



European Union Health Policy Forum

**Answer to DG SANCO consultation
on chronic diseases**

13 January 2012

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1. EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

1. The European Commission will launch in the coming months a public consultation on chronic diseases following the Council conclusions of 7 December 2010¹. Ahead of this consultation, the European Health Policy Forum (EU HPF) was asked by DG SANCO to provide its recommendations and views on how to best address the issues related to chronic diseases, with the guidance of a DG SANCO explanatory document, listing a series of questions to be taken into consideration when reflecting on the matter².

The EU Health Policy Forum (HPF):

2. **Welcomes the initiative from DG SANCO** as the impact of the major chronic diseases³ (cardiovascular diseases, cancer, diabetes, chronic respiratory diseases, musculoskeletal conditions, oral diseases, mental disorders and others) is alarming: taken together, these conditions account for an estimated 86% of the deaths and 77% of the disease burden in the WHO European region; the EU must take action now to reduce the risk of chronic disease, to improve the health of its citizens and reduce the financial burden on Member States' health systems;
3. **Underscores the mortality and morbidity differences** that currently exist between EU Member States in particular for cardiovascular diseases, cancers and respiratory diseases and their underlying behavioural determinants: smoking, diet, lack of or insufficient physical activity and alcohol consumption. In some Member States mortality rates due to chronic diseases have grown during the last decade, in contrast to the general EU trend;
4. Calls for **specific attention to the social gradient in health**, to equity between and within member states, and to a specific focus on addressing the needs of disadvantaged groups.
5. Underlines the **importance of the human and financial burden of chronic diseases**: the World Economic Forum and Harvard School of Public Health estimate that chronic diseases will cause a US\$ 47 trillion global economic output loss over the period 2011-2030⁴. This is particularly relevant in a context where health expenditures are increasing at the national level and specifically for chronic diseases;
6. Calls for scientifically appropriate population level **prevention programmes and patient-centred care models**, based on health literacy and patient empowerment, that provide the necessary tools for patients to properly manage long-term chronic conditions, thus improving health outcomes;
7. Notes that when tackling chronic disease, **citizens face age-discrimination and gender discrimination**⁵;

¹ http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/lsa/118282.pdf

² "EU Health Policy Forum, EU reflection on chronic disease", annexed to this document

³ The EU HPF welcomes the use of the term 'chronic disease' instead of 'non-communicable disease' (NCD).

These terms are often used interchangeably but can cause some confusion because some chronic diseases or conditions have a infectious origin (e.g. HIV/AIDS)

⁴ <http://www.hsph.harvard.edu/news/features/features/noncommunicable-diseases-report.html>

⁵ AGE UK published together with Help Age International a Briefing on the eve of the UN summit on NCD stating clearly the issue of age-discrimination in the field of CD/NCD (ref. <http://www.helpage.org/get-involved/campaigns/non-communicable-diseases-lets-get-older-people-on-the-health-agenda/>)

8. Expects the present reflection process to lead to the **development of a European strategy on chronic diseases** aimed at eliminating avoidable diseases and premature death. The ultimate goal of an EU strategy on chronic diseases must also be to improve the health and quality of life of European citizens, including persons at risk of, or affected by, chronic diseases. The strategy should be based on the **common European values of universality, access to good quality care, equity and solidarity. It should adopt a holistic approach to health** that encompasses both physical and mental health and social integration. Health, after all, is not only a state of physical but also mental well-being, not merely the absence of disease;
9. Expects the above-mentioned strategy to **address key risk factors in a broad context, in conjunction with all relevant policies and sectors**, taking into consideration the pre-requisites and the social, cultural, gender/sex economic and environmental determinants of health in order to foster coordinated actions on the determinants which underpin the CDs epidemic across populations;
10. Notes that the European Commission (EC) **does not define chronic diseases or their scope**. For the purpose of this consultation and in line with the World Health Organisation (WHO) presentation of the subject matter⁶, the EU HPF focuses in this paper mainly on heart diseases, stroke, cancer, chronic respiratory diseases, diabetes, oral diseases, musculoskeletal, neurodegenerative and mental disorders;
11. Stresses the **need for an overarching goal and a set of time-bound targets** — for example an average increase of 2 healthy life years for EU citizens by 2020, as identified by the European Innovation Partnership on Active and Health Ageing; and calls for a 25% reduction of deaths from preventable cardiovascular disease, cancer, diabetes and chronic respiratory diseases by 2025⁷ in line with the call from the Non Communicable Disease Alliance⁸.
12. The EU HPF calls for a **drastic reduction of avoidable hospitalisation** and length of stay in hospital and verifiable measures of improvement in quality of life of those with chronic diseases;
13. Requests that the notions of “disability-adjusted life years(DALYs)”⁹, and of Quality Adjusted Life Years (QALYs) be part of the reflection process;
14. Considers that the **psychological and socioeconomic causes and impact** of chronic diseases are of too great importance to be neglected and must be incorporated into the consultation document and process;
15. Underlines that it **understands “prevention”** measures as including programmes for health maintenance and health literacy in primary¹⁰, secondary or tertiary approaches

⁶ http://www.who.int/topics/chronic_diseases/en/

⁷ This target is from the [Proposals on NCD targets from a WHO Technical Working Group](http://www.who.int/publications-detail/proposals-on-ncd-targets-from-a-who-technical-working-group)

⁸ <http://www.ncdalliance.org/>

⁹ Defined by WHO for a disease or health condition as “the sum of the Years of Life Lost due to premature mortality in the population and the Years Lost due to Disability (YLD) for incident cases of the health condition

¹⁰ **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 treated. 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. Tertiary prevention includes activities intended to cure, to ameliorate or to compensate. For example,

that differ in aims and target groups. Health promotion¹¹ should have an expanded and comprehensive role, and together with, disease prevention, chronic disease management and end of life care should be seen as aspects of a holistic continuum: effective prevention interventions can save resources of the healthcare system that can be used to provide high quality services for patients. Patients, when appropriately supported, can participate actively in society, including employment and avoid further complications and deterioration of their health.

16. Appreciates that the document concentrates not only on prevention, but also emphasises the role of treatment and care.
17. Stresses that the recommendations and proposed measures are to be seen in the light of **Article 168 of TFEU** and especially respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care.

2. *THE BURDEN OF CHRONIC DISEASES*

2.1. *Evidence on chronic diseases: data and prevalence*

1. Over 100 million citizens or 40% of the population in Europe above the age of 15 is reported to have a chronic disease¹².
2. 2 out of 3 people, who have reached retirement age, have had at least two chronic conditions.
3. Each year, 36 million people die prematurely from largely preventable chronic non-communicable diseases such as cardiovascular diseases, cancer, diabetes chronic respiratory diseases. This represents 63 per cent of the annual 57 million deaths globally.
4. It is predicted that premature deaths from chronic diseases will increase by 17% over the next 10 years if the roots of the problem are not tackled.
5. In the WHO Europe region, 59% of DALYs are attributable to behavioural determinants that are common to various chronic diseases.
6. Globally, Europe has the highest burden of chronic diseases which are responsible for 86% of all deaths.¹³
7. WHO considers the rise in chronic diseases an epidemic and estimates that this epidemic will claim the lives of 52 million people in the European Region by 2030¹⁴.

the avoidance of complications of the prevention of progress of disease would be classed as tertiary prevention.
Source: Van der Maas and Mackenbach 1999.

¹¹ For a definition of health promotion, please see: Tannahill A. What is health promotion? Health Ed J 1985; 44:167-8. and Downie RS, Tannahill C, Tannahill A. Health Promotion: Models and Values. Oxford: Oxford Medical Publications, 1996.

¹² http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/steering-group/operational_plan.pdf and European Chronic Disease Alliance, WHO Europe

¹³ WHO high level Consultation <http://www.euro.who.int/en/what-we-do/event/regional-high-level-consultation-on-noncommunicable-diseases> accessed June 23 2011

8. There are significant differences in how men and women are affected by chronic diseases. With very few, highly specific, exceptions, men are more likely at all ages to die from all of the most common causes of death recorded by Eurostat. By far the most common of these causes of death are cardiovascular disease and cancer, both of which are strongly associated with periods of chronic ill health particularly in later life.¹⁵ Women, on the other hand are more likely to suffer illness and disability in later life. **Gender differences** not only have a direct impact on the health behaviour, exposures, social factors, needs and access to care of women and men, but gender is now recognised as a specific risk factor for many diseases. Significant differences exist between women and men in their health needs and in their access to relevant resources.¹⁶
9. **Cardio-vascular diseases** cause nearly half of all deaths in the WHO European region. They cost the EU economy in excess of €192 billion a year¹⁷.
10. The financial implications of **cancer treatment and recovery** are starting to be assessed across Europe. Findings are pointing to increased costs for individual patients and families due to increased household costs, loss of income, lack of disability/illness allowances, use of savings for treatment and drugs (especially amongst young patients) and severe psychosocial effects such as fatigue and loss of self-confidence. Losses in productivity to cancer in the UK alone in 2008 were estimated at €6.6 billion related to cancer survivors and €8.81 billion related to cancer deaths¹⁸.
11. **Respiratory diseases:** the 5 major diseases, asthma, lung cancer, chronic obstructive pulmonary disease (COPD), pneumonia and tuberculosis cause a financial burden of over €100 billion in Europe due to health care costs and lost working days¹⁹.
12. **Diabetes** affects nearly 10% (52.8 million) of the adult population in the WHO Europe region and cost €131 billion in 2011²⁰. There is a wide variation in the prevalence of diabetes in the region, and in the mean diabetes-related expenditures per person with diabetes. Worldwide, in 2011, 366 million people were reported to have diabetes and this is predicted to rise to 552 million by 2030²¹.
13. **Oral diseases** are a major health burden in Europe, with the majority of adults reporting not having all their natural teeth²² and with the percentage of young people aged 6 to 19 years being affected by dental caries ranging between 42% in Sweden and 97,6 % in Latvia²³. Oral disease is the fourth most expensive disease to treat in industrialized countries²⁴ and maybe a risk factor to other chronic diseases. Worldwide, the cost of curative dental care in high-income countries is estimated to account for 5 to 10% of

¹⁴ United Nations General Assembly 19 May 2011 [Report by the Secretary-General on the prevention and control of non-communicable diseases](#) (A/66/83) accessed June 23 2011

¹⁵ White A. (2011) *The State of Men's Health in Europe*. Brussels: European Commission Directorate-General for Health & consumers.

¹⁶ ENGENDER Policy Brief <http://engender.eurohealth.ie>

¹⁷ European Heart Network (2008) European cardiovascular disease statistics 2008
¹⁸ (Policy Exchange, The Cost of Cancer, Featherson and Whitman, 2010)

¹⁹ Loddenkemper R, Gibson GJ, Sybille Y, editors. European Lung White Book, The first comprehensive survey on respiratory health in Europe, European Respiratory Society, ERSJ, 2003:16-25

²⁰ 3rd edition of the Policy Puzzle: Is Europe making sense, 2011, IDF Europe, FEND, EURADIA and PCDE

²¹ IDF Diabetes Atlas 5th Edition 2011

²² Special Eurobarometer 2010: Oral health

²³ The Oral Health Atlas, FDI World Dental Federation & Myriad Editions 2009

²⁴ http://www.who.int/oral_health/media/en/orh_report03_en.pdf

public health expenditure²⁵. In 2000, it was estimated that the total spending on oral healthcare within 16 Member States of the EU was €54 billion per year²⁶.

14. Almost 50% of work absence is due to **musculoskeletal disorders**²⁷.
15. The **economic cost of mental health problems in the EU** is estimated to be 3-4% of the gross national product (GNP) but expenditure on mental health constitutes on average only 5.8% of overall health expenditure. A 2004 review by Sobocki *et al*, "The Cost of Depression in Europe," calculated that depression alone had an economic cost for the EU25 and European Free Trade Agreement (EFTA) countries of up to €118 billion, or €253 per person per year. Among the measurable components of the economic burden are health and social service needs, lost employment and reduced productivity, impact on families and caregivers, levels of crime and public safety, and the negative impact of premature mortality
16. It is widely acknowledged that **70% to 80% of healthcare costs are spent on chronic diseases**. This corresponds to €700 billion in the European Union and this number is expected to rise in the coming years²⁸.
17. **97% of health expenses are presently spent on treatment, only 3% is invested in prevention**²⁹.
18. The **absence of reliable data** remains a barrier to assessing the true burden and cost of chronic diseases on individuals, communities, healthcare systems and economies in Europe. It also prevents governments from assessing the impact and effectiveness of national chronic diseases policies, programmes and treatment.
19. **Data on the social gradient of chronic diseases** and their risk factors is limited, with many health measures not being linked with policy monitoring systems of other sectors; current challenges include the inability to collect and analyse data from the health sector and other sectors and a lack of adequate measures of socio-economic status (equity stratifiers)³⁰.
20. There is a need to optimise the use of resources to ensure that our future health systems are able to address chronic disease risk factors and ensure equitable, high-quality care to citizens in a sustainable way – avoiding a situation where the funds **available for other health care, education, capital, savings**, food, clothing and shelter are reduced, thereby affecting the economy and people's overall quality of life³¹ and leading to increasing inequalities in health due to poor socioeconomic status³².

²⁵ <http://www.who.int/mediacentre/factsheets/fs318/en/index.html>

²⁶ Windstrom, E., Easton, K.A. (2004) Oral healthcare systems in the extended European Union. *Oral Health Prev Dent*, 2(3): 155-94

²⁷ Fit for Work Europe Report - <http://www.fitforworkeurope.eu/>

²⁸ See <http://www.oecd.org/dataoecd/43/9/48245231.pdf> and "The future of healthcare in Europe", The Economist Intelligence Unit Limited 2011 (http://www.eufutureofhealthcare.com/sites/default/files/EIU-Janssen%20Healthcare_Web%20version.pdf)

²⁹ Together for Health: A Strategic Approach for the EU 2008-2013, White paper, European Commission, COM(2007) 630 final

³⁰ ref. UCL, WHO Europe, Interim first report on social determinants of health and the health divide in the WHO European Region

³¹ Stuckler D, Siegel K (Eds.) *Sick Societies: Responding to the global challenge of chronic disease*. Oxford University Press Inc., New York, 2011; p.73

³² CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.

2.2. Consequences - impacts

1. **The outlook for the burden of the main chronic diseases is due to a balance of four contributory factors:** demographic changes with ageing of populations and shifts through migration; temporal and geographical changes in modifiable risk factors linked to urbanisation and economic globalisation; a relative decline in infectious diseases, meaning that people live long enough to acquire chronic diseases; and better medical knowledge, technology and insights that allow people to survive acute and critical cases, leading to a relative growth in chronic diseases.
2. **Patients with chronic conditions rely heavily on the health services.** The recently published **OECD “Health at a Glance 2011”**³³ report demonstrates *inter alia* that hospital admission rates are too high and would have been unnecessary if prevention and treatment by primary care had been better developed, in particular for asthma and diabetes. The findings of the report highlight the importance of strengthening prevention and management of chronic disease and ensuring a sufficient supply of primary care providers.
3. Chronic diseases **affect labour supply** in terms of workforce participation, hours worked, job turnover and early retirement as well as wages, earnings and positions reached. In a time of economic crisis, Member States and the European Union are looking at **cost savings and greater labour productivity or economic growth**, but these should not be the main criteria for evaluating specific strategies in chronic disease management. In order to understand the implications of chronic conditions and diseases, further economic implications should be examined. When one assesses the burden of chronic diseases, one must also take into consideration its impact on consumption and savings, quality of life in general, education, the employability of family carers and the domino effect on the general family income.
4. **Chronic diseases carry significant human costs** – the burden on individual patients, their families and carers, which is due to the effects of illness itself which can be physical, psychological, emotional, economic and social; chronic diseases also create vulnerabilities due to being dependent on timely access to safe, high quality healthcare and related support services; reduced capacity or non ability to work and the resulting loss of income and risk of poverty; the direct and indirect costs of illness; and social discrimination and stigma.

3. **PREVENTIVE MEASURES THAT PAY – WHAT MORE SHOULD BE DONE**

Corresponding to section I of the consultation document: “health promotion and disease prevention: what more should be done?”

Consultation questions:

1. *What additional actions and developments are needed to address key risk factors to prevent chronic diseases?*
2. *How can existing actions on primary prevention be better focussed and become more effective?*

³³ OECD Health Data 2011

3. *What potential is there for broad based early detection action?*
4. *In what areas is there a particular need for additional action at EU level?*
5. *In what areas is there a particular need for action at national level?*
6. *What will you/your organisation contribute to address this challenge?*

1. It is important to **adopt a life-course approach to health promotion** as the earlier the issue of healthy life-style is tackled, the better its impact. It is important to continue to deliver health promotion messages all through the life-course (and in different context: school, education institutions and the workplace) and to adapt the messages³⁴. For instance, it is important to re-address the issue of chronic diseases as people are ageing since the risk increases, recalling the need for healthy food and physical activities is still necessary and useful³⁵. Health promotion helps preventing chronic diseases thus improving healthy ageing and mitigating the rising costs of long-term care³⁶. The EC could take an active role in encouraging Member State action and ensuring the quality of the health information thus provided by setting out guiding principles to the need for evidence-based health information, free from conflicts of interest.
2. For some chronic diseases, especially those for which major risk factors are normally distributed throughout the population (e.g. serum cholesterol fractions, or blood pressure, in the case of CVDs), **population level prevention programmes** can be spectacularly effective and also cost-effective (in the UK, NICE issued guidance in 2010 on such programmes applying to CVD³⁷). Such population programmes would usually be implemented at Member State or regional levels, although some might be implemented at EU level (e.g. reform of the CAP designed to reduce the saturated fat content of the European diet).
3. Given that men and women have different risk factors and are affected differently by chronic diseases, in order to respond appropriately to their specific needs and to effectively prevent, mitigate and reduce chronic diseases, **prevention and health promotion programmes need to be made gender-sensitive**.³⁸
4. Health practitioners can positively encourage individuals to pursue a healthier life-style, sometime even with **brief interventions during consultations**: they can help individuals make changes to high risk behaviour such as smoking, poor nutrition, excess alcohol consumption and too little physical activity. Further than this however there is a broad need for healthcare providers to support individuals in developing an on-going awareness of their health (notion of self-help) and how to maintain it.
5. Providing **health education and training in schools, community centres, and health centres**, by creating posts of health maintenance teachers and managers in all those places and setting up audits of common illness prevalence among the populations where these health maintenance services are available will enhance health promotion. They would need to be supported by on-going media campaigns extolling their benefits. The

³⁴ AGE "Healthy ageing, good practice examples, recommendations, policy actions" (Sept. 2007).

³⁵ "Healthy Ageing, a challenge for Europe", 2007 - http://www.fhi.se/PageFiles/4173/Healthy_ageing.pdf

³⁶ OECD "Health Wanted? Providing and paying for long-term care", p.7 "Encouraging healthy ageing."

³⁷ Ref.: NICE public health guidance 25, at <http://www.nice.org.uk/nicemedia/live/13024/49273/49273.pdf>, extracted 28.12.11

³⁸ For example, a US study just published shows that women who take statins have a 48% greater chance of developing type II Diabetes. Ref coming

content of health literacy training should be elaborated in co-operation with competent health authorities in order to safe-guard health standards.

6. **Innovative prevention and treatment approaches could enhance prevention rates**, even if they are not yet taken into consideration by all health insurance/reimbursement systems.
7. There are **large variations between European countries and socio-economic groups as regards eating habits (e.g. consumption of fruit and vegetables), fresh food and vegetable availability, and the prevalence of smoking, alcohol consumption, obesity and physical activity**³⁹. For example, the prevalence of daily smokers in men varies 3 fold between EU countries and smoking rates are very high in Central and Eastern Europe. Countries with high rates of smoking combined with low rates of exercise and unhealthy diet are also countries with the lowest life-expectancy in the EU.

3.1. Acting on risk factors

1. The WHO estimates that if the risk factors associated with chronic diseases were eliminated, at least 80% of all heart disease, stroke and type-2 diabetes would be prevented⁴⁰.
2. There are big differences in lifestyles and living and working conditions depending on age, gender and socio-economic status with higher percentages of unemployed people that smoke (53% compared to 30% the median value EU27), or tend to drink too much alcohol (12% compared to 7% the median EU 27)⁴¹.
3. By having a healthy diet, being physically active, decreasing the level of alcohol, and stopping tobacco consumption, 75% of premature deaths from cardiovascular disease could be prevented⁴², as well as 30-40% of premature cancer deaths⁴³. Therefore, a targeted and cost-effective way to improve the health status of people in Europe is to focus on health promotion and disease prevention, using public health interventions⁴⁴.
4. Different approaches may be adopted when tackling risk factors for chronic disease and Member States might want to put the responsibility on the community or on the individual, depending on cultural views regarding the role of the state and individual autonomy⁴⁵ - e.g. on the one hand, environmental factors and social conditions; on the other hand, individual's choice to engage in risk behaviours such as tobacco, and alcohol consumption, a sedentary lifestyle, inadequate protection from the sun, or bad nutritional habits. Cost effective actions should therefore be adapted to the culture of the country and not be one-size-fits-all. However, the following general observations are relevant:
 - Some type of surveillance of European adult populations (e.g. by opportunistic or systematic screening) can be used effectively in respect of certain diseases (e.g.

³⁹ Cavallars et al., 1998, Mackenbach, 2006

⁴⁰ <http://www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases/cardiovascular-diseases>

⁴¹ Source EUROBAROMETER 283

⁴² O'Flaherty & Capewell S. Recent levelling of CHD mortality rates among young adults in Scotland may reflect major social inequalities. BMJ 2009; 339: b2613

⁴³ World Cancer Research Fund Recommendations for Cancer Prevention, 2008

⁴⁴ F. Sassi: Obesity and the economics of prevention: Fit not fat", OECD 2010

⁴⁵ Busse and Schlette 2007

diabetes) to identify undiagnosed cases; these can then be managed in the context of (diabetes) registers to facilitate effective long term treatment;

- Population based preventive measures can be radically effective in reducing⁴⁶ incidence and mortality rates, especially in respect of normally distributed risk factors, by altering the distribution of risk factors within populations.
5. The EU HPF believes that action on health promotion, disease prevention and education should be done **at EU and national levels in parallel**, with interventions that reach the whole population (including taxation and regulation). The EU HPF underlines that small changes in risk factors in the population can bring about dramatic health gains⁴⁷.

3.1.1. Health in All Policies and acting on common behavioural factors

1. From a Health in All Policies perspective, it is important to **involve non-health stakeholders** such as infrastructure and public transport actors in health policies aimed at increasing the population's levels of physical activity and facilitate social inclusion of all vulnerable groups. By ensuring proper design of buildings and public transportation systems, it is possible to encourage people to be physically active through taking the stairs, walking to the bus stop, and taking a bicycle to work instead of a car, as in the models set by "Smart Cities and Communities Initiative"⁴⁸.
2. Likewise, **agriculture and food production policies** should have inbuilt health-contributing tests established through appropriate taxes and use of subsidies, designed to curb population consumption of saturated fat (replacing some of this with unsaturated fat) and to encourage consumption of fruit and vegetables.
3. Physical activity and exercise should be encouraged throughout life **alongside a policy of including it in healthy living education**, throughout primary, secondary and tertiary education. Health promotion and communication measures without the above will yield poor return on investment. Models for healthy living at community level should be developed and financed.
4. **Supportive environments that encourage independence** are a key factor in reducing the economic burden of chronic diseases: the quality of life of patients can be enhanced through a supportive environment which includes enhanced urban planning and transportation policies. There is a strong link to the work done on age-friendly environments (EY 2012) and the Accessibility Act foreseen in 2012. These initiatives are very important for the dignity and rights of patients, their families and carers since they can substantially alleviate the economic burden of the disease. In addition, enabling environments are likely to mitigate the costs on healthcare systems by reducing the need for long-term care^{49 50}.

⁴⁶ A BMJ leader "United Nations' dietary policies to prevent cardiovascular diseases, BMJ 2011; 343: d5747; Capewell S, O'Flaherty M, Rapid mortality falls after risk-factor changes in populations, BMJ 2011; 378: 752-753; Capewell S, Ford ES, Croft JB, Critchley JA, Greenlund KJ, Labarthe DR, "Cardiovascular risk factor trends and potential for reducing coronary heart disease mortality in the United States of America, Bull World Health Organ 2010; 88: 120-130

⁴⁷ Capewell S, O'Flaherty M. Rapid mortality falls after risk-factor changes in populations. The Lancet 2011;378(9793):752-753.

⁴⁸ http://ec.europa.eu/energy/technology/initiatives/20110621_smart_cities_conference_en.htm

⁴⁹ See also a peer review that took place in October 2011 in Stockholm, on "Closing the gap. In search for ways to deal with expanding care needs and limited resources" – the paper presented by Sweden highlights the

5. Strategies for chronic diseases services should encompass **employment**, aiming to enable patients with chronic conditions to remain in employment for as long as possible. This is important for quality of life and to avoid exacerbating the financial impact of chronic diseases. An important part of such a strategy would be addressing discrimination and stigma against persons with chronic diseases through guidelines and education for employers, more awareness regarding non-discrimination legislation e.g. the EU Directive on Equal Treatment in the Work Place, and the use of Structural Funds for workplace adjustments, flexible arrangements and reasonable accommodation.
6. While health behaviours (healthy diet, maintaining an appropriate body weight, not smoking, moderate alcohol intake, and regular physical activity) are discussed separately under this heading, there is a lot of evidence that health risks increase dramatically if people show **several unhealthy behaviours**. For that reason, health promotion and disease prevention initiatives should whenever possible focus on multiple behavioural targets in order to maximise effects.
7. **Monitoring of social gradient in chronic diseases and their risk factors within and across countries** must be strengthened to fill in the gaps in existing knowledge, especially gaps relating to the effects and effectiveness of policies in the health sector and other sectors to address chronic diseases and their risk factors.
8. It should be ensured that the **potential synergies** in the areas of prevention and chronic disease management offered by a variety of initiatives, such as the Innovation Partnership on Active and Healthy Ageing and the 2012 Year of Active Ageing and Solidarity between Generations, **are fully exploited**.
9. **The EUHPF calls for stricter regulation and more transparent premium setting policies by private for profit insurance companies for people with chronic diseases**. It also calls for methods of consumer protection against malpractice by private for profit insurance companies to be researched and 'best practices' identified and disseminated to assist people with chronic diseases who need to query claims.
10. **Promotion of a wide approach on health literacy** such as defined by WHO⁵¹, meaning that education policy should encompass children and young people, as well as healthcare professionals who have a role to play in health promotion. Staying healthy is harder than just avoiding the lifestyle and psychological habits that contribute to and/or cause disease because it requires changing behaviours in a way that is often perceived to be less rewarding. Supported self-education develops the awareness of knowing one's human strengths and weaknesses and to understand the impact of one's actions on one's health and helps develop personal responsibility for one's own health.

comprehensive approach of this country that invest in health promotion and prevention, in accessibility and quality care – ref. <http://www.peer-review-social-inclusion.eu/peer-reviews/2011/closing-the-gap>

⁵⁰ http://cpme.dyndns.org:591/adopted/2011/CPME_AD_Brd_26112011_057_final_EN.pdf

⁵¹ "Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal *lifestyles* and *living conditions*. Thus, health literacy means more than being able to read pamphlets and make appointments. By improving people's access to health information, and their capacity to use it effectively, health literacy is critical to *empowerment*. Health literacy is itself dependent upon more general levels of literacy. Poor literacy can affect people's *health* directly by limiting their personal, social and cultural development, as well as hindering the development of health literacy." Ref: http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf

11. However, we should not overemphasise individual education interventions. The latter need to be supported by structural interventions and community-led interventions. The limited effectiveness of individual education interventions is in part due to the fact that **they fail to address the circumstances that lead people to choose unhealthy options**⁵². In line with this, structural interventions and community-led interventions that address unhealthy environments can help make it easier for people to be healthy⁵³.

3.1.2. Acting on diets and food consumption

1. The 2003 WHO report on “diet, nutrition and the prevention of chronic diseases” underlines nutrition as a major modifiable determinant of chronic disease, with scientific evidence increasingly supporting the view that **alterations in diet have strong effects, both positive and negative, on health throughout life**. According to Eurodiet, a pan-European project that started in 1998, nutritional factors and inactive lifestyles are implicated in 30-40% of cancers and at least one third of premature deaths from cardio-vascular diseases in Europe⁵⁴. Overweight and obesity resulting from unhealthy diet also increase the risk of type 2 diabetes⁵⁵.
2. The 2010 WHO review “the effect of fiscal policy on diet, obesity and chronic disease” indicates that **food taxes and subsidies can influence consumption** in high-income countries and that imposing substantial taxes on foods that are high in energy density but low in essential nutrients may improve health outcomes such as body weight and chronic disease risk.
3. Regarding obesity, the vast proportion of cases results from adverse lifestyle factors to do with poor diet⁵⁶ and/or lack of exercise. It may be argued that obesity cannot truly be defined as a disease but as a sub-standard state of health that predisposes to the development of a number of diseases. However, for the purpose of this consultation, the EU HPF considers that obesity is a risk factor of chronic diseases and a condition itself.

Therefore, the EU HPF recommends the following measures to tackle overweight/obesity and diet-related chronic disease:

4. **Regulation and fiscal measures:** subsidies on fruit and vegetables and special taxes on foods high in saturated fat, salt and added sugar, government regulation of advertising of unhealthy foods to children, compulsory nutrition labelling that people can understand; prohibitions of certain food products; mandatory compositional standards.
5. Primary-care based interventions: identification and counselling of individuals at risk.

⁵² Syme SL. The prevention of disease and promotion of health: the need for a new approach. Eur J Public Health 2007;17,4:329–330

⁵³ Stuckler D, Siegel K (Eds.). *ibid*, p.108-120

⁵⁴ http://ec.europa.eu/health/ph_determinants/life_style/nutrition/report01_en.pdf

⁵⁵ WHO Fact sheet EURO/13/05 of 12 September 2005: The challenge of obesity in the WHO European Region

⁵⁶ The global obesity pandemic: shaped by global drivers and local environments - Boyd A Swinburn, Gary Sacks, Kevin D Hall, Klim McPherson, Diane T Finegood, Marjory L Moodie, Steven L Gortmaker Lancet 2011; 378: 804–14

6. Adopting a **holistic approach and promoting health in all policies** (see below) to tackle chronic diseases by enabling health promotion through public policies. This commitment should be demonstrated by meaningful provisions in framework strategies adopted in these fields, such as the next Community strategy on health and safety at work.
7. Health education and health promotion⁵⁷: **mass media campaigns, school-based interventions, worksite interventions; programmes to promote diets containing adequate amounts of fruit and vegetables and low in fat, physical activity and moderate alcohol consumption.** Diet is crucial in the management/prevention of chronic disease and education is central to empower people and give them some control over their diseases. It must be noted that many people struggle with creating affordable, simple meals. A 'nutrition club', conducted on a weekly basis could be used to educate people on ways to improve their diet and would provide motivation and support. To address the needs of lower income areas, clubs need to be located in remote and/or rural areas as well as in urban low income areas. This type of club would provide cooking lessons, handouts containing recipes to attendees and advice on simple lifestyle changes that are easily implemented. This type of approach is most valuable in low income areas where people may not have access to information on diet.
8. **Supporting a work environment that promotes healthy lifestyles** (including mental health issues⁵⁸) and addresses health and safety in work policy. An area of special importance is that of older people and their transition between work and retirement. Corporate practices within the food system and government policies must encourage and enable healthy and sustainable food choices – through public procurement but also using fiscal or other policy mechanisms⁵⁹.

3.1.3. Promoting physical activity

1. The consultation document presents broad policy recommendations under the heading "health promotion and disease prevention: what more should be done?". However it is interesting to note that **promoting physical activity is not a component of the suggested actions.**
2. **Physical exercise is increasingly recognised as playing an important role in the prevention of cardiovascular diseases (CVD), diabetes and many types of cancers and other chronic diseases.** Regular moderate intensity physical activity – such as walking, cycling, or participating in sports – has significant benefits for health. For instance, it can reduce the risk of cardiovascular diseases, hypertension, diabetes, colon and breast cancer, and depression. Moreover adequate levels of physical activity will decrease the risk of a hip or vertebral fracture and help control weight. It is generally accepted that at least 30 minutes of daily exercise done at least 5 days per

⁵⁷ Rajgopal et al. (2002)[1] : Cost-benefit analysis of the 'Expanded Food and Nutrition Education Program' (EFNEP) in the US, The Expanded Food and Nutrition Education Program (EFNEP) is a federally funded program administered through Cooperative Extension and is designed to assist limited resource homemakers and other family members to acquire the knowledge, skills, attitudes, and practices necessary for a sound diet, with the long-term goal of improved health and disease prevention. The initial benefit-to-cost ratio was \$10.64/\$1.00, with subsequent sensitivity analyses producing ratios ranging from \$2.66/1.00 to \$17.04/1.00

⁵⁸ "Healthy ageing, a challenge for Europe" – Chapter 3

⁵⁹ Sustainable Development: a key to tackle health inequalities- UK Sustainable Development Commission, February 2010

week⁶⁰, such as brisk walking, swimming, cycling or dancing have shown to reduce risks of chronic diseases. There is strong and sufficient evidence that physical activity reduces the risk of several of the major cancers, and that between 9% and 19% of cancer cases could be attributed to lack of sufficient physical activity in Europe.

3. Enhanced planning of the urban environment will favour widespread engagement in every-day physical activity.
4. **People from low income households are the least likely to meet the recommended levels of physical activity.** They are also the most likely to be sedentary - achieving less than 30 minutes of physical activity per week. These low physical activity levels are significant cause of health inequalities with inactive groups suffering poorer health and living shorter lives than the general population.
5. The EU HPF recommends that **the involvement of employers' organisations and trade unions** is sought in order to consider improving working conditions for the European population, with a view to tackling exposure to workplace environmental risk factors such as poor air quality chemicals and radiation, reducing stress in the workplace due to poor management practices as well as promoting healthy eating, exercise and physical activity in a work related context. We encourage the European Commission to support and complement initiatives that seek to promote workers' health in this respect, and to use their competences on health and safety to improve the situation. The Faculty of Public Health of the Royal College of Physicians in the UK has published a leaflet⁶¹ which identifies practical steps that can be taken in order to improve health in the workplace together with lists of resources to help employers and employees implement such actions. The Finnish national public health programme also includes promoting healthier work places⁶². Information on European initiatives like the ones from OSHA (European Agency for Safety and Health at work) should be more publicly available.

3.1.4. Acting on alcohol consumption and smoking

The EU HPF promotes the following measures for tackling tobacco and alcohol as major chronic disease risk factors:

- pricing policies: taxes, minimum duties and minimum prices; and in particular a yearly 5% above inflation increase of taxes on all tobacco products;
- information and communication: limits on advertising and promotion, product displays and marketing of alcohol products; total ban of advertising, marketing and promotion of tobacco products; strong requirements for compulsory labelling of both tobacco and alcohol products;
- packaging: minimum size of packs of cigarettes; mandatory pictorial warnings covering 80% of the front and the back of packages of tobacco products in combination with plain packaging;

⁶⁰ CM friedenreich, HK Neilson, Brigid M Lynch, State of the epidemiological evidence on physical activity and cancer prevention, EJC 46, 2010

⁶¹ Creating a healthy workplace-
http://www.fph.org.uk/policy_communication/downloads/publications/leaflets/healthy_workplaces_leaflet_2006.pdf

⁶² <http://osha.europa.eu/en/publications/magazine/magazine11>, p.26 and <http://www.ttl.fi>

- substance modifications: ban ingredients which help make tobacco products appealing: flavours, sugar and other substances that make cigarettes more tasty and attractive especially to young smokers;
- consumption: comprehensive smoking bans in closed public places, bars and restaurants and in the workplace without restrictions, and the active dissemination of information on the harmful effects of smoking in the presence of children and pregnant women;
- smoking cessation: support and possible incentives for behavioural assistance and for following a proven effective treatment;
- product distribution: ban on sales to minors for tobacco products and alcohol; ban of cigarette vending machines; tobacco products to be displayed below the counters at the points of sales; sales of alcohol restricted to licensed retail outlets or during limited hours;
- combination of all: promote a strategy combining health promotion campaigns, government regulation and family doctor counselling
The OECD has shown that the latter would cost from USD 10 to USD 30 per capita per year depending on the country as opposed to the average OECD region USD 3184 health spending per capita per year.

3.2. **Early detection to optimise healthcare spending and provide better health for citizens**

1. **The EU HPF promotes screening for people at risk** (genetics, family history, etc.) at primary care level. 'Promoting' entails that early screening where this has proven to be effective should be communicated properly to people at risk, be made easily accessible and paid for by the national health system. Greater international cooperation, collaboration, implementation of effective, population-based, quality assured screening programmes, evaluation of social inequalities and development of novel tools to detect chronic disease in at-risk populations are all measures that should be encouraged. High risk groups may be identified through a simple questionnaire to assess risk factors such as age, gender, smoking habits, waist circumference, family history, cardiovascular history and gestational history. Good example of the use of such health risk appraisal procedures can be found in many workplace health promotion programmes.
2. The EU HPF also supports effective tertiary prevention for chronic diseases in order to prevent premature death, and costly treatments for complications. It has been shown that the most effective means of organising tertiary prevention is by the **establishment of disease registers for all populations**. These are already well developed in some Member States, especially in the case of diabetes. Such register-based services can reduce massively both premature mortality and serious complications. A recent report in the UK showed that nationally, 13,000 diabetes-related deaths could be saved annually through more effective use of diabetes registers. Support for the introduction of interoperable disease registers for diagnosed cases of chronic diseases throughout the EU should be encouraged.
3. We call for **more training on chronic diseases for primary and community healthcare professionals** - this would further enhance knowledge of risk factors and the early identification of chronic diseases.
4. The EU HPF stresses the strong need for **equitable access to early diagnosis**, followed by prompt treatment and support services. Early intervention is crucial to ensure good health outcomes and quality of life, as well as to avoid complications of chronic

disease that often lead to more complex and expensive medical interventions. For example in Parkinson's Disease, due to the motor and non-motor aspects of the disease, hospitalisation and healthcare use rates are high and the economic burden of the disease in both direct and indirect costs is high. However, early intervention has been shown to reduce the economic burden, to both the individual and to society.⁶³

5. **Investment in prevention can free resources to provide better quality healthcare for patients:** investment in high-quality chronic disease management can maximise patients' quality of life, reduce the disease burden on individual patients, and optimise their use of healthcare resources. Patients are also able to function and be economically active for longer, thus benefiting the economy and society as a whole⁶⁴.
6. While it can be justified to target early detection programmes to specific age groups for public health reasons, **age limits should not exempt (older) people from** screening programmes and everyone, in particular those in high risk groups, should have access to prevention programmes adapted to their individual needs. Ageism is still pervasive in the provision of healthcare across the EU and this requires measures to raise awareness among healthcare professionals and more generally in society of the need to combat all forms of discrimination including age discrimination in access to preventive and curative healthcare.

4. HEALTHCARE SYSTEMS

Corresponding to section II of the consultation document "healthcare".

Consultation questions:

1. *What changes could be made to enable health care systems to respond better to the challenges of prevention, treatment and care of chronic diseases?*
2. *What changes could be important to better address the chronic disease challenge in areas such as: financing and planning; training of the health workforce; nature and location of health infrastructure; better management of the care across chronic diseases?*
3. *How much emphasis should be given to further developments of innovations, including eHealth and Telemedicine in prevention and treatment of chronic disease such as remote monitoring, clinical decision support systems, e-health platforms and electronic health records?*
4. *In what areas is there a particular need for additional action at EU level?*
5. *In what areas is there a particular need for additional action at national level?*
6. *What will you/your organisation contribute to address this challenge?*

⁶³ The European Parkinson's Disease Standards of Care Consensus Statement, Vol. 1 (2011), pp.11-12, available at <http://www.epda.eu.com/parkinsons-consensus-statement>

⁶⁴ For example, the ParkinsonNet trial results published in the Lancet Neurology journal indicate that a ParkinsonNet network provides improved quality of care at substantially reduced costs compared with usual-care networks. Efficacy of community-based physiotherapy networks for patients with Parkinson's disease: a cluster-randomised trial, The Lancet Neurology, Volume 9, Issue 1, Pages 46-54 -Marten Munneke, Maarten J Nijkrake, Samyra HJ Keus, Gert Kwakkel, Henk W Berendse, Raymund AC Roos, George F Borm, Eddy M Adang, Sebastiaan Overeem, Bastiaan R Bloem

4.1. The situation

1. Many patients with chronic diseases receive sub-optimal care and there are quality issues with how this care is provided:
 - Only half of patients with chronic diseases are adequately identified
 - Only a minority of patients receive the proper care in the appropriate setting
 - Diagnostic registries are incomplete
 - Evidence-based guidelines are not followed
 - Hospital readmission rates are unnecessarily high
 - Patient centred care, including patient self-management support is inadequate
 - Advice on prevention and healthy lifestyles to patients from health professionals from primary to tertiary care is often inadequate or missing altogether
 - Continuity in care between the primary care and hospital settings, as well between social- and health care is inadequate
 - Compliance with clinical management and adherence to therapies are poor
 - Too little training in communications and psychosocial support amongst healthcare professionals
 - There are difficulties accessing information about planned and on-going clinical trials and the results of these trials
 - There is a lack of information to patients on health-related issues, including medical and non-medical treatment options, and options in cross-border healthcare
2. In an ageing population, the increasing prevalence of **multiple chronic diseases (comorbidity) presents a particular challenge**. There are complex causal relationships between chronic diseases, which are often likely to occur together and an unhealthy lifestyle can be the common cause of more than one disease in one patient. More than half of all older people have at least three chronic conditions, and a significant proportion has five or more. These are often unrecognised and untreated.⁶⁵ The presence of comorbidity often indicates greater severity and poorer prognosis of chronic disease. The clinical management of patients with comorbidity is much more complex and time-consuming than that of those with single diseases.
3. Most healthcare services today are still structured around acute episodes and curative healthcare. However, tackling chronic diseases effectively requires a **long-term and complex response**, involving coordination of primary care health professionals with different medical specialists with access to the necessary drugs and equipment, and extending into social care.
4. **Workforce shortages and the sustainable management of health professionals' mobility** is a major concern for health equity and health systems' capacity. Both are vital to safeguard patient safety and quality of care across the EU. The EU Commission estimates a shortage of one million⁶⁶ health professionals by 2020 if action is not taken. A lack of health professionals will result in 15% of care services not being delivered due to lack of resources⁶⁷. This is particularly relevant in the context of the on-going economic and financial crisis, which has triggered cuts in healthcare spending and increased cross-border mobility of health professionals at all levels.

⁶⁵ F Luppi, F Franco, B Beghe, LM Fabbri (2008) "Treatment of chronic obstructive pulmonary disease and its comorbidities", ProcAm Thorac Vol. 5. Cited in the EIP-AHA Operational Plan, p. 26.

⁶⁶ European Commission Communication "An Agenda for New Skills and Jobs: A European contribution towards full employment", /* COM/2010/0682 final */.

⁶⁷ Sermeus W., and Bruyneel L. "Investing in Europe's health workforce of tomorrow: Scope for innovation and collaboration," p. 11

4.2. **Recommendations: shifting focuses, organisational models and approaches**

1. Health systems need to shift away from a reactive, treatment model of healthcare towards a **more pro-active, inclusive, planned and structured approach**, adopt a model that embraces prevention (primary, secondary, tertiary) health promotion, health maintenance and patient-centred chronic disease management.
2. In the context of the financial crisis, it is imperative to address financial cuts, savings and restrictions that have a high impact on chronic diseases prevention, care and management⁶⁸. **Re-orienting primary care to focus on preserving health and preventing disease requires funding** to be directed to the restructuring of primary care delivery. This includes education and provision for financing highly educated, motivated and competent health professionals, enabling them to deliver preventive health actions: e.g. lifestyle counselling, advice on healthy work-life balance, screening, early diagnosis services and health promotion/education in general.
3. The strategic **strengthening of primary healthcare** systems must be a central component of any reform processes aiming to overcome obstacles to increase access to healthcare⁶⁹. As a key pillar for the promotion of access to primary healthcare, governments should strategically invest to support their primary healthcare workforce and its services⁷⁰.
4. To effectively address *comorbidity* it is necessary to adopt **integrated care plans and disease management programmes** centred on the patient (often frail and older) rather than the disease, including lifestyle modifications, implementation and dissemination of good practice guidelines, training of health professionals, promoting holistic models with measurable outcomes, implementing innovative, user-friendly technologies to enable self-management and monitoring. These programmes are not equally available to the majority of the patients in the different Member States. Integrated care must bridge institutional boundaries between primary care and the acute setting, as well as between social and health care. The programmes require standards, clear objectives and quality assurance mechanisms; they should be supported by networks and clinical pathways that cut across the traditional boundaries of healthcare delivery. Healthcare professionals should furthermore be better equipped with the skills, resources and infrastructure to adequately diagnose and treat comorbidity in patients. The European Commission should encourage a planning of resources at national level which accommodates this need.
5. We recommend greater investment in **deinstitutionalised contexts** centred on the community. For example, long-term care may involve a range of support services such as assisted housing, food delivery, physical and psychological support services, home medical visits or installation of specialist medical equipment etc. This greater integration in organisation and delivery of health and care services should be reflected consistently in the European Commission's approach. Patients with one or more chronic diseases generally need more frequent visits at home or in community settings for follow-up and monitoring to prevent further complications, and also for advice on self-care and lifestyle.

⁶⁸ The Lancet on the greek situation: <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2961556-0/fulltext>

⁶⁹ World Health Organisation WHA62.12 Primary Healthcare, including health systems strengthening. Sixty Second World Health Assembly. 2009.

⁷⁰ International Council of Nurses (2011). Closing the gap: increasing access and equity: International Nurses Day 12 May 2011. ICN. Geneva, Switzerland.

6. The **continuum of care** concept must address all aspects of preventing and treating chronic diseases in an integrated way (primary prevention, early detection, care, secondary and tertiary prevention) as well as different age groups of the target population (children and youth, families, active population, and elderly).
7. **Psychosocial** assessments should be done at the point of diagnosis to help patients and care givers to receive and provide the appropriate resources throughout the patient pathway. **Chronic stress** is often a precursor to chronic illness. Consideration should therefore be given to implementing a referral scheme where GPs could refer patients to existing interventions and appropriate therapies (including treatments).
8. **Social inclusion, particularly of older people with chronic diseases or cognitive impairments, should be supported.** The EU and Member States should co-operate on providing solutions, pooling socio-economic evidence on return of investment and viable business models for innovation, building on users' experience, and diffusing this information for re-use. Proven solutions with validated socio-economic evidence on the benefits for users and return on investment and viable funding models should be widely implemented⁷¹.
9. **Enhanced health literacy** is essential to ensure patient empowerment and meaningful involvement of patients in managing their health, which is crucial for improving adherence to therapies and lifestyle advice, among other things. This can be promoted *inter alia* through the development of innovative tools and applications of new evidence-based approaches to medicines at community level .
10. Patient **involvement/empowerment** is among the shared operating principles of European health systems, as recognised in the Council Conclusions of 2006; nevertheless in practice there is wide divergence across the EU in the level of involvement. The Chronic Care Model⁷² is an example of a widely used generic model for the management of care services for chronic diseases; it recognises patients as active participants in self-management, and the importance of patient empowerment and health literacy. The latter is seen as a key strategy to equip patients to take on this role and to motivate patients to take more responsibility for their own healthcare.⁷³ Patient empowerment⁷⁴ is a crucial component of patient-centred healthcare, but also an indispensable part of the future sustainability of European health systems, to enable them to cope with the challenges posed by organizational and structural reforms, the increasing prevalence of chronic conditions, and innovative technologies. Patient empowerment should therefore include dealing with socio-economic factors in the health care setting at the point of diagnosis and after treatment, such as the provision of advice about finances, private insurance (eg life, health and travel insurance) and employment options
11. **Patient-centredness** is increasingly recognised as a core component of high quality care, in line with the overarching values of universality, access to good quality care,

⁷¹ For further reference, please see the Strategic Implementation Plan of the European Innovation Partnership on Healthy and Active Ageing

⁷² Wagner, E.H. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998;1:2-4.

⁷³ More information available on the "homepage" of the CCM at http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

⁷⁴ Empowerment is defined as a process that helps people gain control over their lives, increasing their capacity to act on issues that they themselves define as important. (ref)

equity and solidarity⁷⁵. In the future vision of healthcare systems, patients should be perceived not only as recipients of services and benefits but in equal measure as empowered citizens and active participants of societies including the labour market.

12. Adequate **training and support to carers** can yield a double saving (formal and informal care): to people with chronic conditions, by supporting them to stay in their own homes and benefit from good care; and to the carers themselves (who are often older people) by ensuring that they remain in good health and mentally fit⁷⁶.
13. Better, complete and unbiased monitoring of patients, sometimes seeking care abroad should be promoted inter-alia through European Reference Networks.
14. The above would entail an agreed common package of indicators/parameters that will allow specialists to compare country statistics and results.

Tackling health inequalities

15. **Poverty and poor health literacy are other key risk factors in chronic diseases.** More specifically targeted cohesion funds could have an impact on both of these especially the latter, while the factors determining poverty overall are perhaps beyond the scope of this consultation. The risk of dying from chronic diseases in low socio-economic groups was found to be 25 - 50% to even 150%⁷⁷ more than in higher socio-economic groups and relative inequalities in mortality have increased in several countries. Chronic diseases are often a direct outcome or a cause of health inequality;
16. In many chronic diseases, **inequalities persist both in terms of access to healthcare and the quality of that care.** The EU and Member States must adopt effective measures to ensure equitable access to healthcare, eradicate poverty, address the environmental impacts on health and the generally poorer levels of health literacy in lower socio-economic groups as well as the causes of addictions.
17. The Strategy should aim to **identify and highlight good practices on how inequalities, relating to specific patient populations and genders, can be addressed** – whether in physical or mental illness, urban or rural environment, or diverse cultural contexts. A mechanism should be developed to ensure that identified “critical success factors” can be transferred into more ambitious, large-scale policy and projects.
18. A better understanding of **differences in the social distribution of environmental risk factors** can be helpful for policy, since specific population groups such as those on low incomes, children and the elderly, may be more vulnerable, mostly due to their health, economic and educational status, access to health care and lifestyle factors that affect their adaptation and coping capacities⁷⁸.
19. Due to the strong influence of social determinants on health inequalities it is essential that this **discussion is pursued with stakeholders and decision-makers from sectors beyond healthcare**, in particular social services, employment and education.

⁷⁵ S Jayadevappa and S Chhatre (2011) “Patient-centred care – a conceptual model and review of the state of the art”, *Open Health Services and Policy Journal*, 4, 15-25

⁷⁶ EIP-AHA Operational Plan, adopted on 7 November 2011, page 26. Available at http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=implementation-plan

⁷⁷ Mackenbach; Johan. “*Health Inequalities: Europe in Profile*,”p. 6.

⁷⁸ OECD, 2006., The distributional effects of environmental Policy. SerretY.; Johnstone, N. (Eds.) Paris

Healthcare professionals

20. The EU Member States must ensure an **adequate supply** of highly qualified health professionals across the entire Union, including poorer Members States and rural areas, so that mobility of professionals and patients becomes not economically-driven but a personal choice. To achieve this, long-term investment in health systems, including via the modernisation of the Directive 2005/36/EC on the recognition of Professional Qualifications, in education and training, and in infrastructure is imperative so that recruitment can occur equitably, institutions are well equipped, and qualified staff can be retained. The EU HPF strongly recommends an increase in the numbers of health personnel trained and effectively employed in health systems, where such an increase is justified by appropriate forecasting of workforce needs.
21. The EU and Member States must **plan resources and training of personnel** to ensure they have the skills needed to implement holistic, patient centred care, including better integration of prevention recommendations into the practical advice to patients and families⁷⁹. There should be a shift of the provision of services towards communities, collaborations with community leaders, to generate and maintain health and prevent diseases. Posts of health counsellors and community health generating/promotion managers should be established, public health programmes should be integrated with disease treatment mechanisms resulting in a holistic approach to the whole person and families. Audits at national and European levels of the impact of such an integrated approach should be carried out. Knowledge and skills from other healthcare traditions where the primary focus is on health generation and disease prevention should be introduced in the curricula, when they are evidence-based.
22. Different **healthcare professionals** (medical doctors, dentists, nurses, midwives, physiotherapists, etc.) should **be encouraged to share knowledge about chronic diseases and work together** at all levels, rather than attempting to tackle each chronic disease in isolation. Healthcare professionals need to be trained in risk factors and symptoms of major non-communicable chronic diseases at undergraduate level and during continuing professional development (CPD), to enhance prevention and increase the possibility of an early diagnosis of chronic diseases.
23. **Healthcare professionals must be supported and rewarded for promoting healthy lifestyle**; there should be an investment in education and training for health professionals that encourages patients to lead healthier lifestyles and primary care systems must be awarded the necessary financial and human resources to effectively implement health promotion and prevention. Health care professionals could have incentives for promoting preventive measures and for providing continued care.
24. **Discussion should be held on how to finance the necessary changes in the healthcare delivery system** encompassing all stakeholders such as patients, care providers, insurance institutions, public authorities and industry. **New business models** should be defined in order to overcome the increasing cost of healthcare, the cost of necessary innovation and research in a way that financing of care delivery and medical innovation is sustained but still keeping the goals of care delivery for all citizens. This discussion could consider the potential role in healthcare system of for example Public Private Partnerships.

⁷⁹ WHO Global Strategy on Diet, Physical Activity and Health, para. 45.

Care, medicines and treatments

25. The EU and Member States must ensure **access to essential care**, treatment and other vital therapy, especially in some of the poorer countries and rural areas of Europe.
26. **The EU and Member States must promote adherence to treatment** complemented by adherence to healthy life styles especially in the case of chronic diseases where there is room for improvement of the health condition and quality of life of patients. It is their role to better coordinate provision of healthcare among different settings to support adherence. There are specific issues to be taken into account: over medication is a big concern and has a major impact on adherence, in particular for older people⁸⁰. Adverse-drug reactions is another concern that could be addressed with appropriate medication safety systems in place⁸¹ and by enhanced coordination among healthcare professionals and with care staff and informal carers. Strategies to promote adherence should be based on the concept of concordance⁸² and encompass health literacy, user-friendly information, and improved patient-health professional communication.
27. We invite the EU and Member States to adopt the **recommendations of the Steering Committee of the EIP on AHA on “Care & Cure”** and to pilot multi-morbidity case management, with new models of care for a range of chronic conditions, including protocols and individualised care plans. This should also include support the dissemination and implementation, as appropriate, of protocols, education and training programmes for health professionals, care personnel and informal/family carers with special attention to emerging roles and comprehensive case management, for example on frailty, multi-morbidity and remote monitoring.
28. Reform of healthcare systems to meet the recommendations above should be accompanied by **reform of education systems to include health literacy** and healthy living practices as a core subject.

5. RESEARCH

Consultation questions:

1. *How should research priorities change to better meet the challenges of chronic disease?*
2. *In what areas is there a particular need for additional action at EU level?*
3. *In what areas is there a particular need for additional action at national level?*
4. *What will you/your organisation contribute to address this challenge?*

1. The EU HPF recommends that **research focuses on innovation, health prevention, promotion, compliance and integrated care**. Research on *Public* health should remain as a core principle to orient research efforts towards a healthier society. Disease prevention and health promotion are crucial and researchers must bear it in mind when

⁸⁰ WHO recommendation on no more than 4 different medicines a day. – WHO Drug for the Elderly:

<http://www.euro.who.int/en/what-we-publish/abstracts/drugs-for-the-elderly.-second-edition>,

⁸¹ W Kaplan and R Laing (2004), WHO report ‘Priority Medicines for Europe and the World’, pp. 90-91. Available online at <http://archives.who.int/prioritymeds/report/final18october.pdf>

⁸² Note that concordance is not synonymous with adherence. Concordance is a key concept of patient-centred care, with the aim of creating a “therapeutic alliance” between physician and patient. See: *Br J Clin Pharmacol*. 2007 November; 64(5): 710–711.

establishing evidence and guidelines that will have an impact on EU citizens, to maintain main optimised health within and across disease groups. Innovation is needed for integrated chronic disease care⁸³ in order to identify examples of models that ‘work’ from the users’ viewpoint in delivering good quality services, and to identify ‘critical success factors’ or common elements of such models that are transferable across EU Member States and disease areas.

2. Research is needed **to identify which behavioural determinants for diseases are most cost-effectively** addressed through population level prevention, and similarly to identify the most cost-effective application of screening for diseases or for risk factors.
3. Even though each Member State will have their own challenges, we believe that the management of chronic diseases constitutes a common framework to work together. The **EU level needs to serve as the umbrella to interconnect, boost and upgrade the resources that already exist at national/regional level**, creating partnerships and avoiding unnecessary duplication. A coordinated research agenda is crucial to eliminate unnecessary replication and target research funds effectively.
4. The current Seventh Framework Programme (2007-2013) has a leading field for Health and within this a sub-programme for Public Health. Yet analysis of the funding allocated so far shows that the allocation broadly described by the European Commission as research for **public health research** (which includes some clinical research) has **averaged just 5%, and in 2011 fell to 4% - just €26 million out of a total €650 million**⁸⁴.
5. Research should **be designed to answer the questions of concern for the end users in a complex society**. Research driven by users’ needs has a greater possibility of leading to innovative solutions that meet the real needs of end-users. The involvement of patient organisations, and other civil society organisations, in research projects should be made easier with simpler rules, less bureaucracy, and adequate funding. Research should also be better synchronised between different funding programmes.
6. In order to better connect the person/community for whom it has been designed to the research outcomes, **the Commission should improve the evaluation and dissemination mechanisms for research findings**, so as to ensure that evidence-based, valid information can be communicated to the relevant target audiences more effectively.
7. **More research** should be undertaken on the processes underlying **prevalence and incidence of chronic diseases – but also on their impact** on the daily lives of patients, families and caregivers. Some research should be performed to study to what extent the increase in chronic disease incidence is due to the conversion of deadly diseases like cancer or CVD to chronic diseases. If the increase results from patients surviving such diseases, this contribution to the increase has to be separated out from other contributions due to lifestyle changes (e.g. obesity-induced diabetes, smoking-induced COPD etc.).

⁸³ Innovation should be understood in a broad sense as including social and organisational innovation, low-tech, and people-focused – for example in the design of health and social care systems, and how care is delivered. Innovation should be valued for its potential to improve the quality of health services, quality of care and quality of life, while increasing equity of access.

⁸⁴ McCarthy M: Who supports health research in Europe? European Journal of Public Health, 2010, 20(1):3-5

8. Although many individual chronic conditions are treated well by existing medications in isolation, **treatment of multiple morbidities** is an area where **additional R&D** is needed.
9. Horizon 2020 should include EU wide studies of **the actual effectiveness of current approaches**, of projects that create self-responsibility for health and promote health maintenance in general as well as specifically for chronic disease, and of pilot projects of the integrated approach mentioned above. The EU HPF stresses the need for studies of the integration of evidence-based conventional and non-conventional health care for chronic conditions that includes evaluation of the impacts on personal health, productivity and cost effectiveness.
10. Special consideration should be given to **the social determinants** of health. EU funding should take account of social innovation activities providing more funding to these activities and not only to promote technological development. Qualitative research on the experiences and needs of healthy citizens, patients, health professionals, social workers, is important and often neglected. More research is needed on societal and environmental factors that make unhealthy choices the easiest choices. If we could figure out how to eliminate the avoidable inequalities in chronic diseases by social class or education, the reduction in the levels of chronic diseases would be greater than by applying preventive medicines.
11. **Research policy should aim to create patient-centred, and personalised healthcare approaches.** The value of a coordinated approach to the research field as well as the added value of evidence for public health interventions on health inequalities and the wider determinants of health has been demonstrated and has resulted in better public health interventions, new management of chronic conditions, innovative ways of providing healthcare, technology to allow self-management, educational tools for prevention and compliance and health promotion, and increased understanding about the associations between diet, alcohol consumption, tobacco use, and the environment with health. The outcomes of health research in the EU can improve health policy and support health initiatives on the local, regional and national level.
12. The EU should **establish priorities for data to be centrally collected** and support standardisation to obtain and provide **comparable, gender and age disaggregated** data that will allow better planning across the EU. The EU does not have a sufficient data set for a number of diseases. In some areas, a lot of research has taken place but the collation and exchange of knowledge between concerned parties has been inadequate. More efforts need to be made to coordinate and consolidate the research that has already been conducted in different areas and in various Member States, in order to implement the results for better evidence-based policy making and link it to current practices. A reliable data set should be developed for the evolution of obesity, chronic diseases, including cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases – the prevalence of which is increasing in Europe and globally.

6. INFORMATION AND COMMUNICATION TECHNOLOGY

Consultation questions:

1. *What more needs to be done on the development of information and data on chronic disease?*
2. *In what areas is there a particular need for additional action at EU level?*
3. *In what areas is there a particular need for additional action at national level?*
4. *What will you/your organisation contribute to address this challenge?*

1. **Innovation**, in all its forms – technology, process and social – can be a crucial **contributing factor to improving the health and well-being of citizens**, as well as the sustainability of care systems, and to enhancing Europe's global competitiveness and growth. Innovation should be based on a user-centred approach.⁸⁵ From an equity perspective and an economic perspective, it is key to ensure that eHealth does not create new inequities between the 'have and have nots' of eHealth services and remains as the provider of cost cutting measures that are essential to ensure sustainability of quality health systems.
2. **eHealth has huge potentials in fostering communication and collaboration** between the healthcare team with clear implications for safety, quality and efficiency; especially valuable for individuals with long-term conditions, and improving access to the health system. Electronic records, ePrescribing, and telehealth services such as tele-consultation, tele-diagnostic, tele-training, tele-monitoring are or start to be in place in many EU Member States with successful results. The role of technology to engage the general public in health education and promotion activities (such as health websites/portals on lifestyle advice and campaigns) is a reality. For patients with chronic conditions in particular, eHealth can significantly improve health outcomes and quality of life. For instance, tele-monitoring can empower patients with diabetes to monitor and report their glucose levels to healthcare professionals on a continuous basis, without having to disrupt their professional or personal lives⁸⁶. Appointments with healthcare professionals can be conducted on the basis of accurate data, saving time and allowing for a more structured dialogue.
3. **ICT supports the modernisation of the whole care system** (e.g. facilitates the integration between healthcare services, as well as between social and healthcare).

⁸⁵ European Innovation Partnership on Active and Healthy Ageing, *Strategic Implementation Plan* adopted by the High-Level Steering Group on 7 November 2011.

⁸⁶ Practical examples of this type of services can be found at www.renewinghealth.eu/health-services. The Renewing Health project (REgionNs of Europe WorkINg toGether for HEALTH) is a European project, partially funded under the ICT Policy Support Programme, by the European Union. It aims at implementing large-scale real-life test beds for the validation and subsequent evaluation of innovative telemedicine services using a patient-centred approach and a common rigorous assessment methodology.

⁸⁶ Another example of this, with a lower level of technology, but with high benefits can also be found in the "Sophia" project in France, telephone-based services aim to improve the quality of life of people living with diabetes: nursing professionals act as health counsellors – in support to the primary care level – and are available by telephone to give support, information and advice to people on the management of their diabetes. The health counsellors act as intermediaries between general practitioners and people with diabetes with the aim of limiting health complications (IDF Europe, Diabetes Policy Puzzle: Is Europe making progress ?, 3rd Edition, 2011).

eHealth can contribute to the empowerment of patients, alleviate the administrative burden and allow for more quality time and efficiency for staff. eHealth technologies should also assist healthcare professionals in their work by allowing for prompt communication with other healthcare professionals (thereby supporting a multidisciplinary approach) and with patients, hence saving valuable time which can be re-oriented to direct patient care where professionals are needed most.

4. **eHealth enables efficiency, quality and continuity of care but requires:**

- Continuity of communication and standardised information systems at all levels to provide holistic and integrated care for European citizens;
- Community care facilities equipped with interoperable eHealth services to support channels of communication among healthcare professionals;
- Support in the implementation of eHealth services by users;
- High standards of cooperation, active flows of communication, team working and multidisciplinary approach within integrated delivery systems having patients empowered and health professionals responsible for the healthcare delivery access to the information;
- Training and better understanding of the capabilities of ehealth and tele-health for both healthcare professionals and patients;
- Evaluation of existing initiatives since not all eHealth interventions are equally effective.

Based on the above, the EU HPF recommends:

5. **Enhancing “e-health literacy” of patients and carers** as a key requirement for the acceptance and confident use of ICT-based tools. Whether eHealth services will ultimately be adopted on a large scale depends on users, including the patients’ perceptions of real benefits and safety of these services and interest in using them. Other barriers include low awareness of existing solutions by patients and health providers, organisational barriers such as ‘silo’ budgeting, lack of clarity concerning reimbursement, need for training in new skills and competences.
6. That the following steps are implemented to **improve awareness raising and empowerment among patients and citizens**:
 - End users should be included in the design of eHealth solutions from the outset to ensure that they respond to their needs (i.e. designed appropriately) and that they will be implemented properly;
 - Given the novelty of eHealth solutions, it is essential to **find new ways of communicating on eHealth** not only to patients but also their families/caregivers so they can help the patient, should there be a problem with the eHealth solution;
7. **Exploring synergies with the priority areas set by the European Innovation Partnership on Active and Healthy Ageing** that seek to break down barriers to the uptake of ICT-based solutions such as eHealth, as part of the EU strategy on chronic diseases;
8. Fostering the deployment and take up of **interoperable eHealth and independent living solutions** based on open standards as interoperable solutions in order to contribute to the defragmentation of the market, hence allowing more affordable technology solutions.;
9. Fostering the deployment and take up of proven eHealth solutions, **by supporting research and innovation work**. However, to do this properly, it is essential to take stock of existing developments. EU should play a prominent and open role in the establishment of a set of accepted ICT standards for terminologies and communication.

10. Service innovation should focus on **both high tech and low tech eHealth solutions** ⁸⁷;
11. **Support for Electronic Health Records** development as they are a foundation for most of the eHealth services. In the context of chronic disease management, they can also be used to track patients likely to develop chronic diseases or to monitor patients' medication and treatment regimes.
12. Action to provide a better overview of the different projects funded at EU level in the area of ICT and chronic diseases along with their results with the aim of establishing a strong evidence-base and encouraging Member States/Health authorities to invest further in it.
13. The introduction of eHealth will lead to fundamental changes in the healthcare professional-patient relationship, which must be acknowledged and planned for through developing the right competences for health professionals and patients.

7. ROLES OF MEMBER STATES, THE EU AND STAKEHOLDERS

Consultation questions:

1. *What additional activities on chronic disease beyond the four areas described above should be considered at EU level?*
2. *How can the EU engage stakeholders more effectively in addressing chronic diseases?*
3. *How can EU Member States engage stakeholders more effectively in addressing chronic diseases?*

1. To ensure an effective EU strategy on chronic diseases, it is essential that **all relevant stakeholders**, including patient organisations, older persons' organisations, youth organisations, health professionals' organisations, and health and civil society organisations, are engaged and involved in the policy-making process as well as implementation of the strategy. The EU and Member States must exclude the tobacco industry from any engagement in addressing chronic and other diseases, thus respecting the FCTC Article 5.3 they ratified: *"In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law."*⁸⁸

The EU HPF calls for an enhanced stakeholder dialogue to:

2. **Ensure coherence with on-going WHO and UN initiatives in this field**, to avoid unnecessary duplication and to benefit from the work already done so that we can make a real step forward.
3. **Ensure coherence and synergies among EU initiatives/policies**: for example the European Innovation Partnership on Active and Healthy Ageing addresses partly the challenge of chronic diseases and would gain in efficiency if coordinated with a strong strategy on chronic diseases based on health promotion throughout the life-course. The European Year 2012 on Active ageing and Solidarity between generations will also be a

⁸⁷ See footnote making reference to the "Sophia" example (IDF Europe, Diabetes Policy Puzzle: Is Europe making progress ?, 3rd Edition, 2011)

⁸⁸ <http://whqlibdoc.who.int/publications/2003/9241591013.pdf>

good opportunity to foster an EU strategy on chronic diseases for example by promoting independent living and thus better quality of life for older people living with chronic diseases. Last but not least, we could refer to the strategy to be developed on long-term care since DG EMPL will publish a staff working paper in 2012 and a Communication in 2013: again ensuring coordination with an EU strategy on chronic diseases would reinforce the two. That same synergy could be achieved with the eHealth strategy.

4. **Improved cooperation among different EC DGs** that could have an impact: DG SANCO, DG EMPL (health inequalities, issues around healthcare staff and carers, health and safety at work, long-term care issues, link with the social Open Method of Coordination), DG JUSTICE (Accessibility Act and Fundamental Rights issues), DG TREN (transport), DG AGRI, DG RESEARCH, DG INFSO (eHealth and eInclusion), DG EAC (education as well as physical activities), DG ENVI, etc.
5. **Increase consultation with healthcare providers, patient groups** and more generally with **civil society** organisations such as consumer organisations, older people's organisations – to find out where they feel support is most needed and how they can be helped. We suggest some consultation with non-traditional medicine providers so that their contribution can be assessed and understood. In this sense, appropriate mapping of relevant stakeholders is essential for a long-term sustainable chronic disease strategy.
6. **Create innovative partnerships** in which the key relevant stakeholders are the leaders supported by the relevant EU resources to guide the development of the concept, the proposed actions, their management and their implementation.

This consultation response represents the collective views of members of the EU HPF, excluding.

The following organisations contributed to the drafting of this paper:

1. **AESGP** Association of the European Self-Medication Industry
2. **AGE** European Older People's Platform
3. **ASPHER** Associations of Schools of Public Health in the EU Region
4. **BEUC** Bureau Européen des Unions de Consommateurs
5. **CED** Council of European Dentists
6. **COCIR** European Coordination Committee of the Radiological, Electromedical and healthcare IT Industry
7. **CPME** Standing Committee of European Doctors
8. **ECHO** European Confederation of Care Home Organisations
9. **ECL** Association of European Cancer Leagues
10. **EDMA** European Diagnostic Manufacturers Association
11. **EFCAM** European Federation for Complementary and Alternative Medicine
12. **EFN** European Federation of Nurses Associations
13. **EFPA** European Federation of Psychologists Associations
14. **EFPIA** European Federation of Pharmaceutical Industries and Associations
15. **EGA** European Generic Medicines Association
16. **EHMA** European Health Management Association
17. **EHN** European Heart Network
18. **EHTEL** European Health Telematics Association
19. **ENSP** European Network for Smoking and Tobacco Prevention
20. **EPF** European Patients' Forum
21. **EPHA** European Public Health Alliance
22. **ER-WCPT** European Region of the World Confederation for Physical Therapy
23. **ESIP** European Social Insurance Platform
24. **EUPHA** European Public Health Association
25. **EUROHEALTHNET**
26. **HOPE** European Hospital and Healthcare Federation
27. **IDF** Europe International Diabetes Federation - European Region

Members of the EU HPF are:

- 1 **AAE** Aids Action Europe
- 2 **ACN** Active Citizenship Network-Cittadinanzattiva
- 3 **AER** Assembly of European Regions
- 4 **AESGP** Association of the European Self-Medication Industry
- 5 **AGE** European Older People's Platform
- 6 **AIM** Association Internationale de la Mutualité
- 7 **ASPHER** Associations of Schools of Public Health in the EU Region
- 8 **BEUC** Bureau Européen des Unions de Consommateurs
- 9 **CE Caritas** CE Caritas Europa aisbl
- 10 **CED** Council of European Dentists
- 11 **COCIR** European Coordination Committee of the Radiological, Electromedical and healthcare IT Industry
- 12 **CPME** Standing Committee of European Doctors
- 13 **ECHO** European Confederation of Care Home Organisations
- 14 **ECL** Association of European Cancer Leagues
- 15 **ECPC** European Cancer Patient Coalition
- 16 **EDMA** European Diagnostic Manufacturers Association
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- 22 **EHMA** European Health Management Association
- 23 **EHN** European Heart Network
- 24 **EHTEL** European Health Telematics Association
- 25 **EMA** European Midwives Association
- 26 **ENSP** European Network for Smoking Prevention
- 27 **EPF** European Patients' Forum
- 28 **EPHA** European Public Health Alliance
- 29 **EPSU** European Federation of Public Services Unions
- 30 **ER-WCPT** European Region of the World Confederation for Physical Therapy
- 31 **ESIP** European Social Insurance Platform
- 32 **ESQH** The European Society for Quality in Healthcare
- 33 **EUCOMED**
- 34 **EUFAMI** European Federation of Associations of Families of People with mental illness
- 35 **EUPHA** European Public Health Association
- 36 **EUREGHA** European Regional and Local Health Authorities Network
- 37 **EUROCARE** The European Alcohol Policy Alliance
- 38 **EUROHEALTHNET**
- 39 **EUROPABIO** The European Association for Bio-industries
- 40 **EURORDIS** European Organization for Rare Diseases
- 41 **GA2LEN** Global Allergy and Asthma European Network
- 42 **HOPE** European Hospital and Healthcare Federation
- 43 **IAPO** International Alliance of Patients' Organizations
- 44 **IDF** Europe International Diabetes Federation - European Region
- 45 **IFMSA** International Federation of Medical Students' Associations
- 46 **IUHPE** International Union for Health Promotion and Education
- 47 **MHE-SME** Mental Health Europe
- 48 **PGEU** Pharmaceutical Group of the European Union
- 49 **SFP** Smoke Free Partnership
- 50 **UEHP** Union Européenne de l'Hospitalisation Privée
- 51 **UEMS** European Union of Medical Specialists
- 52 **YFJ** European Youth Forum