

**Presentation by Zsuzsanna Jakab, WHO Regional Director for Europe**  
on “The future of health care in Europe” at The Economist Conference

Geneva, Switzerland

17 March 2011

**SLIDE 1**

“The Economist” Conference  
17 March 2011, Geneva

**The Future of Health Care in Europe**

Zsuzsanna Jakab  
Regional Director, WHO/Europe

 World Health Organization  
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Ladies and gentlemen,

I am really very grateful to have been invited to speak to this distinguished audience on the future of health care in Europe.

I do so knowing of course that so many predictions have been wrong. Famously, in 1899, Charles H. Duell of the United States Office of Patents said that: “Everything that can be invented has been invented”.

Well, I shall be a little more optimistic about our capacity to explore the future than Mr Duell, but I shall also remember how hazardous prediction can be.


WHO is a public health organization, concerned with describing and analysing the health of populations, in terms of the full range of determinants. It is also concerned with working with its Member States and others to define and implement practical policies and actions to improve health.

## SLIDE 2

**1948 WHO definition of health**

“A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”

World Health Organization

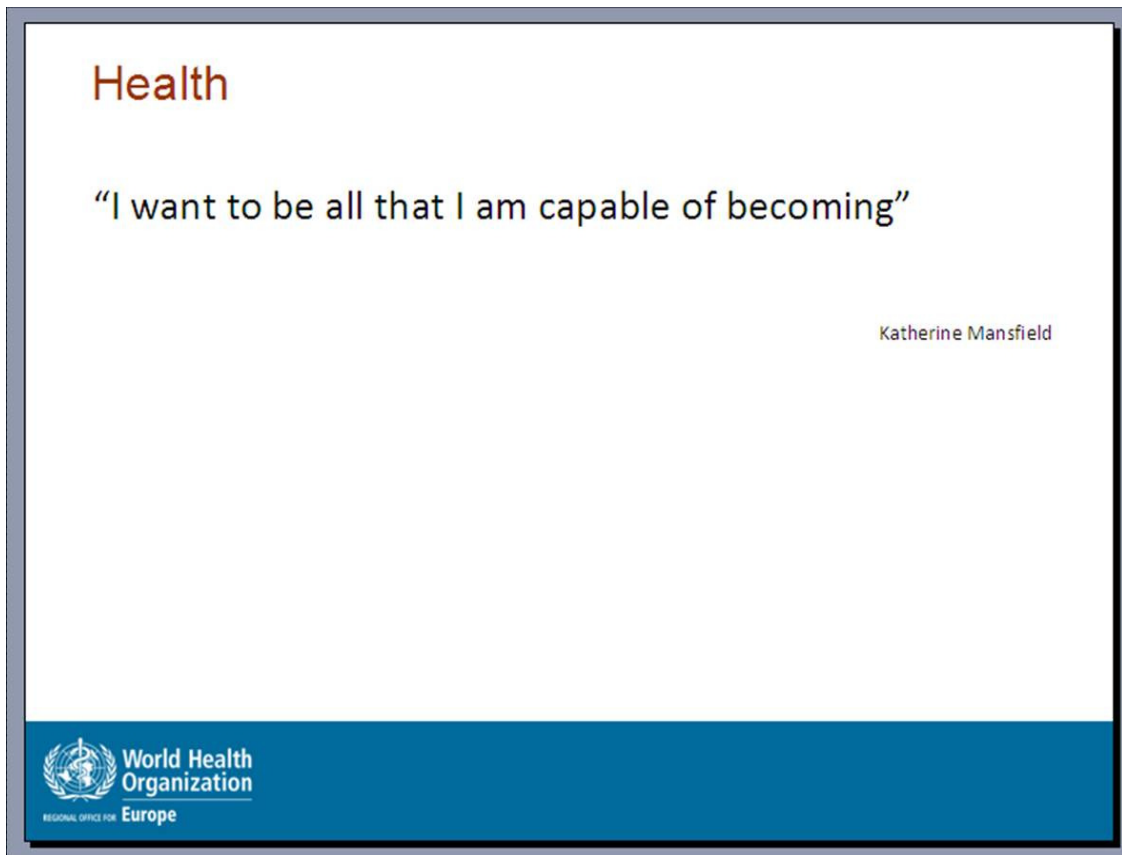
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In its famous definition of 1948, WHO defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”<sup>1</sup>. This definition includes both health and well-being. It is of course an ideal, and needs to be given practical description.

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<sup>1</sup> Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946


## SLIDE 3

A slide with a white background and a blue footer. The word "Health" is written in orange at the top left. Below it, the quote "I want to be all that I am capable of becoming" is centered in black. To the right of the quote, the name "Katherine Mansfield" is written in a smaller black font. The footer is a solid blue bar containing the World Health Organization logo and the text "World Health Organization" and "REGIONAL OFFICE FOR Europe".

Health

“I want to be all that I am capable of becoming”

Katherine Mansfield

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Many have tried to do this, yet the definition I most enjoy is that of Katherine Mansfield: “I want to be all that I am capable of becoming”<sup>2</sup> Ultimately then that is our goal, to enable our peoples to be all that they can be, to live as long as they can live, in, as Katherine Mansfield also said, that “full, adult, living, breathing life in close contact with what I love – the earth and the wonders thereof”.

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by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948

<sup>2</sup> Entry in her journal (10 October 1922) which she tore out to send to John Middleton Murry, before changing her mind. This later became the last published entry in *The Journal of Katherine Mansfield* (1927) ed. J. Middleton Murry

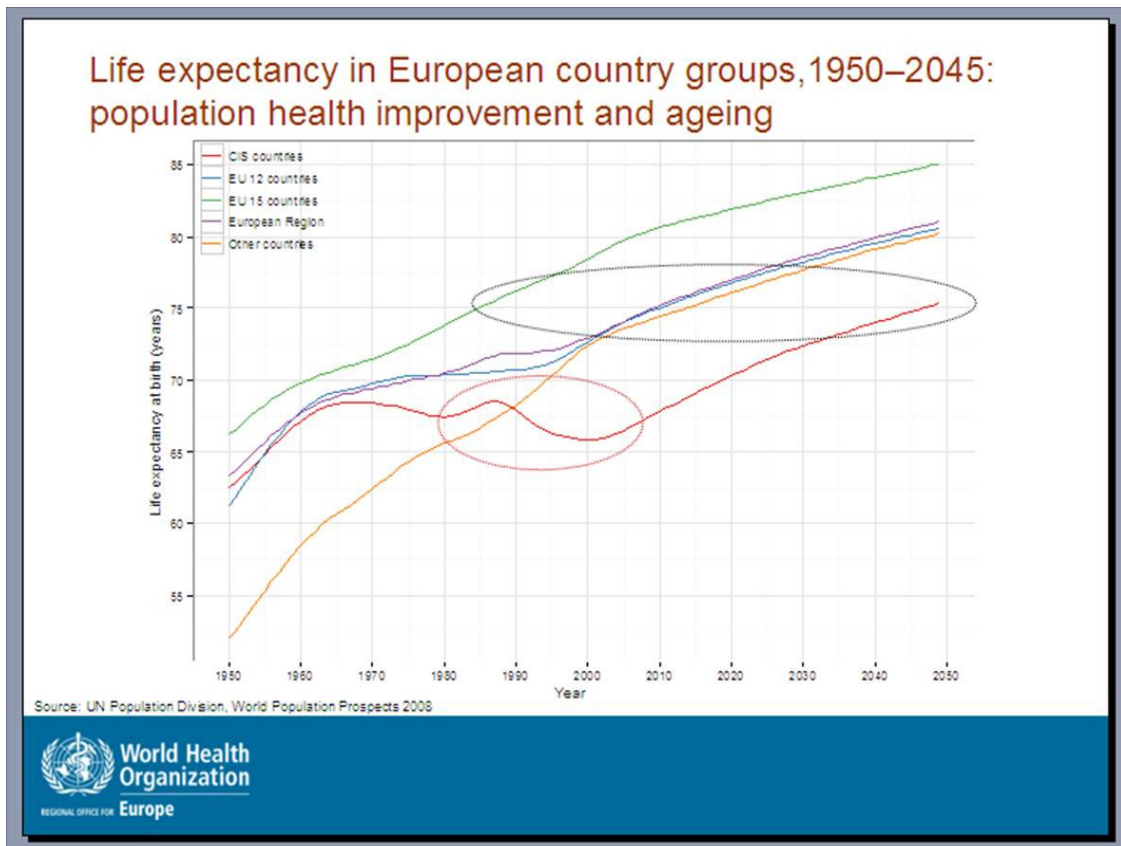
If this is our goal, we are far from achieving it now. Although the current state of health across Europe is improving, it is far from what it could and should be with the current state of our knowledge and technological capacity to intervene.

Across the European Region there is great variation and change in the establishment and capacity of both public health and health care systems, as well as the resources that are available, particularly as we have passed through a period of acute financial crisis.

This change and variation will provide the context for what I will say today.

The WHO European Region consists of 53 countries: from Iceland and Greenland in the west, to the Pacific coast of the Russian Federation in the east. It comprises almost a billion people.

## SLIDE 4

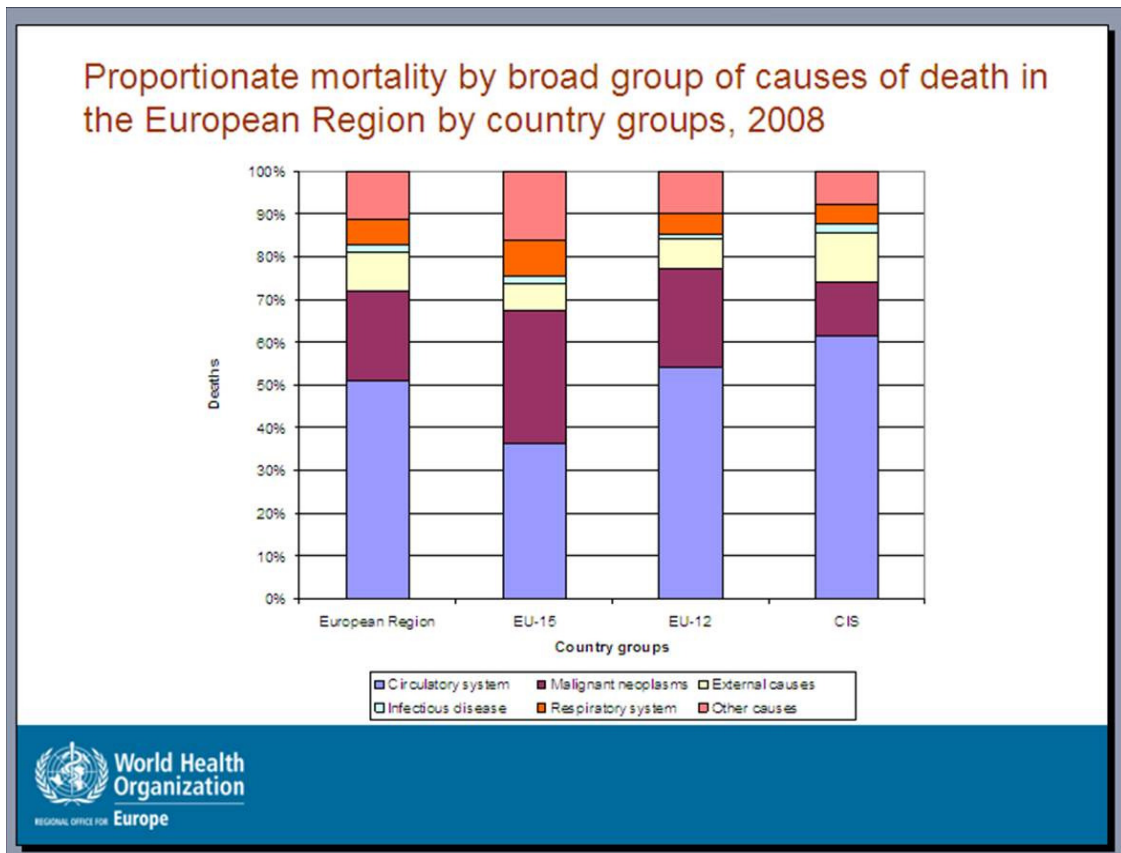


Overall health in Europe is improving as shown by life expectancy at birth, which has increased by 5 years since 1980 and reached 75 years in 2010. Projections suggest it will increase to nearly 81 years by 2050, at a similar pace to the 1980-2010 period.

This improvement is far from uniform. The EU-15 countries have already reached the 2050 level expected for the whole Region and it is estimated that their life expectancy will continue to grow, reaching 85 years in 2050. In contrast, the CIS countries are only expected to reach 75 years of life expectancy by 2050, that is, the same level observed in Europe 40 years earlier and in the EU-15 countries 65 years earlier.

This is just one example. Across the Region health-related inequalities persist between and within countries, stratifying populations according to ethnicity, gender, socioeconomic status, educational status and geographical area.

## SLIDE 5



I will now consider the current causes of death in the European Region. Noncommunicable diseases cause the largest proportion of mortality, accounting for around 80% of the deaths in 2008. Among broad groups of causes, mortality from circulatory system diseases accounts for nearly 50% of all of deaths with ranges from 35% in the EU-15 countries to 65% in the CIS. Cancer mortality follows in frequency, causing 20% of deaths in Europe and varies from 7% to 30% in CIS and EU-15 countries, respectively.

Yet also, emerging and re-emerging communicable diseases remain a priority area of concern in many countries of the Region. These diseases include HIV/AIDS, multiple drug resistant tuberculosis, and the growing threat from anti-microbial resistance. Also of note are alarming outbreaks of potentially global significance, such as pandemic H1N1 influenza in 2009 and last year the re-emergence of poliomyelitis in Tajikistan threatening the Region's polio free status, which it has held since 2002.

These groups of causes are followed by the injuries and violence group with rates at 67 deaths per 100 000. External causes of death are particularly relevant for the CIS countries, where they are the second greatest cause of premature death.

There are more sophisticated epidemiological analyses available and in the time available I can illustrate only one of these.


The use of disability-adjusted life years (DALYs) as a tool for assessing health status beyond mortality provides another focus for assessing health, since not all the burden of diseases is related to death but may be related also to morbidity and disability.

## SLIDE 6

Leading causes of DALYs lost in EU countries, 2004

- **Unipolar depressive disorders**
- **Ischaemic heart disease**
- Hearing loss, adult onset
- Alzheimer and other dementias
- Chronic obstructive pulmonary disease
- Cerebrovascular disease
- Osteoarthritis
- Diabetes mellitus
- Cataracts
- Road traffic accidents
- Trachea, bronchus and lung cancers
- Poisonings
- Alcohol use disorders
- Cirrhosis of the liver
- Inflammatory heart disease
- Self-inflicted injuries

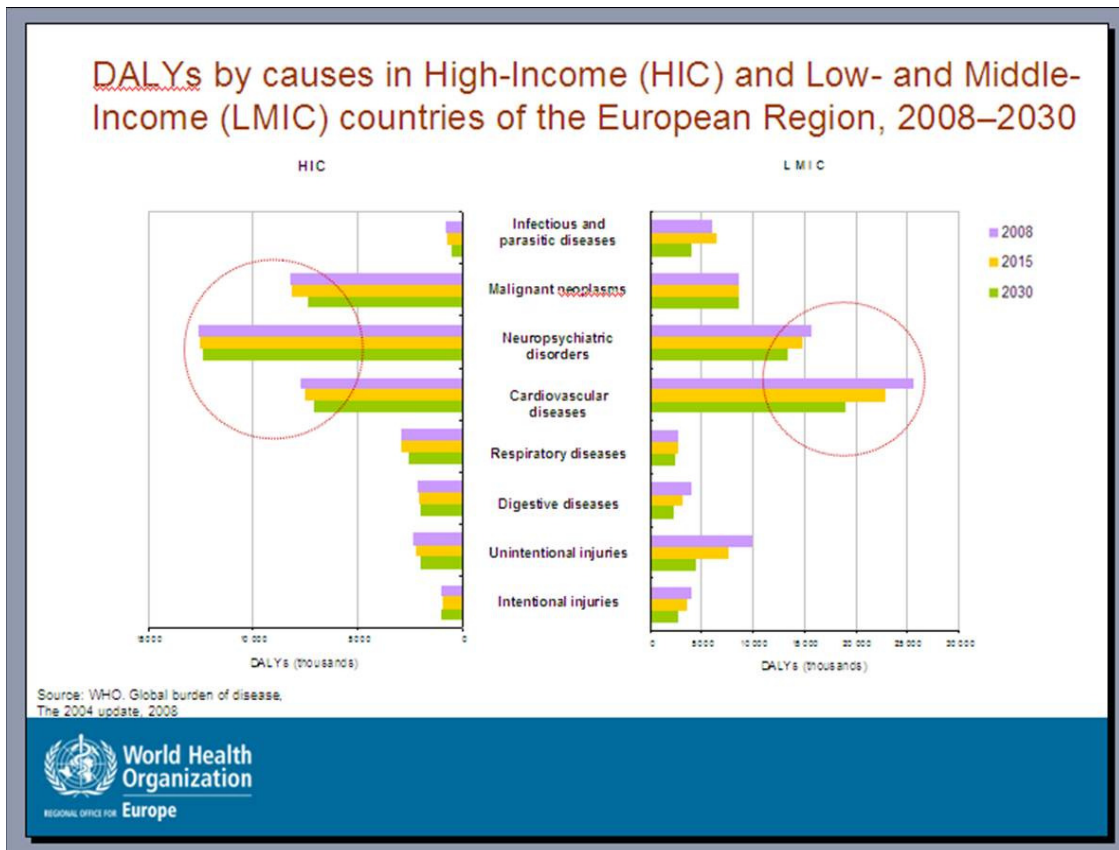
Source: WHO. Global burden of disease. The 2004 update, 2008.

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The latest revision of the global burden of disease in 2008 produced a list of leading causes of DALY loss for EU countries. The ordered list, with unipolar depressive disorders and ischaemic heart disease as the top disease

entities, also includes many non-fatal outcomes or diseases with low case fatality but that may cause severe and/or long-standing disability.

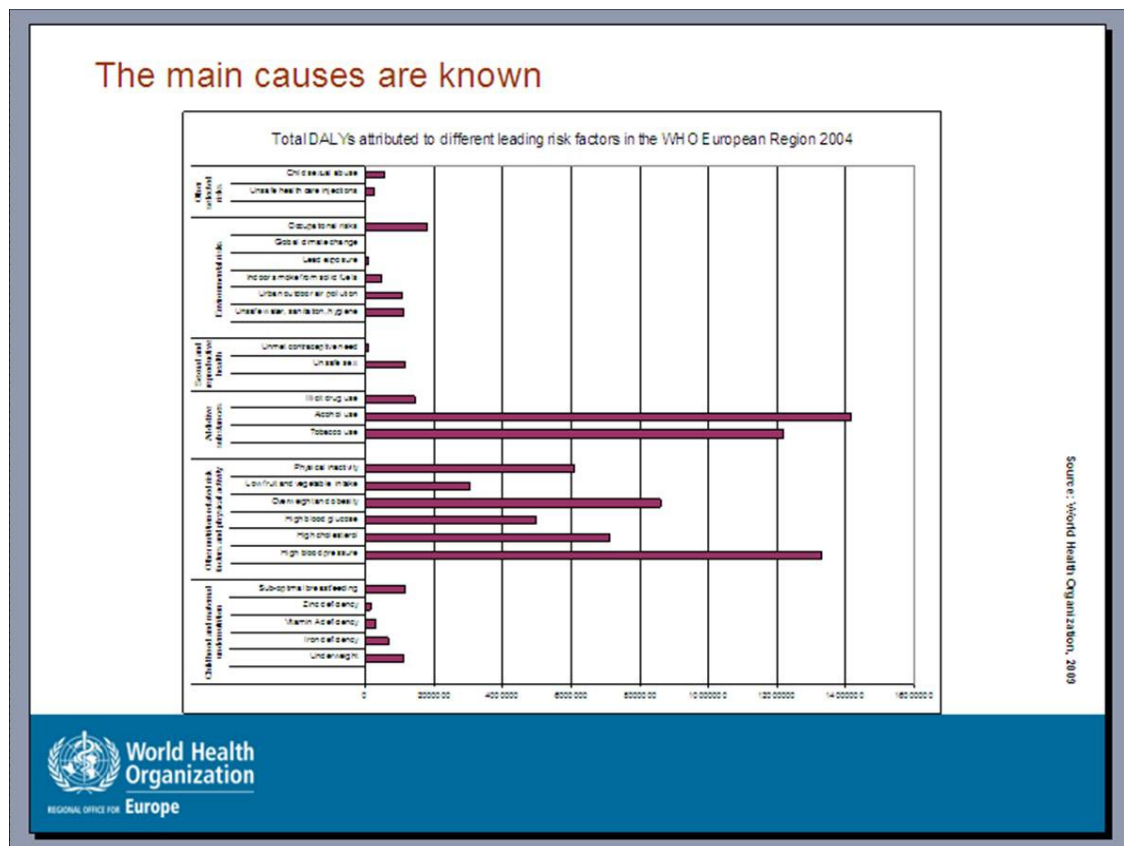
## SLIDE 7



Although continuously revised, the total DALYs have been attributed to different leading causes in the European region. As a result, it is possible to identify and establish the most important areas for intervention such as nutrition, physical activity and addictive substances, mainly to reduce overweight, obesity, high cholesterol and blood pressure, and alcohol and tobacco use.



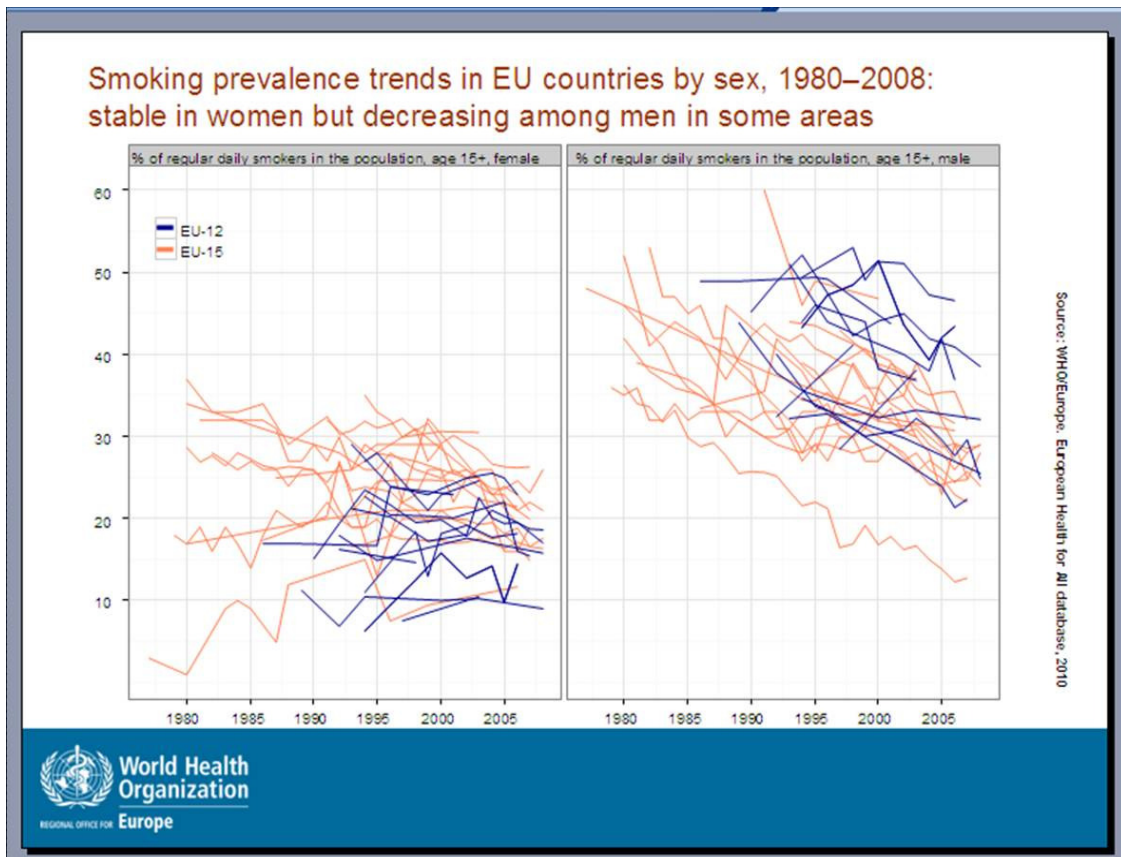
## SLIDE 8



I will consider now some risk and behavioral factors relevant to this burden on non-communicable diseases. Alcohol is of particular importance in Europe today. Total alcohol consumption rates show increasing trends in Europe, particularly among low and middle income countries with levels converging with the consumption rates of high income countries.

Also in low and middle income countries the consumption of high content alcohols (spirits) is nearly 35% higher than in high income countries. This situation is linked to permissive consumption policies, affordable alcohol prices and aggressive targeted marketing.

## SLIDE 9



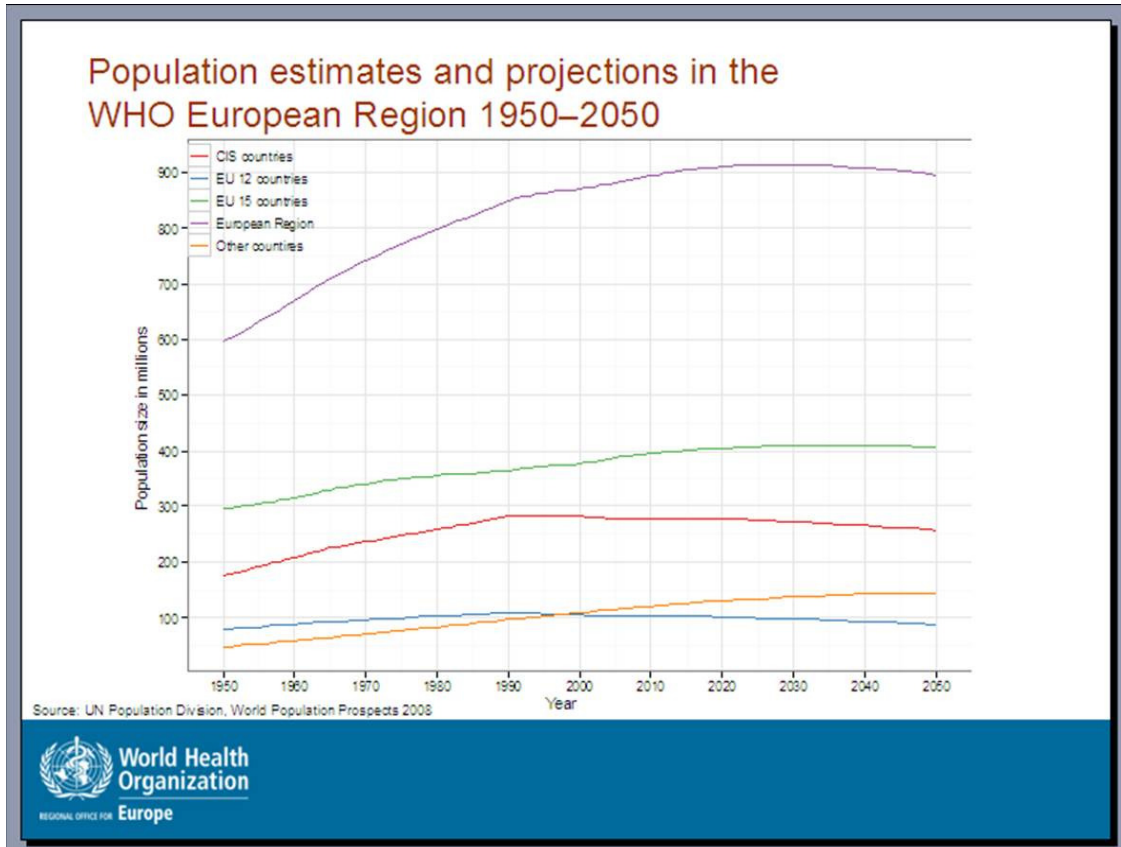
Overall smoking prevalence in the EU is 27%, nearly 35% among men and just below 30% among women. Smoking prevalence is decreasing in many countries among men, particularly in the EU-15, in contrast with the stable situation observed among women in most countries.

We have seen the development of effective whole society interventions against tobacco consumption at the legislative level such as the Framework Convention on Tobacco Control (FCTC) and the control of tobacco consumption in public places.

Yet in spite of this progress much more needs to be done to tackle the current burden of noncommunicable disease in a more integrated way, encompassing other behavioral determinants such as alcohol, diet, exercise and substance abuse, in order to reduce the incidence of noncommunicable diseases for all populations and the subsequent costs for the health system.

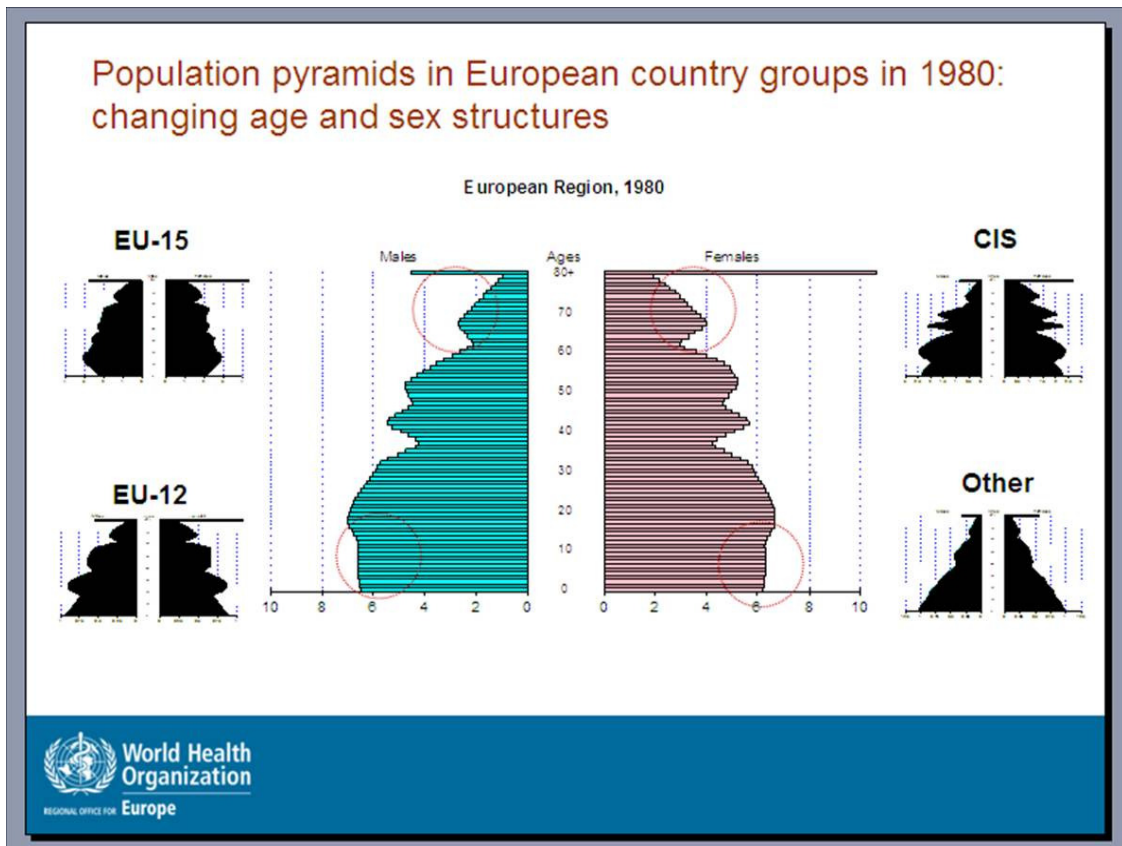
We are perhaps seeing the beginnings of change here with some legislative controls on the availability for consumption of trans fats.

## SLIDE 10



I turn now to demography. In terms of size, the population of the 53 countries of the European Region reached nearly 900 million in 2010, 44% of whom live in EU-15 countries and another 33% in the CIS.

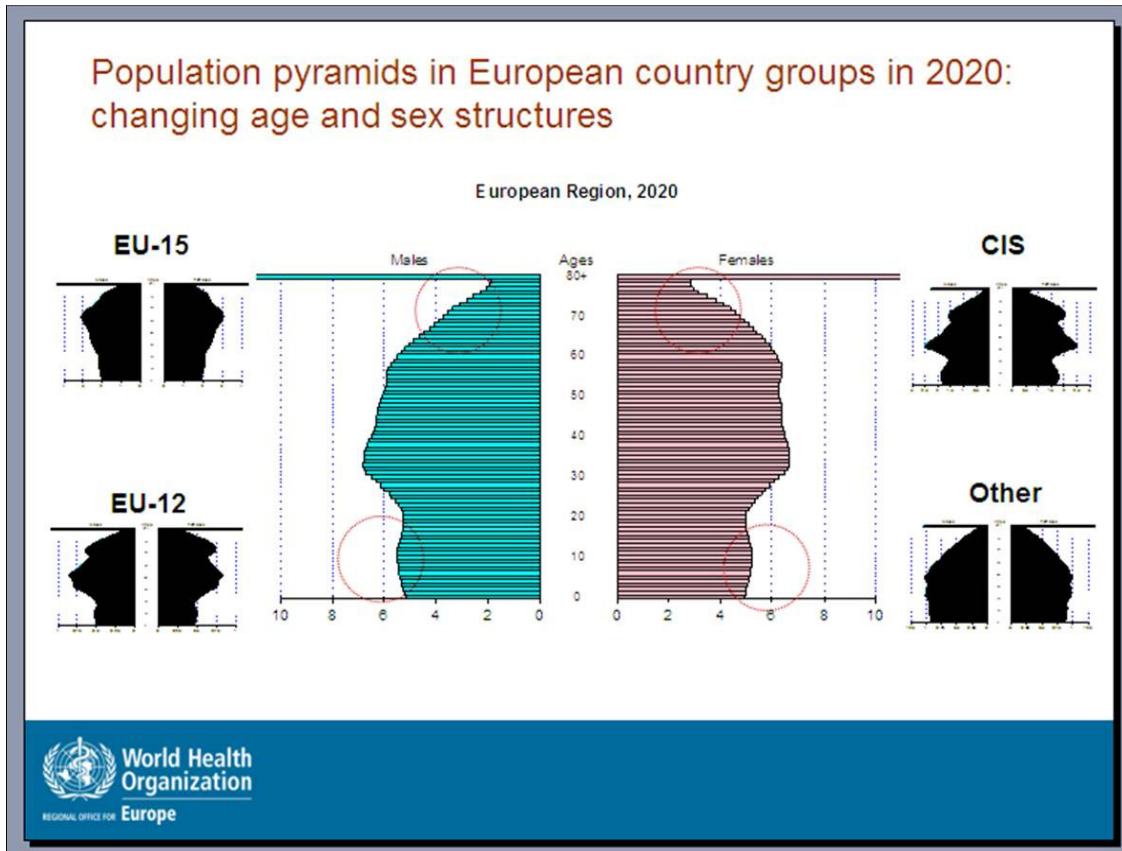
## SLIDE 11



The age and sex population pyramids provide insights on the combined demographic effects of the natural population increase and migration. The trends and projections of the European population from 1980–2020 show important structural changes, including marked differences by country groups. Between 1980 and 2000 decreasing young populations contrasted with fast growing segments of the elderly population aged 65 years and over in all country groups.

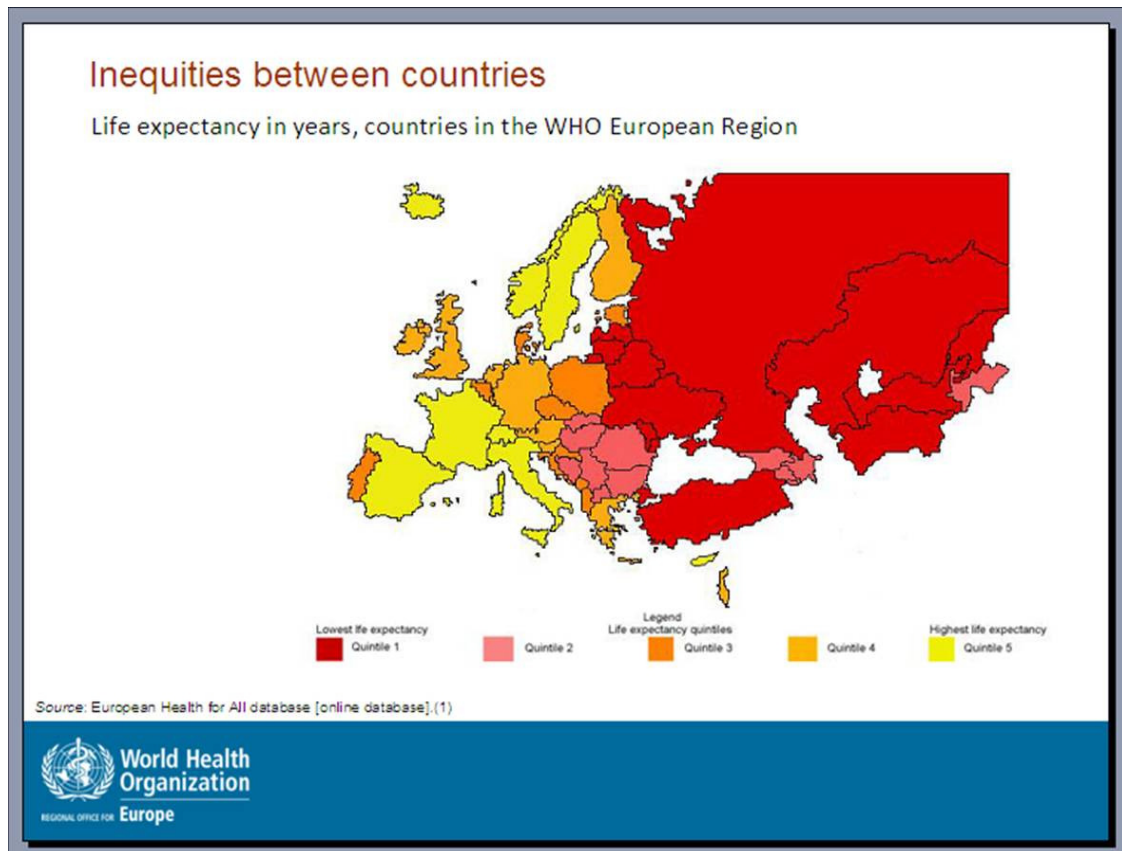
This ageing Europe will mean different challenges for the health and welfare systems: preparing and acting now on policies and strategies for improving the living and health conditions of the population in the future will be essential to mitigate potential negative impacts.

## SLIDE 12



Migration is another very important demographic factor. An estimated 73 million migrants, 52% of whom are women, live in the European Region, accounting for nearly 8% of the total population of the Region. This usually younger, less affluent group, may be more frequently affected by illness and have more limited access to health care than the rest of the population.

## SLIDE 13



Looking now at social trends, as I have said, there are large inequities in health across the Region, arising from inequalities in the social determinants of health, social policies and programmes, economic arrangements and the quality of governance. These determinants are responsible for inequalities in the lives people are able to lead and affect their health through experiences in their early years, including education, working conditions and employment levels, income levels and distribution, community life and public health and health systems.



It is also important to understand the critical role of the health system in addressing the determinants of health. Social determinants often affect whether a person is able to access health care services and the quality of care they receive. Health ministries have a vital role to play both in ensuring the contribution of the health system and in advocating for health equity in the development plans, policies and actions of players in other sectors. The health system alone cannot reduce health inequalities.

I would also highlight society's expectation of a new form of governance for health that is far more participatory as far as citizens are concerned at every level. Alongside national governments now are a plethora of regional and local administrations, the private sector, nongovernmental organizations, institutions, communities and individuals, which all are, and must be, involved.

Citizens now have high expectations, reflecting an increased awareness of their rights and choices. Health is increasingly seen in human right terms. Citizens want to be involved in their own health, including when decisions are made on disease management and treatment.

Then patients have often been quicker to take up many of the new communication technologies than the health professionals serving them. This is especially true in the field of chronic disease management, where patient involvement in care has shown positive effects in terms of outcomes.




## SLIDE 15

### Definition of technology

“The use and knowledge of tools, techniques, crafts, systems or methods of organization in order to solve a problem or serve some purpose”

Merriam-Webster



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I shall take a broad definition of technology, namely: “The use and knowledge of tools, techniques, crafts, systems or methods of organization in order to solve a problem or serve some purpose”<sup>3</sup>

So here technology refers to the whole range of health policies, systems, programs, and activities that constitute societal action for health, as well as specific utilities used for diagnosis and treatment.

With the strong support of the Regional Committee for the WHO European Region a new European policy for health (which we are calling Health 2020) is being designed and implemented as a collaborative initiative between WHO, Member States and their health-related institutions and stakeholders.

This will be a visionary policy, encompassing what is known of health and its determinants, the necessary new governance for health, the political, economic,

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<sup>3</sup> Merriam-Webster

social, environmental, institutional and health system underpinnings of health, and pathways to health and well-being.

The WHO Regional Office for Europe will seek collaboration from scientific partners and relevant professional groups, civil society and policy communities. Diverse stakeholders<sup>4</sup> will be engaged in order to strengthen existing evidence, know-how and support for action to achieve better health for Europe.

In my view a renewed commitment to public health in Europe is essential. Health 2020 will focus therefore on a commitment to strong public health infrastructure and essential public health operations across Europe, comprising health protection, health improvement, and health service development. Primary health care must also be strengthened.

In many countries now, investment in population-based health promotion and disease prevention services is lamentably low. It is through interplay between improved public health functions and capacities, and more effective, responsive and efficient health care, that health will be improved. Public health and health care are mutually supportive, and must never be thought of as distant to or working against each other.

Leadership will be vital. Today's leaders for public health must initiate and inform a health policy debate at political, professional and public levels, taking a "horizontal" view of the needs for health improvement across the Government and society as a whole. They must create innovative networks for action among many different actors and be catalysts for change.

I consider now health care systems. The issue facing all countries in the European Region is how to demonstrate value by improving performance and reducing costs, maintaining and improving health system performance, while maintaining the values of solidarity, equity and participation that European Member States have several times agreed in international commitments, for example in the Health for All policy, HEALTH21, and the Tallinn Charter.








Health care systems will become more capable, with a greater impact on health experience at both individual and population levels than hitherto.


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<sup>4</sup> Scientific experts, policy makers, professional and other networks, NGOs and development institutions from across sectors and covering Pan European, National, regional and local levels of administration

## SLIDE 16

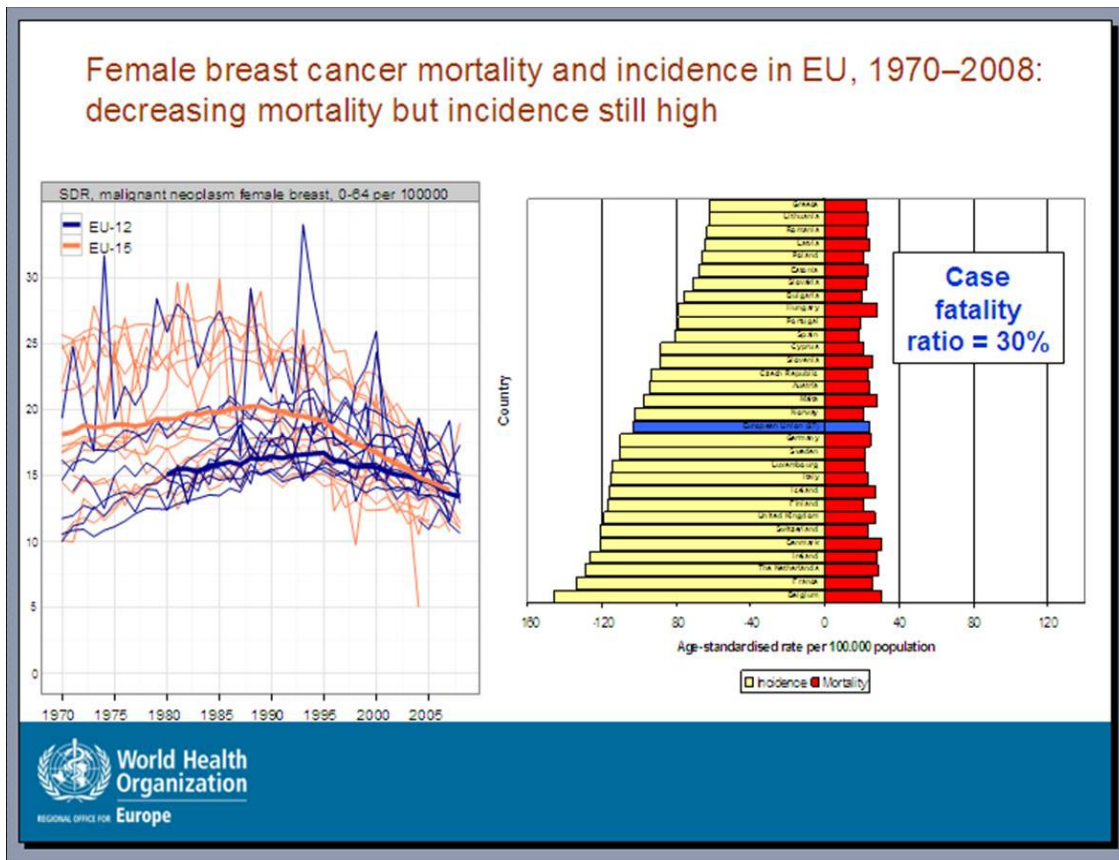
### Some nanotechnology applications

	Surface-bound platinum particles used as carrier materials in car catalyts	
	Carbon <u>nanotubes</u> incorporated into solid materials (ratchets, bikes)	
	Titanium dioxide suspended in liquids e.g. sunscreens	
	Airborne <u>nanoparticles</u>	

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Diagnostic, medical and surgical interventions have been transformed, as has drug based therapy. E-health and telemedicine are examples of the transformative impact of new information technology. Nanotechnologies are on the horizon. The possibilities emerging from new medical genetics may be profound.

## SLIDE 17



I will take a specific example of breast cancer which highlights the interplay of determinant factors and also the importance of health care systems. Breast cancer mortality is the single most frequent cause of cancer death among women in Europe at 23 deaths per 100 000 women, and the cancer with highest overall incidence.

Mortality trends show that after an earlier period of stable or increasing rates, most countries experienced reductions and convergence towards the average value for the EU (24 per 100 000). Also, while incidence rate patterns are high and show a gradient, mortality is nearly constant for most countries, yielding an encouraging case fatality ratio of 30%.

Increased disease risk has been associated with diet, alcohol, obesity, reproductive history, with fewer children at older ages, and the use of hormone therapies. There is also a type of cancer affecting younger women that has been linked to genetic factors and family history.

In the absence of very clear modifiable risk factors and effective interventions to limit incidence, efforts have been directed to increase survival after diagnosis. An important related aspect has been the improvement of the health care system, which has led to increased survival, due to cancer screening and early diagnosis and the increasing availability of effective treatments.

## SLIDE 18

Cost drivers?



The slide features two images. The left image shows four elderly individuals (two men and two women) sitting on a wooden bench outdoors, with a body of water and a clear sky in the background. The right image is a close-up, top-down view of a large pile of various pills and capsules in different colors (yellow, pink, blue, red, white) and shapes.

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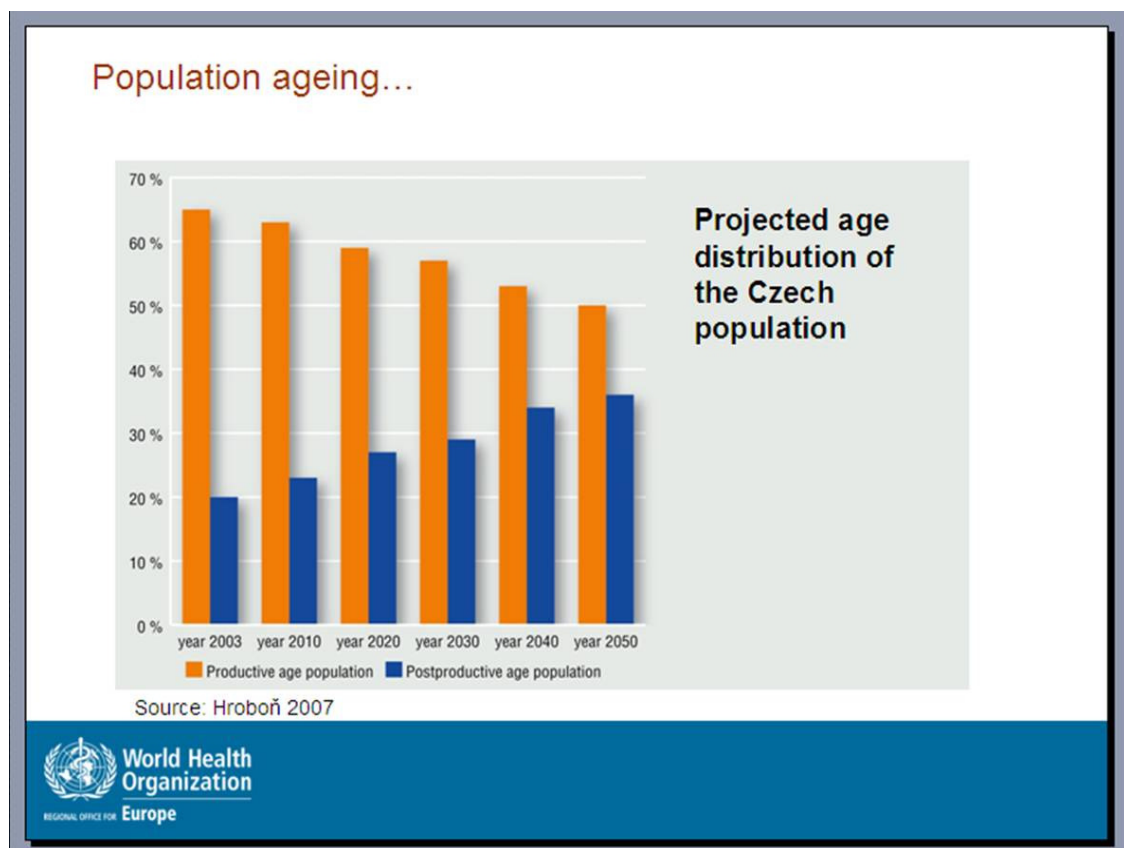
I turn now to economic factors, given additional prominence during the recent economic crisis.

There will be an increase in societal pressure for a higher proportion of GDP and government budgets to be devoted to health. The factors that have driven costs upwards in the health sector over the past twenty years will continue to intensify. These include the demographic and ageing pressures I

have already mentioned, and also the expansion of what is possible in terms of the diagnosis and treatment of disease.

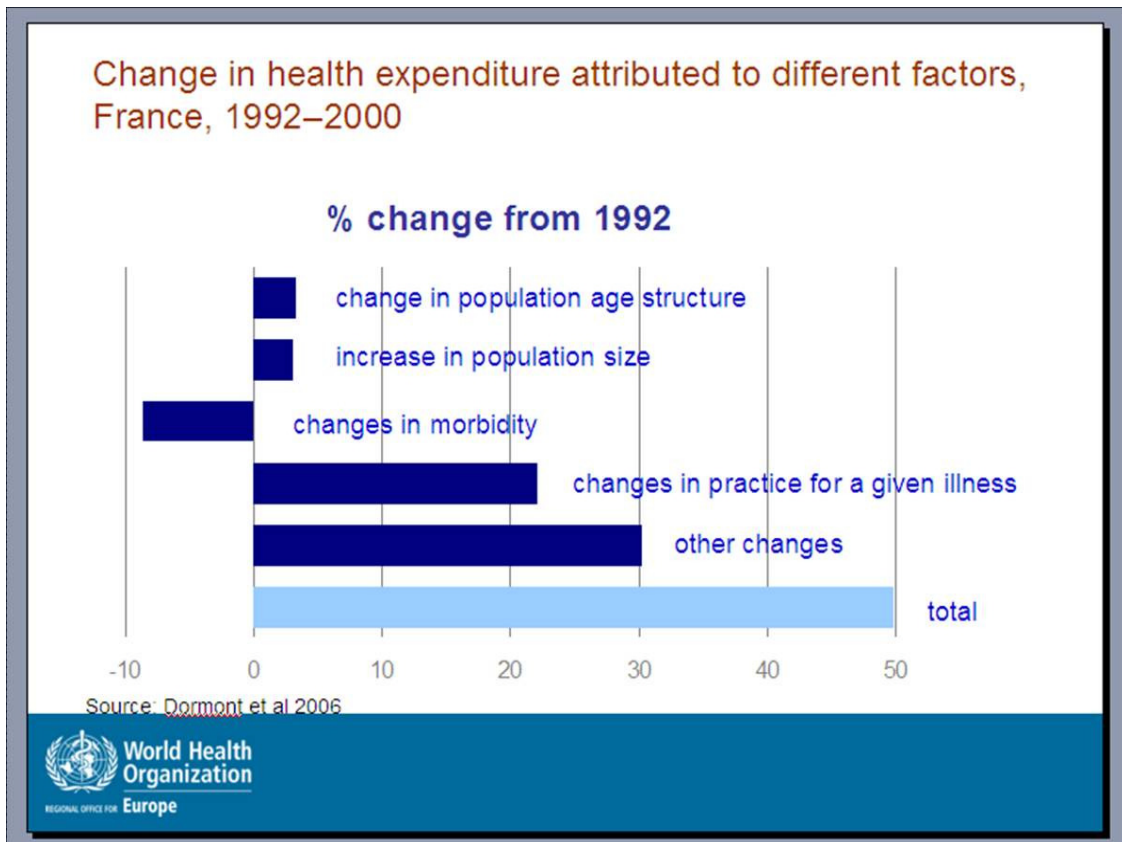
The weight of international evidence suggests that technological change leading to changes in clinical practice is a main driver of costs. Studies summarized in WHO's work for the Czech EU Presidency Conference on Financial Sustainability suggest that technological development accounts for between 50 and 75% of the growth in health care costs.

## SLIDE 19



While aging has long been cited as a cost driver, evidence suggests that it exerts far less pressure on costs than technological change. Studies suggest that ageing per se accounts for less than 10% of the growth in health costs.

## SLIDE 20





These data for France show that the impact of technological change, combined with income growth and expectations (summarized as “other changes” in the figure) is substantially greater than aging.

However ageing will have other effects. With an aging population, a smaller share of the total population will be of economically active age. Growing dependency ratios imply that a smaller share of the total population will be “contributors”, serving a larger number of “dependents”. This is a particular challenge for those countries where most revenues come from wage-linked contributions.

## SLIDE 21

**Improving efficiency**  
helps reduce the adverse effects  
of the crisis and secure popular  
and political support for more  
spending in the future



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Europe

Also we can be certain that there will be a greater search for savings and efficiencies. It is difficult to argue for more public spending on health when there is waste and inefficiency in the system. Not all public spending is good spending! We must ensure that no public money is wasted in the system due to poor governance and organization of service delivery.

That said, budget cuts create huge pressure on service providers to increase efficiency. However, there is a limit to how much and how fast efficiency gains can help deal with a financial crisis. Savings need to be carefully managed, so that patients get access to the care they need, even during transition.

While short-term solutions are important to keep the system running during times of economic crisis, these balancing acts may not be sustainable in the long run. We should aim for sustainable efficiency gains such as improving energy efficiency, shifting more care to outpatient settings, allocating more to primary care and cost-effective public health programs such as health



promotion and disease prevention, cutting the least cost-effective services and improving the rational use of medicines, to name a few.

There will also be a need to demonstrate cost-effectiveness, seeing an expanded role for agencies such as the National Institute for Health and Clinical Excellence in the United Kingdom, using criteria to create advisory judgements on the impact and cost effectiveness of new technologies.

## SLIDE 22

History has taught us that growing inequity is socially unsustainable



So when we speak of financial sustainability, we should be speaking of sustainability of achieving equity, financial protection and health. History has taught us that growing inequity is socially unsustainable. As always, our actions should be guided by values.

## SLIDE 23

### Combine values with an understanding of context

- Values still at the core of our approach
  - equity, solidarity, participation
- Operationalize these through goals and measurable objectives
  - health gain, equity in health, equity in finance, financial protection, responsiveness
- Wider economic pressures demand increased attention to efficiency: getting the most health from the resources we use

## SLIDE 24

### Commitment to solidarity

- Economic and social distress tests attitudes to solidarity
- Equity in finance and utilization
  - The larger the **share of public financing** for health, the greater the scope for solidarity
  - **Targeting the poor and vulnerable** requires political commitment: in many systems, the rich benefit more than the poor!



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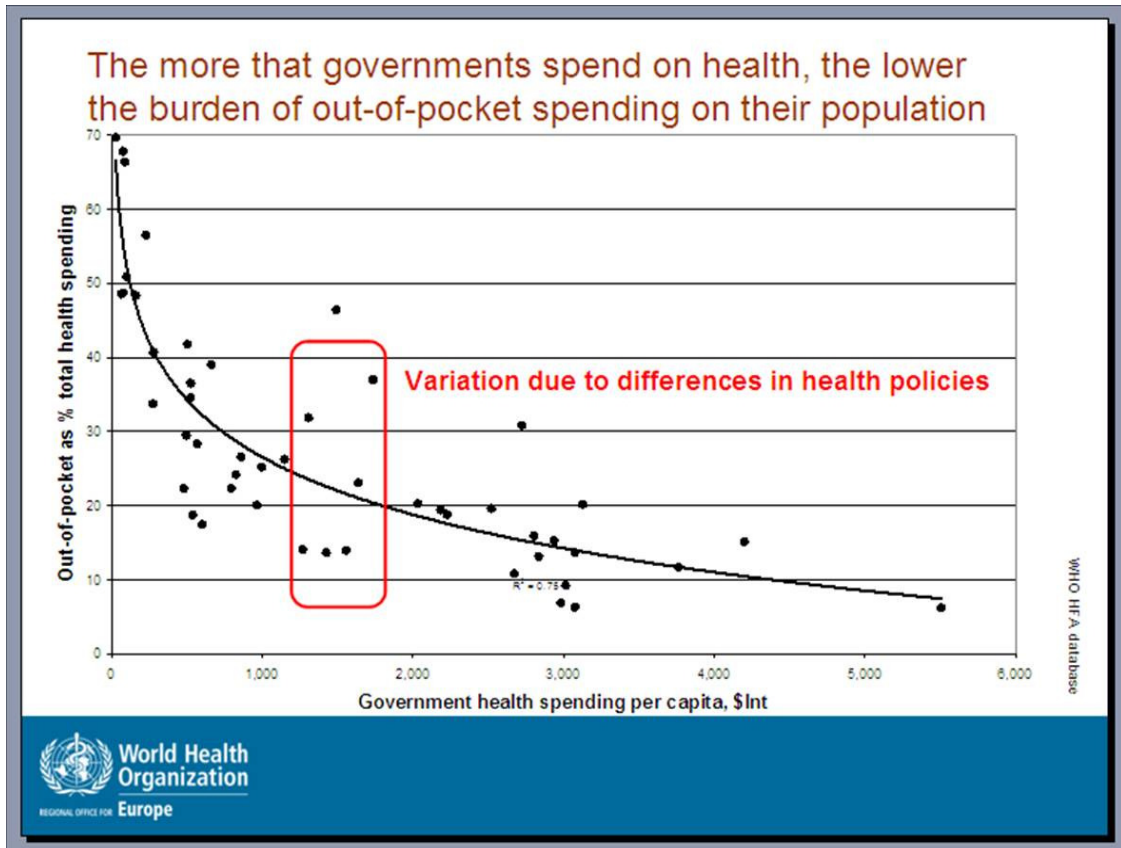
Finally I will speak a little more fully about the recent economic crisis. A crisis does present opportunities not to be missed. Recently, the effects on our health care system have been extensively reviewed by WHO.

Economic and social distress tests commitment to solidarity. A crisis can lead to the erosion of solidarity, yet also it has the potential to bring about increased popular support for solidarity, as more people become exposed to the risk of unemployment, feel less secure about the future and experience health problems.

Policy tools can help sustain equity in finance and utilization. We know that the larger the share of public financing, the greater the scope for redistribution, hence for solidarity. Redistribution of resources to the poor and vulnerable is not just a question of the taxation system, but can also be addressed through better targeting of benefits.

The recently published World Health Report<sup>5</sup> on universal coverage provides a comprehensive overview of the global situation with regard to universal coverage and offers actionable recommendations on how to move forward in strengthening the health financing systems of Member States.

## SLIDE 25



There is a strong correlation between government spending on health and the burden of out-of-pocket spending on the population, as this chart shows. However, what we also know from this chart is that government policies can make a big difference. It is not just about the available resources and how wealthy a country is. It is also about good governance, the right decisions and the right policies implemented. So we argue for more public spending and better public policies across government.

<sup>5</sup> The World Health Report Health System Financing-the path to universal coverage World Health Organization Geneva 2010

SLIDE 26

### Analysis of Financial Protection in Hungary

Gábor P. Evertovich, T. Mészáros, É.

**Objectives and relevance**

The paper studies trends of financial protection indicators in Hungary for the period of 2002-2007. The policy intention of the study period is that overall health policy measures were implemented in 2007, such as the introduction of patient co-payment in ambulatory and hospital care, and significant increase of out-of-pocket for pharmaceuticals. We aimed to evaluate the WHO methodology for financial protection indicators based on expenditures on total net (i.e.) appropriate in the Hungarian context, and if alternative methodologies significantly change the results.

**Methods**

We used three indicators of financial protection: catastrophic health expenditures, impoverishing health expenditures and the difference in the poverty gap due to out-of-pocket health payments. The rates of all three indicators changed in similar epidemiological directions, except which we have studied the method for the calculation of the poverty line (impoverishing health expenditures) since that has been used only before the present paper as a result of several previous studies on health care expenditure in Hungary. The present study is a continuation of the WHO methodology for financial protection indicators in Hungary. The methodology of the Hungarian Central Statistical Office. Utilization of indicators of health services and perceptions data is based on administrative data of the Hungarian National Health Insurance Fund.

**Results and discussion**

Despite the relatively high level of gross health expenditure in Hungary (about 87% of total health expenditure in the selected region), the WHO methodology for financial protection (i.e. catastrophic health expenditure) is still high, and the poverty gap is wide. The a majority of 22 million administrative data respondents reported to have had catastrophic health expenditure with a poverty gap of EUR 13.5 million.

Between 2002-2006, we see a decreasing trend, while in 2007 a specific increase is observed. However, the 2007 trend is still below that of earlier year 2002. The increase in 2007 is in line with our expectation that the health policy measures implemented in that year had adverse effects on financial protection. Our analysis of distribution according to socio-economic status suggests that impoverishing health expenditures affected significantly the poorest quarter of the population and the distribution of catastrophic health expenditure is also very skewed towards the poor households. It has to be noted that annual growth rate ranges from 17% in 2002 and 17% in 2006, but dropped to -4.5% in 2007 which may have contributed to the observed level of financial protection.

**Figure 1: Percentage of Respondents Reporting Catastrophic and Impoverishing Health Expenditures, Hungary, 2002-2007**

**Figure 2: Percentage of Respondents Reporting Catastrophic Health Expenditure, Hungary, 2002-2007**

**Figure 3: Percentage of Respondents Reporting Impoverishing Health Expenditure, Hungary, 2002-2007**

**Conclusions and recommendations**

Findings according to the WHO methodology suggest that financial protection did not improve substantially due to the health policy measures of 2007. Hungary has a relatively well functioning social safety net, which protects the poor through a combination of out-of-pocket and expenditure free co-payments for health services and pharmaceuticals. This fact explains the modest deterioration of financial protection observed. The WHO methodology may underestimate the real magnitude of impoverishing effects. In the context of Hungary (and other middle and high income countries in Europe, where there are few issues with a cold water the expenditure on coping and shielding opportunities to reduce vulnerability from the impoverishing effects) and the incidence of catastrophic expenditure are much greater with the alternative methodologies, and these results are even alarming. It is, therefore, recommended that financial protection indicators are calculated and published not just according to the WHO methodology, but also using the more detailed standard based on marginal costs and full cost (including the social) approach. In the applied methodology, the potential effects on overall cost, risk or personal equity (equity) indicators of financial protection should be integrated into the regularly published statistics in Hungary to allow to better interpret policy makers.

“Today, it is unacceptable that people become poor as a result of ill health”

Tallinn Charter

**INCOME-RELATED INEQUALITY IN HEALTH CARE FINANCING AND UTILIZATION IN ESTONIA SINCE 2000**

Health Financing Policy Paper 2002/3

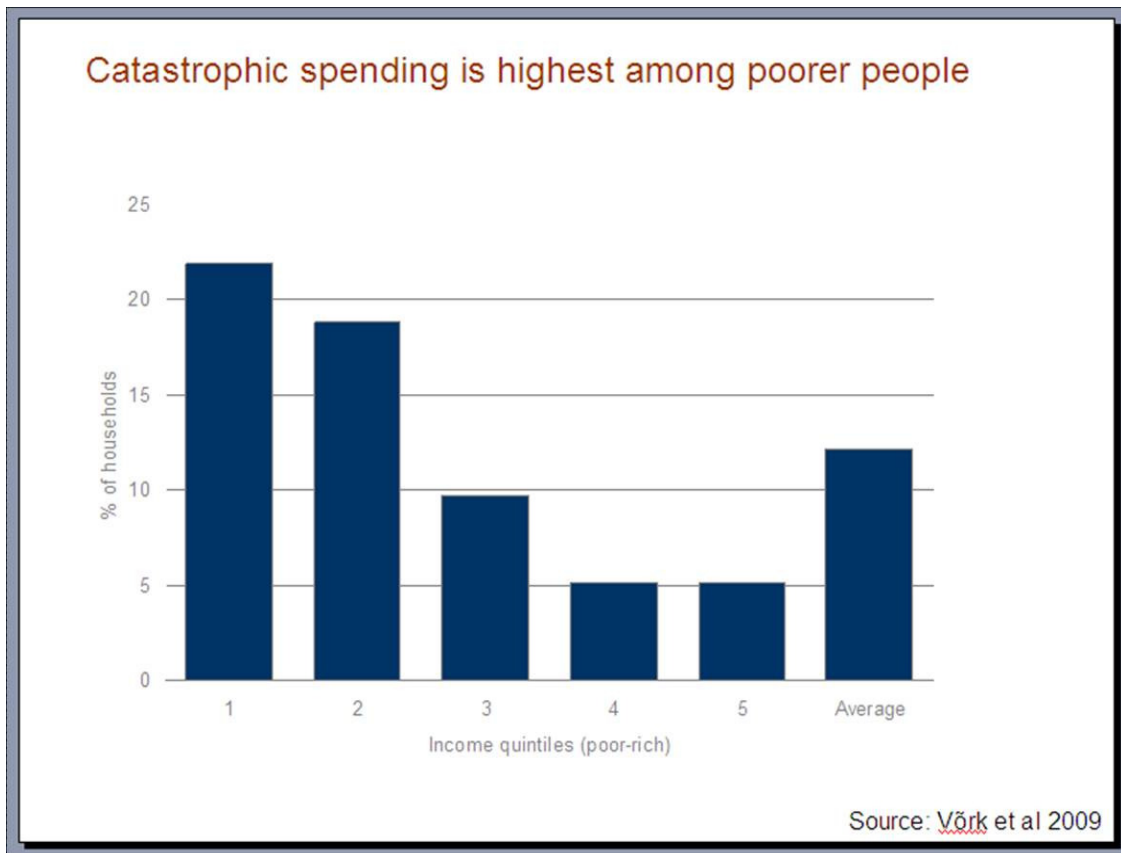
**EXTENDING POPULATION COVERAGE IN THE NATIONAL HEALTH INSURANCE SCHEME IN THE REPUBLIC OF MOLDOVA**

Health Financing Policy Paper 2002/1

Today, it is unacceptable that people become poor as a result of ill health!

29

## SLIDE 27

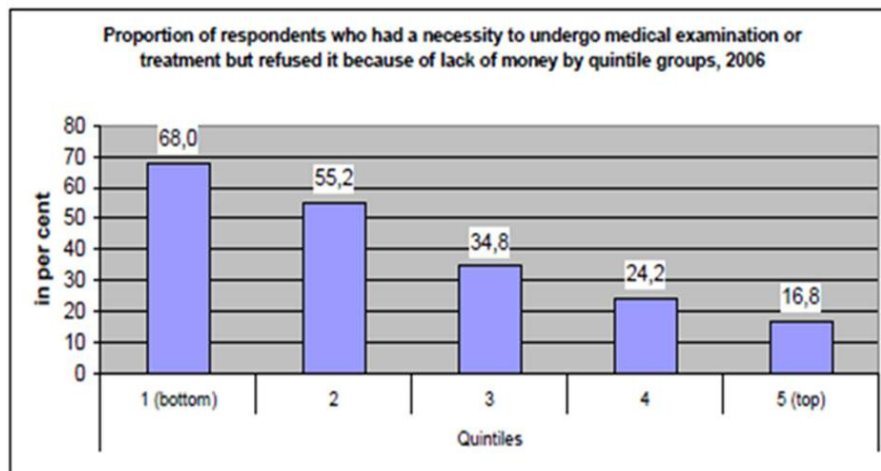


For example, this chart shows the distribution of the financial burden by income quintiles of the population in an EU Member State. On the left, the highest reaching blue bar stands for the poorest 20% of the population. Catastrophic spending is highest among the poor. If we look into the composition of out-of-pocket spending, then we see that the cost of medicines is by far the greatest burden for the poor, while the rich spend relatively more on other goods and services, some of which are discretionary.

## SLIDE 28

### Patients forego seeking care or do not buy prescribed medicine

The unmet need for health services was already high before the crisis  
(data from an EU Member State)



Source: EU-SILC 2006

The previous slides provided evidence on out-of-pocket expenditure. This slide shows that a lot of patients forego seeking care or may not buy the prescribed medicines due to high cost. Again, the poorest 20% of the population is most likely to delay care seeking due to fear of financial catastrophe.

## SLIDE 29


The economic crisis led to a reduction in utilization even though health care needs probably increased

Where the cost of seeking care is lower, the reduction in utilization is also lower

Country	Changes in Utilization of Routine Health Care Since the Crisis			Net Change (Reduce - Increase)	N
	Reduce	Same	Increase		
United States	26.5	66.5	7.0	19.5	1901
France	12.0	82.7	5.4	6.6	868
Germany	10.3	83.0	6.7	3.6	879
Canada	5.3	89.3	5.4	0.0	1032
Great Britain	7.6	84.4	7.9	-0.3	757
5 Country Avg	15.2	78.3	6.6	5.9	5437

“Reductions in routine care today might lead to undetected illness tomorrow and reduced individual health and well-being in the more distant future.”

Source: Lippaugh et al. The economic crisis and medical care usage: 2010. Harvard Business School

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In fact this issue is a problem for many countries. The economic crisis has led to a reduction in utilization even though health care needs have probably increased. This study looks at 5 of the most developed countries and the changes in utilization since the crisis started in 2008. In the United States 26% of the surveyed population reduced their utilization of health services, while in Canada and in the UK this figure was 5 and 7% respectively.




## SLIDE 30

### Protecting the poor and vulnerable

- Exempt the poor from paying user charges/co-payments
- Extend coverage to the long-term unemployed
- Target health spending better
- Target social assistance better



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So, how can we protect the poor and vulnerable especially during the crisis?  
Some options include:

- Exempt them from paying user charges and/or co-payments
- Extend coverage to the long-term unemployed
- Target health spending better
- Target social assistance better

Social welfare spending also has a major health impact. A rise in social welfare spending is associated with a sevenfold greater reduction in mortality than a rise of similar magnitude in GDP. Our work on financial protection found that in countries where social welfare spending was maintained or even increased when there was a drastic reduction in public expenditure on health, the impoverishing effects of the cuts were very small.

Ladies and gentlemen, I have endeavored to provide a broad overview of the current state of health in Europe, and some of the factors and uncertainties which will affect health in the future. Change will be relentless and will likely accelerate dramatically. Technology will mean that much more can be done. There will be an increasingly strong political and social message that what can be done should be done. When we can prevent effectively and at manageable cost we certainly must do this. When we can diagnose and treat we should, but the cost and efficiency pressures on health care delivery systems will only increase. Dealing with these countervailing forces will be a major political and social challenge in our societies, and one in which our values and our commitment to social justice and equity must be at the fore.

Thank you