



Health in Europe

Editorial



Much has been said about the havoc wreaked by the economic crisis on the world markets and the snowball effect it has had on national

budgets and sovereign debt levels. Worryingly, the crisis also appears to have worsened health inequalities between and within regions, with rising unemployment and budget restrictions leading to greater inequity in health across socio-economic groups. The increased poverty risk also carries negative consequences for health, particularly for children, the elderly and people with disabilities. And of course health budgets could suffer as national governments impose severe spending cuts to contain debt.

So what can be done to reduce these inequalities and create the healthy workforce Europe so desperately needs in coming out of the crisis? Health policy may remain a national competency, but the EU health strategy, with the involvement of the regions, can help deliver broader targets relating to prosperity, solidarity and security. Mechanisms such as e-health can also help ensure that all of Europe's citizens – regardless of their socioeconomic situation or geographical location – have access to high quality and efficient healthcare.

This is where AER comes in. As the political voice of more than 270 regions from 33 countries, we can raise awareness among regional leaders and together help shape EU health policy. Regions must reject moves to cut health spending every step of the way. We must work together to keep health at the top of the political agenda, sharing best practice examples of how innovative solutions can be used to boost accessibility and reduce inequalities between and within Member States. <

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Europe's health check

URGENT ACTION IS NEEDED AT REGIONAL LEVEL TO TACKLE HEALTH INEQUALITIES



AER fights the effects of the economic crisis on health services.

Politicians at all levels of government have expressed the need for equal access to good quality healthcare for all citizens, and many have raised concerns over disparities in terms of the health and wellbeing of European citizens. Despite this, the range of global challenges vying for the attention of policymakers means there is a real danger that health issues could find themselves relegated down the political agenda.

Health inequalities between regions and countries mean, for example, that life expectancy at birth varies by up to 14 years between Member States. The differences, also evidenced within regions as a result of differing socioeconomic conditions, have worsened with the downturn. So, as the crisis continues to bite, policymakers will have to work hard to maintain health investment and ensure that frontline services do not suffer.

There is also a link between unemployment and poor health. EU-wide unemployment hit around 10 per cent at the start of the year, resulting in a worsening of mental and physical health among Europe's citizens. As such, a country such as Spain – where unemployment figures were almost double the European average – would have to cope with an added health burden on top of its economic

woes. With this in mind, AER will be holding a conference on health inequalities in Brussels in October, bringing regions together to share their experiences of best practice and discuss what can be done at regional level to ensure the crisis does not exacerbate existing health inequalities.

Equality for all

Vulnerable groups such as people with disabilities are particularly at risk from public service cuts. Nearly one tenth of the European population lives with some kind of disability, and AER's working group 'Equal Europe for People with Disabilities' aims to implement the UN Convention on the rights of people with disabilities.

The implementation of the Convention is the responsibility of all levels of government, and requires regional authorities to guarantee equal access to public services for all citizens. There is much that can be done to ensure the objectives are met at regional level and politicians must help break down barriers people with disabilities face in participating in society. As health services come under ever greater strain, we must continue to look at how to increase health accessibility for people with disabilities. <

Across the lines

THE CROSS-BORDER HEALTHCARE DIRECTIVE CAN DO MUCH TO FOSTER EUROPEAN COOPERATION ON HEALTH ISSUES BUT MUST NOT PUT EXTRA PRESSURE ON REGIONS' RESOURCES



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Mobility across national health systems... opportunity or burden?

The cross-border healthcare directive aims to facilitate the movement of patients seeking treatment in another Member State. Under the provisions of the original draft proposal, patients will be able to travel freely to receive treatment in another Member State, mostly without authorisation from their national health system. The directive, which attempts to clarify the currently patchy framework created by case-by-case rulings from the European Court of Justice,

will have profound consequences for the delivery of healthcare at a regional level. Not only does it raise questions over patient mobility, it will also impact how regions organise, deliver and finance their services.

In a 2009 position, the AER Social Policy and Public Health Committee insisted that an advanced warning mechanism was the only way regions would adapt and cope with a change in demand. The warning system would enable regions to monitor the flow of patients and adjust their planning and management systems accordingly, as well as helping to ensure that patients are fully informed about the process of obtaining health abroad. While figures show that just 1% of people travel abroad for their healthcare, AER is concerned over how a change in patient flows could affect hospital waiting lists, healthcare infrastructure and staffing procedures.

The draft directive also raises a number of logistical problems which must be overcome in order to maintain the high quality services needed to guarantee the health of Europe's citizens. For example, the need for translation services for patients travelling across borders will have to be taken into account. Then there is the ever-thorny issue of who picks up the

bill for healthcare received abroad. The directive states that the patient should pay the entire cost up front, which raises questions over whether it makes cross-border healthcare available to all patients – or only those who can afford additional travel costs. Indeed, Parliament's rapporteur, deputy Françoise Grossetête, warned that the directive could discriminate against poorer patients.

In June 2010 the EU Health Ministers agreed on amending the Commission's draft text. Under the terms of this agreement, Member States can require that patients seeking treatment abroad obtain prior authorisation for certain treatments and reimbursement is subject to a number of specific conditions.

What the final text will look like remains to be seen, with MEPs expected to propose further amendments. But one thing is clear: local and regional actors are key players in the planning and delivery of healthcare services and the EU will need to work hard to involve them every step of the way if the cross-border healthcare directive is to achieve its aim of opening up health services for all of Europe's citizens. <



Interview

Christina Wahrolin, Vice-President of 'Social Policy & Public Health' Committee and County Councillor of Värmland (S)

AER: How can Committee 2 help the regions to improve their health systems?

Christina Wahrolin: The most important tool for our members is the opportunities AER offers for regions to meet and exchange. Our AER events allow regions to share experiences, learn from each other and develop joint projects, as we have done on alcohol, e-health and demographic change. Exchange of best practice is one of the key issues for Committee 2 and for AER as a whole.

AER: What are the key priorities for the Committee?

CW: Currently our priorities include improving health and social services, addressing demo-

graphic change, preventing alcohol-related harm, disability issues and gender equality. AER is a democratic forum: our members determine what we work with. It is regional politicians who, every year, adopt the Committee's political priorities and work programme and discuss how we can work together to achieve our goals.

AER: What are the main health challenges in your region?

CW: I think it is important to recognise that health is key to generating sustainable economic growth and prosperity in the regions. We often talk about growth, but this is impossible without a healthy population. We must

also invest in developing our staff's skills, engaging in a fruitful dialogue with our citizens and addressing demographic change.

AER: How can the regions support people with disabilities?

CW: I think there is much work to be done in this area. People with disabilities represent a big part of our society- it is not only people in wheelchairs or the blind, but also those less easy to spot, such as the hard of hearing. Regions must commit to implementing the UN Convention on the rights of people with disabilities. We are no longer talking about addressing special needs – this is now a question of respective basic human rights that the UN Convention enshrines. I think we need to raise awareness about the Convention among the regions and to take it into account in all policies within the health sector. And we the politicians need to communicate about disability issues and about what we are doing to address them.

On the agenda

AER CAN HELP EUROPE'S REGIONS MAKE THE MOST OF MONEY AVAILABLE THROUGH THE EU STRUCTURAL FUNDS



AER Committee 2 brainstorming for a better use of structural funds in the field of health.

A 2007 Eurobarometer survey identified health as the top priority for 99% of EU citizens. As such, it is a cause for concern that spending on healthcare services has been pared back as national governments seek to contain debt levels. Although the European Commission's structural funds identify health as a priority, the sector is lagging behind in uptake and regional politicians will have to look carefully at how to protect future

health systems from the spending squeeze.

The AER 2009 conference in Katowice, Slaskie (PL) looked at the impact of the economic crisis on healthcare and how structural funds could be used for health investment. A Declaration adopted at the conference called for a flexible, long-term approach to developing new technologies that can benefit health, and for more analysis of how the private sector can contribute to delivering healthcare.

Billions of euros are available for health promotion under the European Regional Development Fund (ERDF) and European Social Fund (ESF). Projects funded in this way can improve quality of life, reduce health inequalities and maintain the healthy workforce needed for sustained economic growth. The €5bn of ERDF funding available for health in the 2007-2013 budgetary period was set aside for, among others, the modernisation of existing healthcare systems, the improvement of medical equipment and the development of e-health infrastructure – something

which AER considers essential in providing healthcare services in the 21st century. On top of this, the ESF can be used, for example, to boost investment in health and safety at work and provide information on disease prevention. Projects on cross-border cooperation and healthy ageing – particularly important in light of demographic change – are also entitled to support through the structural funds.

It is clear that more must be done to help regions make the most of EU funding for health in terms of accessing the funds and optimising the impact of their investment.

The Euregio III (EIII) project, of which AER is a collaborating partner, seeks to help local and regional authorities optimise the use of structural funds for health. The project is showing that regions often experience difficulties in accessing the funds. Not only does the involvement of several players make for a complicated process, but also many people in the health sector don't fully understand how to apply for money through the structural funds, what the money can be used for, where it comes from or how it fits into national health budgets. <



Interview

Agneta Granström, President of AER e-he@lth network and County Council Commissioner of Norrbotten (S)

AER: Why is e-health important?

Agneta Granström: E-health is a tool we need to maintain good healthcare for a growing elderly population with increasing care needs and fewer healthcare professionals employed per patient. E-health and ICT can deliver both health and social services, in rural areas and in cities. It is a way of delivering energy-smart online health care 365 days a year seven days a week to anyone. E-health makes it possible for health organisations to deliver services of equal or higher standard more efficiently, regardless of where a patient lives.

AER: What role do regions have in promoting innovation in health?

AG: In most countries in Europe it is the regional or local level that delivers healthcare. E-health is a new area where a region's industry base can expand and where SMEs can get involved in the delivery of online healthcare services. So a region fostering e-health is at the same time fostering a new market and a fast-growing industry. The AER e-he@lth network supports regions launching e-health in their territories and can voice their needs. Our aim is that health services delivered by ICT become just as common as shopping on eBay or using an online bank account.

AER: How can regions make the most of ICT in healthcare?

AG: They need to have a regional strategy on how to develop and implement e-health. Even without such a strategy, politicians must work with this question in mind. The healthcare professionals drive the development of ICT in healthcare, and their priorities are not always the same as those of politicians or citizens. It is therefore important that regional decision-makers take a lead in this area and make sure patients' needs are at the centre of e-health.

AER: What best practice examples would you highlight in relation to e-health?

AG: In Scandinavia, for example, we have a shortage of x-ray doctors so we buy services from Barcelona – sending them the x-ray for analysis. Another example is the use of university clinics, which can give a diagnosis online for a baby with suspected heart problems. There are many more examples.

Healthy debate

THE EU HEALTH STRATEGY MUST INVOLVE THE REGIONS IF IT IS TO FULLY ADDRESS THE NEEDS OF CITIZENS AT REGIONAL LEVEL



Regions are essential for implementing EU Health Strategy.

The European Health Strategy is based on the premise that health action is closely interlinked with broader EU objectives relating to prosperity, solidarity and security. AER recognises this, and supports

the “*health is the greatest wealth*” principle on which the strategy is grounded. While the majority of competency for health rests with member states, there is still much that can be done at EU level on issues relating, for exam-

ple, to cross-border health threats, patient mobility, and reducing health inequalities.

These are all issues which impact significantly on the development and delivery of health services for which regions are often responsible, so it makes sense to include them in the formulation of EU policy right from the offset. This is not only in accordance with the subsidiarity principle, but will also help ensure that the EU Health Strategy reflects the needs of people in the regions.

As discussions continue ahead of the next cohesion policy funding period, AER is adamant that health remain a priority. This, combined with a mainstreaming of health across EU policy areas, is key to improving health. But the EU must not overlook the impact of the financial crisis, which has reinforced health inequalities and presented obstacles in implementing health policy. It is with this in mind that AER is currently conducting a survey among regions on how the economic crisis has affected regions' ability to manage, finance and deliver health services on the ground. <

Last orders please

AER REGIONS TACKLE THE PROBLEM OF ALCOHOL-RELATED HARM



An intergenerational dialogue to develop a sustainable regional alcohol policy.

Alcohol costs the EU some €125bn per year and causes one in four deaths among young men and one in ten among young women. With such significant economic, health and social impacts, the regions must work hard to tackle the problem of alcohol-related harm. An AER meeting in Barcelona in May 2010 focused on these issues, and delegates

called on regions to work with all stakeholders (including hospitals and the police) to develop an effective and sustainable regional alcohol policy. AER also said more must be done to control the availability of alcohol by, for example, raising the drinking age, reducing serving hours and increasing prices, and called on regional policymakers to raise awareness and boost networking opportunities. Jönköping County (S) international relations officer Karin Mernelius says, “*We can see that many regions lack resources and knowledge when it comes to prevention work. That makes it even more important to work together and learn from each other.*” Regions have a “*very important role to play*” in tackling alcohol-related harm, she says, adding, “*The regions have to be the link in this work between the local and national level.*” Like Mernelius, Robert Uitto, a county council commissioner in Jämtland (S), wants politicians to show leadership and keep the issue high on the agenda. Ultimately, Uitto thinks initiatives such as those to tackle alcohol abuse should be used “*to start the movement against drugs*”. “*The debate must begin,*” he says. “*Courage is required to accomplish good results.*” <



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