COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

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On 29 June 2011, the CPME Executive Committee adopted the "CPME Statement on the Future of the Health Programme of the EU post 2013" (CPME 2011/116 EN)

CPME Policy on

CPME Statement on the Future of the Health Programme of the EU post 2013

The Standing Committee of European Doctors (CPME) represents medical doctors across Europe and is composed of the most representative National Medical Associations of 27 European countries. CPME aims to promote the highest standards of medical training and medical practice in order to achieve the highest quality of healthcare for all patients in Europe. CPME is also concerned with the promotion of public health, the relationship between patients and doctors, and the free movement of doctors within the EU. CPME also cooperates closely with national medical associations from associated and observer countries, as well as with specialised European medical organisations and international medical associations.

1. *Does the structure for the new programme as presented to you (briefly above+ slides during the meeting) seem reasonable/satisfactory?*

CPME welcomes the Commission's commitment to take into account the results of the ex-post evaluation of the present health programme when establishing the priorities and structures of the new programme and the opportunity for stakeholders to comment on the process. In addition to the findings presented, we wish to highlight the following points which we see as important considerations in the creation of the next programme's structure based on good evidence:

- The programme should further the role of the EU in enhancing a solid, coherent and equitable framework for quality care and the integration of the health dimension in all EU policies.
- The new EU health programme's structure should seek to identify within the priorities set mechanisms to carry on work that builds on successful actions of the present programmes and policy activities and ensure a coherence with the goals therein. Examples of interventions which have created roadmaps and networks which require continued support are the actions addressing the semantic and technical interoperability of eHealth systems, such as the eHealth Governance Initiative, and the current work on promoting health in an ageing society by facilitating the implementation of the Strategic

Implementation Plan of the European Innovation Partnership on Active and Healthy Ageing. Continuation of work would also include the continuation of communication with the stakeholders and Member States involved in successful actions.

- The new programme should furthermore establish structural mechanisms that ensure a greater integration and coherence of programme actions with the evolving context of EU health policy and health-related policies in other EU policy fields. Creating priority-review and inter-service exchange mechanisms, e.g. with DGs INFSO, RTD, MARKT and AGRI, would improve the relevance of actions, pursue the 'health in all policies' objective and decrease the duplication of work, thus proving more cost- and outcome-efficient. Cooperation at global level with the WHO or international NGOs representing patients, physicians and other healthcare professionals, would further improve the integration of actions in the policy context.
- The evaluation of individual actions must also be reframed, so as to deliver useful outcomes and continuous insight into whether actions are indeed achieving the targets set for relevance and cost-efficiency, both in content and format. Assessments of impact of actions can only be meaningful if target audiences and the timing of evaluations are chosen carefully and in coherence with the overall programme aims.

2. *What do you think the objectives and priority areas with a real EU added value of the next Health Programme should be?*

CPME welcomes that the need to address inequalities in access to and provision of healthcare and public health interventions by considering the social determinants of health has been identified as a cross-cutting concept to be considered under all priority pillars. CPME welcomes the fact that the next health programme's priorities have been streamlined. These 'umbrella' topics should offer sufficient scope to address very relevant issues on the current health policy agenda. CPME suggests that, for a variety of reasons, including the increased burden of chronic disease, and a projected massive increase in "lifestyle-related diseases", such as obesity, alcohol-related harm and diseases related to smoking, all EU healthcare systems will be placed under ever greater strain, and will ultimately become unsustainable. There is therefore an urgent need to develop cross-cutting policies and co-ordination between DGs on a "health-in-all" approach to such core issues as education, prevention, housing, green technology, and nutrition, to name but some.

Sub-priorities should furthermore respond to the following:

1. Patients safety both through appropriate information for empowered and health-literate patients and continuing professional development of physicians and other health care professionals in order to improve patient care must be a dimension of all actions, but also to be considered in their own right.

2. Special focus should be on supporting the implementation of the Cross-Border Healthcare Directive, including the continuation of activities undertaken in the fields of eHealth and Health Technology Assessment and the implementation of the 'Pharma Package' legislation, especially the 'Information to Patients' Directive as well as tackling rare diseases.
3. The current momentum on tackling Non-Communicable Diseases should be translated into actions taken under the heading of 'prevention', with a focus on learning from and transferring existing good practices. A further important issue which must be given consideration in this pillar is the increase of antimicrobial resistance and the need to promote awareness and good practices around this issue. In light of the up-coming review of the Tobacco Products Directive, the health programme should also support actions informing on prevention and smoking cessation, without replicating efforts of the HELP! campaign. The 'prevention' pillar should also tackle issues which are inherently cross-border by nature, such as health security and communicable diseases in order to establish networks. All this must be based on well-established scientific evidence.
4. Under the pillar of 'innovative solutions for health', the extensive efforts invested in the European Innovation Partnership on Active and Healthy Ageing should be given a framework to continue beyond the initiative's lifetime in order to aid the implementation of its roadmap and support the structures created to stress that prevention as well as care should be seen as good investments also from an economic point of view. Innovation in health must also consider the health workforce and actions e.g. aiming to improve working conditions should be supported and streamlined with related topics in other policy fields. While preparing a friendly environment for the elderly in future, Europe must not forget about supporting families and people in their fifties and earlier right now in preparing for healthy and active ageing.
5. The current rather haphazard roll-out of eHealth projects needs reconsideration, and must be based on a clearer strategy, based on what will benefit patient care. Evidence is now becoming available that well-targeted interventions - based on "telehealth" - produce major reductions in healthcare costs. Streamlining new projects to build on this evidence will benefit patients and industry alike.

While the suggested priorities reflect the real needs of both citizens and health systems, the streamlining of the priorities through the adoption of a holistic approach involving both civil society and Member States could help in reaching better results.

3. Do you agree that the EU added value would be an exclusive criterion for the ranking of priorities? Could other criteria be used?

While a certain scale of measurement that could separate high level from medium level priorities could be useful, EU added value should not represent *a sine qua non* criterion for action. A more ambitious approach would be to involve both active and inactive Member States and encourage engagement in tackling common concerns as well as addressing and creating solutions for problems identified in the

implementation of policies. A criterion which may also be considered valuable is the health programme's potential to address gaps in the policy programmes on both European and national level, so as to provide a forum and resources to address issues which may be of high importance, but for political or economic reasons, cannot be adequately explored in their current frameworks. The relevance of these issues for the advancement of policy should however be evaluated objectively.

4. *Which criteria could be used for measuring the EU added value?*

EU added-value could be measured based on the problem area coverage and by identifying common problems. The degree of involvement of Member States and relevant stakeholders can also give an impression of the perceived added value, as it proves of a willingness to address issues outside the national context. In addition, the potential volume of transfer of good practices could point to an achievement for EU action. The success in establishing more coherent policies and thus more equitable health outcomes in Europe could also be of relevance for the measurement of value added.

5. *Which of the indicators do you think could help measure the impact of the programme?*

Implementation and uptake are key for the success of the programme and it could represent a good indicator. Hence, the indicator could be defined in terms of the rate of the implementation and uptake of programme outcomes in the different Member States and stakeholder groups as well as the actual rate of predefined results achieved. In addition the visibility and uptake of outcomes of individual actions beyond the actors directly involved are a valuable measurement tool. In order for this to be achieved, however, the communication and evaluation mechanisms within individual actions must be reviewed, so as to allow for meaningful impact assessments.

6. *Ideas to motivate inactive member states to participate in addition to technical assistance provided by the EAHC or alternative cost models.*

Inactive member states could only be motivated to participate if the priority areas reflect the concerns that are of relevance at national level. Additionally, inactive member states need to see benefits in terms of concrete proposals for action as well as assistance funds. Inactive member states need to identify a win-win situation that could bring them additional benefits that extend beyond healthcare. The streamlining and simplification of administrative procedures as well as a greater visibility of the programme itself can also help improve the situation. Medical and other health professional organisations at national and European level can be active partners in motivating inactive Member States.