finding a cure. Rather, it should be based on a broader, holistic approach. Also, treatment should be heterogeneous, because within the same disease, there can be very different patients - and very different outcomes. Personalised medicine is helping us get better outcomes in the overall patient population.

Maurizio Scarpa, Coordinator, European Reference Network for Hereditary Metabolic Diseases, stressed the importance of sharing knowledge and experience, stating that the added value of sharing data is at the core of the discussion. He mentioned the new European Commission Network of Excellence programme that facilitates building a network of different disease centres across the EU. At this moment, it gathers 300 patient-centred centres of excellence, with 24 specialised units contributing different aspects of expertise and knowledge. Precisely this mode of cooperation is the answer to how to unify pathways and empower the clinical pillar - the shared knowledge can accelerate early diagnosis and thus provide better health outcomes.

Ain Aaviksoo, Secretary General for E-services & Innovation, Ministry of Social Affairs, Estonia, and Vice-Chair of the ICPerMed initative pointed out that the definition, understanding and range of different diseases are changing quickly with research and innovation. Because of this, there also needs to be a changed approach to tackling diseases. The new approach to rare-diseases is an important step, and can only be accomplished successfully if operated at EU level. Since healthcare provision is still a Member State competence, more effort should be put into shared projects and exchange of data; to be successful, we need to work at the meta-level, while still providing context-specific solutions.

Terje Peetso, Head of Sector eHealth & Ageing policy, DG CONNECT, European Commission, pointed out that there are already many ways of gathering medical data across the EU, but that they need to be extended regionally and nationally and across borders. Also, there needs to be the clear political will to work towards interoperability, and this can be accomplished only by demonstrating all the benefits of such a system.

Páll Jónsson, Associate Director for Research and Development, UK National Institute for Health and Care Excellence (NICE), added that everyone needs to work harder on synthetising data, especially real-world data. Whenever only few patients are recruited for trials, real-world data becomes a necessity. However, this is difficult because of the potential inherent bias. To solve this, academia, clinicians and the broader community need to agree on how to use data sources.

The audience provided input on issues related to the secondary use of Big Data, the General Data Protection Regulation, and European Reference Networks. It was agreed that there needs to be a European consortium as well as a shared health-data and genomics bank. Data should be uniform and able to travel to different countries. One of the biggest challenges here at EU level is that health remains a Member State responsibility, and collaboration remains on a voluntary basis. But common registries should be used from diagnosis to clinical trial: the only ones who have the real-life experience of what having a rare disease means are the patients. To take this into account we need to have registries that capture the heterogeneity of a disease. We also need to know what data we are collecting, and why.

Aaviksoo referred to yet another issue: the topic of this conference is Health in all Politics – and one problem is that 'tech-smart' people talk amongst themselves about what should be done, and then push for it. We need to translate this "tech-talk" into common language, and make the case political and European. There are already many initiatives for interoperability and the revision of health digitalisation, and we should continue working towards creating a mentality that is striving for value-based guidance and managed care for all patients.

Written by Rafaela Tripalo

Speakers and panellists

Interventions from
OLAF RIESS, NeurOmics Project Coordinator, University of Tübingen
AIN AAVIKSOO, Secretary General for E-services & Innovation, Ministry of Social Affairs, Estonia /also: ICPerMed Vice-Chair
MAURIZIO SCARPA, MD PhD Coordinator European Reference Network for Hereditary Metabolic Diseases
PÁLL JÓNSSON, Associate Director for Research and Development, National Institute for Health and Care Excellence (NICE)
VINCIANE PIRARD, Senior Director Public Affairs Specialty Care - Europe, SANOFI Genzyme
TERJE PEETSO, Head of Sector eHealth & Ageing policy, DG CONNECT, European Commission

Moderation
IRENE NORSTEDT, Head of Innovative and Personalised Medicine Unit, DG RTD, European Commission

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Organised by DG RTD, European Commission

European Commission

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Making cancer care more efficient

What role can different stakeholders play?

Organised by All.Can | Secretariat represented by The Health Policy Partnership

This forum was opened by Vivek Muthu from Marivek Consulting, a member of the multi-stakeholder platform All.Can, which was established to create political and public engagement in cancer care and which organised this session. Muthu described how important it was for healthcare to be sustainable. We all need to work together to reduce waste, which ultimately harms patients, since funds are not directed towards the fields where they are most needed. He highlighted the importance of a multi-stakeholder approach in producing policy recommendations for tackling inefficiencies, promoting innovation, and better allocating resources for sustainable cancer care.

Kathy Oliver, Chair and Co-Director of the International Brain Tumour Alliance (IBTA), gave a presentation on patients' perspectives on waste and inefficiencies in cancer care, based on a literature review performed by All.Can. For patients, waste and inefficiencies manifest themselves in:

- delays and time wasted,
- poor communication and limited information,
- overuse, underuse and inappropriate treatments and care,
- disconnect between patients' needs and care given,
- fragmentation of care and lack of follow up,
- inadequate consideration for health literacy and
- insufficient use of data to inform and improve care.

She presented numerous case studies which showed that waste could be addressed - sometimes even with simple and cheap measures - to measurably improve outcomes. It was argued that a no-blame culture and cooperation were

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Cathryn Gunther, MSD

Cancer patient care should not stop after the last session of chemotherapy.

Kathy Oliver, International Brain Tumour Alliance

required to find solutions to reduce waste, and improve sustainability.

The audience was then invited to split into groups and take on the role of one of the stakeholders in cancer care: patients & caregivers, healthcare professionals, biomedical science industry, payers, academia and research, policymakers, non-biomedical science industry, and healthcare managers.

The individual stakeholder groups then had to come up with ideas of what the particular stakeholder group could do to improve efficiency and outcomes, what the possible barriers to achieving these were, and what they needed from other stakeholder groups to achieve their objectives.

The five panellists then proceeded to give their perspectives on what they thought their respective sector could do to improve efficiency and foster innovation in cancer care.

Birgit Beger, CEO of the European CanCer Organisation (ECCO) brought up the quantity versus quality argument. We should understand what is truly important for patients to be able to direct our efforts to what truly matters. She advocated for multidisciplinary tumour management boards which would enable faster cancer care pathways, and for harnessing the power of technological innovations.

Tit Albreht, Head of the Centre for Health Care at the National Institute of Public Health in Slovenia, also referred to the importance of having a multidisciplinary approach to cancer care. Going further, he highlighted the importance of having structured cancer care across a spectrum, from prevention, screening and diagnosis, all the way to treatment, survivorship and palliative care. He echoed Beger's view that different stakeholders need to do more to listen to patients and understand their priorities.

Deepak Khanna, Senior Vice President and Regional President (EMEAC) of MSD Oncology, highlighted the advances that have occurred in cancer treatments in the last decade. The next big challenge is a personalised medicine approach which would tailor treatments according to individuals' needs. This would help reduce waste, and improve outcomes. Khanna echoed Muthu's introductory statement, accentuating the need for collaboration and trust across all stakeholder groups to effectively tackle waste and inefficiencies.

Wendy Yared, Director of the European Cancer Leagues (ECL), emphasised the potential contribution of civil society organisations on this topic. They can influence policy at national and international level and contribute towards improving cancer care by providing funding for research and innovation.

Oliver pointed out how important it was to focus on the entire cancer pathway and not just on treatment. Good strategies and mechanisms need to be in place even at the survivorship stage, since some cancer survivors may face challenges after a cancer has been cured.

The audience had the opportunity to ask the panellists several questions. The main point that emerged from this discussion was the importance of empowering patients to get involved and help them participate in healthcare sector reforms. There needs to be a commitment by all stakeholders to acknowledge the importance of listening to patients and their caregivers to improve patient care. Patients can be trained in advocacy, given mentorship by existing patient groups, and given support to help them reach out to policymakers.

Key take-home messages

- We are seeing exciting progress in cancer care with advancements in treatments that are transforming the lives of patients – but costs are rising and sustainability is under question.
- Solutions must be long term and structural – not 'quick fix' cost containment.
- All.Can believe the starting point to creating sustainable care is to listen to patients and focus on their needs – policies focused around patient outcomes will reduce waste and inefficiency (as resources will only be targeted where it matters).
- Stakeholders involved in cancer care are evolving to include 'new players' like technology companies, IT, data providers, as well as patients, caregivers, clinicians, policymakers etc. – we all need to be included in the discussion and work together to achieve sustainable cancer care.

Written by Sascha Reiff and Tanja Fruhmann

Speakers and panellists

Interventions form
TIT ALBREHT, Head of the Centre for Health Care, National Institute of Public Health, Slovenia
BIRGIT BEGER, CEO, European CanCer Organisation (ECCO)
DEEPAK KHANNA, Senior Vice President and Regional President (EMEAC), MSD Oncology
KATHY OLIVER, Chair and Co-Director, International Brain Tumour Alliance (IBTA)
WENDY YARED, Director, Association of European Cancer Leagues (ECL)

Moderation
VIVEK MUTHU, Marivek Ltd.

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Early diagnosis linking Big Data - hope or nightmare?

Hosted by Roche

The term Big Data was once used to describe datasets so large and/or complex that traditional data processing software was inadequate to deal with them. Nowadays, the phrase is mainly associated with predictive analytics and is increasingly called upon in the healthcare sector to advance early diagnosis and treatment.

This workshop, chaired by Armin Fidler, Senior Lecturer and Member of the Faculty, Management Centre Innsbruck, explored whether Big Data can live up to these expectations. The session focused on the examples of breast cancer and Alzheimer's disease to illustrate opportunities and challenges related to Big Data in early diagnosis, complemented by insights into the realisation of Big Data in Health.

With one in nine women developing breast cancer during their lifetime, Dietmar Berger, Global Head Clinical Haematology and Oncology, Genentech, used the "global breast cancer crisis" as context to demonstrate the added value of Big Data in early diagnosis. He specifically focused on HER2-positive breast cancer, a very aggressive type of cancer that mainly affects younger women, has a high risk of recurrence and generally high mortality rates. HER2-positive breast cancer patients could benefit the most from early diagnosis as only the earliest of three disease progression phases is curative and has the chance of a complete recovery. Here, early diagnosis could lead to concrete, measurable outcomes in improved life expectancy, as well as economical and societal benefits for patients, health systems and communities.

The point for early - or rather timely - diagnosis for a disease that currently has no cure was made by Marc Wortmann, former Executive Director of Alzheimer's Disease

Reinhard Riedl, Marc Wortmann, Dietmar Berger and Armin Fidler

> *Using Big Data without considering the ethical aspect is unethical, but not using Big Data at all is unethical as well.*
>
> *Reinhard Riedl, BFH Centre for the Digital Society*

International. As we are facing an ageing population, the prevalence of these type of age-related diseases is expected to significantly increase worldwide. Although the economic burden of Alzheimer's disease is not visible in direct medication and hospitalisation costs, the social and informal care costs are substantial. A timely diagnosis could provide opportunities for better mitigation, medication and psycho-social treatment of patients and their social environment. However, this opens different ethical and legal questions that are not considered for diseases where effective treatment is available, such as dealing with employers/employees and insurance companies. These need to be carefully examined and regulated with policies.

Main challenges of Big Data implementation

Reinhard Riedl, Head of Transdisciplinary BFH Centre Digital Society, Bern, talked about the role that data science can and will play in the future. Rather than defining Big Data in terms of the 4Vs (volume, variety, velocity and veracity), he described it as extracting additional information hidden in data not primarily created and collected for this purpose. Big Data can give us a bigger picture, and enable us to perform better and earlier diagnoses. One example is the identification of specific risks by taking a broader look at a patient´s history or living environment, or finding key system failures by examining health system performance data.

The five pillars necessary for Big Data to exist are data, algorithms, skills, knowledge and ethics. At the same time, five of the main challenges currently facing the implementation of Big Data are:

- **Data - accessibility of the data**: A lot of data already exists in Europe. However, the data is not available for research and development due to privacy and legislative issues.
- **Skills**: The fast-developing area of Big Data requires continuous learning the and development of expertise from competent researchers. Advances in Big Data simultaneously entails the development of new careers and job descriptions.
- **Awareness of policy-makers**: There is an urgent need to increase the visibility of this field to policymakers and provide them with robust information on the necessity and benefits of Big Data usage: that is the only way to adapt current legislation to make the data more accessible to researchers.
- **Transdisciplinary collaboration**: The myth of the "lone genius" has long been debunked. In order to make real impact, there is a need for even more and broader transdisciplinary collaborations, starting from clinical and pre-clinical health experts, through molecular biologists, and computer scientists, all the way to mathematicians. These types of collaboration need to be fostered early on in the education system, so that genuine mutual understanding and communication can be achieved.
- **Ethics beyond bureaucracy**: It is crucial not only to define the ethics of Big Data at the legislative level, but to promote the understanding of the ethical dimension of the work with Big Data among researchers.

While the individual benefits of early diagnosis are obvious at a patient-level, the panel discussion emphasised the need to better assess the costs and benefits at the systems-level. It was argued by the panellists that beyond the individual benefit of early diagnosis, there are concretely measurable cost-benefit outcomes for the health system, but also less tangible effects, such as societal contributions, return to the workforce, or child rearing (in case of breast cancer). Thanks to the digitalisation in many dimensions of the system, a lot of procedures might be replaced by software, and hence become cheaper and more sustainable.

It was further pointed out that the use of Big Data in health does not necessarily pursue the goal of making the health system cheaper, but rather more effective. In order to be effective, high quality data needs to be generated and curated. To increase the generation of high-quality data, the eHealth system and tools should specifically be designed to match the needs and routines of health care professionals. The more practical and user-friendly the tools are, the higher the acceptability and usability will be, leading to increased quality of the generated data. Furthermore, the more recognition and value is given to the curation of data, the higher the quality will be. First endeavours in this area have been made by ETH Zurich that is currently developing and implementing a platform for data curation.

Another question that came up during the discussion was related to the outlook on whether Big Data would lead to more control and management of personal health among citizens. This was linked to the empowerment of citizens and the need for continuous education, and, possibly, development of new professions that would support personalised health management.

Conclusion

As a conclusion of the session, the panellists provided insights into their “moon-shot ideas” about Big Data in health and whom we need to bring on board to achieve these ambitious goals.

Marc Wortmann called for an increase of the budget for dementia research to at least 1% of the global cost of the disease, in order to tackle this growing burden on the social system.

Dietmar Berger argued for the pursuit of a holistic approach to diagnosis to provide better care for cancer patients. This would require the provision of decision support from all partners: diagnostics, treatment, research and the regulatory perspective.

Reinhard Riedl would like to see the full implementation of Big Data in health by the establishment of a European personal health data platform bound by proper restrictions and clear governance; an advancement necessitating an increased awareness among politicians and adapted education systems.

Written by Durdica Marosevic and Ramona Ludolph

Speakers and panellists

The evolution of early diagnosis and treatment in Breast Cancer and its impact on patients & society
DIETMAR BERGER, Global Head, Clinical Hematology and Oncology, Genentech

The challenges and opportunities to early diagnosis in Alzheimer's Disease
MARC WORTMANN, Former Executive Director, Alzheimer`s Disease International

Big Data as a driver of early diagnosis and treatment
REINHARD RIEDL, Head of Transdisciplinary BFH Center Digital Society, Berne, Switzerland

Moderation
ARMIN FIDLER, Senior Lecturer and Member of the Faculty, Management Center Innsbruck (MCI), and former Lead Adviser for Health Policy and Strategy, Human Development Network, The World Bank

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Executive summary

The EHFG 2017 survey was sent out to all delegates via email and was posted on our social media outlets and was open for five weeks. The survey was completed by 102 respondents (20% of all delegates).

The survey was divided into four parts, in which respondents were asked general questions (1), questions concerning the different sessions and workshops they attended (2). They were also asked to express their opinion about the registration and organisational elements, and their overall impression of the conference (3). In the last part of the survey, there were open ended questions about the participants' recommendations for improvement of the next years' conferences (4).

In most of the survey questions the respondents were asked to choose one answer they find most applicable. However, to some questions they were allowed to give multiple answers and express their personal suggestions or points of criticism.

Respondents

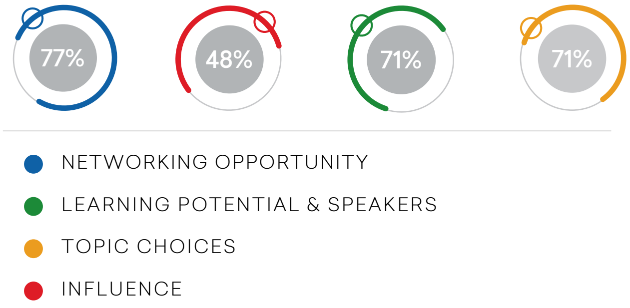
56% of the participants who completed the survey were female, 44% – male.

Over two thirds of the respondents identified health policy as one qualification of their field. Half of them chose health care and nearly half of them health research. Around 25% chose health promotion, 18% management and 6% journalism. Pharma sector, medical technology, management, insurance, IT and social security were other selected categories.

More than half of the respondents were representing public institutions during the 20th EHFG, followed by representatives of teaching and research (21%), NGOs (18%) and politics (12%). Industry as well as press was represented by 10% survey respondents each, interest groups by 4% of respondents.

Main reasons to attend the conference

The main factors of influence on the decision to attend the EHFG 2017 were networking opportunities and potential for learning. For 77% attending the conference was influenced by networking opportunities, 71% attended because of potential for learning and over 60% because of topic choice, more than half attended because of the calibre of speakers. A half considered the influence on European health policy as a decisive factor to attend the conference.



Session quality assessment

General rating scheme used in this survey was a scale 1 to 5:

- 1 - no influence / total disagreement / poor (knowledge)
- 3 - medium influence / neutral / medium (knowledge)
- 5 - high influence / total agreement / excellent (knowledge)

Plenaries

Overall, the Opening plenary was rated 3,68 out of 5. With 4,33 average rating, the moderation by Tania Dussey-Cavassini received the highest ranking (3,87), followed by the quality of the policy reaction by Francesca Colombo (3,76). The newsroom team and the interactive conference tool received an average score of 3,67.

The Thursday plenary received an overall rating of 3,95. The highest rating of 4,17 was received by the moderation (Matthias Wismar), followed by the online message-to-the-moderator system (3,94). The standard of the debate and the plenary speakers was rated with 3,91.

The Closing plenary was rated with an overall rating of 3,90. The quality of the conference film received the highest voting with 4,12. The quality of the moderation by Robert Madelin received 4,16, while the quality of the anniversary film was rated with 4,11, followed by the newsroom team and the conference tool with the score of 3,83.

The Thursday Plenary was ranked highest in the quality of speakers and debate (3,91).

Parallel fora

Forum 12 received the best average rating of all fora sessions (4,64), followed by Forum 6 (4,25), Forum 8 (4,21), and Forum 3 (4,11). At the other end of the scale, F9 Session with 2,57 and Forum 7 with 3,29 received the lowest ratings.

Comparing all fora sessions, the assessment of the length of presentations of the fora was overall positive. The presentations in Forum 4 (58%) and Forum 9 (56%) were criticised for having been too long.

Overall, the number of presentations of the fora was considered as very good. Only in Forum 9, 60% of the respondents who participated criticised that there were too many presentations. Furthermore, 43% of respondents considered the number of presentations as too many in Forum 6.

For around one half of the respondents, Forum 4, Forum 6 and Forum 10 did not offer enough time for interactive discussions, the same was criticised by 44% and 33% of respondents who participated in Forum 7 and Forum 2, respectively. One third of respondents who participated in Forum 1 and Forum 9 criticised that there was too little time allocated for interactive discussion.

Workshops

The average ratings for the workshops were all above 3,56. The best rating was given to Lunch Workshop 1 (4,36), followed by Workshop 3 (4,13) and Workshop 4 (4,13), Workshop 7 (4,09), and Workshop 2 (4). The respondents gave their lowest overall rating to Workshop 1 (3,56).

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Evaluation report

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We would like to thank the following institutions, organisations and companies for their expertise, generous support, sponsorship and fruitful cooperation which makes the European Health Forum Gastein such a successful event and without whom we would not have been able to realise our goals. We are looking forward to continuing these partnership on our way towards *CREATING A BETTER FUTURE FOR HEALTH IN EUROPE*

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- European Social Insurance Platform (ESIP)
- Ministry of Health and Woman’s Affairs, Austria
- Gesundheit Österreich GmbH (GÖG)
- Health Literacy Coalition
- Health Promotion Administration, Ministry of Health and Welfare, Taiwan R.O.C.
- London School of Hygiene and Tropical Medicine
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Public Health Genomics

Das österreichische Gesundheitswesen (ÖKZ)

Der Standard

Imprint

Publisher
European Health Forum Gastein
Tauernplatz 1, 5630 Bad Hofgastein, Austria
www.ehfg.org
info@ehfg.org

Editorial team
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Photos
Gasteinertal Tourismus GmbH (section dividers)
framez. / Fabian Kapo, Andreas Steger, Anna Dziubinska
Harald Minich HBF (CM Auer)

Cartoons
Floris Oudshoorn / Comic House

Corporate design
CRCL . Design + Direction / www.wearecircle.at

Report online version 10 January 2018