EUROPEAN
HEALTH PARLIAMENT

RE-THINKING
EUROPEAN HEALTHCARE
RECOMMENDATIONS BY THE NEXT GENERATION

JUNE 2016

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Driving change and forward progress often requires innovative approaches and a shared commitment to action, as the challenge to deliver care that is safe, high quality, and efficient continues. This spirit is embodied in the work of the European Health Parliament, which for the second time embarked on the journey to deliver tangible proposal on how to improve healthcare in Europe and stimulate new legislation.

The EHP recommendations call for coordinated efforts among providers, regulators, researchers and consumers of healthcare services. Although, each policy paper brings a unique set of challenges, issues and expertise, many common concerns and opportunities emerged, including the pressing need to improve trust and transparency into the system, to foster a commitment to evidence-based care and to build learning into the culture of healthcare by accelerating advances in medical technology and access to healthcare. In their work EHP members address many challenges that policymakers are facing nowadays, and come up with innovative solutions and unconventional proposals while addressing these issues.

Patients and providers can only make good health decisions insofar as they have good information. Young professionals of the European Health Parliament are there to contribute to the knowledge base with their insights and fresh ideas, encouraging healthcare leaders to use their recommendations.

I believe that bringing the voice of the young into the discussion on the future of healthcare is a big step towards making Europe a healthier place, and the results of this project will serve as an inspiration for the EU Parliament and other legislative bodies.

Giovanni La Via
Chairman of the European Parliament ENVI Committee

Dear readers,

Ever since the first session of the European Health Parliament started off, it was very obvious that this initiative was far too important to be just a one-time event. The enthusiasm of 80 young healthcare experts led to strong recommendations on 7 topics.

More and more we need an European approach to health care. It is not only medical science that has to cross borders if we want to strive to excellent health care. The way we implement new technology and new insights in the relation patient-provider demands cross border policies.

Therefore the 2015 recommendations were put on the agenda of both European Commission and the member states. It is no coincidence that this year's session has drawn the attention of Health Commissioner Andriukaitis. It is the evidence that the European Health Parliament is doing good work in breaking borders.

As for myself, I will be following your progress from another level. As of May 2016, I've said goodbye to the European Parliament to become State Secretary in the Belgian federal government for Privacy, the North Sea and the Fight against Social Fraud. I can reassure you: MEP's come and go away, but the European dream is here to stay..

Philippe De Backer
State Secretary in the Belgian federal government for Privacy, the North Sea and the Fight against Social Fraud.

The European Health Parliament is a brilliant idea - a way for talented, motivated young professionals to participate in policy development and to help address, with new ideas or by just challenging common wisdom, the key questions for the future of Europe's healthcare systems and indeed for citizens. The key strength of the project is to bring together the participants with policy makers, industry and academics to develop informed and targeted recommendations with concrete impact beyond aspirational statements. I am particularly pleased that this year the Parliament discusses topics as relevant and critically important for the Commission and for present and future generations as climate change, antimicrobial resistance and migration: we need fresh ideas on all of these, if we are to ensure accessible, effective and resilient health systems for all. We need your ideas and your recommendations.

Xavier Prats-Monné
Director-General DG SANTE European Commission

Ten years ago, in June 2006, the EU Council of Minister adopted Conclusions on Common values and principles in European Union Health Systems, in which the Council recognized that the EU Member States organise and finance their health systems differetly, but they share common values - universality, access to good quality care, equity and solidarity. These share values are and will remain in the centre of the cooperation in the area of public health among EU Member States as well as at an EU level. Undoubtedly, this cooperation has been strengthen in past 10 years, being it in the management of communicable diseases, tackling the problem of chronic diseases and ensuring sustainability of health systems. It is obvious that in such a vast area as healthcare provision more can be done. That is why ideas developed 'outside of official government circles' can positively contribute to collective reflection on what are common challenges that all EU Member States face and how to address them. The European Health Parliament represents an innovative way to engage young professionals in the debate on the health topics and offers their assessment on what could be done to protect the health and improve the health status of the EU citizens. Their recommendations presented in five reports this year are timely and inspiring. Let's wish they will be taken-up by policy makers and stakeholders.

Juraj Sykora
Head of Unit for Public Health, Pharma and Foodstuffs,
Council of the European Union

"Making the healthy choices easier" is a slogan that WHO has been advocating for a number of years. It is at the core of modern public health and places prevention as the key policy for a sustainable future of our health systems. With the growing population ageing and the increase of health care costs due, for instance, to innovative medicines and new technologies, without investing in prevention we will not be able to guarantee to all people health and a proper access to care and rehabilitation.

It is encouraging to see how much emphasis the young professionals involved in the European Health Parliament have put in all their work on prevention and policy coherence. They have pointed out the need to ensure that expressions such as "health in all policies" become a reality rather than a "politically correct" lip service, by exploring innovative and somehow provocative strategies to implement what has been mentioned, cited and written for years. This requires brave decisions and political leadership. It also requires the capacity to face and contrast vested interests for the sake of public interest, re-equilibrating within our societies the balance between powerful stakeholders and the general public. It needs to overcome the useless confrontation between economic growth and health development, environmental protection and employment that often emerge in the public debate and paralyses action. Any day lost without strengthening preventive action in our societies means additional diseases, disabilities and deaths. It means real people suffering for something that could be avoided, or delayed or made less severe.

The EU can play a great role in these developments and can indeed show through courageous initiatives, its role in ensuring the health and well being of all citizens, thus regaining credibility and public support.

I am encouraged by the work of the young professionals of the EHP who are the one who will lead European public health and finally translate these visionary objectives in reality.

Roberto Bertollini
Chief Scientist and WHO Representative to the EU

It is a great honour for EPF to be here with you today, and thrilling to see so many enthusiastic young brains get together!

In these times of financial hardship and growing burden on healthcare budgets, it is high time to think about and develop innovative solutions for our healthcare systems. We all know the current situation is untenable. With ever increasing costs due to demographic pressure, solutions have to be found outside the box. I have to say I was really impressed by the recommendations of the different committees. They all are of great quality, covering the many aspects of innovation, also pinpointing patient and citizens' engagement and really building on the best of your different backgrounds and experiences.

Congratulations to you all, your imagination knows no boundaries!

Nicola Bedlington
Secretary General, European Patients' Forum (EPF)

We and other Europeans value health as a key component of our well-being. However, we are also faced with a reality where health rarely makes the top of the list of current political priorities; health concerns are often forgotten amidst other urgent crises, and mainstreaming health considerations across policies is easier said than done. The risk is great: silent worries over people's health and health systems are expected to turn into an economic and social crisis of our life-time if action is not taken in time.

It is clear that rethinking health and healthcare is desperately needed at all levels of the European society. Europe has a strong interest to promote health, prevent diseases and ensure the long-term sustainability of its health systems. Delivering health efficiently requires addressing all the determinants of health, be it lifestyle, environment, or healthcare. Diets play a role. Research shows that over-consumption of meat is not only bad for people's health but also for the climate and environment. Air pollution invokes a great disease burden and thus cost on European societies. Traffic pollution, namely due to Europe's love affair with diesel, and fossil fuels are a significant cause of lung, heart and brain damage. Healthcare delivery will be far from optimal as long as the focus is on inputs rather than on health outcomes. Reforming healthcare requires addressing inefficiencies such as a lack of continuation and integration of care; inadequate access to health promotion and disease prevention; insufficient data collection and use of IT and big data; investment in non-cost-effective technologies and solutions; and over-prescription of drugs that do not work or lead to further complications.

Delivering health efficiently and ensuring the long-term sustainability of health systems in the face of reduced public budgets requires fresh new thinking, energy and willingness to think outside the box. The European Health Parliament is an important initiative in this regard. These young experts, future decision-makers and top healthcare professionals, are already challenging the traditional ways of thinking about health and healthcare delivery – and they will hopefully become the voice of change.

Annika Hedberg
European Policy Centre (EPC)

RECOMMENDATIONS

TACKLING A GLOBAL PUBLIC HEALTH CRISIS

EUROPEAN HEALTH PARLIAMENT 2016
COMMITTEE ON ANTIMICROBIAL RESISTANCE

EUROPEAN HEALTH PARLIAMENT 2016
COMMITTEE ON ANTIMICROBIAL RESISTANCE

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EXECUTIVE SUMMARY

Antimicrobial resistance (AMR) is the resistance of bacteria and other microbes to previously effective drugs, resulting mainly from the misuse and overuse of antimicrobial drugs. Drug resistance is threatening the ability to treat common infections[1]. Each year, antibiotic-resistant infections lead to 25,000 deaths in the European Union[2] and 700,000 deaths worldwide[3]. If resistance is left unchecked, the death toll is predicted to rise to 10 million people per year by 2050[3].

Global antibiotic consumption grew by 30% between 2000 and 2010[4] and in the EU, overall antibiotic consumption in the community and in hospitals increased between 2010 and 2014[5]. In China and India, antibiotic pollution in rivers and waterways is leading to the proliferation of resistant bacteria, both locally and also worldwide through travel and trade[6,7,8].

This report makes eight recommendations in four key areas:

1. EU Member States should make cross-border healthcare more visible

- *Set up a "European Health Semester": a platform for sharing best practice and country-specific recommendations focusing on cross-border health threats.*
- *Put in place national AMR teams: multidisciplinary teams to ensure effective implementation of national AMR action plans and targets, reporting back to the European Health Semester.*

2. EU Member States should prevent AMR through GP practice intervention and education

- *The EU should encourage R&D into affordable point-of-care diagnostic tools through initiatives such as the Innovative Medicines Initiative 2 (IMI2).*
- *Delayed e-prescriptions should be introduced at Member State level in combination with the use of rapid diagnostic tests.*
- *Member States should introduce a national requirement for healthcare professionals to complete a module on infection control as a part of the renewal of their licence to practise.*
- *Member States should promote health literacy from childhood.*

3. EU Member States should implement manufacturing standards to prevent pharmaceutical pollution that leads to AMR

- *Environmental risk assessments should be conducted on antibiotics manufacturing.*

4. Stakeholders should create access to innovative tools and treatments against AMR

- *Create an AMR Global Access Fund that would ensure access to existing and newly developed AMR tools (antibiotics, rapid diagnostics, and vaccines) for developing countries through the collaboration of international organisations, payers and charities.*

AMR, A GROWING AND GLOBAL THREAT

A POST-ANTIBIOTIC WORLD

AMR is the resistance of microorganisms to an antimicrobial drug originally designed to treat it, meaning that the antimicrobial drug no longer works, or works less effectively. Without urgent action to reduce AMR, it is estimated that 10 million people – equal to the population of Portugal – will die worldwide each year from drug-resistant infections by 2050. This is more than the current death rate from cancer and eight times that of road accidents[3].

Without effective antibiotics, many standard medical procedures will become increasingly difficult to carry out[3]. Hip replacements, chemotherapy and organ transplants are some of the treatments threatened by the spread of resistant organisms. Furthermore, common infections and minor injuries will increase hospital stays and lead to a greater risk of death. The extra healthcare costs and productivity losses associated with AMR are conservatively estimated at €1.5 billion annually for the EU[2], and could cost the world economy 100 trillion USD by 2050[3].

THE FACTORS DRIVING AMR

The development of resistance in bacteria is a natural phenomenon driven by the selective pressure of the bacteria to survive. Several human factors, however, have accelerated its emergence and its spread to unprecedented levels. The main reasons are:

(1) In human medicine, a key driver of AMR is the excessive and inappropriate use of antibiotics[3]. Another is the lack of rapid diagnostic tests, and under-use of existing tests, which makes it difficult for clinicians to determine whether an infection is bacterial or viral, and thus whether antibiotics are needed[9].

(2) In agriculture, a considerable amount of antibiotics are used in healthy animals to prevent infection or speed up their growth. This increases resistance and can subsequently be passed onto humans[3].

(3) Poor infection control practices in hospitals help the spread of healthcare-associated infections (HAIs), a quarter of which are caused by antibiotic-resistant bacteria[10]. In the EU, national training programmes for infection control exist in 55% of Member States for nurses and in 33% for doctors[11]. These differences result in widely varying capacities of healthcare institutions to deal with the surveillance, prevention and control of HAIs.

(4) The presence of antibiotics in the environment can promote antibiotic resistance[6]. For example, the dumping of active pharmaceutical ingredients (APIs) into rivers and waterways used by local populations can lead to the spread of resistant strains around the world through travel and trade. Since most of the world's antibiotic drugs are manufactured in China (which produces 80-90% of antibiotic active pharmaceutical ingredients-APIs) and India[7], the issue goes well beyond Europe's borders.

(5) Across the world, countries show variability in antibiotic consumption, resistance rates and in policy response to AMR[14], which is a problem in the face of the cross-border nature of AMR[7,8].

(6) The lack of long-term investment in research and development into novel antibiotics, preventive approaches and alternative strategies to antibiotics[3] means that there is a gap between the medical need to combat AMR and the size and quality of the therapeutic pipeline. Moreover, equitable and affordable access to innovative tools is lacking, particularly in low- and middle-income countries, some of which have the highest rates of AMR[1].

This paper focuses on resistance to antibacterial drugs or 'antibiotics' because (i) antibiotic resistance has been described by the WHO as the single greatest challenge in infectious diseases today, threatening rich and poor countries alike and (ii) although drug resistance in HIV/AIDS, malaria and fungal infections is also an immense challenge, much effort is already being devoted to research and implementation in these areas[15].

THE POLICY ENVIRONMENT OF AMR

On a national level, there are many examples of valuable AMR-related initiatives. In the Netherlands, mandatory AMR teams in hospitals help ensure appropriate use of antibiotics[16]. In France, nation-wide media campaigns have led to the decrease of overall antibiotic consumption by 10.7% between 2000 and 2013[16].

Many EU initiatives encourage Member States to develop and implement national policies and action plans for countering AMR. Council Conclusions in 2002, 2009 and 2012 set out strategies to contain resistance, put forward measures on general patient safety and healthcare-associated infections, and called for closer collaboration between the human and veterinary sectors. In November 2011, the Commission launched a 5-year EU Action Plan against AMR[17], which is currently being evaluated. Recently, the European Parliament supported restrictions on the use in animals of certain antibiotics that are reserved for the treatment of human infections, and bans on preventive use of these medicines in animals[18]. Whilst the EU has made legislative progress in tackling AMR in the animal sector, action in the human sector has been limited.

Globally, only 25% of countries have implemented a national policy to tackle AMR[14] and less than 40% of countries have put in place infection prevention and control programmes[14]. The WHO has recently adopted a Global Action Plan on AMR, which focuses on five areas for national and international action: awareness, surveillance and research, infection control, antibiotic stewardship, and sustainable investment[19].

This is not an exhaustive list of on-going and planned initiatives. While our Committee applauds these, we call for increased political will to take further action at Member State level and to mandate an increased role for the EU in coordinating efforts.

KEY CHALLENGES AND SOLUTIONS

Based on the causal factors of AMR, our Committee proposes actions in four areas to contain the spread of resistance:

1. EU MEMBER STATES MUST MAKE CROSS-BORDER HEALTHCARE MORE VISIBLE

The impact of EU actions to date has been limited, as acknowledged by Edith Schippers, Minister of Health of the Netherlands, who said recently: "Two EU Council recommendations, several Council conclusions, a European Action Plan, European Commission Guidelines, European Parliament Resolutions. Several reports on economic impact, a strategic research agenda...In the meantime, we still see resistance levels in Europe rising".

RECOMMENDATION #1

We recommend more coordinated action and tangible outcomes in cross-border healthcare in the EU. Health should be placed as high on the EU's agenda as economic policy. The EU should use its coordinating powers where it adds value, but in the meantime respect Member States' own specific challenges.

We recommend the creation of a **"European Health Semester"**, a comparative tool, based on annual cycles of data gathering, country reports and recommendations. The European Health Semester should focus on cross-border health threats, a clear competence of the EU[20]. AMR should be a key element of the Health Semester, given that it is an urgent threat to the achievements of modern medicine[21].

The tool would work as follows. The Commission would collect data from the Member States each year, based on a set of indicators related to health systems and to AMR. These indicators would be based on existing data from the European Centre for Disease Prevention and Control or the Commission's 2014 Communication on effective, accessible and resilient health systems, with the creation of new indicators as needed. Comparability of indicators would have to be ensured.

Member States could thus measure their progress in fighting AMR, based on annual comparisons of their national data with other Member States. An EU advisory panel would also make recommendations each year.

The Commission would draw up the surveys and the recommendations, the Council would discuss/endorse/adapt the recommendations, and the Parliament would be involved in dialogue throughout. The advantage of engaging each institution would be to foster a more collaborative approach.

RECOMMENDATION #2

Member States should set up **national AMR teams** to implement the European Health Semester and increase political will on a national level.

The teams, comprising physicians, pharmacists, infectious disease specialists, psychologists and patients, would ensure effective implementation of national AMR action plans and achievement of targets, and compile the information required for the European Health Semester.

The government would empower teams to set national AMR targets, improve healthcare practices and prevention methods, and to act as the direct link to the European Health Semester. This would ensure political commitment to fight AMR and contribute to successful implementation of national plans. Teams would be in place for as long as necessary to reduce AMR to a level predetermined by the Member States, and to ensure sustainability of changes implemented. As best practice in Lithuania shows[22], such teams were a success in regional coordination and management of AMR.

2. EU MEMBER STATES SHOULD PREVENT AMR THROUGH GENERAL PRACTICE INTERVENTION AND EDUCATION

RECOMMENDATION #3

Rapid diagnostic point-of-care tests can increase diagnostic certainty and may be used to demonstrate to patients that an antibiotic is unnecessary[3].

• We encourage the development and use of rapid tests. The EU should encourage R&D into affordable point-of-care diagnostic tools through programmes such as IMI2.

RECOMMENDATION #4

Behavioural interventions, for example delayed antibiotic prescription, can also reduce unnecessary use of antibiotics[22]. A patient would get tested at the doctor's office, and the doctor would subsequently call the patient once the results arrive – and send an e-prescription for an antibiotic to the pharmacy in the case of confirmed bacterial infection. E-prescription systems can help delayed prescriptions procedures because they would be electronically stored in a database and could be validated once the test results are in, without even the need for the further communication between doctors, patients and pharmacists that is needed with traditional paper prescriptions.

• Delayed e-prescriptions should be encouraged at Member State level in combination with the use of rapid diagnostic tests. E-prescriptions could be uploaded to a national server connected to all pharmacies, or saved on a patient's electronic health insurance card.

• The EU should foster the development of digital prescription systems in all Member States, and encourage the involvement of all stakeholders - doctors, health ministries, IT and insurance companies - to find solutions that fit the needs of each Member State.

EDUCATION AND TRAINING FOR HEALTHCARE PROFESSIONALS AND CHILDREN

It is estimated that intensive hygiene and infection control programmes could prevent 20-30% of healthcare-associated infections, including drug-resistant ones[11].

RECOMMENDATION #5

• We encourage Member States to introduce a national requirement for health professionals to complete a module on infection control (i) every time they renew their licence with the country's authority and (ii) when they apply for their licence to be recognised in another Member State. The licensing authority of each Member State should provide the training, thus preventing additional costs for hospital management or staff.

• We encourage the Commission to update its requirements for the recognition of professional qualifications in the EU to include infection control and AMR for healthcare professionals.

RECOMMENDATION #6

Together with the Committee on Prevention & Self-Care, we jointly recommend the Member States' health, finance and education ministries to develop cross-funded initiatives to promote health literacy from childhood. This would be done by including education on healthy lifestyles and prevention (notably with vaccines) as well as the proper use of medication (and notably antibiotics) in school curricula.

3. IMPLEMENT MANUFACTURING STANDARDS TO PREVENT PHARMACEUTICAL POLLUTION THAT LEADS TO AMR

At present, the regulatory framework for Good Manufacturing Practice (GMP) in the US and Europe pays insufficient attention to environmental safety. Even though supply chains from India and China are regularly inspected, no sanctions can be applied for polluting practices, because verification of this parameter depends exclusively on local governments[23]. To prevent pharmaceutical pollution that leads to AMR, manufacturers should be held accountable for the antibiotics they place on the market and their environmental consequences through the implementation of manufacturing standards. These standards should (i) offer a coherent European solution to address this global issue (ii) integrate all the steps of the supply chain and (iii) be equally applied to medicinal products for both human and veterinary use that are sold in Europe, even when produced in China and India.

The current EU regulatory system requires an Environmental Risk Assessment (ERA) to accompany any application for marketing authorisation of a medicinal product for human use that is submitted since the 'Guideline on the environmental risk assessment of medicinal products for human use'[23] entered into force in 2006. However, antibiotics are predominantly old molecules (many are 30-40 years old) that received marketing authorization before 2006, and most are therefore not affected by this guideline. But there is no scientific evidence that products put on the market before 2006 are of less environmental concern than new products[24].

RECOMMENDATION #7

- We consequently recommend revising the 2006 'Guideline on the environmental risk assessment of medicinal products for human use' in order to require all antibiotics manufacturers, regardless of the marketing authorisation year, to ensure all supply chains comply with the guideline. Requirements to assess the risk for increased antibiotic resistance development should be added to the Guideline.

- A systematic monitoring of the occurrence and effects of antibiotics in the environment, and transparent publication of findings, are needed to fill the current gap in public access to environmental risk data.

- In the long term, environment criteria should be integrated into the overall GMP framework.

4. STAKEHOLDERS SHOULD CREATE ACCESS TO INNOVATIVE TOOLS AND TREATMENTS AGAINST AMR

Research initiatives for new antibiotic drugs and alternatives, such as the Innovative Medicines Initiative or the Global AMR Fund[15], are useful only if the solutions are made accessible in low- to middle-income countries, particularly in those with a high prevalence of antimicrobial resistance[1]. With increased travel and trade, the spread of diseases at Europe's borders is inevitable, and action is therefore needed on a global scale.

RECOMMENDATION #8

- We recommend the creation of an **AMR Global Access Fund** that would ensure access to existing and newly discovered AMR solutions (such as vaccines, diagnostics, drugs and other alternatives) for developing countries, and which would be complementary to the Global AMR Fund proposed by Jim O'Neill[15]. Payers, charities and international organisations would pool their resources to 'buy out' patents from innovators and allow other manufacturers to produce these products through licensing agreements. The initiative would reward innovation, whilst ensuring equitable and affordable access to solutions able to tackle AMR globally.

CONCLUSION

Our Committee realises that the problem of AMR is complex and multi-faceted, and requires an equally sophisticated solution. We have touched here upon current gaps, and proposed ideas that could be implemented as complements to existing initiatives. We encourage the EU and Member States to work together in implementing the recommendations. We look forward to discussing our ideas further with key stakeholders and policy makers.

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TACKLING MEAT PRODUCTION AND CONSUMPTION

EUROPEAN HEALTH PARLIAMENT 2016
COMMITTEE ON CLIMATE CHANGE AND HEALTH

EUROPEAN HEALTH PARLIAMENT 2016
COMMITTEE ON CLIMATE CHANGE AND HEALTH

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EXECUTIVE SUMMARY

Excessive human consumption of meat, in particular red and processed meat, is associated with major environmental and health impacts. In the past decade, evidence has shown that livestock industries in Europe and around the globe produce more greenhouse gas emissions than all transport devices combined. This puts significant pressure on public health and national healthcare systems, as well as representing a growing threat to planetary health.

The Committee on Climate Change and Healthcare believes urgent action is required to counter this challenge, and has elaborated four recommendations. Central to the committee's proposal is to trigger dietary change, which means overcoming the awareness gap among the population and leading EU bodies. Other items include reviewing meat industry advertising and related legislation, and consideration of financial support for better regulation of the meat industry. This paper will elaborate on tackling meat production and consumption by providing evidence-based recommendations aimed to attain innovative change in healthcare by 2030 in the European Union.

INTRODUCTION

Human consumption of meat and dairy products is a major driver of climate change. The livestock sector alone is responsible for 18% of the planet's emissions, producing more pollution than all forms of transportation globally. Global meat production and consumption is not projected to decline. On the contrary, the increase in the world's population and the growing purchasing power of developing countries support predictions that the global demand for livestock will double by 2050[1][2][3].

Dietary change is essential to contain this trend.

Even with ambitious supply-side mitigation policies in the agriculture sector, and without drastic shifts in consumption of meat and dairy products, growth in agricultural emissions will leave insufficient space for other sectors within a 2°C carbon budget[4].

In addition, meat consumption has been shown to be associated with a significant disease burden: the World Health Organization (WHO) states that over 80.000 cancer deaths per year worldwide are attributable to diets high in red and processed meat[5]. As recently as October 2015, processed meat was classified as carcinogenic to humans as asbestos and tobacco, whilst red meat was classified as probably carcinogenic to humans. It was further estimated that annual EU healthcare spending related to colorectal cancer amounts to €13.1 billion, and to €196 billion for cardiovascular diseases.

A study from the International Agency for Research on Cancer (IARC) concludes that *each 50-gram portion of processed meat eaten daily increases the risk of colorectal cancer by about 18%*[6]. The current meat production and consumption patterns impose a heavy burden on both human and planetary health, and consequently on national healthcare systems in Europe and elsewhere.

Despite the evidence, a major awareness gap exists among leading European authorities and civil society about the connection between the meat industry and health. Additionally, there is a lack of consistency in European policies, as subsidies are granted to support unsustainable agricultural and husbandry businesses, whilst climate change technical mitigation strategies are adopted.

The Committee on Climate Change and Healthcare calls for new policies on livestock management, and highlights the need for an urgent reduction in meat eating in the European Union.

Awareness-raising strategies are one of four key recommendations, alongside a review of legislation on labelling and advertising of meat products. In addition, financial support should be given to tightening regulation of the meat sector, and incentives should be created to promote wide change involving civil society, industry and policy makers.

1   Garnett T., "Livestock-Related Greenhouse Gas Emissions." *Environmental Science & Policy, Volume 12, Issue 4, June 2009.*

2   Rowlinson P., M. Steele and A. Nefzaoui, *Livestock and Global Climate Change, British Society of Animal Science, May 2008.*

3   Food and Agricultural Organisation, *"Tackling Climate Change through Livestock: A global assessment of Emissions and Mitigations Opportunities, Rome, 2013, p.1-115.*

4   McMichael et al., *"Food, Livestock Production, Energy, Climate Change, and Health."*

5   World Health Organization, *"Q&A on the carcinogenicity of the consumption of red meat and processed meat", 2015, http://www.who.int/features/qa/cancer-red-meat/en.*

6   IARC, *"IARC Monographs Evaluate Consumption of Red Meat and Processed Meat.", Press Release n° 240, October 2015, https://www.iarc.fr/en/media-centre/pr/2015/pdfs/pr240_E.pdf.*

DEVELOPING AWARENESS CAMPAIGNS ACROSS EUROPE

STATE OF PLAY

Achieving dietary change at the European level to reduce meat consumption offers a rapid and effective way to contribute to meeting global climate objectives spelled out at the 2015 climate change conference in Paris, with its goal of limiting global warming to less than 2 degrees Celsius above pre-industrial levels. But the current access to information in the EU does not allow consumers to be aware of the health related-risks of their consumption habits. Countering this trend is of utmost importance as food safety issues – allergens causing adverse reactions for instance – arise when consumers lack knowledge about nutrition, food handling and preparation (FAO, 2011).

At the European level, the impact of meat consumption on climate change and healthcare attracts too little policy attention, and strategies to curb livestock emissions at the level of Member States are usually less visible than those for other sectors. These strategies face further challenges in terms of implementation, and cannot, on their own, reach emissions targets.

PROPOSAL

Public authorities should actively advertise the impact on public health and the environment of certain patterns of meat consumption. Awareness-raising campaigns at national level should link environmental goals with policy objectives such as reduction of healthcare expenditure. Messages should focus on the co-benefits of reduced consumption of meat, since highlighting the public and individual health benefits will have a stronger impact than a focus on environmental benefit alone. Engaging with mainstream media and non-partisan experts such as scientists would be a positive step towards this objective.

At the policy level, initiatives to adjust meat price should be developed. Direct or indirect subsidies to the livestock sector should be removed, and subsidies given instead to plant-based alternatives. The price of meat could be usefully increased by measures such as a carbon tax.

National authorities responsible for public healthcare and environmental security should make use of scientific resources to raise public awareness and to promote healthy behaviour. All data related to the health and environmental impacts of meat consumption should be centralised in national databases easily accessible by the public. Additionally, a European web-based portal should be developed as a hub for information exchange between national authorities and the Commission.

Public authorities should promote cooperation among health professionals, educators and independent communicators to formulate guidance for public food programs in schools, administration, and governmental agencies) to ensure compliance with dietary science, reflecting the most advanced knowledge on nutrition and environmental impact. In parallel, courses and training in schools should provide education about the nutritional value of common foods and products, to raise awareness about the health and environmental risks of excessive meat consumption.

RETHINKING NATIONAL LEGISLATION ON FOOD ADVERTISING

STATE OF PLAY

At the present time, there are wide differences across the Member States in controls on food advertising and in the use of self- and co-regulation and statutory legislation. Social responsibility in advertising and marketing is encouraged through, for instance, the 2004 Framework for Responsible Food and Beverage Marketing Communication of the International Chamber of Commerce.

EU advertising regulations tackle several health-related issues: obesity, alcohol consumption, intake of fruit and vegetables, and food-related diseases in the European population. Freedom of manoeuvre in the marketing of legal products impedes adequate regulation of advertising and marketing of food and beverages and prevents sufficient restriction of the promotion of unhealthy products[7]. According to the WHO, advertisements for unhealthy foods predominate in all EU Member States over advertisements for healthy items[8].

ISSUE

The Committee welcomes the health experts' call for a comprehensive advertising ban on products considered unhealthy under the WHO nutritional criteria; targeted items include candy and energy drinks, but most importantly red and processed meat. Furthermore, it supports initiatives such as the EU pledge, a voluntary initiative by food and beverage companies to alter their advertisement strategies towards children so that commercial communication is shaped to support parents in making healthy dietary and lifestyle choices for their children.

Simultaneously, the Committee considers there is a lack of consistent EU-wide regulation of food advertising that would highlight the negative environmental

and health impacts of the meat sector. EU legislation is not strong enough, and EU sanctions against food companies are too often not applied when advertising commitments are not respected. Consequently, citizens pursue their food choices unaware of their climate footprint and the impact on their health.

PROPOSAL

The Committee encourages the design of a consumption environment stimulating the choice for a healthy and climate-friendly diet. To achieve this, it proposes the creation of an initiative to assess meat advertising in Europe and its impact on climate and health, and the establishment of a monitoring system of the marketing of red meat and processed meat. Analysis should be conducted of good practices in the countries where mandatory regulation has imposed successful controls. Local and national commitments should be reviewed with a focus on children and adolescents, because it is easier to influence their health behaviour and climate footprint, with a beneficial impact on their individual and environmental health in adulthood.

Longer term, the Committee urges harmonized European rules on meat advertising and new European programs on sustainability and health and environmental preservation that take account of all stakeholders and the diversity in European regulation, and pay special attention to children's health.

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7   Euractiv, European children exposed to less food advertising on TV, published 18 March 2014, accessed 15 February 2016.

8   World Health Organization, Regional Office for Europe, Marketing of foods high in fat, salt and sugar to children: update 2012–2013, Denmark, 2013.

IMPROVING THE EXISTING LABELLING SCHEME FOR MEAT PRODUCTS

STATE OF PLAY

Food packages are important promotional vehicles for companies' products and brands. Appealing images, catchy phrases and buzzwords alongside health claims are designed to induce consumers to purchase.

To assist consumers in their food choices, a new EU law on food information[9] to consumers came into force in December 2014. Regulation No 1169/2011 will apply from December 2016, introducing new requirements on nutrition information, aiming for improved legibility and comprehensiveness. Amongst the changes, the law makes it mandatory for nutritional information to appear on most prepacked processed foods so that it is clear when food is defrosted, if the food contains meat or fish, and the origin of fresh meat from certain animals.

ISSUE

The Committee on Climate Change and Healthcare welcomes the new legislation on food information, as it will enhance consumer awareness. In particular, the provision on processed foods will allow for considered choices for healthy foods and the country-of-origin rule for meat encourages environment-friendly purchasing.

Meat labels do not however provide sufficient information. In particular, consumers remain unaware of or misinformed about the climate footprint of the meat they purchase and eat. No EU labelling scheme provides information about the climate footprint of products and their health impacts.

The Committee is convinced that additional labelling requirements for meat products will help to communicate to consumers more important information, in particular for consumers buying at the end of a long food supply chain.

Additional requirements could also help to protect meat producers from cheap imitations. As the JRC report on "Short Food Supply Chain and Local Food Systems in the EU" reveals[10], labelling can, if well implemented, achieve high recognition and promote high quality, traceable, authentic food.

To address this gap, the Committee encourages European policymakers to work towards increasing consumer awareness over environmental impacts and health benefits of meat products.

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9   European Commission, "Food information to consumers – legislation", accessed 24 March 2016,
    http://ec.europa.eu/food/safety/labelling_nutrition/labelling_legislation/index_en.htm.

10 Kneafsey M., Venn L., Schmutz U., Balázs B., Trenchard L., Eyden-Wood T., Bos E., Sutton G., Blackett M., Short Food Supply Chains and Local Food
    Systems in the EU. A State of Play of their Socio-Economic Characteristics, Joint Research Center, 2013, last accessed 17 May 2016.

PROPOSAL

The Committee on Climate Change recommends the following set of provisions, to be applicable consistently across the European Union.

Meat labels should provide for clear and readable information on climate footprint and health, such as:

- Water footprint,
- Carbon footprint,
- Use of antibiotics and hormones in the animal,

To achieve the necessary harmonisation across Europe, the Committee suggests amending the existing legislation No 1169/2011, via delegated acts, and developing related international standards by collaborating with the International Standards Organisation (ISO).

An expert panel should define the criteria for information labelling on climate footprint and health. Its role and responsibilities would be set out in an Annex.

The Committee also advocates requiring information about sustainability and health on meat products, similar to the regulation of alcohol or tobacco products. This would be developed in conjunction with the advertising recommendations the Committee has put forward later in this paper.

Producers should be allowed transition periods for implementing these provisions, and granted subsidies and/or tax incentives.

National and regional funds could also support an education-related labelling scheme to reward or subsidise primary schools that offer labelled meat in their menus.

SETTING UP FINANCIAL SUPPORT TOWARDS BETTER LEGISLATION ON MEAT PRODUCTION & CONSUMPTION

Two financial schemes could be leveraged to encourage sustainable and healthy practices in meat production and consumption across Europe:

A. the Common Agricultural Policy (CAP)
B. the Fund for European Aid to the Most Deprived (FEAD)

A. THE COMMON AGRICULTURAL POLICY

STATE OF PLAY

The Common Agricultural Policy governs the allocation of subsidies in the agricultural sector. Accounting for 37.8% of the EU multi-annual financial framework for the period 2014-2020, with an overall budget of €364 billion, the reformed 2014-2020 CAP aims at food supply stability while reducing greenhouse gas (GHG) emissions and environmental impacts of agriculture.

Two pillars of this legislative framework are deemed of particular relevance to tackling meat production and consumption across the EU:

1. Greening and Cross-Compliance,
2. Rural Development.

Within the first pillar, Green Direct Payments account for up to 30% of the national envelope and reward farmers for maintaining permanent grassland and ecological focus areas and for diversifying crops. The second pillar focuses on sustainability through reserving at least 30%of the budget of each Rural Development program for voluntary measures benefiting the environment and climate. These include agri–environmental-climate measures, organic farming, Areas of Natural Constraints (ANC), Natura 2000 areas, forestry measures and other kinds of investments.

ISSUE

Though the 2014-2020 CAP reform represents a step forward, it does not fully respond to the environmental and health hazard posed by current farming methods and in particular livestock[11] common anthropogenic GHG emission, which is more than the entire transport sector[12]. Greater efficiency in current production practices will not, therefore, help to win this challenge[13], in a world where meat demand is predicted to increase from 229 million tonnes in 1999–2001 to 465 million tonnes by 2050[14].

PROPOSAL

The Committee recommends that environmental sustainability becomes the leading principle of the CAP

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11 Brent Kim, Juliana Vigorito, "The Importance of Reducing Animal Product Consumption and Wasted Food in Mitigating Catastrophic Climate Change.", the John Hopkins Center for a Livable Future, December 2015.

12 Food and Agricultural Organization, "Tackling Climate Change through Livestock: A global assessment of Emissions and Mitigations Opportunities, Rome, 2013, p.1-115.Agriculture Organization of the United Nations, Tackling Climate Change through Livestock.

13 McMichael et al., "Food, Livestock Production, Energy, Climate Change, and Health.", The Lancet, published 13 September 2007, accessed 23 January 2016.

14 Steinfeld, H., "Livestock Long Shadow.", Environmental Issues and Options, Food and Agriculture Organization of the United Nations, November 2006.

framework, and is applied urgently to the most polluting farming activity: the livestock sector.

Moreover, the Committee would recommend that health be given greater priority in the CAP framework, with incentives for farms that take into account both health and environmental benefits when producing meat.

It is the Committee's belief that this recommendation is in line with the current CAP intentions to reward farmers for a wider set of services that do not have market value, such as landscape preservation, farmland biodiversity, climate stability and population health.

B. THE FUND FOR EUROPEAN AID TO THE MOST DEPRIVED (FEAD)

STATE OF PLAY

Almost one third of the EU's annual humanitarian aid budget is used to provide emergency food assistance[15], making the EU one of the world's major donors of humanitarian food assistance. This is a big opportunity for the EU to intervene in the market, influencing demand for food, favouring healthier diets and boosting awareness among the populations which are traditionally the most difficult to reach.

With €3.8 billion earmarked for the 2014-2020 period, the FEAD's aim is to help alleviate the worst forms of poverty. Its tasks include supporting the collection and distribution of food donations that reduce food waste, and providing direct material assistance like food packages or meals.

The European institutions, through programs such as the FEAD, are providing money to EU Member States to aid them in assisting the most deprived.

When the Commission presents its scheduled mid-term evaluation of FEAD to the Parliament and Council in 2018, it should recommend additional conditions be added for a country to qualify for support through this program.

PROPOSAL

In return for EU-subsidized food support projects, Member States should meet a quality and quantity standard for the meat produced and distributed under FEAD. Meat procurement prices should reflect the costs of environmental damage, and meat provision should be in quantities in line with nutritional guidelines.

The rationale needs to be explained to the beneficiaries to educate them about the health risks of over-consumption of meat and about the environmental impact of meat production. Thus the EU and the Member States will further support environmental sustainable production of meat, and meat provision will match more closely the needs of a balanced diet.

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15 European Commission (DG ECHO), "Humanitarian Food Assistance: From Food Aid to Food Assistance", November 2013, accessed 16 April 2016, http://ec.europa.eu/echo/files/policies/food_assistance/them_policy_doc_foodassistance_en.pdf.

CONCLUSION

Increasing populations and economic growth have made climate change one of the main threats to international stability and peace. To avert catastrophic environmental consequences and maintain global warming levels below 2°C, every need has to be pondered against the costs of meeting it.

The interconnections between climate change, food and health have become more familiar at scientific level in recent years, but remain unaddressed at a policy level. In response, we suggest systemic action to control the supply of and demand for environmental-unfriendly meat.

The Climate Change and Healthcare Committee encourages European and national policymakers to implement this proposal to reduce excessive meat consumption and to promote alternative food styles, with the aims of improving health and reducing the human burden on the environment.

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DIGITAL SKILLS FOR HEALTH PROFESSIONALS

EUROPEAN HEALTH PARLIAMENT 2016
COMMITTEE ON DIGITAL SKILLS FOR HEALTH PROFESSIONALS

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EXECUTIVE SUMMARY

Digital technology, including mHealth and eHealth, is an inevitable part of the future of European healthcare. But are health professionals prepared? ***The Digital Skills for Health Professionals Committee of the European Health Parliament surveyed over 200 health professionals about their experience with digital health solutions, and a large majority reported to have received no training, or insufficient training, in digital health technology.***

To equip health professionals for the digital health future, our committee recommends that greater emphasis is placed on the needs and abilities of the end-users, the health professionals. This should be done through better incentives and improved training:

1. Widening digital literacy in healthcare depends on sufficient demand for digital healthcare. This can be achieved through reimbursement schemes that encourage the use of digital solutions in healthcare.

2. Continuous education of health professionals in the knowledge, use and application of digital health technology should be central to the European agenda for digitizing healthcare. We recommend that the European Union and Member States take the following actions:

> *a.* ***Establish mandatory tailored training programs on digital skills for health professionals*** *from early education to professional development programs.*

> *b.* ***Launch a joint action on digital skills for health professionals*** *to agree* ***among the Commission and Member States*** *on the key issues and determine a common approach.*

> *c.* ***Update clinical guidelines to include mHealth and eHealth solutions*** *that enable healthcare professionals to deliver mHealth and eHealth solutions to their patients.*

> *d.* ***Make healthcare professionals co-developers of mHealth and eHealth solutions.***

We consider digital literacy among health professionals paramount for the successful, effective and ethical implementation of digital solutions in healthcare.

INTRODUCTION

You can have the most technologically advanced device in the world, but if you don't know how to operate it, it will be as useful as jumbo-jet without a pilot.

The digitization of healthcare has long been on the European agenda to modernize and improve healthcare across Member States. The focus has recently shifted from developing the technology to implementation of digital healthcare and eHealth. To explore the results of this shift, the Digital Skills for Health Professionals Committee of the European Health Parliament surveyed over 200 health professionals. It discovered that no change has yet resulted in the education of health professionals to prepare them for this implementation. The EU risks spending time and resources on implementation strategies that will have little effect because attention to the front-line ability to adopt this change has been insufficient.

DIGITAL HEALTHCARE

People are increasingly demanding better quality healthcare. Patients want to be more autonomous and empowered to manage their own health. Digital solutions could provide the necessary tools to help make this possible. However, to benefit from these digital solutions and services, people need to understand them and how to use them. Health professionals also have a role to play in assisting the patient and explaining the use of digital solutions. The digital skills that health professionals will need consequently extend beyond understanding how digital services work, and include the ability to instruct patients in their use.

Patients are also becoming increasingly mobile, sometimes traveling across Europe in search of better and faster healthcare. This resulting increase in cross-border healthcare will oblige health professionals to increasingly rely on health data from other EU countries, interpreting the data to determine how to best treat the patient. This glimpse of the further digitization of health systems across Europe explains why much of the discussion at European level is focused on interoperability and standardization that will facilitate the exchange of information.

However, **what is consistently lacking is the inclusion of end-users in the development of eHealth, despite the obvious need for** the end-user to be able to use the service. The obvious answer is to allow the users – who best know their needs – to be part of the service development, so making it more fit-for-purpose and user-friendly.

THE STATE OF DIGITAL SKILLS IN THE HEALTH PROFESSIONS

There is a special need for digital skills across all the health professions due to the growing demands of a rapidly aging population[1]. Shortages of practitioner skills in information and communication technologies (ICT) have been endemic across many sectors, because the rapid pace of technological innovation and ICT activity has been exacerbated by low availability of employees and entrepreneurs with relevant educational qualifications. In the healthcare sectors, this has particularly slowed the uptake of the internet.

The need for digital skills for health professionals is acknowledged at EU level, and several initiatives take it into account. The Commission's eHealth Action Plan 2012-2020 (eHAP)[2] provides a roadmap to empower patients and health workers, and includes actions to promote skills and digital literacy. The Commission also supports the CAMEI-project[3], which aims to increase IT skills in the curricula of healthcare workers by developing and renewing educational materials and programs of the healthcare workforce in the EU and the USA.

The Joint Action Health Workforce Planning and Forecasting[4], coordinated by Belgium and funded by the third EU Health Programme, brings together expertise from across Europe in an analysis of the health sector designed to define the skills needed in education and training policies. This notes that digital skills are an important future skill for healthcare workers.

Recently, the European Commission (DG CONNECT in collaboration with DG SANTE) and the United States Department of Health and Human Services (HHS) joined forces for a public consultation[5] on a roadmap to guide cooperation on eHealth/Health IT. T**he Digital Skills for Health Professionals Committee** supported this initiative and contributed to the public consultation with the following suggestions:

All health professionals should be familiar with available e-Health and mHealth solutions, and know how to use them in an effective, responsible, and ethical way, with the interests of the patient at the centre:

- **Health professionals** including physicians, nurses, dentists, pharmacists and midwives should possess skills and aptitude for communication, data analysis, computer literacy, medical devices compatibility, data protection programs, mobile applications, cloud storage, surfing internet, and the ability to read, understand and forward information using a smart device.

- **Health informatics professionals** should acquire skills in information security, interoperability, analysing data, design and implementation of tools to measure data, software development, data-driven solutions development, 3D Image processing, project management and communication.

- **Non-clinical and administrative staff** should possess skills in project management, communications, computer literacy, information security, and the use of clinical software.

- **IT professionals working in the healthcare environment** should possess skills in data privacy, information security, ethics, software engineering and database development.

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1 OECD Labour Force Statistics 2015: http://www.data.oecd.org/pop/elderly-population.htm

2 eHealth Action Plan 2012-2020: Innovative healthcare for the 21st century:
   https://ec.europa.eu/digital-single-market/en/news/ehealth-action-plan-2012-2020-innovative-healthcare-21st-century

3 CAMEI EU project: http://www.camei-project.eu/

4 EU Joint Action on Health Workforce: http://healthworkforce.eu/

5 Public stakeholder consultation on next phase of EU-US cooperation in eHealth/Health IT:
   https://ec.europa.eu/digital-single-market/en/news/public-stakeholder-consultation-next-phase-eu-us-cooperation-ehealthhealth-it

Despite the many initiatives underway to improve digital literacy among healthcare professionals and drive the implementation of digital healthcare solutions, our committee has identified some important gaps and shortcomings:

- The need for digital skills is widely acknowledged, but there is limited reference to the health professions. Most current national medical guidelines do not include digital skills, and the Commission and Member States did not propose to help medical societies to update these guidelines. Guidance on digital skills for health professionals is included in only one project, Ens4Care[6], which produced five guidelines for European nurses and social workers on using eHealth – in promoting healthy lifestyles and prevention, in clinical practice, in skills development for advanced roles, in integrated care, and in nurse ePrescribing.

- Existing health professional curricula are inadequate. There is a need to strengthen the educational curricula of health professionals (Directive 2013/55/EU1) and use continuous professional development (CPD) programs to provide them with useful digital skills training.

- eHealth solutions do not always reflect the existing healthcare pathways, nor the needs of patients and health professionals.

- The patients and health professionals who are the end-users of eHealth are not involved in the development of these solutions.

- Member States differ in their readiness to implement eHealth solutions in their health systems, as well as in the structure of their training curricula for health professionals.

To get a better picture of the current state of digital health technology in healthcare, our committee launched an eSurvey (part 3).

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6   eHealth guidelines for nurses and social workers:
    https://ec.europa.eu/digital-single-market/en/news/new-ehealth-guidelines-nurses-and-social-workers

eSURVEY ON THE STATE OF DIGITAL SKILLS IN THE HEALTH PROFESSIONS

AIM

eHealth and mHealth, ranging from electronic patient records to patient-reported outcomes in mobile apps, are increasingly used in healthcare. However, **are health professionals trained for this paradigm shift?** Based on the observed lack of involvement of the end-users in ongoing EU initiatives and implementation plans, our committee, in collaboration with the University of Antwerp, initiated an eSurvey among physicians, nurses, midwives, dentists, health assistants, technicians, students and all others involved in European healthcare delivery. Our goal was to identify their experience with digital health and in digital health education.

OUTREACH

The eSurvey was launched on April 4 2016 to European health students and professional organizations in Member States and the public domain through social media touch points such as Twitter, Facebook, LinkedIn, Google+ and blogs displayed as a link or QR code as shown in Figure 1. The survey closed on May 1 2016.

RESULTS

Total participation was **207** health professionals of distinct backgrounds and age categories, living in **21** Member States (**Figure 1**). Most reported using some digital skills in their practice more than once a week, and basic IT skills and electronic patient records were used daily by more than 50% of the participants (**Figure 2**).

FIGURE 1: **OCCUPATION (LEFT) AND GEOGRAPHICAL (RIGHT) DISTRIBUTION OF THE PARTICIPANTS**
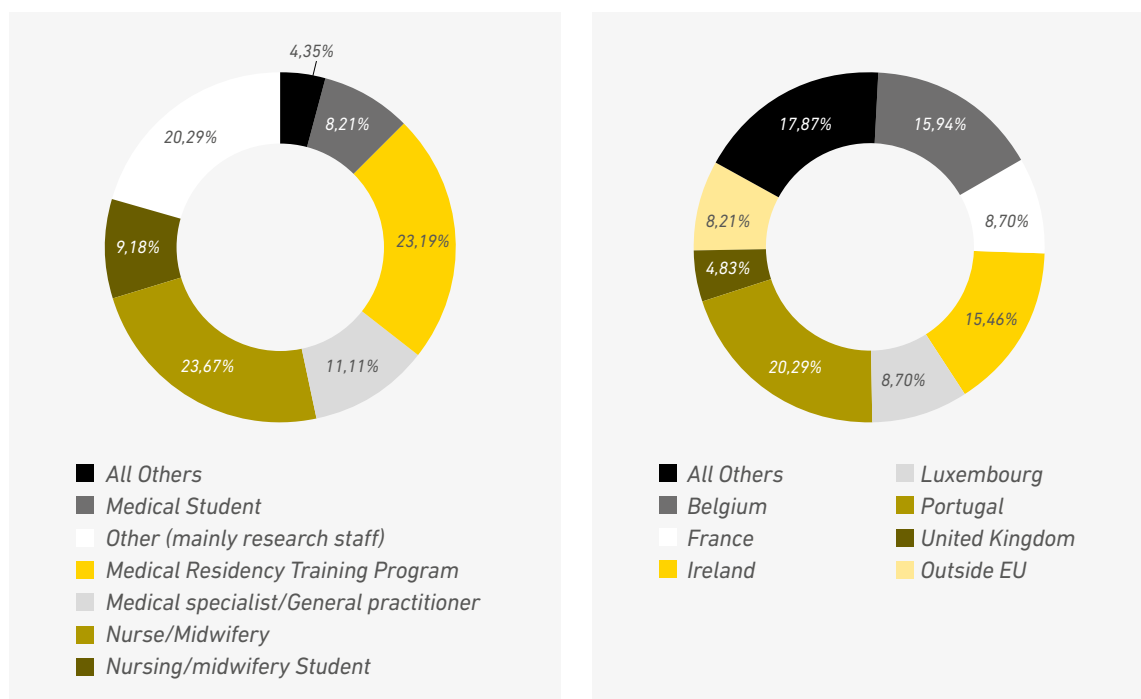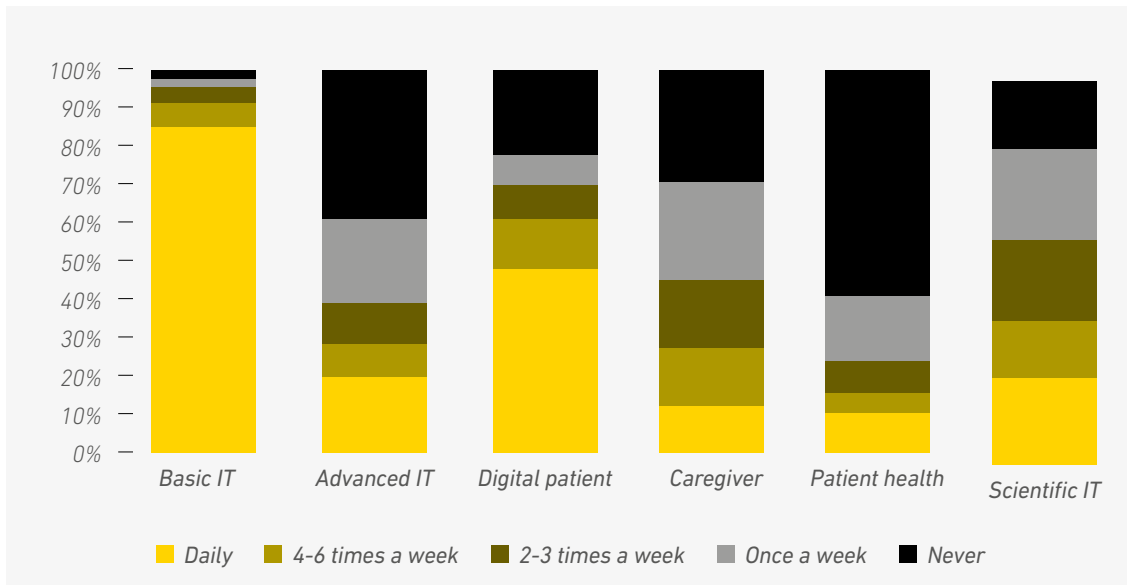

Left chart:
- 4,35%
- 8,21%
- 23,19%
- 11,11%
- 23,67%
- 9,18%
- 20,29%

Legend:
- All Others
- Medical Student
- Other (mainly research staff)
- Medical Residency Training Program
- Medical specialist/General practitioner
- Nurse/Midwifery
- Nursing/midwifery Student

Right chart:
- 17,87%
- 15,94%
- 8,70%
- 15,46%
- 8,70%
- 20,29%
- 4,83%
- 8,21%

Legend:
- All Others
- Belgium
- France
- Ireland
- Luxembourg
- Portugal
- United Kingdom
- Outside EU

FIGURE 2: **USE OF DIGITAL SKILLS IN CURRENT PRACTICE**

A large majority (**79%**), irrespective of their occupation or digital competence, said that eHealth/mHealth has, or will have, a significant impact on their career. There was a significant consensus on positive benefit for patients and professionals: 'more time with patient, less time with 'paper-work;' 'this would really help women in their daily lives and contribute to their care;' 'optimizing medical care'; 'increased efficiency;' 'simplify my daily work;', 'I expect to find information much faster, more detailed and improve communication with other caregivers'. The digital skills most highly rated as useful were basic IT skills, digital patient records and health apps; both patient and caregiver-oriented (**Figure 3**).

However, in response to questioning on whether any digital skills training had been received, the majority (**61%**) replied "no". Additionally, of the participants that received digital skills training, **54%** rated it as insufficient. **More than 80% of participants indicated that the currently available eHealth/mHealth training is inadequate**. This need is reflected across the entire educational spectrum, ranging from pre-university to workplace learning (**Figure 4**).

When asked about suggestions for digital skills training, health professionals favoured tailored training modules, ranging from general basic training to more advanced subjects, with ongoing training as the digital world evolves: 'Specific enough so that healthcare professionals could implement it directly, but general enough so that it could be used over several e-health and m-health tools'.

Education through training is seen as the way forward: 'Start early in education;' 'Basic training needs to be taught at schools;' 'Make it compulsory at schools and then refresher courses provided for each stage of education and then refresher courses provided for each stage of education and clinical practice'. Training - whether on-line or face-to-face - was welcomed by the survey participants.

CONCLUSION (eSURVEY)

Our survey demonstrates that eHealth and mHealth in various forms are already in use in daily practice. However, the uptake of eHealth and mHealth apps could be increased, as the health professionals themselves believe that it could benefit their profession and, ultimately, the patient. **Despite this current use and great promise, a vast majority of health professionals feel insufficiently trained to deal with the digital revolution**. Health professionals ask for education from early on, but believe that training should continue all through their careers. This training should be practical and hands-on, leading to direct patient benefit.

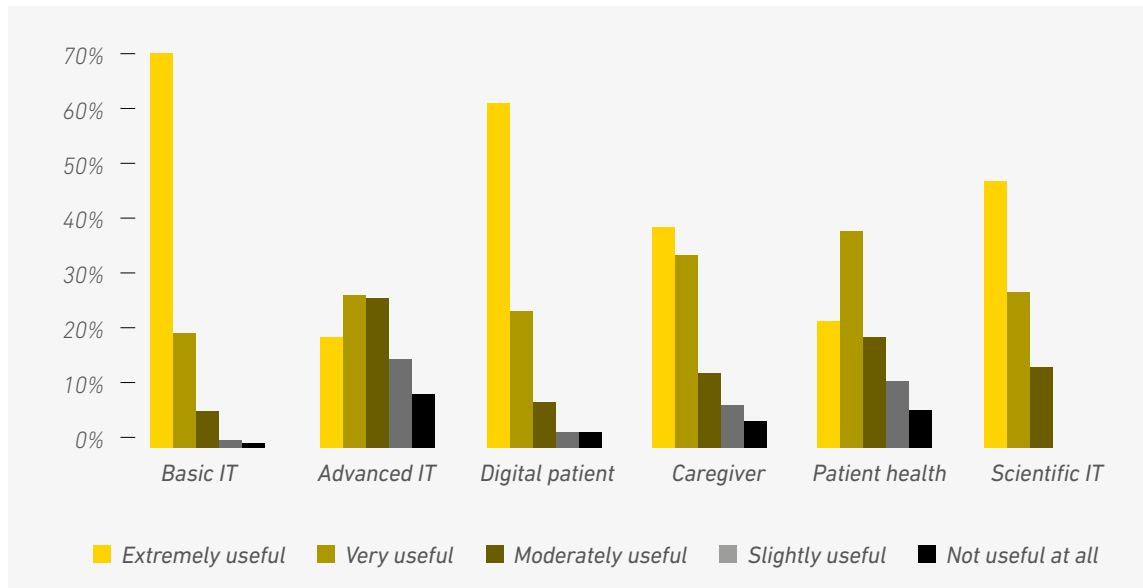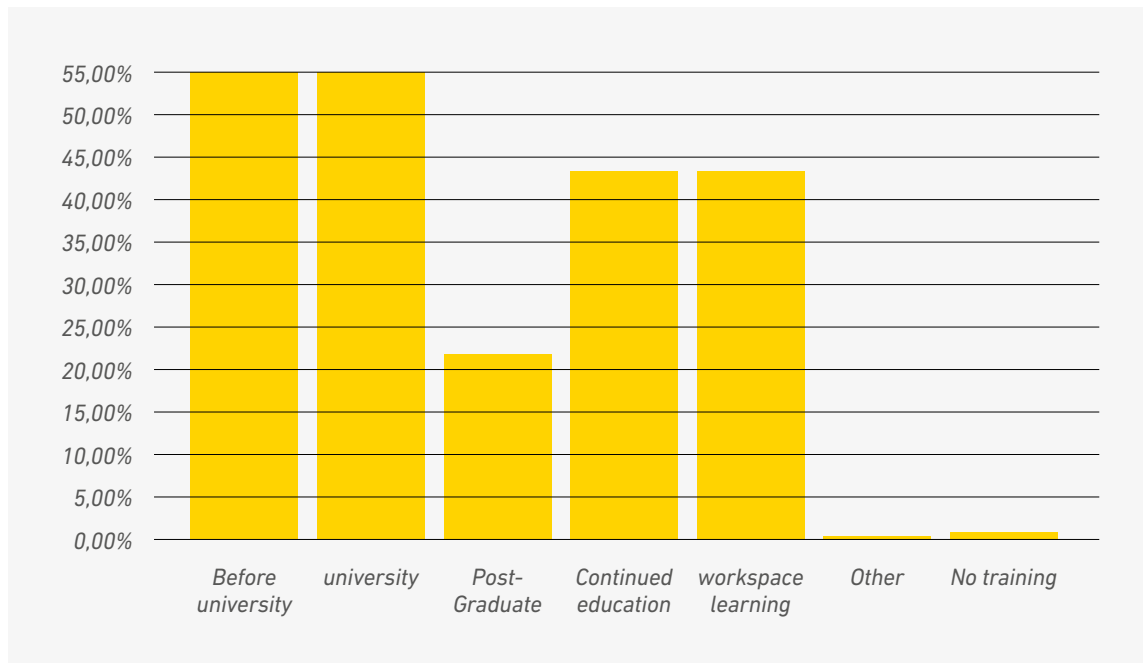FIGURE 3: **RELEVANCE OF DIGITAL SKILLS FOR CURRENT AND FUTURE PRACTICE**

FIGURE 4: **PREFERRED EDUCATIONAL LEVEL FOR DIGITAL SKILLS TRAINING**

OUR RECOMMENDATIONS

Based on the conclusion of our eSurvey, and the observed shortcomings of ongoing EU initiatives, our committee has developed the following recommendations:

1. GENERATING DEMAND FOR DIGITAL HEALTHCARE

Widening digital literacy in healthcare depends on sufficient demand for digital healthcare. Statistics suggest increasing uptake of digital tools in healthcare; however the picture varies across the EU. Moreover, even in countries where digital healthcare is spreading rapidly, much of the population is not included simply because they are unfamiliar with digital technologies.

The EU and Member States should create a basis for improving demand for "digital healthcare goods". A solution might be more advantageous reimbursement schemes for the use of digital tools for medical treatment, especially in the monitoring and treatment of chronic disease.

At European level, the European Commission should provide a platform for better cooperation between healthcare systems to promote the exchange of information and best practices. A European label based on a set of minimum standards could also strengthen trust amongst health professionals and patients, and increase uptake of digital technology in the European health sector.

2. RAISING AWARENESS OF THE USE OF DIGITAL TOOLS AMONGST HEALTHCARE PROFESSIONALS

Continuous education of health professionals in the knowledge, use and application of digital health technology should be central to the European agenda to digitize healthcare. Otherwise, ongoing initiatives may prove ineffective, as the successful implementation of digital technology in healthcare is entirely dependent on the ability of the end-users (and notably the health professionals) to adopt the technology. This can be achieved through coordinated initiatives:

a. **Mandatory tailored training programs on digital skills for health professionals** should be established in Europe. These programs should aim to train health professionals according to their occupation, their needs for digital skills, their frequency of using digital technology, their competence in digital skills etc. The training programs should be continuous, starting from an early stage of education, and continue in work place learning and professional development programs. Additionally, the EU should define program content by determining the digital skills every health professional must possess to use eHealth/mHealth solutions to their full potential

b. **The European Commission and Member States should launch a joint action** to agree on the key issues related to digital skills **for healthcare professionals**. This could promote a single approach, centralizing all existing national initiatives, in close collaboration with medical societies and professional organizations. To respect national differences and speed of adoption, an "option-in" with reimbursement benefits could be applied, where Member States adhering to European recommendations would benefit from the support and experience from the EU. As Member States start recognizing the benefits of these recommendations, the penetration of digital skills solutions in the health sector will increase.

c. **Update clinical guidelines to include mHealth and eHealth, so that** healthcare professionals are able to deliver mHealth and eHealth solutions to their patients. This would require close partnership with the associations that produce yearly guidelines, which could accelerate adoption of digital skills solutions in Member States.

d. **Make healthcare professionals co-developers of mHealth and eHealth solutions** by placing them at the centre of the development process. The role of end-users, the health professionals, is essential in accelerating the adoption of digital solutions. End-users are aware of the challenges facing them, and are well-placed to contribute to solutions tailored to real needs.

CONCLUSION

21st century challenges require 21st century solutions. Health professionals are the gatekeepers of healthcare. They determine how healthcare is delivered to patients. The potential benefits of digital skills in the health sector, including improved efficiency, effectiveness, disease prevention, and patient empowerment, are well established. As stated by one of the participants in our e-survey, 'eHealth and mHealth will empower the patients and change the working environment'. However, a responsible health professional will utilize and recommend treatment solutions to their patients only if they understand and trust them. The Digital Skills for Health Professionals Committee of the European Health Parliament recommends greater emphasis on the perspectives and readiness of healthcare professionals in the transition to a digital healthcare future, as a part of our common goal to create a more efficient and better healthcare system for all.

HEALTHCARE ACCESS FOR UNDOCUMENTED MIGRANTS:
WHY IT IS IN MEMBER STATES' INTERESTS TO SHARE COSTS AND WORK EARLY ON MENTAL HEALTH ISSUES

EUROPEAN HEALTH PARLIAMENT 2016
COMMITTEE ON MIGRATION AND HEALTH CHALLENGES

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EXECUTIVE SUMMARY

In the context of the current migration crisis, concerns related to migration management tend to overshadow the actual needs of migrants arriving in Europe. Among these needs, access to healthcare is crucial. Currently, providing access to healthcare is often left to those volunteer-based organizations that normally operate in humanitarian crises.

This paper argues that providing primary healthcare to migrants with a focus on mental health, independently of migrants' legal status, is legally grounded and economically efficient. Under international and European human rights law, every person has a right to access healthcare. Yet in most European countries this right is granted to asylum seekers and refugees, but not to undocumented migrants, who are entitled only to emergency care. Member States have a common interest in containing national healthcare spending, and reducing expensive emergency treatment and avoiding costs related to mental health treatment can play a role in this. Early treatment and access to basic primary care is not only beneficial for undocumented migrants, but also cost-efficient in the long-term, since it eases demand for emergency care by providing cheaper – and more effective - primary care.

Early treatment is also important for tackling mental health problems. Migrants, frequently exposed to multiple traumas from war and conflicts as well as from travels and resettlement in Europe, face higher risks of mental health disorders. The result can impair physical health and the capacity to integrate into new surroundings. Mental healthcare is consequently crucial, especially for children and unaccompanied minors, who are often the most vulnerable.

Budgetary pressures resulting from healthcare expenditures for migrants, who are often on the move, differ from one government to another. Coordinating their responses and sharing costs could prove beneficial to all Member States.

This paper makes two main recommendations:

1. *An innovative cost-sharing scheme to ease access for undocumented migrants to national health systems. This would be independent of legal status, reducing fear and other possible obstacles, while simultaneously sharing the financial burden among Member States.*

2. *A set of recommendations on how to better address mental health in migrants in the EU with a particular focus on unaccompanied minors.*

INTRODUCTION

The European Union (EU) is dealing with an unprecedented migration crisis that has seen more than 1.5 million arriving on European soil in 2015, legally or illegally. This influx includes economic as well as forced migrants, many fleeing war in Syria, but also many from Afghanistan, Eritrea, Iraq, Nigeria, Pakistan and other countries suffering conflict. Migrants from Syria and Iraq are more likely to seek asylum and acquire the status of refugees or international protection in one of the EU Member States.

Member States face many challenges, from suitable accommodation and timely registration of migrants to geographical allocation and integrating them into the job market, and there is not yet political consensus on the response – in terms of policy, and also from a social, cultural and economic perspective.

The health needs of migrants need to be addressed by the receiving countries. Access to healthcare is a human right, but most Member States restrict access for migrants, both to reduce incentives for further migration and to contain related costs to national health systems.

This paper focuses on (1) access to healthcare for undocumented migrants and (2) the need for a new European approach on mental health for migrants. It makes two main recommendations and suggests implementable solutions.

WHAT IS AT STAKE?

The majority of migrants report health needs similar to most EU citizens. But poor conditions for travel, sanitation, hygiene and housing pose additional risks and can increase healthcare needs, particularly for the vulnerable - pregnant women, women in general, and minors. In addition, mental health is one of the greatest long-term threats, particularly for those fleeing war, political instability, prosecution or discrimination. In minors, undetected and untreated mental illness affects social and psychological development into adulthood, and can impair integration.

In 2015 the German Chamber of Psychotherapists reported that at least 50% of refugees settling in Germany suffer from trauma-related mental issues, out of which more than 70% of refugees witnessed violence and 50% experienced it.[1] 40% of refugee children witnessed violence, also affecting their own family structure.[2] Moreover, many women and children experienced sexual violence, considered as torture or cruel, inhuman and degrading treatment in international law.[3] As a result, tackling mental issues within primary care is crucial.

The right to access healthcare is enshrined in various international human rights instruments, as well as in EU law. However, in practice access to healthcare is not guaranteed for *everyone*. Among Member States, access to healthcare is regulated in different ways. For migrants, legal status can be a major formal barrier, along with language, cultural, and economic barriers.[4] Asylum-seekers generally have legal entitlement to some healthcare, and once they have obtained refugee status or other international protection in a Member State they enter its national healthcare system. But for mental health, even when they have access, migrants also often lack the awareness of their illness or the possibility of treatment and do not consider the opportunity for healthcare in this respect.

For undocumented migrants (UM - estimated at around 1% of the population of the EU[5]), access is limited to emergency treatment in many Member States[6]. These are predominantly migrants who have entered the EU without documentation or on illegal routes without asking for asylum (although it can include those whose visas expired, and guest workers who overstayed their work permits).

Belgium, France, Portugal or Spain offer better UM access to medical care,[7] but most UM access healthcare as a last resort, through emergency care, when treatment cannot be denied because it would endanger life. Emergency care costs are then absorbed by national health budgets.[8] Some national laws oblige healthcare professionals to denounce illegal migrants that access healthcare, further discouraging UM from seeking treatment.[9]

Member States remain reluctant to provide more than emergency healthcare to UM for fear of increasing their attraction as a destination country and giving incentives to UM to seek regular status such as refugees.

We argue that it could be rational for Member States to accept costs and focus more on mental health.

WHY THIS PARTICULAR APPROACH?

Instead of debating the reallocation burden of migrants, Member States should provide better health conditions for migrants.

1. **Legal argument**: all Member States have recognized the right of everyone to the '*highest attainable standard of health*' and to receive medical care in the event of sickness or pregnancy – reading together:

   a. Article 25 of the Universal Declaration of Human Rights (UN 1948)

   b. Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination (UN 1965)

   c. Article 12 of the International Covenant on Economic, Social and Cultural Rights (UN 1966)

   d. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (UN 1979)

   e. Article 24 of the Convention on the Rights of the Child (UN 1989)

   More recently, Member States have ratified the Charter of Fundamental Rights of the European Union (2000), which, in its Article 35, recognizes 'the right of everyone to access to preventive health care and the right to benefit from medical treatment'. Member States are consequently clearly obliged to allow every person on European soil to access healthcare. Denying this right would violate international law.

2. **Scientific argument:** Studies by the European Fundamental Rights Agency and others argue that delaying treating until a health condition becomes an emergency not only endangers UM physical and mental health, but also damages public health in general[10]. This is not because migrants pose a greater threat to public health than regular international travellers: migrants are exposed mainly to the infectious diseases that are common in Europe.[11] With regard to mental health, a study by the OECD has shown that the earlier treatment is given, the fewer other diseases will arise and the less the spill over effects will be.[12]

3. **Economic argument:** The European Fundamental Rights Agency study argues that delayed treatment results in a greater economic burden to healthcare systems, especially when health services are provided through emergency care.[13] Emergency care is substantially more costly than primary care and the cost of excluding migrants from healthcare is ultimately higher than granting regular access to care.[14] Disregarding mental health in early treatments is particularly harmful to national budgets, especially in the long-term. The financial burden posed by migration, should be shared among Member States. Art. 80 of the Treaty of the Functioning of the European Union commit Member States to share the responsibility in financial burden sharing in asylum policy.

RECOMMENDATIONS

RECOMMENDATION 1

ALLOWING UNDOCUMENTED MIGRANTS TO ACCESS *FREE* BASIC PREVENTIVE AND PRIMARY HEALTHCARE ACROSS THE EUROPEAN UNION THROUGH A FAIR AND TRANSPARENT COST-SHARING SCHEME SUPPORTED BY ALL MEMBER STATES

We suggest Member States can comply with their legal and moral obligations at a lower cost by reducing emergency care spending and allowing (UM) free access to basic primary healthcare. The logic is simple: when UM have the same rights in all Member States, there would be no pull-factor for specific countries. UM travel across Europe, and some Member States provide more healthcare than others, so it would be fairer to share the costs among the Member States according to their size and wealth. Sharing the burden would also share the benefits, since UM could settle and register in any Member State.
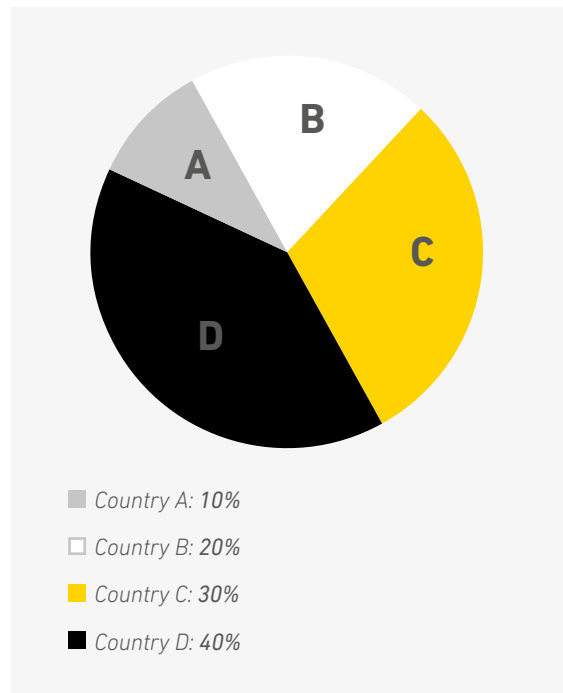
UM should have free access to basic preventive and primary health care, and the total costs should then be pooled among Member States. Reimbursement would be linked to the "Personal Health Record for refugees and migrants" developed by the European Commission and IOM in autumn 2015, and would work as follows:

A. ADOPTION OF A CONTRIBUTION KEY

Member States (MS) would adopt *ex-ante* a contribution key: each MS would agree to contribute to X % of the total costs imputable to healthcare delivered to undocumented migrants in the European Union. This key should be based on the wealth and the size of the country and could be the one the Commission has recently been using for allocating asylum applications among Member States under the reform of the Dublin system[15].

In Figure 1 a simplified example is shown. It is composed of 4 countries that commit to different shares of the total costs. Country A commits to 10%, country B to 20%, country C to 30% and country D to 40% of the total costs.

FIGURE 1: **CONTRIBUTION KEY**

■ *Country A: 10%*
□ *Country B: 20%*
■ *Country C: 30%*
■ *Country D: 40%*

B. STANDARDIZED MEDICAL SCREENING PROCESS

A standardized EU process should be established for migrants, including screening for infectious and contagious diseases (listed in Annex 1), immediate treatment when necessary (see Annex 2), vaccination (a core minimum, listed in Annex 3, and where possible with consent), information and the attribution of an identity number that would match a file in a dedicated EU-wide online database.

*A **European Online Database** accessible to authorised hospitals and medical centres should allocate a unique number for the Personal Health Record issued by a hospital, granting a "health identity", with a picture, some basic personal data, as well as the prescribed treatment and drugs*

Migrants would also be offered mental health screening through a questionnaire relevant to age, so as to allow identification of severe disorders, and to permit the provision of information and advice for possible follow-up treatment. Severe mental illness would be treated immediately in case of a threat to life (listed in Annex 2).[16]

The standardized screening process should be linked to the Personal Health Record that can be delivered by any authorised hospital, medical centre or non-governmental organization (see paragraph C).

C. ATTRIBUTION OF A "HEALTH IDENTITY"

Health screening would result in a "health identity", regardless of a migrant's legal status or future country of settlement, and linked to the Personal Health Record for refugees and migrants. Practically, an **identity number** would be inserted into the health passport along with a photograph, matching a personal file in a dedicated online database. The costs of the screening process would be covered by the reimbursement scheme (point H).

This "Health Identity" would make UM eligible for free basic primary healthcare (Annex 4) across the European Union on presentation of their Personal Health Record. Each UM would also be entitled to one hour of consultation with a psychologist or a psychiatrist free of charge, to assess any needs for further treatment.
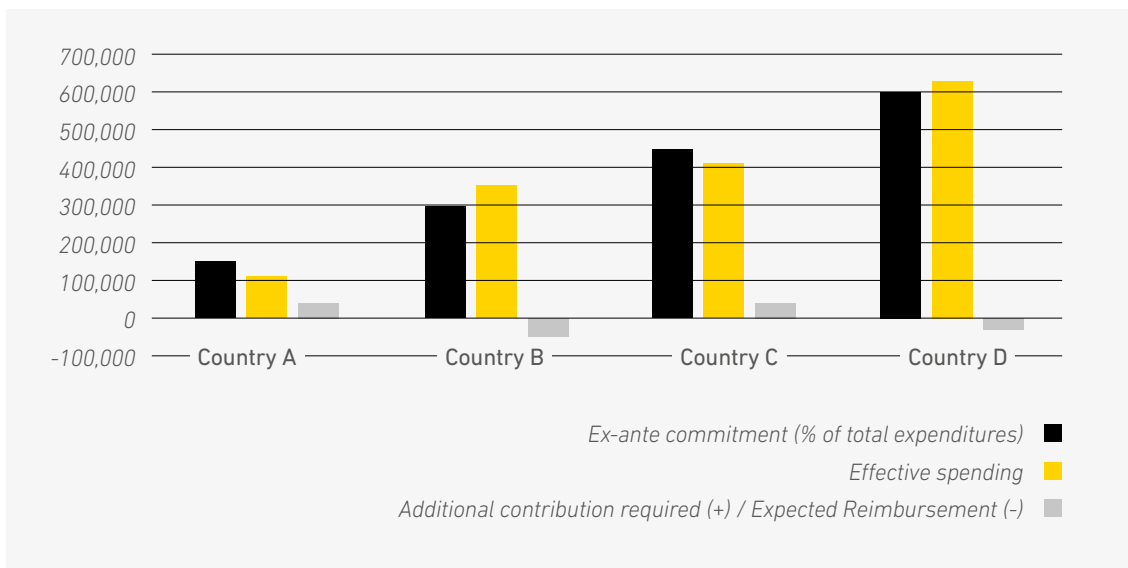
D. PRESCRIPTION OF DRUGS

Any prescribed drugs (generics where available) would be encoded on the UM file on the online database, and the UM could obtain that medication at the pharmacy without charge on presentation of a valid health identity.

E. EUROPEAN COST-SHARING MECHANISM

The prescriber and the dispenser of the drug would encode consultations, treatments, procedures, drugs and costs in the online database and report them also to the national healthcare system, which would reimburse the costs, then report them to the responsible supra-national authority.

FIGURE 2: **EXPENDITURES BY COUNTRIES AND EXPECTED TRANSFERS** *(FOR A TOTAL EU SPENDING OF 1.500.000 EUR)*

Ex-ante commitment (% of total expenditures) ■
Effective spending ■
Additional contribution required (+) / Expected Reimbursement (-) ■

Each year, a summary of total costs in each the country would be transferred to a **central European authority** (e.g. the Commission), along with the list of identity numbers that were treated and their corresponding list of treatments and related costs.

The central authority would aggregate the costs at European level and the costs for UM would be pooled, with Member States paying (or being reimbursed) according to the key mentioned in point (A). This accounting-based reimbursement scheme would compare *ex-ante* commitment in percentage to *ex-post* effective relative spending and automatically ensure that every country spends exactly the share of the total spending it had committed to (see figure 2).

Taking the example from point (A), we have 4 countries in the scheme that committed to a certain share of the costs. Country A committed to 10%, country B to 20%, country C to 30% and country D to 40%. The table below shows that some countries have effectively spent more and others less under the scheme. Countries A and C will have to provide additional contribution, while countries B and D can expect reimbursement.

When an UM registers in any of the 28 Member States (as an asylum-seeker, for example), the authority registering him/her in the EURODAC database will ensure that the identity number is deactivated in the dedicated online database and that it is no longer valid in the framework of this scheme.

For the scheme to be effective it must be delinked from immigration control. The dedicated online database mentioned above should only be used for the purpose of this scheme and not for immigration control purposes.

IMPLEMENTATION – IMMEDIATE ACTIONS REQUIRED

1. Member States to adopt the contribution key in a binding agreement

2. The Commission to integrate the attributed identity number and photograph into the existing health passport system

3. Member States to establish a catalogue of hospitals/medical centres/NGOs authorised to carry out the screening process

4. The Commission to oversee the creation of the dedicated online database and the technical features that would allow healthcare professionals to access it

5. Member States to establish the process for national healthcare insurance authorities to reimburse, file and report the costs imputable to the scheme

6. Member States to repeal legislation requiring healthcare professionals to report UM to immigration authorities

7. The Commission to oversee the automatic financial transfers each year

8. The Commission to establish controls to limit abuses by healthcare professionals for personal gain (abusive reimbursement, false prescription, etc.) and by national authorities (inaccurate reporting, excessive reimbursement, etc.).

RECOMMENDATION 2

ENHANCING MEMBER STATES' AND EU COMMITMENT TO INCREASE THEIR SUPPORT TO COMBAT MENTAL HEALTH ISSUES AMONG MIGRANTS

Many migrants face a range of health challenges, physical and psychological, as described earlier. Mental health can be a major issue, and minors (more than 50% of all migrants) deserve special attention in this respect because they are particularly vulnerable and have specific needs relating to mental health.

Providing mental health care to migrants has a legal and scientific, but also an economic, rationale. Ignoring the mental health would render physical health treatment less efficient where recurring physical ill-health patterns are connected to mental issues. Costs of ignoring mental health issues rank high with regard to healthcare budgets and levels of failed integration, which can in turn trigger radicalisation and hinder educational success – with further implications for integration and employment. Tackling mental health issues can also be regarded as a legal obligation for Member States in light of their duty to ensure each person's *right to the highest attainable standard of health*.

Reimbursing the costs of mental health care through the scheme in Proposal 1 would not be possible, because distinctions cannot be adequately drawn between emergency, primary and secondary care. We therefore make recommendations for targeted projects.

RECOMMENDATIONS FOR MEMBER STATES

1. Local authorities to develop and implement community-level programmes

In order to move away from purely psychiatric healthcare models, which involve high costs due to mostly individual and time-consuming consultations, focus should be put on community-based programmes, which allow for a greater number of recipients at lower costs.

Communication platforms for medical staff and migrants should be provided, since communication is a factor in preventing exclusion. Community programmes should be linked to language programmes, but should also be supported by translators and interpreters.

2. Education ministers to develop school-based intervention programmes

As minors are particularly exposed to mental health problems, school based intervention programmes should reach out directly to those suffering mental health disorders. The framework of education permits addressing several challenges simultaneously: language barriers, integration obstacles and mental health issues. Schemes should be based on the exchange of best practices as well as already existing school based group treatment for children at risk.

Intervention should also take account of existing language programmes – but should not replace mental health intervention programmes with language courses.

RECOMMENDATIONS
FOR THE EU

3. The Commission to increase coordination and support for best practices of migrants' mental health under EquiHealth

The EquiHealth initiative launched by the European Commission and the International Organization of Migration to augment the exchange of best practices between Member States and non-governmental organizations with regard to migrants' health still focuses more on physical rather than mental health. Non-governmental organizations and local authorities working with mental health and migrants should be included and be given the opportunity to share their best practices.

4. The EU to focus more on migrants' mental health within its Health Programme (2014-2020)

Annual work plans within the Health Programme (2014-2020) should include pilot projects and the exchange of best practices in relation with mental health of migrants. The Commission should open calls for projects that target migrants' mental health focusing on the following variables:

(1) Support children regardless of legal status *to target the most vulnerable and to connect mental health to the reimbursement mechanism of the first proposal. Existing EU funded projects such as KITU to provide psychiatric treatment services to asylum seeker children could be an example. Particular attention should be given to traumatic disorders as a consequence of sexual abuse or homicide, as exemplified in the German initiative 'TreatChildTrauma' targeted at children of 7-16 years.*

(2) Parenting support *to increase children's self-esteem and their social and academic competence, and to protect against later disruptive behaviour influenced by parents' mental health problems. With a focus on migrants' mental health, existing projects such as STAKES, a nationwide development and training programme for professionals who work with children and families at high risk, could serve as an example.*

(3) Against violence *to protect children from violence as mentioned in the International Charter of Children's Rights, to promote mental health and wellbeing among children in order to prevent future mental disorder. Projects such as the Belgian HERGO programme of group conferencing in education would be an example. Projects that train children in coping with conflict situations and violence prevention should be considered.*

(4) Against detention *to prevent criminal detention of young people. Funding should be directed at projects that coordinate personnel in schools, the police force and NGOs. Such an initiative is now in place in Poland, where the National Programme for Prevention of Social Maladjustment and Crime among Children and Adolescents has been developed and implemented by an inter-sectorial governmental committee.*

(5) Against stigma and discrimination *campaigns promoting acceptance and integration of migrant minors within school settings to improve children's mental health by positive community experience instead of fear and discrimination.*

These recommendations offer direct solutions to mental health problems among migrants. They could be directly developed and implemented but could also be starting points to increase the focus on mental health in EU policy.

CONCLUSION

Our first recommendation encourages the creation of a cost-sharing mechanism among Member States to allow undocumented migrants to access primary healthcare, and our second recommendation proposes a new European approach to mental health needs of migrants, with a particular focus on minors and children.

From a legal, scientific and economic point of view, it is in the interest of Member States to share the challenges. Access to healthcare for undocumented migrants is neither satisfactory in terms of compliance with international obligations nor cost-efficient. This paper proposes a single mechanism to allow undocumented migrants to access national healthcare services across the European Union, and at the same time reduce the related burden on national healthcare budgets. These arguments should offer enough incentives for Member States to come together around this proposal. For the migrants this means that they can be cured earlier and thus need less treatment, which is also an advantage for Member States in the long run.

A new approach to mental health would take into account the traumatic experiences many migrants experienced. By focusing on specific and tailored projects, it will help governments to better deal with the broader challenge of integration, at an early stage, and at lower costs. While most projects need to be decided and implemented by national governments, the EU can support these efforts by encouraging coordination and exchange of best practices. The Commission should also include a stronger focus on migrants' mental health in its Health Programme.

ANNEX

ANNEX 1

GENERAL PHYSICAL EXAMINATION AND DISEASE SCREENING

When conducting the screening patient confidentiality needs to be fully respected, as well as national reporting mechanisms in cases of public health concerns.

The screening should be adapted according to the country of origin and of transit. Specific disease epidemiology, depending on the countries should influence the diseases to consider.

Intake forms and Medical Histories:

- Dietary history (food allergies)
- Anthropometric measurements, including weight, height, and head circumference for children
- Pregnancy test (Urine test)
- Breastfeeding ability, if applicable

Vector Borne diseases

- Malaria (Blood test and detection of pathogens by PCR)
- Leishmaniosis (Blood test and detection of pathogens by PCR)

Parasitic diseases

- Roundworms/nematodes (Stool and blood test)
- Lice and flea

Bacterial and viral contagious diseases

- Tuberculosis (Tuberculin Skin Test (especially for children under 5 years of age), IGRA or X-ray)
- Cholera (Stool test)
- Diphtheria (Swab test and cell culture)
- Sexually transmitted diseases (STD) such as genital herpes, ulcers, syphilis, gonorrhoea, HIV (Blood and/urine test and detection of pathogens by PCR)
- Acute respiratory infections (Blood test, cell culture and detection of pathogens by PCR)
- Measles (physical examination)
- Rubella (physical examination)

Non-communicable diseases

- Dehydration (Blood test and physical examination)
- Mental health (using specific questionnaires or technological approaches as well as physical examination and screening for intense stomach pain, physical and mental fatigue and insomnia, hallucinations, anxiety crisis

Others

- Anaemia (Blood test and blood cell count)
- Lead levels (Blood test of children 6 months-16 years of age)
- Type 1 Diabetes test in children with family history (metabolic and autoantibody screening)

ANNEX 2

DISEASES TO BE TREATED IMMEDIATELY

Contagious diseases

- Tuberculosis
- Cholera
- Diphtheria
- Measles
- Rubella
- STDs
- Influenza and common respiratory infections
- Typhoid Fever

Vector Borne diseases

- Leishmaniosis
- Malaria
- Salmonellosis

Invasive parasite

- Nematodes

Others

- Prenatal care including vitamin and iron supplementation
- T1D in children
- Severe mental health disorders including schizophrenia, bipolar disorder, major depression or traumatic brain injury

ANNEX 3

VACCINATIONS

- Polio
- DTap: Diphtheria, Tetanus and Pertussis combination vaccine
- MMR: Measles, Mumps and Rubella combination vaccine
- MenC: Meningococcal conjugate vaccine

ANNEX 4

PRIMARY CARE COVERED UNDER THE SCHEME

- Treatments of diseases mentioned in Annex 2
- Pre and post-natal care
- Autoimmune diseases such as diabetes, asthma, arthritis
- Cardiovascular diseases including hypotension
- Chronic diseases such as back pain, thyroid dysfunction
- Basic dental and ophthalmology services
- One consultation session for mental health
- Basic family planning services (including reproductive diseases and sexual education)
- Children under 18 years old and pregnant women should be given extended access to care and treatments

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SELF-CARE AND PREVENTION RECOMMENDATIONS

EUROPEAN HEALTH PARLIAMENT 2016
COMMITTEE ON PREVENTION AND SELF-CARE

EUROPEAN HEALTH PARLIAMENT 2016
COMMITTEE ON PREVENTION AND SELF-CARE

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EXECUTIVE SUMMARY

Healthcare affordability is a crucial theme for European Member States. The benefits of prevention and self-care measures are supported by evidence, but barriers still prevent full exploitation of their potential. In view of the urgent need for change, this Committee recommends three clusters of actions to be taken at EU, Member State and community level. The aim is to empower patients and health and community actors, and to influence policy makers and payers.

AT EUROPEAN LEVEL, THE EUROPEAN HEALTH PARLIAMENT CALLS UPON:

- *The European Commission to enhance the assessment of the performance of healthcare systems, with a focus on patient and societal outcomes of prevention measures, and the effect of fiscal incentives*
- *The European Commission to create a European Joint Action focusing on self-care and prevention to coordinate on-going work in prevention and to increase awareness of self-care as a patient-empowerment tool*
- *The European Parliament to create an Interest Group on prevention and self-care, to promote a unified strategy on prevention and self-care across Europe and to place it as a strategic legislative priority*
- *The upcoming Slovakian and Maltese EU Presidencies to include recommendations around self-care and prevention in their priorities relating to food improvement and obesity, and in particular to encourage collaboration and joint funding among finance, education and health ministries on early childhood initiatives on healthy eating*

AT MEMBER STATE LEVEL, THE EUROPEAN HEALTH PARLIAMENT CALLS UPON:

- *Member States to increase collaborative efforts across health, social affairs, finance, education and environment ministries in support of a "prevention in all policies" approach*
- *Member States to increase their budget allocation for public health and prevention activities beyond the current 3% average*
- *Member States to develop policies, practices and incentives for prevention in the form of financial benefits for employers, and for the implementation of self-care and prevention measures for employees in the work place*
- *Payers to promote and incentivise consumers to make positive choices and adopt healthy and sustainable habits*

AT THE COMMUNITY LEVEL, THE EUROPEAN HEALTH PARLIAMENT CALLS UPON:

- *Investors to take part in a fund for the implementation of self-care and preventive policies and programmes*
- *Public-private partnerships between food, IT and healthcare industries and governments to address current inconsistencies relating to labelling of foods*
- *Patient organisations and associations of healthcare professionals to prioritise education of the community on the importance of self-care and the role of lifestyle in prevention of diseases*
- *Healthcare professionals in the community to embrace and advocate self-care to prevent avoidable chronic diseases*

INTRODUCTION

Imagine a future for the next generation, where they no longer have to worry about the skyrocketing rates of chronic disease[1] and the accompanying escalating costs. What if public-private partnerships were developed to alleviate the governments' growing financial burden in tackling chronic diseases? What if such public-private partnerships identified good practices, ensured outcomes were measured and scaled up effectively, so that all communities could benefit from them? What if private and public investors contributed to national funds dedicated to financing prevention programmes?

More action is required to tackle the issues arising from unhealthy lifestyles, an ageing population and increasing rates of chronic disease. Meanwhile, growing demand for and rising costs of healthcare are obliging health systems to seek increased efficiency. The European Health Parliament's Prevention and Self-Care Committee has addressed these issues with recommendations for integrating self-care and preventive measures into multi-stakeholder solutions, engaging the wider community rather than merely focusing on policy makers at EU and national level.

Since the early nineties, research has demonstrated the benefits of prevention on a meta-level. In 1995, the US Public Health Service calculated that prevention efforts and investments could save up to 11% ($69 billion in 1994 dollars) of medical costs over five years (US Dept. Health & Human Services, 1995). Since then, extensive research activity has provided insights into pathology-specific advantages of prevention.

Efforts are being made at EU and Member State level to reduce preventable chronic disease, with a focus on promoting and implementing self-care, healthy lifestyles and primary prevention solutions. But a major barrier stands in the way of sustainable solutions - the allocation of appropriate funding. Currently, only 3% of public health budgets in Europe is spent on public health and prevention activities (WHO Europe, 2014; OECD, 2016). Huge opportunities exist in prevention and self-care across Europe, but this requires an urgent change of policy.

The European Health Parliament's Prevention and Self-Care Committee seeks to dismantle this barrier. The solution is not simply an increase in funding. It requires a broader solution that will bring tangible benefits for all stakeholders.

"Self-Care is what people do for themselves to establish and maintain health, prevent and deal with illness. It is a broad concept encompassing hygiene (general and personal), nutrition (type and quality of food eaten), lifestyle (sporting activities, leisure, etc.), environmental factors (living conditions, social habits, etc.) socio-economic factors (income level, cultural beliefs, etc.) and self-medication."
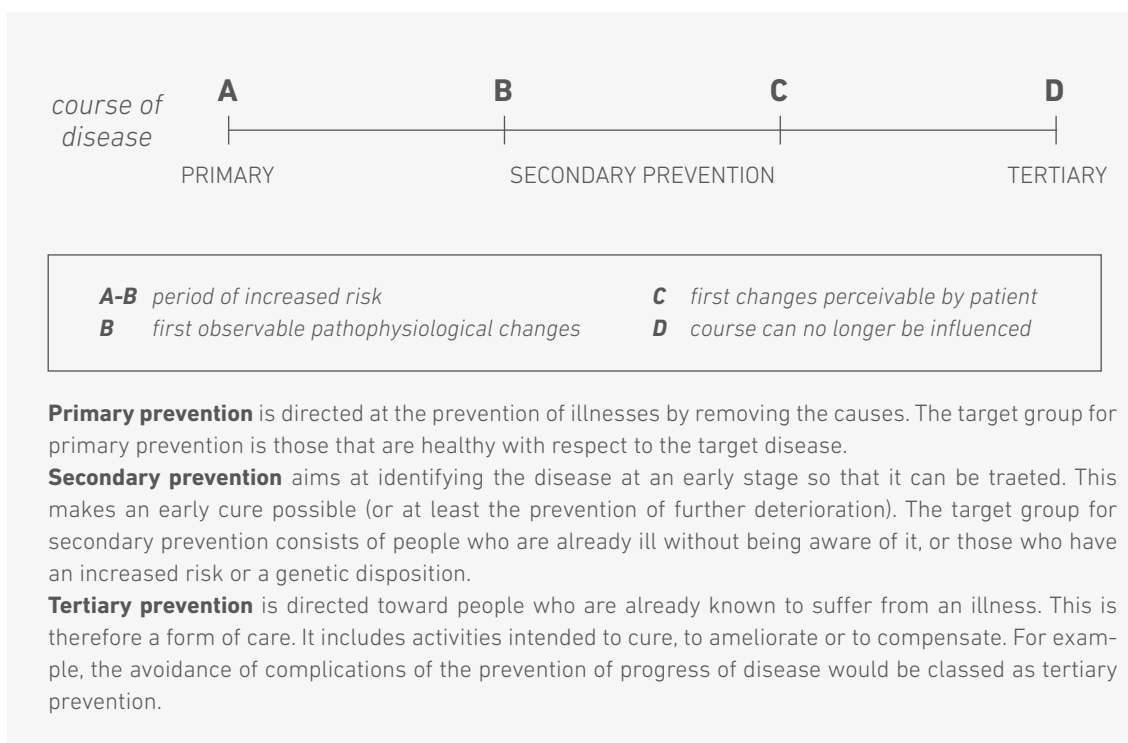
World Health Organisation (1998)

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1   Non-communicable or chronic diseases are diseases of long duration and generally slow progression. The four main types of non-communicable diseases are cardiovascular diseases (like heart attack and stoke), cancer, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes (WHO, 2015)

To align with current EU key priorities, our committee will focus its attention on self-care and prevention which is predominantly related to healthy lifestyles and primary prevention of chronic diseases:

a period in which consumers are living with increased risk

FIGURE 1: **PREVENTION AND STAGES OF DISEASE**

course of disease

| A | B | C | D |

PRIMARY   SECONDARY PREVENTION   TERTIARY

A-B period of increased risk
B first observable pathophysiological changes

C first changes perceivable by patient
D course can no longer be influenced

Primary prevention is directed at the prevention of illnesses by removing the causes. The target group for primary prevention is those that are healthy with respect to the target disease.

Secondary prevention aims at identifying the disease at an early stage so that it can be traeted. This makes an early cure possible (or at least the prevention of further deterioration). The target group for secondary prevention consists of people who are already ill without being aware of it, or those who have an increased risk or a genetic disposition.

Tertiary prevention is directed toward people who are already known to suffer from an illness. This is therefore a form of care. It includes activities intended to cure, to ameliorate or to compensate. For example, the avoidance of complications of the prevention of progress of disease would be classed as tertiary prevention.

Source: Van der Mass and Mackenbach (1999) cited in: EOHSP (2010)

OUR RECOMMENDATIONS: THE THREE LEVELS

Our recommendations address the barriers our re-search has identified to effective policies, and to the scale-up of existing good practices from our communi-ties. The aim is for self-care and prevention practices to be embedded in national health programmes.

TABLE 1: **CURRENT BARRIERS AND LIMITATIONS IDENTIFIED ON A EUROPEAN, MEMBER STATE AND COMMUNITY LEVEL**

LEVEL		
EU	**MEMBER STATE**	**COMMUNITY**
Outcomes and resources from EU tools and initiatives focussed on prevention are not communi-cated to wider society	Lack of adequate budget allocat-ed to public health, prevention and self-care activities	Lack of credible, trustworthy or relevant health literacy aids to enable good decision making by the public
Lack of coordination and follow up between programs and joint actions	Lack of incentives for employers and employees for promotion of health in the workplace	Lack of advocacy of self-care by healthcare professionals
Industry pressure	Existing good practices are often not scaled up due to lack of mea-surement of outcomes	Lack of public health campaigns on prevention and self-care topics
Resistance to behavioural change policy	Investment in prevention does not benefit healthcare budgets	Unhealthy habits widely adopted by citizens
Policy is not always evidence based	Lack of communication between Member States on national approaches that could provide valuable lessons and outcomes	Public-private partnerships are under-utilised
	Lack of coherence and imple-mentation of existing policies	

I. AT EUROPEAN LEVEL, THE EUROPEAN HEALTH PARLIAMENT CALLS UPON:

- **The European Commission to enhance the assessment of the performance of healthcare systems, with a focus on patient and societal outcomes of prevention measures, as well as the promotion of fiscal incentives**

For Europe to put sustainable healthcare systems in place, it must be possible to measure and assess the patient and societal outcomes from healthcare policies and programmes.

The European Health Parliament therefore calls for EU-wide quality standards for health and social care services, with mechanisms to alert countries in fiscal situations that require planned structural reforms to their tax base in order to create a safety net to provide specific inpatient/outpatient care.

The ability to evaluate the performance of healthcare systems is also necessary for effective assessment of the overall financial impact, using specific interoperable e-health prescription tools and activity-based funding. This will bring added value to the health systems of Member States and pave the way for a unified EU agenda on healthcare, with a robust framework for action.

- **The European Commission to create a European Joint Action focusing on self-care and prevention with the aim of coordinating all the ongoing work in the area of prevention and increasing awareness of the importance of self-care as a patient-empowerment tool**

The extensive recent work in Europe in the area of prevention includes CHRODIS (n.d), the Joint Action on Nutrition and Physical Activity (JANPA, n.d), and the European Innovation Partnership on Healthy and Active Ageing (European Commission, 2015). But there are no concrete measurement tools that support the Europe 2020 strategy (European Commission, 2016) with respect to health priorities.

A Joint Action could help to shift attention towards prevention and self-care practices, particularly among vulnerable groups such as pregnant women, patients with chronic diseases and transplant patients. Success will depend on effective scaling-up of good practices and the encouragement of increased levels of investment (European Commission, 2013).

- **The European Parliament to create an Interest Group on prevention and self-care, to promote a unified strategy on prevention and self-care across Europe and to position it as a legislative priority**

The primary aim of such a group is to place self-care and prevention as a priority in raising awareness about prevention of chronic diseases. It can also act as a platform for relevant stakeholders to foster change. Collaboration with Members of the European Parliament (MEPs) will ensure accurate and up-to-date input on best practices and the cumulative visions of food experts, patients, broader society, healthcare professionals, policy makers, representatives from the healthcare, food and IT industries, and payers.

- **The upcoming Slovakian and Maltese EU Presidencies to include recommendations about self-care and prevention in their priorities on food improvement and obesity and in particular, to encourage joint collaboration and funding among finance, education and healthcare ministries to implement early childhood initiatives around healthy eating**

II. AT MEMBER STATE LEVEL, THE EUROPEAN HEALTH PARLIAMENT CALLS UPON:

• *Member States to increase collaboration across health, social affairs, finance, education and environment ministries to ensure a "prevention in all policies" approach*

National government policies can help in building economically viable and sustainable communities – but not if policies are fragmented, services duplicated, gaps are left unfilled and agencies do not communicate with one another (OECD, 2009). Operating in silos can result in reluctance to invest in prevention because investments may not generate direct benefits to investors. Breaking down these silos and creating alliances will promote dialogue and collaboration in budgeting mechanisms for investment in healthcare. A "prevention in all policies" approach can benefit ministries.

Together with the Anti-Microbial Resistance (AMR) Committee, we jointly recommend a pilot approach for the Member States' health, finance and education ministries. This would develop cross-funded initiatives to strengthen health literacy for all, from childhood, by promoting healthy lifestyles, education on prevention (particularly with vaccines) and proper use of medication (and particularly antibiotics) in the school curricula.

• *Member States to increase their budget allocation for public health and prevention activities beyond the current 3% average*

There is evidence that preventive approaches can be cost-effective in the short and longer term, including interventions to promote healthy behaviours, vaccinations and screening. But an average of only 3% of the healthcare expenditure is devoted to prevention and public health services European data for 2012 show a negative relationship between health expenditures for prevention and public health services per capita, compared with age standardised mortality rates (per 100,000 population) for non-communicable diseases (Eurostat, 2015; WHO, 2016). Increased investment in public health can generate cost-effective health outcomes, contribute to wider sustainability and demonstrate economic, social and environmental benefits (WHO Europe, 2014).

"Chronic diseases threaten to overwhelm Europe's healthcare system. Between 70% and 80% of Europe's healthcare costs are spent on chronic care, amounting to €700bn. Chronic diseases account for over 86% of deaths in the EU."

EPHA, 2012

• *Member States to develop policies, practices and incentives, in the form of financial benefits for employers, and in turn, the implementation of self-care and prevention measures for employees in the work place.*

Chronic conditions equal fewer people in the workforce. Evidence demonstrates the impact of chronic disease and risk factors on labour, with negative effects on workforce participation, earnings, hours, job turnover, early retirement and career development (EOHSP, 2010). Employers have a responsibility to provide opportunities and incentives to employees to lead healthy, balanced lives, to ensure health and wellness and to aid prevention of chronic disease.

In 2009, the German Tax Act granted employers a tax exemption of €500 and an exemption from social security contributions for activities undertaken to improve the employees' general health (Eurofound, 2010). Similar measures need to be implemented on a wider basis.

Financial incentives such as tax cuts and reduced social security measures would provide a two-fold benefit:

→ *Employers would have additional funds available to invest in health and wellness related measures for their employees – particularly attractive to smaller businesses that might otherwise face difficulties in paying for such programmes*

→ *Employees would benefit from measures that promoted positive lifestyle choices and improved their health and wellness. What if employee wellness goals were incorporated into their annual goals?*

• *Payers to promote and incentivise consumers to make positive choices and adopt healthy and sustainable habits*

A major factor in the rising demand for national health services is consumer behaviour. Unhealthy lifestyle and dietary choices lead to an increase in chronic disease and inefficient use of healthcare resources (Dixon-Fyle and Kowallik, 2010). Payers can help to improve consumer health and reduce longer-term healthcare costs through providing information and encouragement for healthy choices and incentives to modify unhealthy lifestyles.

Programmes on self-care and prevention could, if there was adequate analysis of the outcomes through algorithms that assessed potential cost savings, lead to significant benefits, for populations and healthcare systems across Europe.
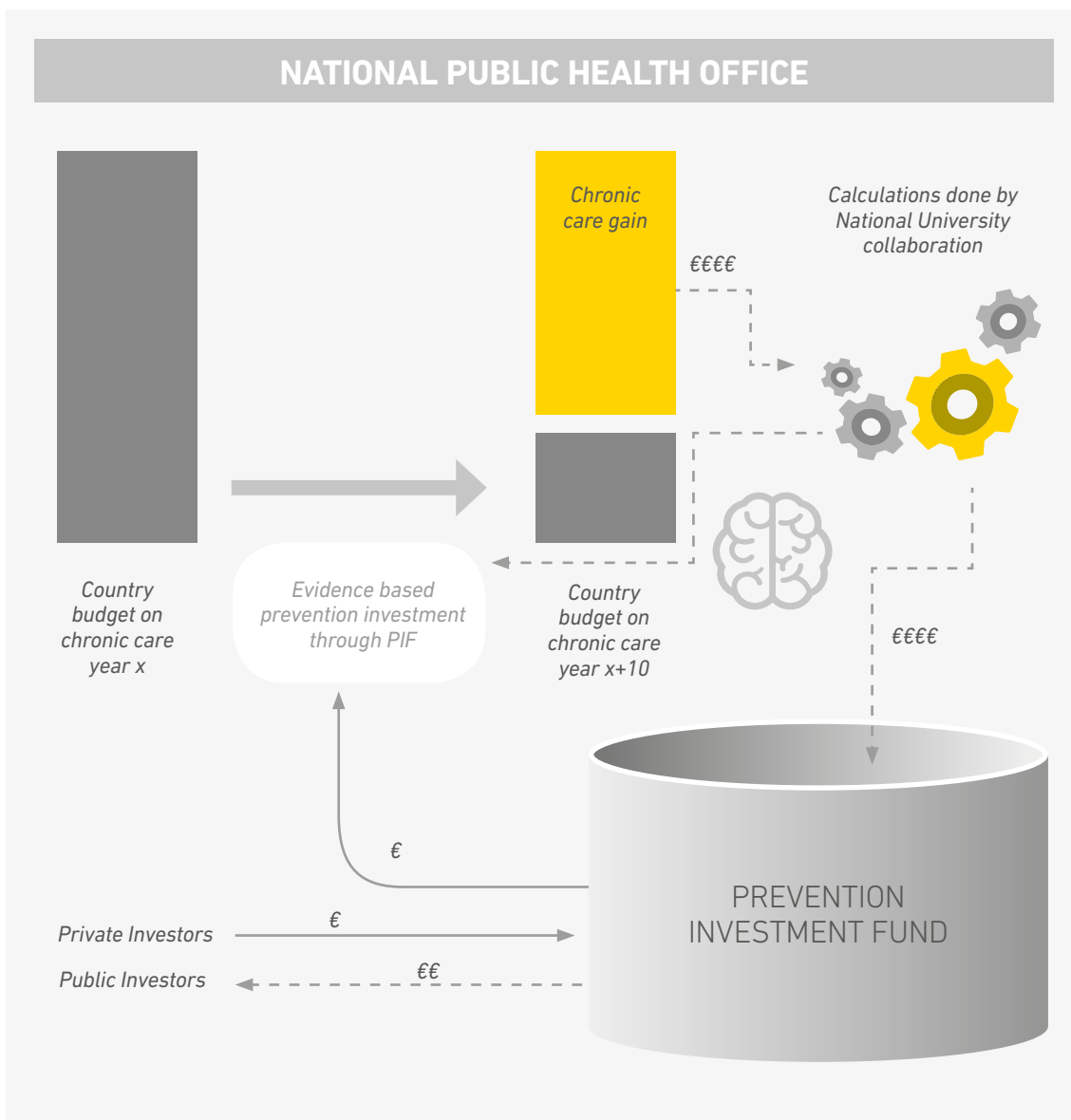
III. AT THE COMMUNITY LEVEL, THE EUROPEAN HEALTH PARLIAMENT CALLS UPON:

- **Investors to take part in a fund for the implementation of self-care and preventive policies and programmes**

Although research indicates the benefits of prevention for health and healthcare budgets, practical application is hindered because many of the benefits are delivered only over the longer term. Investment in prevention today will reap long-term rewards for health and health care budgets – over periods longer than a decade. An investment fund for preventive measures could provide a strong incentive to increase attention to prevention as an investment in the future of health and healthcare budgets around Europe. Figure 2 elaborates on this idea:

FIGURE 2: **ILLUSTRATION ON HOW INVESTORS CAN TAKE PART IN AN FUND FOR SELF-CARE AND PREVENTIVE POLICIES AND PROGRAMMES**

NATIONAL PUBLIC HEALTH OFFICE

Chronic care gain

Calculations done by National University collaboration

€€€€

Country budget on chronic care year x

Evidence based prevention investment through PIF

Country budget on chronic care year x+10

€€€€

€

Private Investors   €

Public Investors   €€

PREVENTION INVESTMENT FUND

Private and public investors could invest in a prevention investment fund (PIF) linked to the national public health authority. The fund, led by a consortium of health economists from national universities, would invest in prevention programs selected on an evidence base and capable of delivering cost-efficient health benefits. The savings in healthcare spending over time would be returned to investors in the form of dividends at a rate calculated by the university consortium. The consortium would itself also benefit from grants for conducting long-term research into prevention.

• **_Public-private partnerships between food, IT and healthcare industries and Member State governments to explore the scaling up of successful pilots on self-care and prevention and to address inconsistencies on food labelling_**

> **_> One solution would be the development of a QR code providing individualised information to consumers on the purchases they make and their impact on health_**

Introduction of mandatory Quick Response (QR) codes (see figure 3) alongside nutrition tables on food and drinks could provide detailed information to consumers about their purchases. Public-private partnerships could play a role in the creation of software that would link QR codes with personalised healthcare information and offer alternative healthy recommendations to consumers.

A programme of this sort could benefit industries involved. For example, a food company could offer healthy alternatives from its own product range.

The engagement this software would provide with consumers who want to make positive health choices could help contain the increase in chronic disease, reduce overall health risks and provide benefits to the European economy.

The public-private partnership could also define outcome measurements to be applied to pilot projects in self-care and prevention, so that governments and other key actors would have a firmer base to endorse the successful pilots or scale them up.

• **_Patient organisations and associations of healthcare professionals to prioritise educating the community on the importance of self-care and the role of lifestyle in prevention of disease, using evidence based sources consistent across Europe_**

There are numerous sources accessible to the public for data and information related to health and lifestyles, but credibility, impartiality and an adequate evidence base is frequently lacking. This can generate confusion and be counterproductive to adoption of healthy lifestyles, or a barrier to implementation in daily lives.

Patient organisations as well as associations of healthcare professionals (HCPs) are well placed to promote relevant and credible training of the public on the role of self-care in prevention.

• **_Healthcare professionals in the community to embrace and advocate self-care, in order to prevent avoidable chronic disease_**

Many chronic diseases can be avoided or tackled through self-care and preventive measures, but the opportunities are often unrecognised or underappreciated (ISCF, 2016).

Transferring more care responsibilities from HCPs to the public requires a supportive framework for the patient and appropriate incentives for HCPs. The relationship between HCPs and their patients also needs to become more collaborative with two-way communication and a supportive approach, which will empower the patient to take more ownership of their health.

More screening services should be made available in pharmacies, general practitioner (GP) consulting rooms and other HCP environments, and self-testing should be promoted among patients. These measures can still involve HCPs in facilitation and follow up, as appropriate.

FIGURE 3:
**EXAMPLE OF A
QUICK RESPONSE
(QR) CODE**

CONCLUSION

A future can be imagined for the next generation in which the impact of chronic disease is reduced, long-term cuts become possible in healthcare costs, and positive returns can be made on health investments. However, for this ambition to be achieved, Europe must quickly shift from a reactive system of healthcare focused on acute treatment and cure of already established diseases, and instead adopt a proactive approach in preventing illnesses before they take hold. Self-care, in the form of preventive measures, can play a major role in this change.

Efforts are being made at EU and Member State level to contain preventable chronic diseases. In line with current EU priorities, the recommendations of the European Health Parliament's Prevention & Self-Care Committee focus on promoting and implementing sustainable and long-term self-care solutions. The recommendations are directed at the three levels of the EU, Member States, and local communities. The key is a holistic and multi-stakeholder approach to combatting this EU wide predicament.

Public-private partnerships, prevention investment funds, and increasing the prevention budget beyond 3% across Europe are all achievable solutions to help reduce the burden of chronic disease - which could have a significant impact on the sustainability of European healthcare systems and the health of our population in the future.

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