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DISCUSSION PAPER

Sustainable Development Goal on Health (SDG3): The opportunity to make EU health a priority

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European health systems face growing, common challenges: the increasing cost of healthcare; an ageing population associated with a rise in chronic diseases and multi-morbidity leading to a growing demand for healthcare; shortages and an uneven distribution of health professionals; and inequalities in access to healthcare. Given the scale of the challenge, improving the performance and sustainability of health systems is crucial. All available tools should be used according to their specific functions, and the Sustainable Development Goal on Health (SDG3) provides an overarching framework to strengthen health for all.

SDG3 – what's in it for European health systems?

The SDG framework is specifically relevant for European health systems, due to the fragmented approach to health in the European Union (EU). Many policies that have an impact on health are not located under the Directorate General for Health and Food Safety (DG SANTE), but related to decisions made, for example, in the areas of environment, transport, energy, migration, agriculture, employment and economic policy, or research and innovation. This requires close and continuous coordination.

The report *Health Care and Long-Term Care Systems & Fiscal Sustainability* (2016) by the Directorate-General for Economic and Financial Affairs (DG ECFIN) notes how the decentralisation of health systems poses a challenge to effective governance in the area of health. The report recommends the setting of clear, overarching priorities and goals for European health systems[1]. When thinking of the patchwork of EU health governance, this advice also applies. Within the rapidly changing health policy environment a shared framework of goals and targets is invaluable. Among the 17 Sustainable Development Goals (SDGs) – adopted by world leaders in September 2015 – is Goal 3 on health, which focuses on ensuring healthy lives and promoting well-being for all at all ages. Goal 3 includes 13 targets that are to be reached by 2030, and the clock is ticking.

The SDG framework is endorsed by all EU governments, and the Union is committed to implementing the SDG Agenda both internally and globally. Therefore, the member states and the EU institutions share a responsibility and can be held accountable for any lack of implementation. Every year in September, until 2030, all 195 world leaders will gather in New York, for the General Assembly of the United Nations, to report about the progress of their respective countries on each of the SDGs. The president of the European Council will address the General Assembly on behalf of the EU.

The good news is that the SDG3 and the EU's efforts in the area of health are mostly aligned. The European Commission (EC) Communication on the *Next steps for a sustainable European future*, and the accompanying staff working document *Key European action supporting the 2030 Agenda and the Sustainable Development*

Goals list in detail the health topics that the Commission will help member states with. The EU domestic actions on the SDG3 target include:

- actions on communicable diseases, including AIDS, tuberculosis, and hepatitis;
- actions on non-communicable diseases, including mental health, cancer, dementia, physical activity, nutrition and obesity;
- work on road safety with a mix of measures aimed at making users, vehicles and infrastructure safer;
- policies and legislation aimed at reducing the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination;
- strengthening tobacco control;
- supporting the EU member states in developing measures to address scarcity of vaccines and to increase vaccine coverage;
- supporting joint actions in the member states to invest in health workforce planning and health workforce skills analysis; and
- coordinating action to address serious cross-border health threats.

In addition, as the EU aims for effective, accessible and resilient health systems and has defined "increasing accessibility to healthcare" as one of the three pillars for an EU agenda for health systems[2], one of the 13 targets for SDG3 on health is particularly relevant to achieve this objective:

"[By 2030] Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"[13].

This target is what policymakers at the national and supranational level should strive toward. Universal Health Coverage (UHC) is an objective of the EU Charter of Fundamental Rights, and it has been embedded in the European Pillar of Social Rights. The target is broad, yet achievable, so let's break it down into smaller areas, and look at the further actions that are needed.

Universal Health Coverage as *the* target for sustainable health systems

The Recent OECD/European Union *Health at Glance* report on Europe (2016) highlights how steady improvements in population health and reductions in health inequalities can be achieved by ensuring universal access to high-quality care. The concept of UHC is well-suited to address the complexity of challenges in the health systems, and now this concept needs to be turned into concrete actions on the ground if its benefits for EU patients and citizens are expected to be seen. The following five points – drawn from the target to achieve universal health coverage – illustrate, how member states and the EU can further employ the SDG3 targets to pull the numerous ongoing and planned actions in the area of health together within a coherent framework:

The importance of enhancing financial risk protection

People without health insurance tend to use more expensive emergency hospital services. In addition, they do not participate in health prevention and promotion activities conducted by health services. After government schemes and compulsory health insurance, the main source of health funding in Europe tends to be out-of-pocket payments (OOPs). OOPs are expenditures borne directly by patients. They include cost-sharing and, in certain countries, estimations of informal payments to healthcare providers. Too many patients in the EU are facing financial hardship as a result of healthcare costs. Furthermore, patients with several chronic conditions are more vulnerable to barriers in accessing healthcare.

High levels of out-of-pocket spending for healthcare have a variety of harmful effects: some people are deterred from using health services or from continuing treatment because they cannot afford it, while others may need to cut spending on basic needs such as food, clothing, and housing. A recent survey conducted

by the European Patients' Forum (EPF) indicates that 36% of respondents forgo or postpone treatments and a further 40% forgo or postpone healthcare visits due to the high cost of care. An additional 41% of respondents reported reducing household spending on essential needs such as food and clothing to be able to cover healthcare costs.[4]

Since 2009, direct out-of-pocket spending by households has grown more rapidly than public spending across EU countries[5]. Private households directly financed 15% of all EU health spending in 2014, and the disparities among member states are striking: the share was above 30% in Cyprus (50%), Bulgaria (46%), Latvia (39%), Greece (35%), and Lithuania (31%), while it was lowest in countries such as France (7%), Luxembourg (11%), the Netherlands (12%), and Germany (13%). The situation has a negative impact on health systems, and the broader functioning of societies; health is wealth, and better individual health creates prosperous societies, and drives workforce productivity[6]. In reverse, health inequalities carry a significant economic and personal cost. It is now recognised that investing in health for all is an investment in the EU's fundamental values, social cohesion and economic development. Thus, decreasing OOPs in order to reduce health inequalities is crucial for the overall health and wealth of societies.

Guaranteed access to essential healthcare services

At first glance, it seems that most EU countries ensure that the whole population is covered for a core set of health services and goods. However, there remains a need to address current coverage gaps for some segments of the population; particularly those from the most vulnerable and disadvantaged groups have difficulties accessing necessary healthcare because of cost. In 2014, on average across EU countries, poor people were ten times more likely to report unmet medical needs for financial reasons than rich people[7]. The EPF report indicates that 64% of European patients belonging to an income group that reported difficulty in making ends meet had to reduce spending on essential needs in order to afford care.

While making sure that the whole population is covered by public (or private) health insurance is an important indicator of access, it is not sufficient. The range, coordination and timeliness of services covered and the degree of cost-sharing applied to these services can also have an important impact on direct out-of-pocket expenditure by patients and financial accessibility. Furthermore, organisational changes are needed to ensure that the package of services covered by healthcare systems are tailored to the needs of patients. In addition, the healthcare coverage data on the EU focuses on access to curative healthcare services. UHC is, however, a broader concept, meaning that "all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship"[8]. Further emphasis on preventive services, such as prenatal care and vaccinations, and mental health promotion initiatives, for instance at work places, are just a few examples that need further attention.

Ensuring the high quality of healthcare services

The main EU-level instrument on evaluating healthcare is the Health Systems Performance Assessment (HSPA), which is governed jointly by the European Commission, the member states, the OECD, the WHO Regional Office for Europe, and the European Observatory on Health Systems and Policies. HSPA provides a platform for member states to assess the effectiveness, efficiency and financial sustainability of their health systems, improve transparency and accountability, aid strategic planning, and identify good and bad practices. One of the focal areas of the HSPA is quality of care. There are divergences in the safety and quality of healthcare in the EU. According to the EPF report, almost 48% of respondents indicated 'sometimes', 'rarely' or 'never' receiving quality care according to standards/guidelines or best practices available for their condition. Although discussions on HSPA started some ten years ago, development has been slow, and it is high time for national systems to make use of the HSPA framework, data and support that the EC has made readily available. The HSPA could be developed further by agreeing on common indicators and methodologies to assess national health system performances on health equity, and member states should share their data openly to allow for effective comparison. Furthermore, the OECD, which

provides data to inform the European Commission and member states' policies, recently launched the Patient-Reported Indicators Survey (PaRIS) to collect and develop indicators on patient-prioritised outcomes and experiences of care, so that policymakers will have a better idea of the things that matter to patients.

Access to safe, effective, quality and affordable medicines

Medicine prices in the EU have risen over the past few decades to the point of being unaffordable for many citizens, which threatens the sustainability of national healthcare systems. This is particularly the case for the most innovative medicines. There is a marked heterogeneity in the pricing, and the lack of transparency leaves space for irregular behaviour by the pharmaceutical industry. On 2 March 2017, the European Parliament (EP) adopted a non-legislative resolution on EU options for improving access to medicines, which calls for measures to improve the traceability of research and development costs (R&D), public funding, and marketing expenditure. It is emphasised that new legislation is needed to ensure full transparency and effective control of the procedures used to determine the prices and reimbursement of medicinal products in the member states. Only this would result in a better balance between EU countries' public health interests and those of the pharmaceutical industry. The resolution also called for closer EU collaboration in Health Technology Assessment (HTA) , which measures the added value of a new health technology in comparison to existing technologies/current standard of care, and making the results actionable at national level. The ball is in the Commission's court now, and even if the legislative process would take the notorious ten years, it could be added to the achievements within the SDG3 by 2030.

Vaccines for all – and health literacy

All countries in the EU have implemented vaccination programmes for children. However, a more thorough assessment of vaccination coverage and more effective information sharing is needed. Europe would benefit from a common strategy for vaccination across a lifespan, and the European Centre for Disease Prevention and Control (ECDC) proposes a life-long vaccination calendar at the EU level. While being a long-standing leader in vaccines, the European Region reports the highest negative responses for vaccine importance, safety, and effectiveness (8.0%, 17.0%, and 11.3%, respectively). Seven of the ten least vaccine-confident countries are in Europe, with 41% of respondents in France and 36% of respondents in Bosnia and Herzegovina reporting that they disagree that vaccines are safe, compared to a global average of 13%.[9] France and Italy have high levels of safety-based vaccine scepticism, while western and northern European countries express less concern about vaccine safety than eastern and southern European countries. This scepticism has consequences. For example, in several EU countries 70% of measles cases occurred among adolescents and young adults in 2014 according to the ECDC. This is due to the insufficient uptake of the measles, mumps, and rubella (MMR) vaccines. Targeted health literacy programmes on immunisation are essential to contribute to building up public confidence in vaccines, and preventing communicable disease outbreaks.

Vaccine hesitancy in the Region is often related to a lack of awareness or misinformation; a study by Yaqub et al. (2014) reported that attitudes towards vaccination in Europe are shaped not just by healthcare professionals but also by an array of other information sources, including online and social media sources, and that healthcare professionals face increasing challenges to building a trustful relationship with patients[10]. According to a Flash Eurobarometer Survey on 'European citizens' digital health literacy' (2014), around six out of ten people said to have used the internet to search for health-related information. As people consult the internet to search for health-related information, critical eHealth literacy skills cannot be emphasised enough. There is a specific role for civil society organisations in this through their online presence.

The benefits of better integrating the SDG3 in the EU's work

Achieving the overall EU objective of effective, accessible and resilient health systems requires stronger governance for health. The SDG3 can provide a clear framework to collate the numerous EU actions in the area of health. Furthermore, it can increase the political weight of health within the broader European agenda, by explicitly highlighting the importance of health in relation to the future of Europe.

First, it offers a way to coordinate what is being done at the EU level, with an amplifying effect, as demonstrated by the target for Universal Health Coverage. Employing the SDG3 as a framework for action enables planning outside short-term political cycles, since the timetable stretches until 2030. All actions are subject to yearly check-ups, as per the UN General Assembly meeting. The added bonus is that there is some low-hanging fruit for the taking: the impact of actions could be detected in shorter time frames – from a few months to a couple of years, especially when it comes to actions on some environmental factors, such as air pollution, and unhealthy behaviours, such as smoking, and physical inactivity.

Second, the SDG framework is not an abstract wish list, but a tool, in which each target is backed-up by different sets of indicators that measure the progress. There is robust work going into the monitoring of the targets, and the collection and analysis of health data is strongly on the agenda of the WHO, the Commission, and the OECD. The evidence is available – or being collected to aid the drafting of action/reform plans. In the context of the European Semester, the EU has developed country-specific knowledge on national health systems, which will be complemented by its two-year 'State of Health in the EU' cycle. The cycle aims to support member states in evidence-based policymaking, and kicked off in November 2016 with the release of the latest OECD Health at Glance publication. To follow is a package of national health profiles for each member state and a Commission paper that links the findings in the profiles with the broader EU agenda. Starting November 2017, the member states can then engage in voluntary exchanges with the Commission to discuss the findings and best practices. The often voiced concern of duplication of work does not really have any merit here, as the main European institutions are collaborating in the area of health; like the HSPA, the 'State of Health in the EU' work is conducted together with the OECD and the European Observatory on Health Systems and Policies.

Whether the evidence coming from the international level will push reform-avert countries to act, remains to be seen. Some member states have already started implementing health reforms, that can be deepened, and the member states that have not started yet, need to do so now. Health systems assessment, transformation, and monitoring is critical for tackling antimicrobial resistance (AMR), for ensuring a sustainable financing basis for the systems, and for providing adequate access to healthcare services and health insurance, including for the most vulnerable. Health is a political choice, and as such the SDG framework has received green light from the top level of each member state, and is endorsed by the EU. The main obstacle for implementation is not the resistance against the targets, but, rather obliviousness – if not ignorance. As the evidence clearly shows, UHC is not a given in the EU, and this situation has negative concequences, for the individual and society. Health spending takes up an increasing share of national budgets in the EU member states; as a ratio to GDP, EU 28 government health expenditure amounted to 6.2% of GDP in 2002 and 7.2% of GDP in 2015. And within the overall numbers, hospital services take up the largest part – 3.4% of GDP in 2015. There is room for tackling waste and inefficiency within the care systems, as well as reducing the high share of curative spending, by advancing preventive measures and universal health coverage. Health is the carrot and the stick, as well-being increases economic and social capital, while illnesses are expensive.

Third, according to a Eurobarometer survey of the EP on 'perceptions and expectations', exactly half of EU citizens surveyed evaluated current EU action in health and social security as insufficient. Public support for EU spending on public health has been growing between 2008 and 2015; 32% perceived it as a priority spending category in 2008; 36% in 2011; and 41% in 2015. In 2015, public health was the policy area with the second highest support from citizens in terms of EU spending (after social affairs and employment)[11]. Consequently, both from the systems sustainability, and the citizens' viewpoint, health has to be further up on the EU agenda. But will the next Multi-Annual Financial Framework (MFF), and its implementation system, the European Semester, achieve this? While the Semester is limited in scope and focuses on economic results, the SDGs can be used to put the bigger picture into focus and identify policy areas that need improvement. Given that the EU has no overarching responsibility in the field of health, the SDG framework can really bring home the message that health is a result of complex systems, and affects a number of other policy domains. Achieving Universal Health coverage (UHC) requires a focus on healthcare vertically and at the same time a growing collaboration across different policy areas at the supranational level.

Finally, while healthcare systems are important, many other factors often linked to social and employment policies, shape health as well. The EU Pillar of Social Rights contains elements that have an impact on the health of people, such as work-life balance, access to social protection systems and employment contracts. The pillar is accompanied by a 'Social Scoreboard', which will monitor the implementation of the pillar by tracking trends and performances across EU countries in 12 areas, and feeding into the European Semester of economic policy coordination. Healthcare is one of the areas, and measured through four indicators: self-reported unmet need for medical care; healthy life years at the age of 65 (males); healthy life years at the age of 65 (females); and out-of-pocket expenditure on health care. In addition, many of the other indicators are also directly related to health and well-being, such as poverty risk, youth and long-term unemployment, and housing deprivation, to mention a few. Therefore, health is a theme that is integral to the pillar. As such, the EU Pillar of Social Rights ties health tightly to the scenarios presented in the Commission's White Paper on the Future of Europe, in which social themes are discussed throughout. But this discussion lacks the *explicit acknowledgement* that these policies have health impacts, and that peoples' health is a prerequisite of well-functioning economies and societies. As a result, there is a risk that health is left out of the equation. This would be a mistake, as human health and well-being is one of the key features of what constitutes a successful, inclusive and fair society in the 21st century. Any targets for inclusive growth are improbable if health is sidelined.

Achieving sustainable development, and the well-being of individuals and societies, requires economic growth, social inclusion and environmental protection. These elements are interconnected and since it sits at the heart of all three, health and well-being has to be highlighted as a core issue at the EU level. In practice, the EU should implement the SDG3 targets as a strategic framework for steering health, with specific attention being paid to the development of UHC and reducing health inequalities. As for the member states, the SDG framework should be used to intensify their actions in health in the broadest sense, and governments should further commit to promoting health in all policies. Reaching the SDG3 targets requires intersectoral, collaborative action between EU countries. All states are aiming for the same targets, so the journey towards them should also be done together.

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Endnotes

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