RE-ORIENTING HEALTH SYSTEMS:
Towards modern, responsive and sustainable health promoting systems
INTRODUCTION

EuroHealthNet is supporting work within the PROGRESS Programme of the European Commission, particularly developing knowledge, actions and links to enhance social inclusion and tackle poverty by addressing the social determinants of health and equity. We know that this cannot be achieved working within health systems alone, but the context of health systems, as broadly defined in the WHO Europe Tallinn Charter, is a vital component for such action.

Therefore in 2011 EuroHealthNet has undertaken a Policy Dialogue Process with its members, EU institutions, experts and key stakeholders from a range of relevant sectors to identify key factors which will contribute to gains for societal challenges in Europe. This was carried out in three key contexts:

- The consequences of the lasting economic and social difficulties across much of Europe;
- The EU 2020 strategy
- The WHO Europe Health 2020 strategy.

This position paper, commissioned by EuroHealthNet and authored initially by Nicoline Tamsma of RIVM, whom we sincerely thank, aims to succinctly capture the key aspects of the approaches needed for sustainable health and social protection systems across Europe, and to focus on the part that the EU can play. Its aim is to help stimulate debate and actions, together with other initiatives. We do not act alone: it contains a wealth of other references, links and evidence in detail which can be taken up, and we encourage working in partnerships and knowledge transfer initiatives.

The draft document was used as a starting point for a high quality public debate held by EuroHealthNet as part of its Week for Health and Equity in Brussels in May 2012. Among many incisive comments, these points were made by expert speakers:

- “So far, pension systems tended to represent the main challenges to sustainable public finances in our ageing societies. The attention is now shifting to health and long-term care. Preventing health problems and making systems more efficient will be key to ensuring adequate social protection on a sustainable basis in the decades to come. We therefore need to prepare for a difficult debate with member states about the sustainability of health systems.”

- “Social protection and health systems should be seen as an opportunity for the EU economy.”

- “We have already identified the correct values and principles, and how health connects with other sectors a long time ago. Equity was the number one target in the health strategy of 1994. We now need to convert all the good theory and jargon into practice and recognize the complexity in which we work. We should focus on the causes of the causes.”

- “The current systems are not working for patients but for other actors such as medical professionals and industry. It should be more balanced.”

- “People’s real needs should be put before markets’ interests but the EU keeps investing in growth and jobs instead of social capital and people”.

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“It has been said ‘Never waste the opportunity of a crisis’. We need to look at services based on prevention, care and independent living. We need to move away from the paternalistic approach of service provision and create partnerships between service providers and service users to develop innovative, effective and sustainable services.

“A reflection process on health systems is needed, and we need to assess health system performance. “

“We seek a new deal for 21st century health promotion, based on established values but meeting modern needs and much more broadly based.”

So, already a mix of challenging scenarios and practical solutions are being proposed. EuroHealthNet now publishes this paper as a contribution to the discussions being widely held in EU states and regions, most particularly in the context of:

- EU Reflection groups within the Working Party of Public Health at a Senior Level;
- Social Protection Committee Reports;
- The imminent proposal for an EU Social Investment Package;
- The EU Semester process including the Annual Growth Survey approaches;
- The EU Convention against poverty and social exclusion;
- The development of multiple EU programmes for the new Financial Framework Period 2014 – 2020;
- The WHO European Region Health 2020 strategy implementation, including its Public Health and other Action Plans and Essential Operations;
- The EU Health Policy Forum.

Please bear in mind this is a concise text because, although it is a massive subject, we want it to have an impact with policy makers and people who work in or have a stake in public health systems. So we need short points backed by evidence.

We will be very happy to explore these issues with other stakeholders and institutions as these discussions and consequential actions go forward, and the national and regional agencies that comprise EuroHealthNet will be engaged in the developments in their areas of responsibility.

If you wish to discuss this further, or to receive any further information, please contact our office at c.needle@eurohealthnet.eu or call 00 322 235 0320.

We look forward to a constructive debate and, while current economic circumstances are indeed dire for many, to the prospect of real change towards long overdue reorientation of health systems to help meet the social, environmental and economic goals of Europe as well as improving health outcomes equitably for all.

Clive Needle
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1. Policy context and urgency

**Sustainability of systems on the agenda**

The sustainability of national health systems is a core concern of the European Member States, the European Commission, and the World Health Organisation.

WHO defined health systems as comprising ‘all public and private organisations, institutions and resources mandated to improve, maintain and restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions to address the social, environmental and economic determinants of health’\(^1\). While improving health is the main objective of a health system, there are two aspects to this objective: achieving the best attainable average level of health (‘goodness’) as well as the smallest feasible differences among individuals and groups (fairness)\(^2\).

As early as 2001, the European Commission identified ‘financial viability’ as one of three long-term objectives for national health systems, along with accessibility and quality\(^3\). Since then, the development of high-quality, accessible and sustainable services has been in the spotlight of different EU policy agenda’s: social protection, public health, and economic and financial affairs.

Initially, the issue was incorporated in the EU social protection and inclusion processes\(^4\). Health ministers addressed the issue of health systems for the first time in 2006. Stressing the importance of safeguarding overarching values of universality, access to good quality care, equity, and solidarity, they also acknowledged the challenge of reconciling individual needs with available finances\(^5\). The Economic and Financial Affairs Council discussed financial sustainability of health and long-term care for the first time in 2003.

**Consensus on health promotion investment as best value for money**

The economic and financial crisis has put pressure on public spending, including health system expenditure. In the opinion of the EU Social Protection Committee (SPC), tackling health inequalities through addressing social determinants of health can alleviate this pressure, and greater attention to health inequalities can improve healthcare efficiency. They advised accordingly, suggesting to shift resources towards health promotion and preventive measures aiming to reduce health inequalities\(^6\).

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Against this backdrop, the EC Directorate for Economic & Financial Affairs (DG ECFIN) and the Economic Policy Committee (EPC) zoomed in on health systems, aiming to understand the drivers of health expenditure. In the quest for policies that strengthen financial sustainability as well as access to and quality of services, one of the most important challenges in the coming years is to get more value for money out of health sector resource allocation. The report identifies several policy challenges that need to be addressed ‘resolutely’ given the current system strengths and weaknesses. These include improving health through more effective health promotion and disease prevention in and outside the health sector.

EU Member States confirmed the urgency of tackling this challenge, and the need to further strengthen health promotion and disease prevention in this respect. The ECFIN Council highlighted the contribution of health to economic prosperity and pointed out that ‘there appears to be scope to improve the health status of the population without increasing health spending’ in many countries. According to ECFIN ministers, ‘getting more value for money is crucial if countries are to ensure universal access and equity in health’ and that this should be factored in to proposals in the framework of the Europe 2020 strategy.

EU health ministers joined their financial and economic affairs counterparts in the view that health promotion and disease prevention are key factors for the long-term sustainability of health systems, further adding that:
- Health is a value in itself, as well as a precondition for economic growth;
- Reducing major disparities and closing serious health gaps between and within Member States are of utmost importance;
- European Structural Funds should be used to advance health system objectives and reduce health inequities;
- The health sector should play an adequate role in the implementation of the Europe 2020 strategy, and social and organizational innovations can be instrumental;
- Health should be adequately addressed in the National Reform Programmes.

This was mirrored by the OECD Health Committee’s call for a long-term view and for spending money wisely by investing in prevention. As stewards of the health system, these OECD health ministers - many of whom also represent EU Member States - felt this to be the best way forward in order to ensure value for the large financial resources spent on health.

Re-investing is crucial in times of crisis

Nearly one year further into the economic crisis, EU Commissioner Dalli expressed his concern that this crisis may nevertheless trigger a health crisis. He urged to resist the political temptation to make short-term cuts that can inflict serious long-term damage. He also warned against abandoning prevention programmes, calling instead to seize opportunities to push reforms, think more freely and embrace new ideas. Reflecting the potential of health as a booster for economic growth and its importance within Member States’ policy agendas, he also called for a more prominent role of health

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in the 2012 European Semester, a process for the EC to help a more coordinated approach to state systems.\(^{12}\)

Thus, the crucial contribution of health promoting approaches to sustainable health systems and Europe’s social and economic capital is clearly acknowledged, and so is the urgency to re-orient health systems accordingly. Yet, real life proves resistant to change, suggesting health systems reform needs to be re-invented if such reform is to pick up on the challenge posed by the guardians of public finance.

Social innovation in health systems should push for investment in health and health equity, advocating health promotion approaches and incorporating these within the other elements of the system. As the best measure of health system performance is its impact on health outcomes\(^{13}\), planned health system reforms should also be pre-assessed for health and health equity impact. This will provide policy makers with clearer insights into one of their key concerns: are we investing wisely and really getting the best value for money out of health sector resources?


2. Investing in equitable health

*Health and health equity: a health system deliverable*

Across the EU Member States, the average life expectancy at birth (for 2009) was 75.5 years for men and 81.7 years for women. Differences between countries are significant: the gap between the countries being 12.3 years (figures ranging from 67.5 - 79.8 years) for men and 7.6 years for women (ranging from 77.4 - 85.0 years).

Not all these years are lived in good health. The average healthy life expectancy (also for 2009) in the EU-27 was 61.7 years for men (ranging from 52.4 – 70.7, so a difference between countries of 18.3 years) and 62.6 years (ranging from 52.6- 71 years, thus a difference of 18.4 years) for women. Thus, while men are not expected to live as long as women, they can expect to live a slightly larger proportion (80%) of their life in good health than women (76%)\(^ {14} \)\(^ {15} \).

Both life expectancy and healthy life expectancy (a key EU indicator) are shorter with increasing levels of deprivation. In other words: health follows a social gradient\(^ {16} \). Consequently, by improving the life expectancy of disadvantaged groups, a general increase in overall life expectancy is also to be expected\(^ {17} \). Figures 1. and 2. illustrate this gap in healthy life expectancy in relation to (1) education level in The Netherlands\(^ {18} \), and (2) neighbourhood income deprivation in England\(^ {19} \).

Previous work led by EuroHealthNet has illustrated the cyclical relationship between health, poverty and social inclusion. There are a many pathways via which poverty and social exclusion can lead to ill health and vice versa: ill health leading to poverty and social exclusion\(^ {20} \). Indeed, poor health and mental well-being may even be more prominent predictors of social exclusion than low income or paid employment. Public health and health promotion have a crucial, ‘upstream’ role to play in breaking this cycle\(^ {21} \).

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\(^ {14} \) See http://www.eurekalert.org/pub_releases/2012-04/ind-le041812.php  
\(^ {15} \) http://ec.europa.eu/health/indicators/indicators/index_en.htm.  
\(^ {18} \) as published in De Volkskrant, November 2008 to illustrate some of the work by Prof. Johan Mackenbach  
Fig. 1: Life expectancy and healthy life expectancy by education level in The Netherlands, 2008.

Fig. 2: Life expectancy and disability-free/healthy life expectancy, by neighbourhood income deprivation

Life expectancy and disability-free life expectancy at birth by neighbourhood income deprivation, 1999-2003
Health inequalities may differ over time, across countries and between countries. They may also vary for specific diseases. In fact, a benchmark exercise that would combine the narrowest inequalities in mortality observed for any disease anywhere in Europe could present a virtual situation in which inequalities would almost be eliminated. In reality, however, health inequalities have proven to be persistent over the past decades, with relative inequalities in mortality increasing in many EU countries. This increase can predominantly be ascribed to differences between socioeconomic groups, with higher socioeconomic groups benefiting more from improvements in health-related behaviours and the introduction of effective healthcare interventions.\(^{22}\)

Levelling up the health gradient is a key objective of any health system. The urgency to deliver on this is even more pressing given the current demographic and economic situation. The number of people over 65 years of age will almost double in the next 50 years: from 80 million in 2008 to 151 million in 2060. Should we not be successful in our efforts to increase healthy life expectancy across and within EU Member States, European citizens -on average- will not be expected to live in good health beyond the age of 62. Consequently, then we will see a huge increase in the number of Europeans living in poor health in the coming decades.

If we do succeed, however, we could unleash a huge health potential, especially among those in lower socioeconomic groups. We may also expect less pressure on health care expenditure. Evidence suggests that ageing per se is not a key driver of health care costs, but accounts for only 10% of increased spending.\(^{23}\) Economic growth, higher income, new technologies and medical progress are much more powerful cost driving factors.\(^{24}\)

**Investing in a healthy older workforce**

By 2060, the ratio of people of working age (15-64) for every person aged over 65 in the EU will have halved from one to four, to one to two. Already in the next decade the ageing workforce will be dominated by the people of 50 years or older, most of whom will have acquired very valuable experience and knowledge over their working lives until then.\(^{25}\)

In 2009, labour force participation of older (55-64 year old) workers in the EU was 46%: considerably lower than the overall rate of 64.6.\(^{26}\) Evidence suggests poor health reduces labour force participation, including hours worked. Poor health is a key determinant of early retirement, and plays a role in the decision to retire. The impact of health on retirement is particularly strong among


people with low income levels. People are more likely to leave employment after suffering a health shock, which then is then also associated with reduction of income. More specific illness-related data show that mental ill-health and musculo-skeletal conditions are the two leading conditions affecting employment levels.2728.

Increasing the average healthy lifespan in the EU by two years by the year 2020 is the primary objective of the showcase EU Innovation Partnership on Active and Health Ageing. The European Commission expects this initiative to not only contribute to improved health and quality of life – especially for older citizens - but also to long-term sustainability and efficiency of health and social care systems29. Given the available evidence, adopting a strong equity focus throughout the various actions supported via the partnership is likely to increase a healthy return of investment.

Investing wisely: the economic argument

The interrelationships between health status, health systems and economic growth has been extensively described, researched and illustrated30. All three factors also have a direct as well as mutually reinforcing relationship with societal well-being. This is also illustrated by the OECD ‘Better Life Index’, which includes health as one of 11 well-being components, along with various health determinants such as income, education and environment31. The Index is an attempt to move away from using GDP (gross domestic product) as dominant measurement of economic performance and social progress32.

As a concept, ‘societal well-being’ stands for the total well-being of an entire society, touching on notions of happiness and quality of life33. Promoting the well-being of its peoples is one of the three primary aims of the European Union, firmly embedded in article 3 of the Lisbon Treaty. The importance of health for the well-being of individuals and society is also a prominent principle in the EU’s Health Strategy, which consequently considers spending on health to be an investment, not a cost34.

31 http://oecdbetterlifeindex.org/
Attaching an economic or monetary value should not be interpreted as contesting the unique value of health as such, or its status as a human right. Nevertheless, in the quest for cost- and health efficient systems, spending wisely is key and data on health and financial outcomes are important. This is especially true for a topic such as health, as health not only impacts heavily on other policy areas but also benefits strongly from the right investment in other policy areas.

The economic impact of socio-economic health inequalities is substantial. Estimates published before the economic crisis suggest that for the whole of the EU a 2.8% of average personal income - translating to a 1.4% reduction of GDP- is lost through health inequalities. The negative impact on health care cost was an estimated € 26 billion for physician services and € 59 billion for hospital services. All in all the impact of health inequalities on total health care costs in the EU25 would amount to approximately 20%. To this, 25% of disability benefits (€ 55 billion) and 3% of unemployment benefits (€ 5 billion) could be added.

Measuring costs, gains and effectiveness of public health and health-promoting interventions is a challenge, as such interventions are usually complex and not suitable for carrying out that exercise that is often demanded when effectiveness is to be proven: a randomized control trial. Also, benefits as well as costs of these interventions may extend beyond the health sector. Effective action is quite often of a multisectoral nature, requiring commitment and investment from multiple sectors. Similarly, the (health) benefits may not necessarily impact where investments are made.

The evidence base on (cost) effective health promoting interventions is growing. Examples include early years’ interventions aiming to improve children’s physical and mental health, interventions at the workplace or to prevent road transport injuries, vaccination programmes, and programmes aimed at smoking cessation or responsible use of alcohol. Evidence also suggests that many of these preventive interventions deliver more value for money than investment in clinical interventions.

The impact of two specific health problems – mental ill-health and obesity- may illustrate how health promoting interventions can help improve lives as well as the economy.

Mental disorders represent the greatest share of disability-adjusted life years in the EU. The total societal cost of the two most prevalent of these, depression and anxiety disorders, were estimated at €136.3 billion (in 2007), nearly € 100 of which was due to productivity losses from employment. Poor mental health is a leading reason for early retirement or withdrawal from the workforce on health grounds. In the UK, 90% of people with complex mental health problems are unemployed.

An economic evaluation of health promoting interventions targeting young children and their parents, school children, people at the workplace and older people made strong case for investment in

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parenting and health visitor related programmes, comprehensive workplace health promotion programmes and stress management projects, and group-based exercise and psychosocial interventions for older people. Obesity is responsible for 1-3% of total health expenditure in most countries. The OECD expects these percentages to rise in the coming years with the progressing onset of obesity-related disease. In The Netherlands, the figure is indeed 1.6%, amounting to direct healthcare costs of over €500 million annually. Productivity-related costs are estimated to be four times as high: €2 billion.

When someone is obese, they incur 25% higher health care expenditure compared to someone with a normal weight. Obesity also related to inequality. It is more common among people with lower education and less income, especially among women, as illustrated by Figure 3. Obesity is not only related to poor health, but also to social benefit expenditure, at least in northern European countries, where obese people are three times more likely to receive a disability pension.

**Comprehensive health promotion programmes, focusing on diet and physical activity offer cost-effective solutions.** They would avoid tens of thousands of premature deaths (an estimated 75,000 in Italy and 70,000 in England). The cost of a comprehensive prevention strategy per life year gained, as calculated by OECD for five OECD countries is less than $20,000. Examples of preventive approaches to counteract obesity and improve health equity in children can be found in a recent overview by EuroHealthNet.

*Fig. 3: Obesity as an equity and gender issue in OECD countries*

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40 OECD Obesity Update 2012.
41 See [http://www.rivm.nl/vtv/object_document/o3094n19669.html](http://www.rivm.nl/vtv/object_document/o3094n19669.html)
42 OECD Obesity Update 2012.
3. Investing in equitable access

**Access as a right and prerequisite for system outcomes**

Access to good quality healthcare services is a prerequisite for social integration and inclusive growth. It was recognised as a key objective of EU Member States’ social protection systems as early as 1992\(^{44}\), and has remained firmly on the social policy agenda ever since. Achieving access for all to adequate health care and long-term care is embedded in the current, streamlined, EU Open Method of Coordination for social protection and social inclusion (‘Social OMC’), along with another health-related objective, i.e.: tackling health inequalities.

The right of access to preventive health care and the right to benefit from medical treatment is embedded in the EU’s Charter of Fundamental Rights\(^ {45}\). It is also prominently listed as one of the four common values and principles of EU health systems, along with universality, solidarity and equity\(^ {46}\).

The World Health Organization (WHO) defines accessibility as ‘a measure of the proportion of the population that reaches appropriate health services’\(^ {47}\). When it comes to equity of access, two different aspects can be distinguished:

- **Horizontal equity**: the extent to which individuals on equal incomes are treated equally and/or to which individuals in equal need are treated equally;
- **Vertical equity**: the extent to which individuals on unequal income are treated unequally to achieve equity in health care finance. This is also perceived as the “fairness” of health systems.

An equitable health service, therefore, is one where individuals’ access to and utilisation of the service depends on their health state alone, and not upon their socio-economic status, except in so far as that affects their health status\(^ {48}\):

**What do we know?**

Vulnerable groups experience disproportionate amounts of morbidity and mortality. Equitable access to healthcare is therefore essential to minimise their disadvantage. Evidence gathered through cross-national and national studies strongly suggest, however, that horizontal and vertical inequities are persistent features across EU health systems. People in equal need do not receive equal treatment at all income levels, not even in EU countries with a longstanding reputation in providing rather universal and comprehensive health services coverage arrangements for their population. In


\(^{47}\) WHO Regional Office for Europe 1998, Terminology – A glossary of technical terms on the economics and finance of health services; EUR/ICP/CARE0401/CN01.

addition, the relative financial burden of health systems finance is not always fairly distributed which has serious consequences for overall health\textsuperscript{49}.

Over the years data have shown a consistent pattern where people from higher income brackets are relatively more likely to receive specialist, dental and preventive medical services, whereas those on lower incomes are more inclined to access primary care\textsuperscript{50}.

One way to measure equity of access is to look at unmet need for medical examination\textsuperscript{52}. ‘Self-reported unmet need for health care in the past 12 months’ is included in two international surveys: the Survey on Health, Ageing and Retirement in Europe (SHARE) and the EU Survey of Income and Living Conditions (EU-SILC). It is also one of the shortlisted EU Community Health Indicators.

Figure 4 illustrates that in most EU countries, financial factors are the most important given reason for people in the lowest income bracket to miss out on medical examination in spite of experiencing a need for such a service.

\textit{Fig. 4: Unmet need for medical examination, selected reasons by income quintile (OECD based on EU-SILC 2007 data)}

\begin{table}
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
\textbf{Quintile 1} & &  & \textbf{Quintile 5} & \\
\hline
\textbf{Higher income} & \textbf{Could not afford to} & \textbf{Waiting time} & \textbf{Lower income} & \\
\hline
Austria & & & & \\
Belgium & & & & \\
Czech Republic & & & & \\
Denmark & & & & \\
Finland & & & & \\
France & & & & \\
Greece & & & & \\
Hungary & & & & \\
Iceland & & & & \\
Ireland & & & & \\
Italy & & & & \\
Luxembourg & & & & \\
Netherlands & & & & \\
Norway & & & & \\
Poland & & & & \\
Portugal & & & & \\
Slovak Republic & & & & \\
Spain & & & & \\
Sweden & & & & \\
United Kingdom & & & & \\
\hline
\end{tabular}
\end{table}

\textsuperscript{49} Tamsma N and Berman P. The role of the health care sector in tackling poverty and social exclusion in Europe. EHMA and EuroHealthNet, December 2004.
\textsuperscript{52} \url{http://www.healthindicators.eu/object_document/o5956n29063.html}
Within the context of the Social Open Method of Coordination, EU Member States were asked to include specific measures to counter inequality of access to health services in their National Action Plans (NAPs) on Tackling Poverty and Social Exclusion. An analysis of 2003-2005 NAPs showed that adequate attention to the interaction between poverty, ill health, access, and affordability was often lacking.

The recommendations based on this study targeted social inclusion policy agenda’s and included suggestions to:

- explore health care as a more significant component in national plans to alleviate poverty and social exclusion;
- include an analysis of specific health needs of disadvantaged groups and communities;
- provide information on horizontal and vertical equity of access to health services in NAP (or their current successor: National Strategy Reports);
- include an impact assessment of health system finance on poverty and social exclusion.

It was also suggested Member States should support measures that counteract negative consequences of health systems finance for people living in poverty and for groups that are disproportionately affected by ill health\textsuperscript{53}.

Further research into inequity of access to healthcare services carried out at the request of DG EMPL\textsuperscript{54} explored access barriers of particular relevance to people at risk of social exclusion. It also highlighted the impact of public and private financial resources in breaking the circle that exists with regard to poverty, ill health and inequitable access to high quality services:

- Across EU Member States, coverage of basic health care costs is universal and mandatory for everybody with a residency status, and organised under public programmes irrespective of ability to pay. Those without public health coverage, however, are often people at risk of poverty and social exclusion, such as migrants and people depending on social assistance. This includes people with limited capacity to organise and regularly pay for social –never mind additional- health insurance in those countries where this is an individual responsibility.

- Health baskets offered within the scope of public programmes are fairly comprehensive, but vulnerable people may still miss out on certain services: dental care, physiotherapy and certain mental health services are often excluded from basic packages. Taking out additional insurance cover (for instance for dental care, see fig. 5) may be a financial step too far for people on lower incomes, thereby severely restricting their access to such services.

- Organisational barriers, such as waiting lists or limited surgery opening hours also have a relatively greater impact on people at risk of poverty. If waiting lists are long, they usually lack the means to turn to alternative providers in the private sector. People in blue collar jobs and/or working in shifts may have less flexibility to attend surgery hours. When they feel their job is at risk they may delay seeking care.

\textsuperscript{53} Tamsma N and Berman P. The role of the health care sector in tackling poverty and social exclusion in Europe. EHMA and EuroHealthNet, December 2004.

Fig. 5: Out-of-pocket dental expenditure in 2009 or nearest year (OECD Health at a Glance 2011).

- Groups at risk of poverty and/or social exclusion are disproportionately affected by the financial burden of cost-sharing arrangements. In those countries where a relatively high percentage of healthcare costs is covered through out-of-pocket or informal payments this may result in catastrophic expenditures for groups at the lower end of the socio-economic spectrum as these forms of funding are regressive. This also impacts negatively on the uptake of necessary services. In some countries, special arrangements exist to compensate people on lower incomes for the relatively high costs incurred. In those cases, clauses that provide general exemption rules are more helpful than setting payment ceilings, as the latter may require complex paperwork to reclaim costs and people still have to pay the full costs upfront.

- Geographical barriers are especially relevant to older people and those with limited mobility. Such barriers may be exacerbated in rural areas, where poverty risk also tends to be higher.

- Inappropriate health beliefs and limited levels of health literacy -the ability to understand how to make sound health and health service choices and to communicate with health professionals- may impose additional access barriers.

- Somatic health needs of people with mental health problems are very often overlooked. Meanwhile, avoidable mortality and somatic co-morbidity levels are relatively high within this group suggesting systems fail to meet their health needs.

More recent (2011) data from the OECD\textsuperscript{55} further suggests that income is an important factor in accessing health services: in most countries people in lower income brackets report considerable more cost-related problems in accessing services (see Figure 6).

\textsuperscript{55} OECD Health at a Glance 2011
The overall picture that is emerging is one of health systems that could improve on making their products more accessible to their primary ‘clients’: people with lower social-economic status who live more years in bad health compared to their richer equivalents. Instead, reforms and innovations predominantly focus on the informed, well-educated health service consumer. Unfortunately, this approach may increase health inequalities as well as health service expenditure.

Concern for financial sustainability and public health service budgets were identified as major policy hurdles in abolishing access barriers such as cost sharing or culturally sensitive services. Given the aspiration of Europe 2020 –two additional healthy life years for Europeans- there is, however, a world to win via targeted measures to improve health service access for disadvantaged communities. To achieve maximum impact on Europe 2020 targets, health system innovations should focus on dismantling access barriers and improving health literacy. This also includes a revision of co-payment arrangements. More traditional incentives aiming to reduce service uptake by introducing financial barriers may well have adverse effects in the longer term.

In this era of demographic ageing a special word of caution should also be expressed with regard to cuts in coverage of social, long-term or home care services. In an attempt to further reduce public expenditure, some countries reduce the range of services their citizens are entitled to, introduce means testing and/or intensify co-payment arrangements. This may undermine the wish and ability of older people to continue to live independently and could lead to unnecessary and more expensive in-patient or residential care.

It also puts a great financial burden on older people in need of such services. Accumulation of co-payments in health and social care increases the risk of poverty. The modernisation of pension schemes may put further pressure on the ability of older people to pay for services. Older women may be especially vulnerable as their financial position is often less favourable than that of men. Yet, their need for health care and long-term care services is higher as they can not only expect to live longer than men, but also to live more years in ill-health.
**Equity of access in times of crisis and austerity**

In spring 2009, WHO acknowledged the risk that the economic crisis posed to health and health systems. In a dedicated resolution, Member States were urged to ensure their health systems continue to protect those most in need (such as people living in poverty, older people and people with ill-health). The particular importance of fair financing, universal access to health promotion, disease prevention and health care was also stressed.

More specifically, Member States were recommended to:
- invest in health to improve wealth;
- protect health budgets and health insurance coverage;
- include health- and environment-related investments in economic recovery plans;
- protect cost-effective public health and primary health care services;
- strengthen universal access to social protection programmes in a more coordinated way;
- Ensure universal access to health services and social safety nets for the most vulnerable social groups.

Working towards their new long-term policy vision, WHO again expressed concern that in this era of economic constraints the costs of newer and more extensive technologies could outrun the public monies available to provide affordable access for all to sustainable, good quality health care.

Meanwhile, in some countries, citizens have already reported they are facing difficulties accessing health care. In October 2010, nearly 30 % of EU respondents reported the affordability of healthcare was somewhat or much more difficult 'in the last six months'. The December 2011 Flash Eurobarometer on the social impact of the crisis suggests that difficulties in access to services are an increasing problem: 32% of EU citizens say it has become more difficult for them to afford general healthcare. The SPC suggests rises in unmet need for care might be due to high out-of-pocket payments that people can no longer afford, or to a weakening in the public provision of services.

Cuts in social spending in the context of EU Member States’ budget consolidation programmes impact strongly on the availability of social and health support services, particularly to those in need. These cuts coincide with a greater demand for social services at a time when 23.4% of the EU population are at risk of poverty or social exclusion.

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57 [http://www.euro.who.int/__data/assets/pdf_file/0005/68945/RC59_eres03.pdf](http://www.euro.who.int/__data/assets/pdf_file/0005/68945/RC59_eres03.pdf)


59 2011 Social Climate Eurobarometer.

4. Investing in capacity

Capacity building as a change agent

The need to invest in health promotion and prevention if our health systems are to deliver best value for money has clearly been acknowledged by our European and national leaders. The previous chapters have illustrated this political commitment and made the case for a strong focus on health, health equity and equitable access to services. In other words: modern, responsive and sustainable health systems are health promoting health systems. Health promoting health systems are systems that invest in health and quality of life of all Europeans, and therefore in the wealth and social well-being of a smart, sustainable and inclusive Europe.

Of course health professionals cannot achieve this by themselves. Action on social health determinants, for instance, needs involvement from other sectors as well a political commitment. But health systems and those responsible for health system stewardship do have an essential and pivotal role to play: both in advancing efforts from other sectors as well as in delivering all other functions of health systems and services. As such, health systems are a powerful social determinant of health.

Re-orienting health systems accordingly can only happen if we also re-orient and re-build the capacity of those working within those systems. This can be supported through several major initiatives and instruments in the EU and WHO European region.

Supporting capacity building: opportunities and instruments


The WHO Office for Europe is currently developing a new, overall strategy for the coming decade: Health 2020. It is dedicated to pursuing better and more equitable health and well-being. In the draft document outlining that strategy, WHO observes health systems are not as productive in producing health as they could be. In their analysis, public health services and capacity are relatively weak, and developing primary care, including health promotion and disease prevention need more attention. Consequently, strengthening public health capacity, including health promotion, is among the strategy’s key areas for action.

A new European Action Plan for Strengthening Public Health Capacities and Services (EAP/PHS) is to support delivery of the strategy’s aims and objectives, especially within the WHO member states. For this purpose, WHO has developed a self-assessment tool that can help countries identify their current strengths and weaknesses. The Plan is to integrate public health operations across sectors and levels of society. It distinguishes ten ‘Essential Public Health Operations’, including health promotion, disease prevention, and assuring a competent workforce.

The Plan presents a unique opportunity to reshape public health and deliver fresh, innovative approaches, especially at national and regional level. For that purpose, the Plan should also put

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strong emphasis on developing public health advocacy and leadership skills; co-ordinated data collection and analysis; prioritisation and capacity to strengthen the evidence base policy making; improving capacity and tools for monitoring and evaluation; and cost-effectiveness analysis.

2. Action Plan on EU Health Workforce

In April 2012, the untapped potential of the health sector as an engine for employment was recognised by The European Commission, along with that of two other sectors: green economy and new technology. The new ‘Toward a job-rich recovery’ employment package also sets out how EU funds can be used to make long-term investments in human capital.

The European Commission has developed a specific action plan as part of this broader initiative, in support of job-creation in the health workforce. The Action Plan on EU Health Workforce aims to assist Member States to tackle urgent challenges. This includes improving workforce planning and forecasting to better match demand and supply. It also sets out actions to foster cooperation and share good practices.

Health professionals are well placed as health advocates, to influence social determinants of health, and to tackle health inequalities: yet their role is often under-utilised. They are involved in direct patient care are in contact with people over longer periods in their life – e.g. general practitioners and dentists-, at key points across their life course - e.g. midwives, health visitors, school nurses, nursing home staff-, or at times of illness – primary, secondary or even tertiary care teams-.

In primary care, shifting service provision away from vertical, disease-oriented programmes towards horizontal community-oriented programmes promises to yield results. There is also great potential for healthcare professionals to support and empower communities and individuals taking more control over their health and well-being, especially when they join forces with local health trainers, community health champions and community development work.

The health care sector can play a role in more ‘upstream’ health promotion efforts, but clearly has the lead in what is their core business: delivering good quality, responsive services that are accessible to all. Health systems are, access to health systems and their capacity are factors that contribute powerfully to health and well-being as well as care. In this sense, the health system is a powerful social determinant of health.

We have seen people from lower socioeconomic groups are disproportionately affected by many of the various barriers that may hinder health service access, and that a lot of health may be gained by tackling these. This calls for increased efforts to level up the horizontal and vertical inequity of access that currently exists in our health systems. Health care professionals can make an important

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contribution here, for instance by providing more client-focused responsive services, respecting diversity, improving communication and increasing health literacy.\(^{70}\)

Public health professionals are briefly referred to in the Action Plan, but there are no clear signs at the moment how far the scope of the Action Plan extends beyond the health and social care sector of health systems. Given the strong plea from EU health, social and financial policy makers to invest in health promotion and disease prevention (see Chapter 1), however, it seems prudent this new employment initiative will also support investment in a health promoting workforce and existing tackle shortages. The plan can provide a unique opportunity to re-build a truly innovative workforce, providing for more health promoting capacity, public health and health promotion skills, and understanding of health equity approaches.\(^{71}\)

### 3. Contribution from EU Structural Funds

The EU Cohesion policy focuses on economic, social and territorial disparities, aiming to reduce the significant gaps that exist within Europe between less-favoured regions and more affluent ones. The Structural Funds act as the financial mechanism of Cohesion Policy by facilitating the structural adjustment of specific sectors, regions, or a combination of both. Monies are primarily allocated via three major funds: the European Regional Development Fund (ERDF), the European Social Fund (ESF) and the Cohesion Fund (CF), each pursuing different policy objectives.\(^{72}\)

Health-related actions can be supported by Structural Funds, including the ESF, and indeed are being used as such.\(^{73}\) This opens up options to support a health promoting workforce, for instance through:

- Fostering health promotion, e.g. by enhancing local capacity to plan and implement public health activities on a regional level; increasing health awareness and the skills of people to make healthy choices.
- Investing in human capital, e.g. through establishing lifelong learning opportunities for health professionals. Funds could, for example, be used to improve health promotion knowledge and skills across health professionals and multidisciplinary working or health in all policy approaches.
- Enhancing access to employment, also improving job opportunities in the health sector for socially vulnerable populations. Funds could, for example, be used to train peer health educators from socially disadvantaged and/or minority ethnic communities and create employment opportunities for them in health promotion or in support of culturally responsive service provision.
- Providing attractive workplaces in the health sector, for instance in support of a diverse workforce.

Within the scope of the future Multiannual Financial Framework (2014-2020), the European Commission has proposed to set additional conditions for granting funds for health investments.\(^{74}\) These include the existence of a national or regional strategy for health, also addressing access to

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\(^{74}\) COM(2011) 615 final/2.
quality health services and economic sustainability. Actions that are geared towards active and healthy ageing objectives should be designed in cooperation with relevant stakeholders. Both conditions may open up additional opportunities for multisectoral involvement and health promoting initiatives. They also point towards the incorporation of health promoting objectives in national health strategies as a crucial step to safeguard support for health promoting capacity. EuroHealthNet is advising partners, through the EU Joint Equity Action and other mechanisms, on how to prepare for the next iteration of Structural funds on a multi-sectoral basis.

4. EU Social Inclusion instruments: PROGRESS and Peer Reviews

PROGRESS, the European Community Programme for Employment and Social Solidarity, is a financial instrument supporting the development and coordination of EU policy in five areas, including social inclusion and social protection. It is also to strengthen Member States' commitments and efforts to create more and better jobs and to build a more cohesive society.

The programme supports policy coordination, sharing of best practices, testing of innovative policies and sharing of best practice. Tackling health inequalities is one of the objectives of the EU social inclusion policy and PROGRESS is available to support capacity building. Indeed, the grant EuroHealthNet received to that effect is a good illustration of how health promoting networks and exchange of good practice are supported via this social policy fund.

The programme also funds studies that can underpin the implementation of the EU social policy objectives. An example of this is the ‘Working for Equity in Health’ project in which EuroHealthNet is a partner. This explores the relationship between work, worklessness and social protection as social determinants of health inequalities. PROGRESS also funded the work carried out on quality in and equality of access to healthcare as cited in Chapter 3 on equity of access.

Peer Reviews are one of several instruments within the scope of the Social 'Open Method of Coordination' (OMC). They are designed to facilitate mutual learning on social protection and social inclusion policies between EU Member States. More specifically, the reviews evolve around a selected good practice in one country, with experts from other countries, stakeholder organisations and the European Commission providing feedback. Peer reviews are also to foster knowledge transfer and gathering insights on effective policies.

Until now, none of the peer reviews have been addressed to health promotion per se, but many have focused on social health determinants. Initiatives aiming to improve access to health and social services have also been subject to peer review. This is an area for potential improvement.

5. EU Public Health Programme

The current European Community Action Programme in the field of Health (2008-13) supports various capacity enhancing activities. This is also underpinned by the EU health strategy, which calls to increase capacity in public health, for example by strengthening training and public health structures. The programme has funded a range of projects and other activities until now.

Examples include:

- Crossing Bridges - Developing methodologies and building capacity to advance the implementation of Health in all Policies and achieve health equity, led by EuroHealthNet;
- CompHP- Developing Competencies for Health Promotion Capacity Building in Europe;
- Capacity building for public health and health promotion in Central and Eastern Europe
- Reviewing Public Health Capacity in the EU. This is a systematic exercise to map public health and health promotion capacity within the 27 Member States and address the need for further capacity building.

The 2012 work programme included two additional calls for capacity building, one of which aims to improve older people’s health literacy: this is another initiative EuroHealthNet aspires to participate in. The proposed third EU health programme explicitly supports the development of effective health workforce forecasting and planning.

Other programme opportunities may be anticipated in due course.

**Next steps**

EuroHealthNet is taking forward the concepts and approaches suggested in this document as one basis for negotiations in policy processes outlined within it. Details of the development of such initiatives at international, national and other levels, may be found within our family of websites interlinked via our hub site [www.eurohealthnet.eu](http://www.eurohealthnet.eu)

We also publish frequent news and information updates in our health Highlights Newsletter which may be obtained on free subscription via that site.

*To become involved, receive further information or comment on any aspects please contact our office via c.needle@eurohealthnet.eu or call 00 322 235 0320.*

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