EUROPEAN HEALTH FORUM GASTEIN

INVESTING IN HEALTH, INCREASING EQUITY AND WEALTH

Meeting Report

European Patients' Forum,

Rue du Commerce 31, 1000 Brussels, Belgium

EPF Office Phone number: +32 (2) 280 23 34

Email: info@eu-patient.eu Web: www.eu-patient.eu

WELCOME NOTE

Tamsin Rose (Independent EU Health Activist), in her role as chair, welcomed participants and underlined the aim of the meeting i.e. explore what can be done to ensure quality and equitable health services against the background of the current crisis. As this is the most severe crisis since the 1930s, it has huge implications for the ways health services are being organised and how healthcare is being delivered.

1. PART ONE : SETTING THE SCENE

Josep Figueras (WHO Observatory on Health Systems and Services) introduced healthcare provision as the cornerstone of well-functioning systems. The question is how sustainability, innovation and equity can be balanced. The current conundrum is to 'how we can have the cake, eat it and actually enjoy it'. Health economists are convinced that this is not possible, even in times without a crisis.

However, there is more to this issue than finances and budgets only; the European value system comes into play here. The European social model guides our value systems. While austerity may be one of the core solutions towards solving the crisis, it has negative consequences for patients; it impacts both on access to health care as well as on health status. Healthcare is being rationed and this is a trend that can be seen across the EU. While governments are trying to maintain universal access, some population groups are being hit hard by the current austerity measures (e.g. migrants). There are implicit rationing measures as well (e.g. long waiting lists for certain interventions). Pharma spending is also increasingly being scrutinised, as some of the medicines coming on the markets do not add value and some are simply not cost-effective. Out of pocket expenses – borne by patients – are increasing.

There is a risk of health inequalities increasing. Inequalities do not relate to values only; they also threaten social cohesion, and economic development requires social cohesion. The recognition that health and wealth are intrinsically related is central to EU policy.

Much is being said about whether innovation would stimulate the performance of health systems, both in terms of cost effectiveness as well as in terms of better health outcomes. However, this is only the case is eHealth applications are

aligned with concrete health policy objectives. It is difficult to assess the cost=effectiveness of eHealth applications and developments, as these do not always result in cost saving, especially in the short term. A broader outlook is required, which includes taking into account savings made in other sectors as a result of investing in eHealth and health systems.

Another question relates to how the industry can be convinced to focus on those areas where the focus is most needed? The pharma industry is increasingly under scrutiny as many new drugs have not come up with good results. Critical articles are appearing on the myths in pharma spending, underlining the amounts spent on marketing and communication as compared with investment in R&D. New business models will be needed, possibly with a focus on increasing volume and lower margins.

In conclusion, Josep underlined the trade-off between equity and efficiency, if access to quality healthcare by all population groups is to be sustained.

2. PART 2: PANEL SESSIONS

2.1 PANEL SESSION 1 : HOW TO MAINTAIN EUROPE'S COMPETITIVE AND INNOVATIVE HEALTH CAPACITY ?

The next speaker, Panos Kanavos (London School of Economics) underlined that unless we continue to innovate, our society may come to a complete standstill; growth will no longer be possible. Clearly, spending deficits have increased in recent years, so solutions are urgently required. While technical efficiency in the area of pharmaceuticals is needed (which is the remit of the EMA) it is crucial to also address the other sectors in the area of health care.

Panos presented the outcome of a recent LSE survey which focused on what options and cost-cutting measures would be acceptable to policy makers. From the responses it is clear that the most preferred solution would be to increase tax on tobacco and alcohol ('sin taxes'). Reallocating budget and more restrictive purchasing of health technology were also amongst the highest scoring preferences.

Alcohol is a good example of where cuts could be made; however, the industry concerned works to convince policy makers of the drawbacks of doing so (i.e. loss of jobs and productivity).

Societal acceptance of austerity measures needs to be measured as well as there is no hard evidence of this to date. LSE is in the process of setting up field experiments to assess preferences in real terms but the data will not be available for the foreseeable future.

Maybe the pharmaceutical industry should pay 'sin tax' as well, but other parts of the system also need to be addressed in order to deliver high quality health care under more different and changing circumstances.

The second panellist, John Ryan (European Commission, DG SANCO) underlined the diversity of the different health systems in the EU. The Commission monitors what health systems are doing quite closely and it is clear that there is a strong risk of 'negative' health systems. However, it needs to be borne in mind that crises, while painful, also provide opportunities for breaking out of existing moulds and putting into question entrenched positions. The current crisis can be used as a jumping board to improve health and get better services. The difficulty is that it requires a certain level of acceptance of the patients and systems involved and this is not immediately obvious in those countries where the crisis is felt most at the moment.

Choices can be hard in political terms as well. Health consumers themselves can influence these choices. Across the EU, the same patient rights apply. While emphasizing rights can be useful for those that have health coverage, this may lead to those that do not have this coverage to be targeted.

Having access to access to safe care is another issue, which relates to issues of empowerment, relevant knowledge and the ability to take informed decisions. At a recent Ministerial meeting patient empowerment in the area of chronic disease was explored, and questions were raised about how patients can be more involved in decisions that affect their health systems.

Governments recognise the importance of civil rights organisations as these can address the real problems that relate to them.

Patient literacy is often coined as a potential solution. However, patients need to be in a position or state to absorb all the information available.

Health systems need to gear up to provide healthy choices. Currently, 97 % budget of the budget is spent on care as compared to 3 % on prevention. This clearly needs to change as a refocus on prevention and early detection would have an enormous effect on health care spending. For instance, obese individuals are 25% more expensive to health systems than non-obese individuals; drugs to treat and keep diabetes in check represent 8% of the total health budget. This is the background to an EU Reflection process on chronic diseases that the Commission has set in motion. A Paper developed by Trio EU Presidency looks at how chronic diseases can be better addressed across Europe. This initiative will feature on the Commission work plan for 2013, as Member States have expressed a strong interest.

Ageing is another priority and action area. Medical innovation help in the short and medium terms but the choices made by ministers will need to take the longer term into consideration as well. Therefore, a reflection on the best ways on investing in health is ongoing and linked to the EU Semester process, which looks at national budgets and the balance of payments in the Member States.

Support to Member States is provided by means of the Structural and Cohesion funds. There is money available for health activities; however, the level of requests for health activities has been limited until now. Countries need to be made more aware of this possibility; under the new European Structural Funds, the aims are to eliminate disparities between Europe's different areas and health investment is an important factor.

The final speaker in this session was Claude Pérol (Sanofi) who underlined that the pharma industry

(and life sciences in general) has to be more active in shaping its environment. The current view that health is a cost should change into an approach where health is regarded as a prerequisite of wealth. The pharma industry is a main player, as demonstrated by the fact that it is a prime industrial sector which employing 665 000 people and has its part to play in this changing approach.

The European pharma sector is a worldwide leader in terms of innovation. It is one of the few sectors where Europe has a competitive advantage and this needs to be fostered by a home market that provides favourable conditions to innovation. Medicines contribute to health improvement; and therefore they contribute towards wealth. An example can be found in the area of cancer, where research has shown that a 10% decrease in death rate results in a saving of 4.4 trillion USD. Other research has shown that 50% of life expectancy increase is related to innovative drugs. In other words, the pharma industry has a responsibility to contribute to wealth and economic growth, and this needs to be taken into account in policy development. Percentages of GDP on drug spending should not be the only criteria for decision makers.

The industry is aware of the need of fiscal discipline and austerity measures. However, recent and current measures have already reached their level of acceptability. Austerity measures are being presented as efficiency measures while they are often just simple cost cutting ones. During 2010/2011, some 7 Billion Euros of such cost cutting measures have already been taken in the field of pharmaceuticals; 2012 will see even higher levels. This obviously has serious consequences for industry in relation to planning, investment and R&D.

As outlined by OECD, growth in health expenditure was zero in 2010 and even negatives in several EU countries such Norway, Denmark and most of Central Eastern Europe. The outlook for 2011 and 2012 does not look positive either. These developments occur irrespective of health status, health needs and the impact of these cuts on health – and therefore wealth. The industry would like to call on decision makers to not only base their policies on purely financial criteria when it comes to health investments.

Industry should be regarded as a partner to ensure a minimum of predictability for this sector. Industry can help design structural reforms enabling a better balance between the need of fiscal discipline, the health needs of citizen and the reinforcement of a strong European industry. Industry can provide input in discussions in financing of healthcare investment (e.g. a better private/public balance), health care sector efficiency and drug sector efficiency. Silo budgeting at state level is a barrier to real efficiency and these needs to be addressed as a matter of urgency. Prevention does not feature high enough on governments' health agendas, as well as integrated solutions facilitated

by e-technologies. In terms of drug efficiency, the industry proposes developing more efficient off patent market (rapid access, competitive pricing), which would create headroom for innovation. Stricter prescription and volume control is another area where improvements could be made. What industry cannot offer is a tier-pricing approach, adapting the prices of medicines to the economic level of individual countries. The negative impact of the widely used international reference price as well as parallel trade of medicines already results in shortages of medicines in some countries. However, the development of value/performance based pricing/reimbursement in all member states can be encouraged. Industry could also forge better cooperation and alignment between its various sectors (generics & R&D). Claude Pérol closed his statement by underlining the need to develop and enforce an industrial policy for the pharma sector in order to reinforce competitiveness of this sector, support to R&D and access to innovation bearing in mind the efficiency of the health care system.

2.2 PANEL SESSION 2 : HOW TO ENSURE PATIENTS' AND CITIZENS' RIGHTS AND HEALTH EQUALITY IN TIMES OF AUSTERITY?

Ludovica Banfi (European Union Agency for Fundamental Rights) presented a recent report published by her Agency, which looks at the law and current practice concerning access to healthcare for migrants in an irregular situation in 10 EU Member States (Belgium, France, Germany, Greece, Hungary, Ireland, Italy, Poland, Spain and Sweden).

In 19 out of 27 EU Member States irregular migrants are entitled to emergency healthcare only. In 11 out of the 19 countries migrants in an irregular situation are entitled to emergency healthcare but have to pay for it (Austria, Bulgaria, Czech Republic, Denmark, Finland, Greece, Hungary, Ireland, Latvia, Poland and Sweden).

More positively, in Belgium, Italy and France irregular migrants may access healthcare beyond emergency care services if they fulfil specific conditions. Spain also had measures such as these in place. However, in April the Spanish government amended the Foreigners Act, which denies access to essential and preventive health care services. This new legislation only allows access to emergency care, maternity and child care. However, as a result of civil society advocacy, regional governments and medical professionals, the Spanish Health Minister decided that primary health care services will be available to undocumented migrants on condition that they adhere to a system of financial contribution. This is similar to a monthly private insurance contribution of 59.20 for those under the age of 65 and up to EUR 155.40 for the over 65's. Obviously, these fees are unaffordable

for many irregular migrants.

The Agency's survey has revealed that there are large differences between the letter of the law and what happens in practice. It needs to be kept in mind that it is not the irregular migrants themselves but also their families that are affected by these access laws.

Another Agency project addressed multiple discrimination in healthcare. There are a number of barriers that hinder access to health care, such as language and ability to communicate in a certain language, financial barriers, lack of information on entitlements as well as organisational barriers. Malpractice, harassment and violations relating to informed consent are reported as well.

The Agency will continue to collect data and monitor how the situation improves. Most of the violations go straight against Article 3, which stipulates the right of informed consent to treatment. It is also about choice and the right to information. Issues in relation to older migrants are also moving up the agenda.

Anders Olauson (European Patients' Forum) emphasized the dramatic and unacceptable consequences of the financial crisis, both for patients as well as their families that are clearly felt by EPF's members across the EU: stories about treatments which are no longer being reimbursed,

patients that cannot afford their care and shortages of supplies of medical devices or medicines are becoming increasingly common. There is evidence that the current economic situation is exacerbating health inequalities.

Health economics - with a short-term outlook - seem to take precedence over fundamental societal values and human rights.

How healthcare is prioritised is a key test for Europe. Reduced investments in people's health lead to severe costs for society as a whole – both in human as well as in economic terms. It is challenging for patient advocates to respond to austerity measures in this climate?

From EPF's perspective, a new holistic model of care should be put in place. In such a model, empowered patients are part of the solution to the future sustainability and quality of health and social systems. Patients are often regarded as a "cost driver" when empowered and informed.

However, informed and empowered patients are an asset to society: they are more discerning about their health, make more informed choices and decisions, are more likely to seek earlier diagnosis, and are more likely to have better health outcomes and use resources in an appropriate and effective way. This is why patients with chronic diseases should be supported to participate proactively in the management of their condition.

Health literacy should be one of the pillars of an overarching patient empowerment strategy. The focus should be on creating an enabling healthcare environment through the universal implementation of the principles of patient-centred healthcare. In this respect, patient literate healthcare professionals are needed, to ensure they support patients in developing the skills to ask for information. Patients' organisations are an invaluable ally in the efforts to promote self-care and health literacy. Patients therefore should be involved in the innovation process - for low tech as well as for high tech solutions - to ensure that investment in resources adds value and that innovations are taken up by end users. Lastly, involving patients' organisations in shaping relevant EU and national level policies and programmes will help target the most beneficial interventions. Anders concluded his contribution by warmly welcoming John Ryan's statements in relation to the need to involve patients and the possibilities of EU support for health projects by means of the EU Structural Funds.

SUMMARY OF ISSUES RAISED IN THE DISCUSSION

1. The vast majority of current savings take place in the pharma sector. This stems from silo budgeting in the health care sector as well as across policy sectors. It would help to consider healthcare spending as a system of inflows and outflows, with related access issues and time aspects. If the time aspect is taken into account, prevention issues can be addressed more easily as it will not be seen as a cost in today's budget but rather as a longer term gain.

2. Equity is the key. There seems to be a high level of enthusiasm for technology as the essence of the solution. However, technology as such holds the risk of enhancing inequalities. It does not work for all; 'technology gaps' exist and could widen. While there was agreement on the potential contribution of technology towards rendering administration more efficient, it was also acknowledged that inequalities could be increased in terms of personal and health use. However, it could also function as a bridge.

3. The need to involvement of patients in decisions about healthcare systems and health care provision was recognised and endorsed by all.

4. Care provision seems to be driven by health care supply rather the healthcare demand, with chronic, complex and rare diseases losing out most.

5. What is needed is patient centred and patient literate health providers as well as patient literate policy makers and regulators.

6. The current systems often actually contribute towards increased spending, such as the use of unit dosages. Pharma companies too often look at where the profit can be found and are not interested in cheaper solutions.

7. Are we sustaining or defending a system? Vested interest often block innovation. The crisis has opened doors to take a critical look at areas of interest that are currently – and maybe wrongly – are being defended.

8. It is difficult to know what to advise health ministries and policy makers as in many cases governments are not able to afford even the basics. Inequalities in terms of access are rampant. Policymakers do not like taking difficult decisions and making difficult choices. So who is in a position to authorise change? Subsidiarity is a difficult issue in this respect. While choices are being put on hold, health professionals are just trying hard to provide the services that are required.

9. Health care spending also needs to be selective; it needs to be identified where the largest benefits can be found. For instance, physiotherapy after major surgery can help people back on their feet quicker than medication and is cheaper to provide.

10. Competition in the health care system is a major driver. Sickness benefits and social services are related but are different budget areas.

11. Moral dilemmas are coming to the forefront, such as whether access to healthcare can be refused on the basis of an individual's lifestyle (e.g. smoking). Who takes those decisions and who CAN take those decisions?

12. Values come into play here and it is not always easy to know what message should be sent to policymakers and what responsibility individuals themselves should take. Who decides what the maximum percentage of the budget should be spent in health care? Should social care be more deserving?

13. Civil society organisations have a huge role to play; they should claim a stake in the health care decisions that affect them. The crisis changes everything: who manages healthcare, who delivers healthcare and who is responsible? We all have responsibilities and we all have a role to play. The health sector needs to lead these new discussions and break down its own silos in order to remain the cornerstone of civilised society.

14. The crisis represents an opportunity to tackle healthcare provision from another angle; it is an opportunity to unmask vested interests, unblock those and explore new ways to organise, fund and finance.

15. Developing a viable business model is proving extremely difficult in reality. Where is the policy support for such new models? In practice, ways can be found to increase capacity which helps better care provision but does not necessarily reduce costs. At the micro level this is being done; the macro level however is lagging behind. Cuts in healthcare provision are looming and will disproportionally impact on those that are poor and excluded. Cuts will result in a loss of skills and experience.

16. Measures that are taken in the health area may generate savings in other sectors rather than its own or in terms of cost. Taking measures in the area of alcohol will probably result in savings in areas like fewer car accidents and less violent crime. Cash freed up by saving measures in the health sector can be used towards something else so that it does not look like savings have been made on health. Benefits in other sectors may result from health measures but will not be considered as health savings. A different look at costs and benefits will be required. This relates to the inability of sector to disentangle where the benefits go.

17. Another issue is the fact the health industry is being targeted as an area where spending can be cut; but other parts of the health system remain untouched.

18. Linking the austerity in health debate to the European Semester is sensible and a good move forward. Questions remain as to how ministers of finance can become allies to invest in health promotion. The Semester entails a budgetary review for each country, with the Commission commenting on budgets before they get adopted. DG SANCO comments on the

budgets on all issues that relate to health. The aim is to rebalance the two sides of the equation and move the debate and various measures to the prevention side. What is rapidly becoming clear in this debate is that general principles and approaches don't work; it can work if more specific areas are being addressed.

Christine Marking, 11 October 2012