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Expert Panel on Effective Ways of Investing in Health (EXPH)

Hearing on the opinion on the organisation of resilient health and social care following the COVID-19 pandemic

Brussels, 20 October 2020 (webinar)

Aim and objectives

The opinions of the Expert Panel on Effective Ways of Investing in Health (EXPH) support the Commission and Member States by providing informed evidence on issues that can make a real change to health systems reforms and health investments within the EU.

The aim of the hearing was to provide stakeholders with an opportunity to share their views on the draft opinion of the Expert Panel **on the organisation of resilient health and social care following the COVID-19 pandemic**. The full draft opinion has been published online prior to the meeting and can be accessed here.

The hearing was organised online via Webex, hosted by the Health Policy Platform. Over 180 participants attended the hearing.

Presentation of the draft Opinion

Panel members: Prof Jan De Maeseneer (chair of the hearing), Prof Luigi Siciliani, Dr Dionne Kringos, Prof Christos Lionis, Dr Heather Rogers

Prof De Maeseneer opened the hearing and introduced the Expert Panel on Effective Ways of Investing in Health. The aim of the meeting was to obtain feedback on the draft opinion 'the organisation of resilient health and social care following the COVID-19 pandemic' in order to see how to improve, correct, and optimize the document. Slido and chat function were used to interact with the audience. The interactive elements were interspersed throughout the presentation and the results can be found at the end of this report.

Prof De Maeseneer introduced the mandate for the Panel and the terms of reference. For this opinion, the Panel was asked to provide guidance on 1) The building blocks to improve care organisation, 2) The conditions for capacity building, 3) Sustainable healthcare provision for vulnerable groups and 4) Criteria to resilience-test health systems.

The Panel members presented summaries of the key points of the draft opinion during the meeting.

1) Health system framework and building blocks

Prof Luigi Siciliani expanded on the WHO healthcare system building blocks framework that the Expert Panel developed further to encompass **inputs, outputs and outcomes**. He explained how this framework could be used to analyse the effect of shocks or structural change on a healthcare system. He provided three examples: an outbreak, a superbug and a structural change.

2) Conditions for capacity building of resilient health and social care

Dr Dionne Kringos presented some key conditions required for capacity building. She highlighted the need for appropriate **information and data for decision-making**. This has three areas. Firstly, measurement capacity is key. It involves the ability to generate the right information using consistent standardised definitions and data gathering mechanisms. This includes patient level data, data on vulnerable groups and data on health determinants, as well as public and patient reported perceptions and experiences. Secondly, information governance requirements are important; such information can be integrated and cascaded across the health system and beyond. She underlined the importance of GDPR in data protection, and how data flows can contribute to safeguarding public health. Lastly, the capacity to use the available knowledge needs to be developed.

She explained the need to **disseminate knowledge and translate it into clinical practice**. For example, there is currently a gradient of clinical guidelines production in the EU. There are few good examples of cross-country, interdisciplinary collaboration on best practice. This could be done more often and at European level.

She mentioned **adaptive resilience**, which includes the ability to anticipate and cope with uncertainties and unplanned events in a timely manner. This also includes recovering basic functions after an unplanned event. This depends on basic resources and the ability of the system to organise itself during and after times of need. Dr Kringos added that a **strong primary care system** is the basis of any emergency response. Adaptive resilience requires strategic planning, some redundancy in the health system, the ability to deploy staff and resources rapidly and good co-ordination of responses.

As an emergency response requires a wide range of actors, good **co-ordination** is important. This can be understood using a soft systems approach. **Clear lines of communication, accountability, and clear data flows should connect each sub-system**. This collaboration draws on the principles of coproduction, scenario analyses and tracing critical pathways that are required to achieve the intended goal.

Dr Kringos then explained **the relationship between government and the general public** that is required for an emergency response; one of mutual trust, evidence based policy and consistent application of policy.

Emergency **procurement** is another important condition. Dr Kringos warned that the suspension of conventional procedures risk abuse. She suggested establishing anti-corruption and governance tools focused on transparency, oversight and accountability. The OECD and WHO provided examples of suitable tools.

Health workers as well as the general public are at risk of developing **mental ill-health**, which can become chronic if no suitable support is available. Mental health therefore needs to be a public health priority and patients should have access to (personalised) recovery plans.

An adequate level of **healthcare workforce** is also important. Staff need to be trained, motivated and well supported. She highlighted the importance of primary care and the need for a legal framework on workforce capacity in the short and long term.

Lastly, Dr Kringos explained the need to **spread the load** across different types of facilities, encourage novel forms of public-private partnerships and separate COVID-19 infected and non-infected patients to ensure continuity of care.

3) Sustainable healthcare provision for vulnerable groups

Prof Christos Lionis explained that the current crisis can be understood as a syndemic and presented a definition of **vulnerable groups** recently published in the Lancet. He went on to present different categories of vulnerable people: medically vulnerable, socially marginalised, professions, which require close proximity to COVID-19 patients, the mentally/psychologically vulnerable and the economically vulnerable. He then presented examples within each of these categories.

Action areas to advance sustainable healthcare provision to vulnerable groups include developing testing strategies, sharing best practices, providing mental health support and developing online trainings for healthcare staff specific to caring for vulnerable groups.

4) Criteria to resilience-test health systems

Dr Heather Rogers discussed what resilience **testing** of healthcare systems might look like. The concept is based on stress tests used for financial institutions. First, she presented an operational definition of resilience, taken from the opinion of the Expert Group on Health System Performance Assessment. She then used the building blocks model presented earlier to understand the elements of resilience and the definitions of "shock", "health system", and the response and "outcomes".

She described the resilience testing process as inclusive with many levels of discussion with different stakeholders involved. The results of the resilience test could be captured in a scorecard that uses a **traffic light system** to display the outcomes of different indicators of resilience. To enable member states to adapt the resilience test to their specific context, the Expert Panel recommends developing a toolkit. Resilience test implementation has five phases (Phase 0-4): a

preparatory phase, qualitative data collection, quantitative data collection, data analysis and system transformation.

Recommendations

- Develop adaptive surge capacity and the local health workforce resilience.
- Research and development for innovative medicines.
- Tackle disinformation.
- Link databases across systems and sectors.
- Invest in primary care and mental health and strengthen system integration.
- Need for equity-driven decision making to reduce the social and ethnic disparities and use data to understand the most vulnerable groups.
- Need for health promotion, lifestyle programmes and inter-sectoral collaborative actions.
- Train healthcare providers, focusing on caring for vulnerable groups.
- The European Commission to invest in developing the methodology and toolkit for the resilience test, put in practice at European level.
- Create learning communities on resilience.

Prof De Maeseneer closed the presentation by calling for EU wide and international solidarity. After the Slido polls, he opened the floor for discussion.

Open discussion: participants' views

EuroHealthNet asked about the lessons learned and the similarities with more chronic emergencies e.g. Non Communicable Diseases (NCDs) or climate emergency. EuroHealthnet also wondered how other EXPH opinions had been integrated. It stated that the opinion feels too restricted to short-term recovery mode in which health systems are expected to operate, and restricted to a bio-medical model of health. The health and social systems reforms agenda in MS is not there, beyond a small reference to the European Semester and its CSRs.

Dr Kringos pointed out that many recommendations, such as task shifting, or a strong primary health system are relevant for NCDs. One does not exclude the other.

Prof Lionis expanded on vulnerable groups. The Expert Panel had agreed that communicable and non-communicable diseases cannot be separated, especially in light of COVID-19, where underlying diseases worsen the course of an acute infection. This has repercussions on community care and primary care. Training and supporting primary care doctors and the multidisciplinary team is key to support vulnerable groups.

Prof McKee added that COVID-19 was hitting those groups most severely that were known to be vulnerable before the pandemic e.g. during the global financial crisis. Interestingly, the countries that have fared best are the Nordic countries (apart from Sweden), which have also managed to minimise the health damage during the global financial crisis. Looking ahead, preparedness for a

pandemic has relevance for all the challenges ahead, particularly climate change, but there are also unknown unknowns.

A **patient**, kidney transplanted, asked whether kidney patients could be specifically mentioned as vulnerable. She also mentioned self-management, such as home dialysis that would be helpful in the context of resilience.

Buitendelijnen NL echoed the concerns of the chronic kidney patient. The pandemic disclosed how kidney patients were among the most vulnerable groups and showed the shortcomings in how treatments are delivered to them. CKD patients are more susceptible to COVID-19 and have worse outcomes than other chronic diseases. Furthermore, for the lessons learned so far, the representative of Buitendelijnen NL stated that a majority of hospitalized COVID-19 patients, entering without kidney failure, developed acute kidney injury (AKI) and a subsequent need for acute dialysis in those patients led to shortages in supplies.

The **European Policy Centre (EPC)** asked about overcoming the fear of using health services, as we have seen in spring. Prof McKee responded that there are ways to protect people such as telemedicine. Examples from the Far East show that they have designed facilities that are robust for situations like this. Much can be done by rearranging patient flows, but it is going to be challenging.

PA-international asked about the Panel's views of an EU body mandated to prepare and prevent future health crises and coordinate amongst countries. Dr Rogers answered that a resilience test would help Member States prepare for a range of known and unknown stressors. In order to conduct a resilience test, the Panel is advocating for creation of cross-border communities and learning communities. If Member States are supportive for EU agency involvement in the resilience test, alongside national authorities, then there is a role for that. It is about building trust, communication and addressing the specific needs of the Member States.

The **European Federation of Neurological Associations** welcomed the focus on non-communicable diseases. They suggested that neurological diseases should be mentioned in the context of vulnerable groups. Prof De Maeseneer responded that COVID-19 affects all systems of the body and emphasised the need to care for people with chronic conditions and ensure their access to care.

The **Association of the European Self-Care Industry (AESGP)** commented how during the pandemic citizens were advised on prevention measures, self-assessment to save healthcare professional for severe cases. It raised questions how responsible self-care has been integrated in this perspective of the "healthcare system" and how much investment in health literacy and prevention can we advocate for as an efficient measure to save up resources and healthcare budget.

Prof Luigi Siciliani commented on some **questions submitted via the chat function**. A recurring question was the **focus of the opinion**: is it COVID focused or more general? He explained that the Panel had tried to focus on both the COVID response and examine the wider opportunity to reform the health system. Many comments focused on primary care, telemedicine, informal carers and self-care. Out of these, he identified **self-care** as an element that could be elaborated further in the opinion. Another theme was about **data integration** across levels, sectors and health systems. Prof Siciliani identified this as another area meriting elaboration. The last common question was about **coordination at EU level**. He explained that there are many options for this. Prof McKee added that self-care was elaborated in detail in a previous opinion on task-shifting.

The **European Federation of Pharmaceutical Industries and Associations (EFPIA)** asked whether the opinion recommended an overarching EU body to collect standardised health data. They further asked how EU agencies can increase their competency in anticipating uncertainty and whether a new approach to R&D will be required. EFPIA also commented that ambitious reform agenda for our health systems should be implemented and the health systems redesigned towards a more value-based approach in order to make them more resilient to all types of challenges. Prof De Maeseneer replied that COVAX demonstrates the need for cooperation and that we need to understand how we can have the maximum impact with the capacity we have. Funding should take the general public interest as the point of reference. Issues such as antimicrobial resistance need to be tackled and put in a general perspective.

Prof McKee added that in the UK a very high proportion of patients entered a COVID clinical trial. You cannot test medications and vaccines before a virus surfaces. However, trials can already be set up prior to a pandemic and, ideally, all patients taking medicines with unknown effect should be enrolled in a clinical trial.

Prof De Maeseneer added that a health system needs integrated electronic patient records to action this.

The **European Organisation for the Study of Obesity (EASO)** pointed out the conundrum of the obesity community. In non-COVID times there is a big push towards primary prevention, although now with COVID they are very vulnerable. They asked to align the point of view of the Expert Panel with the 'no one being left' behind, as during COVID there has been a lot of postponed treatment. EASO also mentioned the ECDC definition of vulnerable populations where under medical vulnerabilities people who have obesity, hypertension, diabetes or cancer were included. EASO advocated towards a more person-centric approach to outcomes based healthcare. Outcomes that matter to people should be the backbone of resilience moving forwards.

Prof De Maeseneer suggested that this fitted with the idea that vulnerability was a very broad concept and thanked for the point.

The **Panhellenic Alliance of Rare Diseases (ESPA)** supported the point on neurological diseases and pointed to the burnout problem that caregivers are facing. They emphasised the need for new staff and technologies such as telemedicine or apps.

EUROLYME asked about development of new diagnostics and incentives to use more plants as part of the pharma industry.

Prof De Maeseneer thanked for the contribution and said that this debate was beyond the scope of the session.

The **European Alliance for Vision Research and Ophthalmology (EU-EYE)** pointed out that hydroxychloroquine (HCQ) had serious side effects for vision. In the case of COVID treatment with HCQ it was unsure how much information was given to patients and their families about the potential side effects, especially in the context of the political backing which caused self-medication. She asked whether resilience also depends on patient education and how patients can be empowered.

Prof De Maeseneer replied that this has to do with good health promotion and patient participation in the processes.

Medtech Europe commented on the definition of resilience and highlighted that there are more opportunities for partnerships between the healthcare and manufacturing community than the procurement process e.g. research.

Prof McKee agreed that the technology sector had a large role to play e.g. in R&D.

The **European Federation of Neurological Associations (EFNA)** said that research is showing that Covid – 19 considerably affects the nervous system in various ways and thus neurological disorders should be taken into account in the opinion.

Vintura (consultancy) asked whether the opinion will contain any learnings on how to improve the health systems in general to become more value-based, person-centred and sustainable.

European Association of Hospital Pharmacists (EAHP) stated that when talking about information and communication technologies across care levels and public health, we should mention data interoperability between different systems (e.g. primary care/secondary care) and different countries. EAHP raised concerns that the draft opinion does not mention enough the problem of medicine shortages, touched upon problems of procurement and supply chains. EAHP highlighted that hospital pharmacists are also an important part of the hospital multidisciplinary team (pharmacovigilance, reconciliation and review, gathering and interpreting research data on medicines used for COVID). EAHP thinks it is important to train all healthcare professionals (including hospital pharmacists) in surge management.

Eurocarers (informal carers representation) pointed at the need to strengthen the partnership/interface between care professionals, patients and their informal carers. However, the

latter group already faced numerous challenges before COVID (e.g. lack of recognition, limited access to info and training, limited opportunities for respite care, etc.) and the crisis has aggravated their situation and isolation so there is a need to acknowledge and support informal carers.

Joint United Nations Programme on HIV/AIDS (UNAIDS) representative stressed the importance of linking data bases across systems and sectors to assess the disruptive impact on the management of other health concern. UNAIDS referred to Covid19 and HIV as colliding epidemics, worsening achievement of the 2020 HIV prevention and treatment targets in many parts of the world, undermining the achievement of the goal of ending the AIDS epidemic by 2030. This particularly affects vulnerable and marginalized populations, including LGBTI, disrupting access to critical life-saving services.

European community pharmacists (PGEU) pointed at several issues that would deserve more attention in this opinion including availability of medicines: looking at procurement but also how to increase the capacity of the healthcare systems and supply chains to prevent and manage occurring medicine shortages. How to remove accessibility barriers for patients to their needed medicines via e.g. investing in home deliveries and make certain hospital medicines accessible in primary care. PGEU welcomed the references to task shifting but asked to make also references to expanded roles of community pharmacists who especially during lockdowns, been a vital element of healthcare systems to maintain continuity of healthcare services, supporting responsible self-care of the population and reducing pressure on overburdened healthcare services in primary care. PGEU acknowledged telemedicine as an important element to pandemic responses, but stressed the need to look into complementary ways of healthcare service delivery in primary care, especially for vulnerable groups, such as home care services and home deliveries of medicines.

Edwards (health innovative technologies company) asked how to strengthen the ageing population and make the health systems more resilient to the demographic shift and any future health crisis.

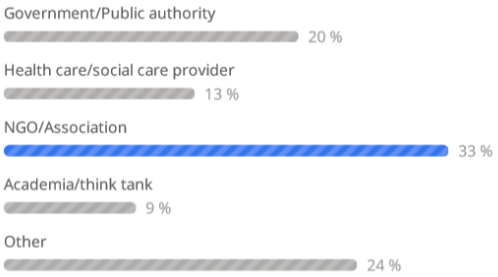
Medicines for Europe stated that although the Panel mentions the importance of access to medicines and their availability, recommendations focus on R&D but there is no mention as to how health care systems should manage medicines supply to be prepared for a potential health crisis and during a health crisis. It is obvious that this was paramount in treating COVID patients but also on supporting treatment continuity for chronic patients. What should MSs and EU do to be better prepared for future health crisis in this matter?

Prof De Maeseneer thanked to all for their active participation, also via chat, concluded the hearing and invited participants to send written comments by 30 October.

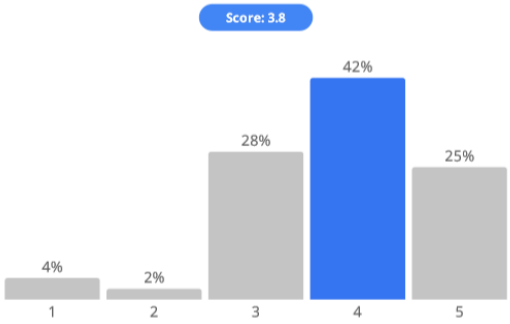
Slido poll results

1) **What is your nationality?**

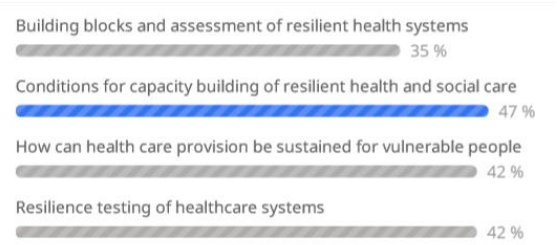
2) **What type of organisation do you represent?**



3) **How relevant is the opinion for your work?**



4) Which part of the opinion is the most relevant for your work?

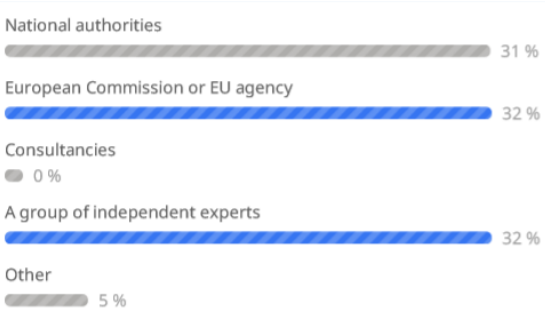


5) What is for you the most important element in the resilience test? (Free text answers)

- Workforce wellbeing
- Testing strategies
- Role of digital to deliver on the needs relationship between the degree of preparedness and outcomes
- Generation and Flow of information
- Development of the relevant indicators (for example, vulnerable populations, etc.), solidarity mechanisms
- cross-sectoral cooperation (finance ministers etc.)
- participation of relevant stakeholders
- Focus on practice and self management of individuals as starting point
- Real world data on providers efficiency is missing
- Structural changes following stress test
- Share knowledge
- Check patient satisfaction
- statistical analysis
- impacts on health equity
- vulnerable people not left behind
- Share Best practices
- Involving both public and private sector in the resilience test
- Multidisciplinary exchange and cooperation
- Long-term stability and adaptability
- Good interface between professionals, patients and informal carers
- Prevention
- Communication of all stakeholders
- The capacity of a health system to continue to deliver the same level healthcare services
- Lessons learned implementation
- Prevention and Detection
- People resources and community resources, combined
- Sufficient health workforce
- Adaptability to different MS health systems

- Unfortunately, the most important element (health outcomes measurements for real people) was conspicuously missing.
- Contribution of all stakeholders
- Important to look at various scenarios
- Confidence and remove the uncertanty in your treatent as a patient
- Availability and willingness of workforce to collaborate
- efficiency hospitals
- Prevention and detection
- Information governance& integration
- Financial sustainability
- Prevention
- indicators
- ICU Capacity
- Comprehensiveness
- Worforce
- Prevention is always a red light!!
- Adaptability
- The need to contextualize
- Phase 0
- Indicators assessing health workforce
- Hospitals

6) Who should be responsible for conducting resilience tests of health care systems?



7) Are you planning to send us written comments?