HEALTH: TOMORROW'S EUROPEAN SOLIDARITY ECONOMY?

Speakers: Nathalie COLIN-OESTERLÉ, Member of the European Parliament | European Union, **Antoine FLAHAULT,** General Manager of the Institute of Global Health of the Faculty of Medicine at the University of Geneva | Switzerland, **Philippe JUVIN,** former Member of the European Parliament & Professor of Emergency Medicine at the HEGP | France, **François KRABANSKY,** Public Health Doctor, MSA – Mutualité Sociale Agricole | France, **Véronique TRILLET-LENOIR,** Member of the European Parliament | European Union, **Sandy TUBEUF,** Professor of Economics at the UCLouvain | Belgium

Discussion led by **Guy VALLANCIEN**, President of CHAM | France

The fear of evaluation is holding back Europe on its way to a unified healthcare

Health falls within the national competence of the Member States, but the EU has a duty to coordinate, harmonize and complement the policies of the Member States, in order to ensure a high-quality health policy for the citizens and to enable crisis management at community level. Many bodies already exist such as the European Centre for Disease Prevention and Control (ECDC) or the European Medicines Agency. Among them, the European Medical Corps, which enables the transportation of goods, professionals and patients, was activated with some success during the pandemic.

Although the EU already has tools at its disposal, it still lacks a structure capable of activating them in an efficient and coordinated manner; the lack of concrete resolutions, such as the creation of a "one-stop-shop" to coordinate agencies, the chartering of European medical trains that may be used during a crisis, the creation of a European emergency pharmacy (which was proposed to the European Parliament), has often been criticized. However, Member States are reluctant to entrust regulatory powers to European bodies out of fear of being evaluated on the relevance of national decision-making processes. The broader use of regulations instead of directives, which may be considered as not binding enough, could help speed up the process.

Beyond the actual health care system, which only accounts for 25% of healthcare results according to a Canadian study, European authorities must commit themselves to a broader public health policy, also covering the economy, the environment, transport… Health promotion consists in informing citizens to such extent that they adopt healthy behaviors on their own, without forcing them to do so.

The sharing of practices comes up against technical and cultural obstacles.

Some measures could bring significant benefits if they were being deployed across the Union, such as a Shared Medical Record. Such a system would increase efficiency and generate a valuable database for research and the management of healthcare systems. Alongside with the widespread use of other digital tools such as telemedicine, European Reference Networks could be developed, enabling the sharing of skills and expertise, and facilitating access to high-tech care.

However, the implementation of such a shared record, already mentioned in 2011 during the vote on the European directive on patients' rights, faces many obstacles: the handling of personal health data raises questions, although it may be guided by the bank card system, which is practically unbreakable and extremely interoperable. Other obstacles are the current heterogeneity of national health card systems, and the distrust of caregivers and health professionals, which is slowing down the development of digital technology as a whole. The implementation of a shared medical record, even though it is utopian at the scale of the EU at the moment, could start with the coverage of the 220 million cross-border workers.

Another element to be pooled is the evaluation of performance. Setting up a European quality assurance agency would tend to homogenize the quality of provided care and help reduce squandering, since 20% of healthcare spending is deemed unnecessary. A European evaluation scheme, with an objective-based approach (of both means and results) rather than a constraint-based one, would generate a particularly effective incentive dynamic. However, the heterogeneity of practices makes it difficult to establish a relevant common evaluation protocol, and cultural differences may accentuate the reluctance of Member States: the British pricing of one year of healthy life would be unthinkable elsewhere.

The European Union must regain its sovereignty in the production of health products

According to a report submitted by Nathalie Colin-Oesterle, the shortage of medicines is partly due to the absence of production of active substances and finished medicines on the European soil. More than 80% of antibiotics are produced in China, placing the European Union in an imprudent position of dependence.

The full relocation of production means does not seem achievable: even allowing state aid and financial and tax incentives for molecule-producing companies, production costs would remain too high. In addition, relocation also depends on sector-specific issues, specific to healthcare industries: clinical trials on larger scales are mostly carried out in Asia, as patient inclusion is much slower in Europe, where it decreased by 25% between 2014 and 2016.

There are two more realistic objectives can be pursued: first, the diversification of production sites to break free from the Chinese monopoly. Second, the relocation of R&D rather than that of production. In this instance, following the model of the American BARDA (Biomedical Advanced Research and Development Authority), a public-private partnership project is under study: the Union and the Member States would share financial and legal risks with healthcare manufacturers, to encourage them to maintain and repatriate R&D on European territory.