Checking up on the state of EU health union
From digitalisation to ethics, from mental health to cancer – the health sector is faced with several crucial policy challenges.

In recent years, drawbacks in the health systems were exposed even further by the COVID-19 pandemic. In some cases it was translated into policy developments, in others society is still awaiting those.

The recently unveiled digital health data space proposal, and the European care strategy, alongside the legislation to come, such as the revision of the EU pharmaceutical legislation are just some of the topics keeping policymakers busy.

EURACTIV’s health team reports on the latest challenges for the sector from the European Health Forum Gastein, one of the leading health policy conferences.
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Growing awareness of healthcare workers’ mental health in EU

By Giedre Peseckyte | euractiv.com

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As possible shortages of workers threaten European health and care systems, policy debates now turn towards improving the sector’s working conditions with particular attention to mental health.

A recent World Health Organisation (WHO) Europe report sounded the alarm over expected healthcare worker shortages exacerbated by ageing staff and their declining mental health state due, in part, to pressures of the job.

The report found that up to 80% of nurses in some countries reported mental health issues following the pandemic, and “as many as nine out of 10 nurses had declared their intention to quit their jobs.”

Norbert Couespel, chair of the Future-Proofing Health Systems Committee at the European Health Parliament, told EURACTIV that “root causes of poor mental health among health workers are long known and characterised.

One of these root causes is shortages of skilled health professionals and unequal distribution across Europe, leading to the multiplication of severely understaffed facilities, particularly in
“Meanwhile, there has been constant under-investment of health systems in their workforce and under-addressing of these policy issues,” Couespel continues. According to him, this equalled neglecting health workers’ mental health, as they were chronically affected by overburdening across the continent as a result.

### Supporting mental health workforce

Last June, the Expert Panel on effective ways of investing in Health (EXPH), set up by the European Commission, gave an opinion with recommendations directed to the EU executive and member states.

Among them is creating a Charter of Rights to Wellbeing at the Workplace and a supportive environment at the EU level.

For the panel, the reason for both initiatives is “a clear need for policy developments to embed workplace mental health interventions”, which should be followed by the setting up of an EU-level mechanism to measure the well-being of workers.

While the COVID-19 pandemic “shone further light on the issue of lack of medical staff and its consequences on health workers’ mental health, as well as on patients – however, fully convincing and exhaustive policy responses are still awaited,” Couespel said.

Couespel mentioned the need for European-level health workforce mapping, planning and forecasting, funding to tackle shortages, training programmes, and best-practice sharing for improving workers’ working conditions and well-being.

### Care strategy – a step in the right direction

The European care strategy, announced in the 2021 State of the European Union (SOTEU) address by Commission President Ursula von der Leyen and eventually delivered on 7 September, is a step in the right direction.

“We have placed a strong focus on the vital role of care workers and the need to improve their working conditions and address effectively staff shortages that we are seeing across the European Union,” said Commission Vice President Margaritis Schinas during the European Economic and Social Committee (EESC)’s plenary session on Thursday (22 September).

While the Care strategy focuses on the care workforce, Danko Relić, a Croatian member of the European Economic and Social Committee (EESC) and a co-rapporteur for the opinion on the Healthcare Workforce, addressed the healthcare staff's working conditions.

“These workers must have good working conditions,” Relić said.

“We need to keep those who work in the health sector there; they need to have decent working hours, enjoy a good work-life balance and have guarantees for their health and safety at work,” he added.

### 2023 – the year of mental health

Nevertheless, mental health is relatively high on political agendas for the next year.

In this year’s speech, Von der Leyen announced a new initiative on mental health to be presented in 2023.

However, contacted by EURACTIV, a Commission’s spokesperson did not specify if there will be a focus on healthcare staff’s mental health.

In the president’s letter of intent, addressed to European Parliament President Roberta Metsola and Czech Prime Minister Petr Fiala, von der Leyen called the new initiative “a comprehensive approach to mental health.”

The initiative echoes the proposal by citizens in the context of the Conference on the Future of Europe, as the Commission spokesperson told EURACTIV.

The commission’s work on mental health as part of the EU ‘Healthier Together’ initiative on non-communicable diseases (NCDs) was also expanded by the health chief Stella Kyriakides.

One of the initiative’s five strands focuses specifically on mental health and neurological diseases, linking with mental health initiatives addressed via our policies in areas such as research, education, justice, employment, social inclusion, internal affairs, and disabilities.
WHO: Action against out-of-pocket payments must target most vulnerable

Out-of-pocket medical payments are an increasing challenge in the midst of a cost of living crisis. To avoid more catastrophic health spending, politicians must target the most vulnerable, says the World Health Organisation (WHO).

Out-of-pocket payments – medical expenses not fully covered by private or public insurance – occur in all health systems, to a varying degree.

“Most countries try to address [it], especially when out-of-pocket payments are high,” Tamás Evetovits, head of the WHO Barcelona Office for Health Systems Financing, told EURACTIV.

According to him, the biggest challenge is to ensure reductions are targeted to the most vulnerable, and countries are not simply reducing out-of-pocket payments on average and as an overall share of the total expenditure.

Direct payments for health can limit access to healthcare options.
and could force people to choose between health and other essential spending, the Organisation for Economic Co-operation and Development (OECD) has warned, a result known as ‘catastrophic health spending’.

The cost of living crisis is intensifying the problem, as more struggle to pay for basic needs and services such as food, energy and medicine.

**Catastrophic spending**

Describing political initiatives to rectify the problem, WHO’s Evetovits said: “It’s not necessarily the most attractive thing to do, to go after those who suffer the most, because those are usually the least vocal about it.”

If politicians go after who is the loudest, they are not necessarily those who are suffering from financial hardship, he continued.

“That’s a key distinction, out-of-pocket expenditure, whether it gets to a level that it causes financial hardship,” he said.

The issue varies greatly amongst EU countries, with approximately 10% of health spending borne directly by private households in France, Luxembourg and the Netherlands, while the number reaches almost 40% in Bulgaria, Greece, and Malta.

While that does not necessarily determine the exact amount of catastrophic health spending, this trend is growing across Europe.

**Instruments to tackle the problem**

There is a need for innovative financing models in countries’ healthcare systems, to ensure that no one is forced to choose between affording medical and other basic needs, Evetovits said at the European Health Forum Gastein.

One proposal is the exemption of people with low or no income from out-of-pocket payments in order to protect them from financial hardship.

Another solution, used in some countries, is the implementation of a maximum amount of out-of-pocket expenditure for medicines in a year.

An example of an innovative solution to this, according to Evetovits, was in Estonia, where out-of-pocket payments are automatically monitored and not calculated through an administratively heavy process.

“When you walk into the pharmacy they know exactly where you are in terms of paying out-of-pocket. Once you reach that maximum, you pay a lower share,” he told EURACTIV.

Another solution advocated for is fixed co-payments, rather than co-payments based on percentages which are often used for dealing with fiscal sustainability.

Governments can choose to use this model if they want to add a new treatment to their portfolio. However, this model can be expensive for patients depending on the cost of their treatment, while fixed payments better protect against people having to choose between their health and other basic needs.
The European Commission’s health policy is just a first step, as it needs to be complemented by increasing the collaboration of the member states in the health field, Vytenis Andriukaitis told EURACTIV in an interview.

“[The] Lisbon treaty is very weak,” Andriukaitis told EURACTIV at the European Health Forum Gastein (EHFG) in Austria, highlighting the difficulty for the EU to deliver its health agenda while health competencies belong to member states.

“The Commission came up with brilliant ideas – a pharmaceutical strategy, Europe’s beating cancer plan, or the Health Emergency Preparedness and Response Authority (HERA). However, they are only the first steps as they have no chance to overcome legal limits,” Andriukaitis said.

In the Lisbon Treaty, common safety concerns in public health matters are ‘shared competence’, while protection and improvement of human health fall under Article 6 as supporting competence.
As such, the EU can only intervene to support, coordinate or complement the action of its member states.

For Andriukaitis, while health topics remain high on the political agenda after the pandemic, the language and messages from politicians are still far from the reality of the measures introduced.

“In Brussels, they see only economic issues. Cows are more important than people's health. Ministers of agriculture are gathering every month,” he said.

“How often do European health ministers gather in Brussels? Once per half a year. Why? Because there are no competencies at the EU level,” he added.

Recommendations are not enough

One weapon in Commission's arsenal is the ability to make recommendations to member states. However, other than that, the Commission does not have the legal tools to do more, Andriukaitis stressed, citing the long procedure to implement Europe's ambitious beating cancer plan.

In September, the EU executive proposed a revision of the 2003 Council recommendation on cancer screening as a part of the EU-wide plan to combat cancer.

“Now cancer screening [recommendations are] proposed, but how can we encourage member states to cooperate in areas of rare cancers in practice?” Andriukaitis asked.

He added that there is no chance to address those issues for a member state alone due to a lack of knowledge, clinical trials, hospitals, and doctors with the relevant expertise.

Moreover, he said that member states' time is already dominated by other urgent challenges, leaving health priorities on the back burner.

Lack of political will

Another problem, the former commissioner highlighted, is the fragmentation of the different national legislations on health.

“If you compare 27 healthcare systems they all are different. And national regulations are also different,” he said.

“When we're speaking about cross-border healthcare, the main obstacles arise because of different legal situations and different infrastructural developments, and different data and interpretations,” he continued.

Once again, he drew parallels with the agri-food sector. “We do not have the possibility to have one single market for pharmaceuticals, instead, you have 27 different markets. Compare this to food – food has one single market,” he said.

For Andriukaitis, there is a need for lawmakers to walk the talk when it comes to giving health the appropriate weight in the political agenda.

“We need to strengthen political will at the European Council level, namely between heads of state and of government,” he said, adding that only EU leaders can decide to increase cooperation in health while the Commission has no right to do so.

“If you remember, many, many years ago, Francois Mitterrand [former president of France], who had cancer, proposed an initiative: Europe against cancer. Why? Because it was his reality and there was political will,” he concluded.
Five years ago, I described the European Health Forum Gastein (EHFG) as “a marketplace for good ideas to drive the health reform agenda” and spoke confidently about our collective ability to implement and manage these ideas. Today, as we celebrate EHFG’s 25th anniversary and meet in hybrid form for the first time, the mood may be more sober or even sombre. Still, we remain more determined than ever to embrace a quantum leap in our thinking and, crucially, in our planning on how to deliver health for all.

The world is clearly in a permacrisis: war in Ukraine, climate emergency, energy crisis, rampant inflation, and a surge in migration...
prompted by hunger, famine and civil strife. And all of this comes on top of the baleful legacy of the worst pandemic in a century, a new public health emergency in monkeypox and the near certainty of worse crises ahead. Think of antimicrobial resistance (AMR).

Healthcare systems in Europe and around the world are under severe stress. The long-standing problems of funding to cope with an ageing population in need of ever greater care are intensified by high inflation, staff shortages, ever longer queue for diagnosis and treatment and, increasingly, shifts in policymakers’ spending priorities towards defence and security. The liberal world order and, with it, democracy is at risk of collapse.

There are, nevertheless, some grounds for optimism about the global community’s ability to pull together to manage crises better. Earlier this year, the WHO’s Executive Board, based on a resolution I proposed, agreed to set up a new standing committee on health emergency prevention, preparedness and response – an echo, if you like, of the EU’s own new body, the Health Emergency Preparedness and Response Authority (HERA).

The World Health Assembly agreed on a historic increase in Member States’ contributions to the WHO budget. Instead of 17 (sic!) per cent, they will account for 50 per cent of the total budget. And there is an intergovernmental process set up to negotiate a new legally binding instrument to better deal more effectively with health emergencies. Then there was a partial lifting of the TRIPS agreement (Intellectual Property Waiver), which I consider a sign of good faith towards the Global South that equity in vaccine access for all is a crucial objective. This month, we saw the official launch of the Financial Intermediary Fund (FIF), a $1.2bn fund designed to fill critical gaps in low- and middle-income countries’ (LMICs) health systems – and help overcome glaring health inequalities that are continuing to widen.

**Not cosy consensus but a great leap forward**

However, these small steps are inadequate in facing the challenges we face. It is my fervent wish that this year’s EHFG will set the bar high by rebooting the process of thinking the once unthinkable, shaking us out of what a colleague once described as “our European bubble”, proposing/embracing radical solutions to those multiple health challenges and, last but not least, not being afraid to disagree. We do not need yet another cosy consensus among well-meaning policymakers and stakeholders that gathers dust on a Berlaymont shelf like those so-called visionary reports on the Future of Europe. What we need is what I call the fire: fired-up debate and a bonfire of the old platitudinous certainties. This is why we are calling for a moonshot when it comes to new ways of healthcare thinking.

Mariana Mazzucato, one of our keynote speakers and Chair of the WHO Council on the Economics of Health for All, puts it well when she talks about putting health for all at the heart of government investment and innovation decisions while keeping the common good in mind. She calls for moving from a “healthy” economy to an economy based on health for all. It is indeed time to stop measuring economic success as GDP growth and to start measuring it in terms of human and environmental well-being.

That means a new social contract around very different socio-economic models. Of course, human societies are not yet ready to move toward what the youthful Scottish philosopher, William MacAskill, calls “effective altruism” (making charitable giving work best). But the current course in health and energy use can only mean millions of deaths around the globe and even planetary exhaustion.

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The great financial crisis of 2008 ushered in a period of misguided austerity. In contrast, the COVID-19 pandemic and now the war in Ukraine have seen even “frugal” countries like my own mitigate or even abandon what Professor Mazzucato calls “false fiscal constraints.” But we must go further and adopt state budgets geared to achieving desirable outcomes with actual value – most notably, better health for all and shared well-being. Genuine ESG thinking must become core to policymaking.

**A real European Health Union**

In my opinion, this year’s forum should serve as a call to action for government ministers and others to learn the lessons of the current and
looming pandemic and other crises: out-of-silo thinking, collaboration, pooled sovereignty, solidarity above all. By bringing together so many players in health and other policy areas, the EHFG can set the agenda for extending and completing the EU Health Union.

A large majority of Europe’s people favour greater EU competence in crisis management, rejecting the Fortress Europe approach at the same time. As well as dealing with pandemic preparedness and responsiveness, including vaccine supply, Europe is spearheading measures to promote the digital transformation in healthcare delivery – and this has only just begun. This must lie at the heart of the EU’s global healthcare strategy that DG Sante will present in Gastein on September 28.

So, too, must the future role of Europe’s pharmaceutical sector, including R&D and competitiveness, and market entry barriers. And one must not forget the need to make medicines more affordable and easily accessible in many EU-27 countries. Europe has only just begun discussing novel ways of funding healthcare and, in the context of AMR, incentivising the discovery of new and effective antibiotics. Greenfield thinking about innovative financing is at the top of our agenda here.

This, one might add, is all very well but do we have the professional staff to deliver the enhanced care and treatment we are promising ourselves in Europe? Shortages among general practitioners and hospital-based nurses and consultants are growing at an alarming pace. So, the Commission and Member State governments, which have the greater competence in this field, need to work together with public agencies, including trade unions, in devising workable strategies to recruit and retain and train more significant numbers of motivated professionals.

So that is why it is appropriate for this year’s Forum to ask the fundamental question: European Health Union – if not now, then when. Given our society and the world’s challenges, we might say, “if not now, it will be too late!”.
From London to the Amsterdam Metropolitan Area

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