Hearing of the Expert Panel on Effective Ways of Investing in Health

Brussels, 11 October 2017

Opening

MEP Andreay Kovatchev opened the meeting. He welcomed the cochairs of political groups from the MEP Interest Group on Access to Healthcare. His key points:

- In November, there will be a presentation on country-specific reports in the European Parliament.
- Access to healthcare is linked with the European Social Pillar and other EU instruments.
- Current access measurements have limitations. It is important to measure access to healthcare in a common, evidence-based and efficient manner. Policymakers need that to develop policies.
- Having benchmarks to help EU Member States (MSs) learn from each other and improve is important.

MEP Biljana Borzan – key points:

- There are vast disparities in patients’ access to healthcare across the EU because of the division of competence between the MSs and the EU and because of the differences between MSs.
- Some of the major challenges are the same: ageing of populations, rising inequalities in healthcare because of the economic crisis. The suggestion is that they should be addressed at the EU level.
- To achieve that we need to measure access to healthcare across the EU.
- Current indicators are very quickly dated. They are usually too specific, focussing on particular conditions or interventions. Most have little value unless patients understand their relationship to outcomes.
- Common benchmarks to measure healthcare are needed.
- Vulnerable populations are suffering healthcare inequalities disproportionately and face multiple barriers to access.
- The European Social Pillar opens up a route to make progress in this area.

MEP Cristian Silviu Busoi – key points:

- The development of healthcare services should be top priority for any government and policymakers.
- There is still unequal access to healthcare services at the EU level. Challenges include: rising costs in healthcare, ageing populations (as a result of improving healthcare systems) and diagnosing and treating chronic conditions.
- Benchmarking in the EU is a sure way forward towards understanding the challenges.
- We need to understand similarities and differences across the EU to guide MSs.
We must help and guide MS from the EU level to improve their healthcare systems.
MS have different financing models. We need to tackle the inequalities/disparities.
One area for discussion is how to use EU funds in relation to healthcare.
Joint efforts are key. We have to establish clear and concrete measures and push governments to implement them.

**MEP Lieve Wierinck** – key points:

- It is important that MSs share best practices.
- It is important that our students study in other countries and learn their practices.
- Evidence-based medicine is very important.
- Access to medicine is very important. E-health will help those living far away from cities and hospitals. We need to do research here, e.g. via FP9 (EU research programme – Framework Programme 9).
- Chronic disease – people are living longer and often have chronic diseases. That will cost a lot so we have to do this in a good way so that they all have a good life. It needs to be factored into the budget.
- Diabetes and some forms of cancer are examples of chronic diseases that need to be considered.

**Deputy Director General of the European Commission’s DG Sante** – key points:

- Access to timely, high quality and affordable healthcare is a building block of the European Social Model. It is one of 20 rights under the European Social Pillar.
- The Commission sees today as an expression of mutual commitment in addressing gaps in access to healthcare.
- Limited access to healthcare reduces socio-economic growth potential and has long lasting consequences.
- Today’s Opinion can hopefully draw all stakeholders (not just in the health area) to this issue.
- It is a practical tool for MSs to close gaps. It can only be done via benchmarks and self-assessment tools. Then reform agendas can be geared to address challenges. Access to healthcare differs a lot across MSs and in MSs. It needs a good diagnosis to be addressed.
- Benchmarking can facilitate mutual learning and inspirer decisive steps regarding access to healthcare.
- The Commission will continue work on the basis of this Opinion and other sources.
- The Commission aims to continue to mobilise all existing tools, e.g. the European semester and EU funds. Accessibility to healthcare is stressed in country-specific recommendations to various countries. The Commission will continue to encourage MSs to do more on this.
- Improvements have been made in various countries.
- EU funds are available to implement the necessary reforms
- We have set about to improve the measurement framework. There is a pilot project to improve indicators to measure healthcare.
- We are working to improve data on unmet medical needs based on a study that has just been finalised.
- To make progress, we will need to work with other stakeholders. The Opinion can help support MSs and help bring all stakeholders together.
Our focus should be on delivery.
We rely on your expertise and networks and we need to tap into this.
The aim is to have benchmarks and for them to be systematically used.

Martin McKee (Rapporteur from the Expert Panel)

Martin McKee, the rapporteur from the Expert Panel, gave a summary of the Opinion. Key points:

- We looked at the evidence for unmet needs.
- The annual growth surveys of the European Semester is increasingly paying attention to access to healthcare. We need to tap into these.
- We were asked to provide quantitative and qualitative benchmark/target for the EU and for each MS and to look at the potential for EU funds.
- There is a well known definition on the need for healthcare (the ability to benefit from healthcare) but this is problematic in practice. It requires expensive epidemiological surveys to identify that people have an illness. There may be people with undiagnosed cancer for example. For all those, there are complications in measuring needs.
- If healthcare needs are identified, there needs to be something to improve their treatment – e.g. curing the patients ideally or other treatment such as palliative care. We need to consider the global health context: it makes no sense to give treatment for someone to extend their life from 5 to 6 years if they have a different condition that will lead them to die in six months.
- EU SILC data is a source of information for unmet needs for healthcare. It is far from ideal, but this is the data we have.
- One of the graphs we have produced shows that countries spending more on healthcare have lower levels of unmet need.

Principles for choosing a target

We established principles for choosing a target – the target should be: specific, measurable, assignable, realistic and achievable, time-related. The target should be close to the best performance in EU, realistic given the large differences between MSs and sufficiently ambitious.

Proposal for an initial target:

The median value achieved by the best performing tercile (or quartile or quintile) of MSs.

The aim is to close the gap by 50% over three years (but it could be different – e.g. to close the gap by 75% over 5 years).

NB: the choice of figures is political not technical – politicians may want to go faster or slower regarding the target or take longer.

We were asked for second level indicators

- We would be delighted if there were more data that is comparable but there are not. Examples are differences in waiting times and inequalities within MSs.
- With so much variation, it is almost impossible to come up with a detailed proposal for each MS. We think that each MS should focus on particular groups (e.g. could be Roma in some
countries such as Romania or people in remote rural areas in countries such as Sweden). It could be related to language too, as, for example, there are longstanding inequalities by language in Finland.

We were asked to look at data collection

- More questions could be added to EU SILC data surveys.
- We could look at ‘tracer conditions’ – for some conditions, for the survival of the patient, it is essential that all elements of health are looked at (e.g. for diabetes – that insulin is available and that health professionals with relevant skills are working in teams as there are different patient problems related to diabetes).

We were asked to propose qualitative measures

- We proposed the development of self-assessment tools by MSs.
- This would be designed to capture policy-relevant inequalities.
- It should take account of existing knowledge and emerging inequalities (e.g. the ‘gig economy’, zero hour contracts, the so-called ‘precariat’).
- Civil society should be involved (e.g. via shadow reports).

EU opportunities

- Funding could be provided via structural and investment funds. This could be used for:
- Better information – support for enhanced data collection and for strengthened analytic capacity.
- Exchange of best practice, e.g. via mechanisms such as ERA NET
- Improved access via European reference networks

Open discussion

An open discussion to obtain stakeholders’ views was moderated by the chairperson Sabina Nuti.

Paediatrician from the Netherlands (Elizabeth Siderius)

Paediatricians and children with rare disabilities need a system with harmonised data collection so that data can be exchanged. At the moment, data about children is in different system and hospitals. The data is not exchangeable.

The European Society for Paediatric Oncology (Olga Kozhaeva)

Interoperability of data is very important.
European Public Health Alliance

The speaker was happy to hear that there is discussion about access to healthcare for specific groups. The European Public Health Alliance is doing research at the local level in five countries. At the local level there is a real need for data. The voice of ordinary Roma people has not been heard properly.

He will share the organisation’s position paper and findings around the end of October and hopes that that can be taken into account in the Opinion.

People who should benefit from EU policies are not currently benefitting from them. The main actors that should be consulted are people that are suffering atrocities and sad things – e.g. Roma children not being treated by doctors because they are accompanied by a mother of father with dark skin or a three year old with cancer who could not have a check-up because they did not have the money.

Roma have the daily experience with these sad things and know what they need.

Council of European Dentists (Lea Pfefferle)

The speaker said that the country-specific recommendations in the European semester was looking at healthcare in a financial way in terms of making it more cost-efficient.

She was hesitant about seeing it as a positive way to look at healthcare and would like to see prevention stressed more. The mindset should not just be cost-driven but look at prevention too.

Patients Access Partnership

The Opinion is a very productive paper looking at the complexity of the issues and not recognising any one solution.

There should be emphasis on EU Member States being more proactive along with stakeholders.

In terms of inequalities between and in EU Member States. Different stakeholders (e.g. doctors and vulnerable groups) see access in different ways.

European Glaucoma Society Foundation (Ioanna Psalti)

In terms of expenditure on healthcare and unmet needs for health outcomes, spending more will not necessarily get better health outcomes per se. Expenditure has to be within a context specified by EU Member States.

Amsterdam University (David Ingleby)

Amsterdam University is running a big five-year project on migrants’ access to healthcare. It involves about 150 experts in 40 countries. This work could be very relevant for the Opinion.

Mipex health strand is the name of the project.

The current opinion puts the emphasis on whole populations. We need to reduce the level of unmet needs in countries as a whole. To do so, you have to pinpoint blackspots where the need is greatest.
You need to look at excluded groups that may be left behind. Migrants are just such a group in many countries (not just undocumented migrants but also asylum seekers and ‘legal’ migrants). There are cases where migrants are not allowed to access healthcare systems to which sometimes they are contributing with taxes. This even affects EU migrants.

The barriers are complex. 38 indicators, ranging from denial of access to healthcare to more subtle things that are almost unmeasurable, were used.

We measure policies – defined broadly, i.e. not just national laws but policies as regulated practices, (things that people do not do at their own initiative).

The outcomes are the symptoms. Policies are the cause/‘disease’. There is a good case for using policy indicators.

The data is patchy for now, especially for small groups. The size of samples and sampling method in different countries is not what it should be.

The Commission wants to find benchmarks. For migrants’ access to healthcare, we have developed benchmarks and are planning the next round. We have written country reports for 34 countries. A big problem is to get countries to take any notice of them. The reports are on a website but if they could be recommended for countries to consider, that would be a step forward.

International Organisation for Migration in Brussels (Elena Val)

These reports are independent. We have disseminated midex and are continuing with advocacy. The benchmarks are there and should be considered.

As for work done on data, we have developed, in the digital agenda, a tool for migrants to ensure continuity of care and to ensure care is given to migrants in the EU. This is an electronic tool that is already being used. It has been piloted in countries such as Italy and Greece. We are looking to expand it. Many health assessments have been done.

Paediatrician from the Netherlands (Elizabeth Siderius)

We should work together for one system (e.g. vaccinations are Important for migrants but also for disabled children). If we had one global data harmonisation, that would help.

MEP Lieve Wierinck

It is easier to put data in the cloud relating to immigrants than disabled children.

Health is something for EU Member States and so it is hard to find something that the European Parliament can do.

Aleš Bourek – Member of the Expert Panel on effective ways of investing in health

Systems cannot be imposed on EU Member States.
Extracting data, transforming data and uploading data is the only way to work – if the established data exists.

**Rapporteur from the Expert Panel (Martin McKee)**

Summary of key points from the discussion and his reaction to these key points:

We need to look at how we can do better data harmonisation for any group with a small number.

For Roma health, there is also UNDP data and a paper on using strategic litigation.

We are not focussing on cost-effectiveness. In terms of ‘unmet needs’ anyone reading the Opinion must realise that prevention is an important strategy. But we can mention it, if needed, in the Opinion.

Patient access – data from the general public could be used.

Spending itself is not a guarantee of better outcomes. The US system is hopeless. We assumed that everyone knows that.

Mipex data – we should have put that in the Opinion. It is reasonable to quote Mipex data and we can add that to the Opinion.

We need better data. Speakers have given examples of this.

**Chairperson (Sabina Nuti)**

We need a more proactive approach to this issue.

The data is available. We need to change the way we act. This is a complicated issue.

**Jan De Maeseneer**

Participants can send an email with more input in the next two weeks.

This is an ongoing process. There are different strategies that have been presented that could be used in the EU framework to put access to healthcare on the agenda and to work to improve access to healthcare for all citizens.