EUROHEALTH

> **Our Food, Our Health, Our Earth: A Sustainable Future for Humanity**

- Transitioning to more sustainable food systems
- Commercial determinants of non-communicable diseases
- Building the future One Health workforce

- Towards an equitable and sustainable digital future
- Preparing the European Union's health priorities
- 25 years of collaboration between EUPHA and the Observatory

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> Our Food, Our Health, Our Earth: A Sustainable Future for Humanity

FOREWORD

Health of the public, for the public and by the public

It is our pleasure to introduce this special issue of Eurohealth for the 16th European Public Health (EPH) Conference in Dublin, 8–11 November 2023. As well as reflecting on the five conference plenaries, this issue celebrates the 25th anniversary of the European Observatory on Health Systems and Policies, and our fruitful collaborations with the European Public Health Association (EUPHA). This Eurohealth will mark our close ties, touch upon some of our public health achievements, and highlight the challenges ahead.

Over these past 25 years, the world of public health has changed. It has become broader and increasingly bound up with other disciplines and it has made new calls on our skills and knowledge. We have learned many lessons – perhaps the biggest from the COVID-19 pandemic – and yet have more to learn. The pandemic demonstrated the absolute need for a whole-society approach to addressing new challenges. Citizens had to act; researchers had to publish their findings at remarkable speed; policymakers needed to grapple with the evidence and make tough decisions. Huge steps were taken but although it was the moment when public health should have been in the lead, demonstrating what it is capable of, this was not always the case. Unfortunately many political decisions and individual actions were based on fake news in social media or on political expediency. A focus on protecting fellow citizens was displaced by concerns like restricting freedom of movement. Evidence, whole-of-society thinking, and public health principles were often pushed aside.

COVID-19 has taught us many things – about the necessity of preparedness and keeping emergency plans up-to-date; about communicating better with the public. It has also shown us how much public health is influenced by everything in society: politics, environment, architecture, human rights, social support, laws and regulations, healthcare and more. It has also made clear the contribution that public health has to make to all these different areas. It is therefore essential that we keep working with partners beyond the field of health.

It is also critical that public health policies and actions are evidence-based. Researchers must translate their evidence so that policymakers can understand what is going on and that the evidence goes to the right people and institutions at the right time so they use it to inform political decisions. EUPHA's European Journal of Public Health and its European Public Health Conferences are successful tools for making evidence accessible and for advocacy. The Observatory's work revolves around evidence for policy and disseminating across the interface between the two. In this issue, we explore the experiences of EUPHA and the Observatory in bridging the policy-evidence gap together (see Rechel et al).
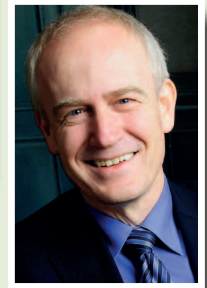
November's EPH Conference and the articles in this issue address five urgent post-pandemic public health challenges: sustainable food systems; the commercial determinants of non-communicable diseases (NCDs); building a one health workforce; technology and public health; and the role of the EU.

Tonello and co-authors start our plenary articles by discussing how we can make our food systems more sustainable to lower greenhouse gas emissions, improve biodiversity, and guarantee food security for all. Nagyova and McKee then consider how to tackle the commercial determinants of health to reduce the rising burden of NCDs. Investing in the younger generation so there are advocates ready to continue the fight for public health and to build a one health workforce is imperative and is explored by Codd and colleagues. There is also a need to ensure that everyone can participate equally in the accelerating use of data and digital technologies in healthcare and public health and this is addressed by Adib et al. The final plenary article by Mauer and Wismar reflects on the health priorities of the European Union and where investment and cooperation can be scaled-up in the future.

The list of priorities may feel large, but it is an indication of how much there is to tackle. The work of EUPHA and of the Observatory is far from over. We need to collaborate, we need to have open communication with all groups concerned and with key partners like EuroHealthNet, EHMA, ASPHER and EPHA, WHO Europe and the European Commission. Collaboration, good, solid evidence, knowledge brokering – these are the first necessary steps towards securing the investment across society that is needed to make the public's health better.

We have done so much together in our first 25 years of collaboration, just imagine what we can achieve in the next 50 years.

Dineke Zeegers Paget, EUPHA Strategic Advisor

Josep Figueras, Director, European Observatory on Health Systems and Policies

TRANSITIONING TO MORE SUSTAINABLE FOOD SYSTEMS THAT SUPPORT HEALTH EQUITY AND WELLBEING

By: Samuele Tonello, Caroline Costongs, Suzanne Costello, Anant Jani, Gunhild A. Stordalen and Tim Lang

Summary: There is now overwhelming evidence that current food systems are not sustainable, due to their detrimental impact on the environment, food-related health concerns, rise in chronic diseases and socio-economic impacts. At the institutional level, the seriousness of the situation has been acknowledged, but policies are still not sufficiently effective to resolve the challenge. We consider the over-reliance on and limits of the 'business as usual' approach, such as self-regulation by industry and focusing on changing individual behaviours in an unsustainable food environment. Instead, coordinated and systemic policies are needed that normalise sustainable and healthy food choice and practices for the whole population.

Keywords: *Food Systems, System Thinking, Health Inequalities, Policy Regulations, European Framework*

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The unsustainability of current food systems

Over the last decades, it has become evident that the way food systems (**see Box 1**) are structured at global, European and regional levels has led to negative consequences in terms of environmental impact, health burden and economic inequalities.

First, food production and distribution have deep and extensive **environmental footprints**, as they emit high amounts of greenhouse gases (GHG) and often rely on industrialised farming and animal husbandry practices which degrade soil, decrease biodiversity, deplete natural resources like freshwater, and pose concerns for animal welfare. Large amounts of food waste further aggravate this situation.[3]

Second, people may experience difficulties in accessing quality food such as fresh fruits, vegetables, wholegrains, healthy fats and sources of protein through lack of physical access, time or knowledge, and economic barriers. This results in excessive levels of production, distribution, and increased consumption of UPF (ultra-processed foods) and HFSS foods (high in fat, sugar, and salt), which leads to both **undernutrition as well as obesity and overweight**. These, in turn, are associated with worse mental health

outcomes [4] and a higher likelihood of developing (preventable) chronic and non-communicable diseases (NCDs), which are responsible for up to 80% of the global burden of disease and cost up to €610 billion per year to the European economy alone.[5] Furthermore, these are not only lifelong issues, often starting early in life and continuing over one's life course, they can also induce epigenetic modifications that are intergenerationally inherited.[6]

> a challenge that humanity cannot afford to delay acting on

Third, food systems are **not sustainable economically**, since there are significant issues related to wage adequacy in different sectors of the food system, and power imbalances which make it difficult for small and medium-sized farmers to compete against big producers.[7] Moreover, wealth redistribution of food systems is highly unequal: while numerous individuals worldwide are unable to meet their dietary needs and food security has become a primary concern in Europe, 'food billionaires' like multinational agriculture and food companies have increased their wealth by $382 billion over the last two years, leading to 62 new food billionaires since the outbreak of the COVID-19 pandemic.[8]

If policy-makers continue with 'business as usual', the health, environmental and socioeconomic problems are not simply going to remain as critical as they are now, but will dramatically worsen. The future threats posed by climate change are well documented in all aforementioned fields; economic inequalities will widen and, to mention just one data point about health, the World Obesity Federation estimates that by 2035, half of the world's population will be overweight or obese unless significant action is taken.[9]

Even one of these points alone would justify immediate action at policy and practice levels. All together, they represent a challenge that humanity cannot afford to delay acting on.

The limits of 'business as usual'

It would be a mistake to state that no actions have been taken to address this 'poly-crisis', since the unsustainability of food production, distribution, and consumption has long been raised at international and national political levels. However, when problems have not only endured, but worsened, it suggests something in the 'business as usual' approach is not working.

A proper analysis of the multifaceted factors leading to the unsustainability of current food systems exceeds the purpose of this article. From a public health policy perspective, one of the main misleading factors is that policies have too narrowly focused on correcting individuals' behaviours rather than addressing the systemic factors that affect the person's behaviours in the first place. In simpler terms, policies over the last decades have kept suggesting or educating individuals on how to behave in an unsustainable food environment (**see Box 1**), rather than fixing the unsustainability of the food systems.[10]

An example of how this problem translates in practice is the approach adopted to tackle rising rates of overweight and obesity. While interventions often focused on nutritional properties, education, dietary pattern explanations, and responsible consumption messaging, food environments have become more and more obesogenic. Health 'bads' outweigh health 'goods'.

For example, advertisement of HFSS and UPF has become more efficient,[11] new unhealthy products have emerged and become culturally entrenched within certain social groups (e.g. energy drinks in adolescents), and the availability of meat and processed meat products has steadily increased and has reached levels of consumption unsustainable for the environment. At the same time, high costs have made fresh, local, organic and healthy products (fruits and vegetables

Box 1: What is a food system? What is a food environment?

Food systems are defined as a system that "embraces all the elements (environment, people, inputs, processes, infrastructure, institutions, markets and trade) and activities that relate to the production, processing, distribution and marketing, preparation, and consumption of food and the outputs of these activities, including socio economic and environmental outcomes."[1]

Food environments can be defined as the "physical, economic, political and socio-cultural context in which consumers engage with the food system to make their decisions about acquiring, preparing and consuming food."[2]

above all) less accessible,[12] also as a result of perverse subsidies of commodity crops.[13]

It is important to acknowledge that while the unsustainability of the food system affects everyone, it does not influence everyone equally, since there is a clear social gradient related to how food systems affect people's health. Fast-food restaurants selling unhealthy food are more accessible in minority and poorer suburbs,[14] while lower socioeconomic status (SES) groups who spend higher percentages of their salaries for basic expenses (food being one of the most prominent), cannot access healthy foods if such foods are not affordable.

While this point pertains to the health dimension, systemic factors leading to social gradients are also evident for the environmental and economic dimensions. At the environmental level, lower SES groups and minorities are more exposed to the effects of climate change, they live in areas with lower air quality, and have less access to green areas.[15] This has repercussions for food security, since floods, wildfires and extreme weather events undermine food production and

Table 1: Examples of shifts from 'business as usual' to the systemic perspective

GOAL	'BUSINESS AS USUAL'	SYSTEMIC ACTIONS
More sustainable, regenerative production by means of chemical pesticide reduction and building or restoring soil health	• weak or inconsistent regulatory structures • Self-regulation by industries • farmers locked in to agrichemical reliance	• Mandatory regulations to reduce the use of chemical pesticides • Incentives for local and small farmers to adopt more sustainable farming and ecosystem services • policy integration of human and ecosystems health frameworks
More sustainable and resilient food supply chains	• No regulations • Self-regulations by industries • Voluntary ESG (environmental, social, governance) investment frameworks • resilience and sustainability presented as consumer choice	• Mandatory regulations to minimise energy consumption, water consumption, waste, and greenhouse gas emissions • Develop labour protection policies • Invest in equity sensitive storage, food processing and distribution infrastructures
Reduce market inequalities	• acceptance that market distortion is inevitable requiring no / low intervention • Self-regulations and/or codes of conduct as 'reluctant' market correction mechanisms • a narrow conception of what markets are which excludes social or moral dimensions of markets	• Enable more equal access to land, water, livestock and fisheries • Apply agro-ecological principles across production and broader food systems • Establish inclusive producer organisations • Reduce monopolies and tax "food billionaires"
Shift to diverse, plant-based diets	• Educational Campaigns about fruit and vegetables • Messages about reducing meat consumption • 'Meat-free days' promotion • Food technology seen as key lever for change	• Stop subsidising industrial meat production • Taxes on red meat and processed meat products • No VAT on fruits and vegetables • Promote increased fruits, vegetables, nuts, whole grains, plant proteins in dietary guidelines and public kitchens • Align public procurement with dietary guidelines • Support for plant-rich and healthy plant-based alternatives
Reduction of overweight and obesity	• Educational campaigns • Messages of concern with little power actually to change social norms • Focus on individual consumer choice in behaviour change • weak or no coherent multi-lever interventions	• Mandatory regulations on advertisement (including social media) of HFSS and UPF • Taxes on sugar, salt, and fat content and/or UPF • Design and implementation of healthier food environments • Fast-food-free school zoning policies • Public procurement policies • Subsidies to buy healthy foods
Reduce food waste	• Self-regulation by industries • Educational campaigns • responsibility for failed waste reduction blamed on consumers • lack of investment in prevention	• Mandatory regulations to improve food packaging • Better food management by retailers and restaurants • Improve date labels and expiry information • Recycling infrastructures • Laws to ban food waste [17]

Source: authors' own

availability. Moreover, these events, together with the repercussions of the war in Ukraine, have already led to a cost-of-living crisis in Europe, with a significant increase in food prices and cost of energy.

Finally, it is necessary to mention the political context in which food system debates take place. Since the 1980s, the neoliberal paradigm has been eroding the pillars of welfare systems, injecting a free market ideology favouring privatisation

and economic deregulation while limiting governmental intervention and regulatory power. This has significantly affected policy regulation over the last decades in two main regards.

First, mandatory legislations necessary to readdress food system sustainability have often failed to be designed and implemented. At best, they have been accepted as self-regulatory frameworks and/or codes of conducts or other voluntary agreements, which have failed to deliver the expected, and needed, promises.[16] Second, the evidence on the commercial determinants of health is increasing, proving that large scale farm and industries have used their economic power to shape a political landscape more favourable to their interests rather than to public health and wellbeing.*

> ## policies have too narrowly focused on correcting individuals' behaviours

In short, 'business as usual' policies, and public health policies in particular, have neglected that current food systems are clearly not making it easy for individuals to choose healthy, sustainable and ethical food. If we are to 'make the healthy and sustainable choice the easy choice', we must first regulate the food systems and food environments, so that citizens are actually able and empowered to make the best decisions.

A systemic perspective on food systems

A systemic perspective on healthy, more equitable and sustainable food systems entails implementing food policies to change the production, distribution, consumption, and management of waste. This policy mix was implied by the 2015 UN Sustainable Development Goals but has not been sufficiently enacted by governments or markets. By failing to

do so, public health, environmental, social, and ethical challenges deepen. **Table 1** offers a few examples of how societies could shift from 'business as usual' to the systemic perspective required.

Conclusion

Food systems are complex ecosystems, where it is necessary to find a balance between diverse and contrasting views, interests and incentives. **Table 1** presents a simplified view of some key systemic measures needed to render our food systems healthier, more sustainable and more equitable. All these points encompass complex connections of diverse stakeholders and industries, know-hows, power inequities and perspectives of how the food ecosystem should work. These different perspectives are now part of the political landscape reflecting peoples' views because food is central in local cultures and practices.

The complexity of the task ahead – transitioning to healthier, more sustainable and more equitable food systems – should not be underestimated and it will be impossible to achieve as long as different sectors continue working in silos rather than jointly addressing the systemic unsustainability of the problem. As depicted by the European Commission in the recent 'Farm to Fork Strategy' (F2F), change requires implementing a systemic and sustainable perspective to policies from the production of food, its distribution, consumption and management of waste. Public health actors also have a responsibility and potential to step up their engagement in the food system debates with evidence and solutions, and to rally around F2F as a step in the right direction.

This will not be easy, as reflected worryingly by the recent postponement and likely dismissal of the implementation of the EU Sustainable Food System Law, one of the flagships initiatives of the Farm to Fork strategy adopted by the European Commission and initially foreseen for the end of 2023.[18] [19] We must also be honest with ourselves that business as usual is not transitioning fast enough to more sustainable food systems. New systemic policies, cross-sector and multilateral

cooperation are required to shift food systems. In this regard, while it must not be forgotten that we all individually play our part and we should maximise the sustainability of our food consumption, we can no longer afford to put the onus on individuals and their behaviours, especially in light of food system pressures introduced by the cost-of-living crisis, Ukraine War and climate shocks that affect food supply.

> ## public health actors also have a responsibility

On the contrary, policymakers at all levels of governance ought to actively move away from the 'business as usual' approach centred on deregulatory or self-regulatory approaches. Instead, mandatory regulations and systemic policies that correct the unhealthy, unsustainable and inequitable character of the food system must be implemented. These policies are necessary to protect citizens' right to health, their right to live on a healthy planet, and finally, their right to enjoy an ethical food system that prioritises everyone's wellbeing over the profit of a few powerful corporations and individuals.

The right time to act is already in the past. We still have a window of opportunity to recover today, but we cannot afford to wait for tomorrow.

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* For a first overview of the topics, see the recently published review in the Lancet of the commercial determinants of health, https://www.thelancet.com/series/commercial-determinants-health

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Health and Care Data:
Approaches to data linkage for evidence-informed policy

By: Panteli D, Polin K, Webb E, *et al.*

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Evidence-based health policy requires good health services research, which in turn requires access to comprehensive and high-quality data. With the digital transformation of healthcare, ever-more dynamic landscapes of datasets, and the availability of 'big data', health services research increasingly relies on linking data within and outside of health for meaningful insights.

Based on 30 case studies from across 13 high-income countries, this HiT review provides an overview of existing practices in data linkage for health services research. It considers the different possibilities of using routine data; approaches to data linkage; access routes for researchers; the use of data for research from electronic patient or health records; foundational considerations related to data safety, privacy and governance; recent developments in cross-border data sharing and the European Health Data Space; and considerations of changes and responses catalysed by the COVID-19 pandemic. The review ends with overall conclusions on the necessary characteristics of data to inform policy-relevant research and highlights possible future solutions for countries looking to expand their use of data.

COMMERCIAL DETERMINANTS OF NON-COMMUNICABLE DISEASES:
THE IMPERATIVE FOR A SYSTEMS APPROACH

By: Iveta Nagyova and Martin McKee

Summary: The increasing burden of non-communicable diseases (NCDs) challenges conventional approaches to public health. The struggle to curb preventable NCDs persists due to narrow reductionist biomedical paradigms and the influence of corporate actors in shaping unhealthy environments, a concept known as the commercial determinants of health. This phenomenon, amplified by globalisation, affects health through various factors. To promote global well-being, commercial entities must be incentivised to shift from profit-driven models to socially and environmentally responsible practices. This shift demands adherence to regulations preventing harm and support for public health policies, urging a systemic understanding of NCDs as outcomes of complex systems.

Keywords: Commercial Determinants of Health, Non-communicable Diseases, Health Policy, Global Health, Systems Thinking

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Introduction

In 2025 the world's governments will convene in New York at the 4th High Level Meeting on non-communicable diseases (NCDs) to review progress in the seven years since they last met in 2018. On that occasion, they signed up to a Political Declaration that committed them to take action to combat cardiovascular diseases, cancers, chronic respiratory diseases, diabetes, and mental health among others. The scale of disease is immense, accounting for 90% of deaths and 85% of years lived with disability in the WHO European Region.[1] The economic and societal impact is also substantial, through reduced productivity and labour force participation and the impact of illness and premature death. The burden falls disproportionately on those already disadvantaged, who often struggle to access the necessities of a healthy life, such as nutritious food and safe environments, and affordable healthcare.

NCDs are largely preventable and have also been treatable for decades. Yet there is a massive gap between what is possible and what is achieved, exemplified by low levels of blood pressure control in

many communities, and the public health community has struggled to implement effective solutions. There are two main reasons why this is particularly difficult. The first is the narrow approach to addressing NCDs, characterised by a continued dominance of reductionist biomedical and individual-level paradigms. The second is the role of corporate actors in creating the 'NCD-genic' environment.[2]

The Dominance of Reductionist Biomedical Models

Historically, public health initiatives have been rooted in reductionist biomedical models, focusing on individual-level interventions.[3] However, these are often the least effective responses to the multilayered drivers of NCDs, which reach from individual behaviours to societal dynamics. Thus, measures such as educational initiatives promoted as ways to reduce childhood obesity or smoking, are often promoted by the industries whose products cause these problems. They are therefore often ineffective or even counterproductive and, even when they have been shown to be effective, may not be generalisable due to the intricate and multifaceted nature of health determinants.[4]

Policymakers, researchers, and practitioners thus need to comprehend the complex web of factors at play in driving the rise in NCDs. Many arise in other sectors, such as transport, agriculture, and food, are all influenced by commercial interests and shaped by national and international agreements, especially on trade. These macro-level forces, both direct and indirect, significantly impact the rise of NCDs and interact with each other via complex pathways, influenced by context, adding layers of complexity to the NCD burden.

Understanding the causative links demands a nuanced perspective. A paradigm shift is essential, acknowledging this multi-layered web of influences. A systems approach, encompassing environmental, political, social, behavioural, cultural, economic, and commercial determinants, is imperative to develop effective responses to the growing burden of NCDs.

Corporate Actors and Their Role in NCD Proliferation

With the accelerating momentum of economic globalisation, commercial determinants of health are becoming an increasingly dominant force shaping public and planetary health.[3] [5] Commercial determinants of health arise in the context of the provision of goods or services for payment and include commercial activities and the environment in which commerce takes place. They can affect people's health directly or indirectly, positively or negatively, and through a variety of factors.[6]

Many corporations contribute positively to societal impacts, for example through their core activities, such as innovating and producing life-saving medicines, but also indirectly, by engaging in philanthropic endeavours, or through participating in health-related public-private partnerships.[7] These corporations are catalysts for positive change, channelling their resources and expertise toward the betterment of society.

However, more typically, corporate entities wield significant negative influence over public health outcomes. Unhealthy products, aggressive marketing strategies, and lobbying efforts often sustain and increase the determinants of NCDs. Over recent decades, the rise of NCDs has led public health researchers to focus their attention on the consumption of unhealthy products such as alcohol, tobacco, and ultra-processed food. More recently, as new evidence on the health consequences emerged, researchers looked to the broader commercial determinants, including those who create air pollution and other toxic exposures, social stressors, or unsafe working conditions, or whose actions limit access to life-saving healthcare.[3] [5]

Corporations are required, by law, to maximise profits, regardless of their effects on health, disease, injury, disability, and death. In 2023, the Lancet Commission on Commercial Determinants of Health identified seven key practices: political, financial, marketing, supply chain and waste, labour and employment, scientific, and reputational management practices.[5] These vary from the legal/ethical to the illegal/unethical, with many in the grey zone between. *Political practices* range from lobbying to bribery, while *financial practices* may include tax avoidance or smuggling. *Marketing practices* work with reshaping cultural norms and framing dominant narratives, including normalisation of health risk behaviour, such as youth smoking or binge drinking through advertisements. *Supply chain and waste practices* often lead to e.g. groundwater contamination and toxic waste release, while examples of *labour and employment practices* include modern slavery, especially in low and middle income countries (LMICs). *Scientific practices* typically employ the purposeful spread of misinformation and disinformation, commodifying knowledge, as well as attacking and undermining legitimate science. The aim of *reputational management practices* is to enhance corporate brand image through seemingly prosocial activities or strategic litigations.[5] [8] [9]

Championing Health Equity

Commercial determinants drive inequities.[2] There is a moral imperative and an epidemiological logic to placing health equity at the core of the fight against NCDs, given their disproportionate impact on those already disadvantaged. Disparities in access to healthcare infrastructure, access to knowledge, digital technologies, nutritious food, clean water and air, and safe living environments exacerbate the NCD burden for these groups. Policymakers must prioritise initiatives that bridge these gaps, ensuring that vulnerable populations have equal access to preventive measures, healthcare services, and information.

The Need for Transformative Policies: Embracing a Systems Approach

A systems approach to understanding NCDs recognises the interconnectedness of the many factors influencing public health.[2] [10] This paradigm views individuals not as isolated entities but as fundamental parts of complex social,

economic, and environmental systems. Policymakers must collaborate across sectors, engaging with public health experts, economists, environmentalists, and corporate stakeholders.

> Equipping health professionals with new skills to combat the impact of corporate actors is essential

Addressing the commercial determinants of NCDs demands transformative policies at both national and international levels. Embracing public health policies that might challenge corporate interests is crucial, even if difficult and, sometimes, dangerous. Public health policymakers must prioritise regulations that tackle harmful practices and products. Corporate social responsibility and environmental stewardship should be integral components of these policies, although caution is needed to avoid "greenwashing". Reputational considerations can encourage businesses to promote societal well-being, although recent experience with Environmental, Social, and Governance (ESG) indicators has been disappointing. Given the global nature of both NCDs and corporate activities, international collaboration is paramount. As the lead UN agency in health, the World Health Organization (WHO) has a formal role in coordinating and, in some cases, harmonising policies and standards. Sharing best practices, conducting joint research, and establishing global frameworks for regulating commercial determinants of health are vital steps toward mitigating the NCD crisis on a global scale.

Empowering a New Generation of Health Professionals

The question is how to empower health professionals in their quest to improve people's health despite the strong influence of corporate actors. What can be done? Echoing McKee and Stuckler's 2018 view, we as public health professionals, are realistic enough to understand that we cannot mitigate all the harm caused by corporate actors. But neither should we believe that we are as impotent as we often appear.[8] Public health experts can take action in four key areas. Firstly, challenging prevailing narratives. Understanding how people's choices are shaped by external forces, often manipulated by corporations, is essential. Secondly, shaping healthy policymaking norms by implementing checks on corporate power. Initiatives like Article 5.3 of the Framework Convention on Tobacco Control, excluding the tobacco industry from health policymaking, can serve as an example.[11] Thirdly, supporting communities that resist corporate influence, such as those implementing soda taxes; and communicating these successes through innovative means, like social media. Lastly, aligning with social movements fighting corporate powers, such as the environmental and health movements. By working with civil society and the public, these actions hold powerful global corporations accountable for their health impacts.[8] [12]

Conclusion

Faced with the complex challenge posed by NCDs, policymakers bear a responsibility to promote a future where the health and well-being of all citizens take precedence over commercial interests. Transformative policies that prioritise public well-being over profits, embrace a systems approach, champion health equity, and foster global collaboration are indispensable. By adopting this comprehensive perspective, stakeholders can better navigate the complexities and design effective strategies to combat the multifaceted challenges presented by NCDs. Equipping health professionals with new skills to combat the impact of corporate actors is essential. Only through concerted efforts and visionary policies

can we navigate this intricate landscape and build a healthier, more equitable world for future generations.

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BUILDING THE FUTURE ONE HEALTH WORKFORCE

By: Mary Codd*, George Valiotis, Nadav Davidovitch*, Polychronis Kostoulas*, Oliver Razum*, Mzwandile Mabhala*, Lore Leighton, Robert Otok and Carlo Signorelli*

> #EPH2023 – PLENARY 3:
Building the future One Health workforce

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Summary: A 'new normal' in public health and healthcare has arisen with socioeconomic shifts, technological developments, political strife, climate change, environmental degradation, and COVID-19. Challenges cannot be solved by one discipline or profession alone, but requires multiple sectors coming together, combining knowledge, expertise and methods. One Health is an integrated epidemiological and economic approach aiming to sustainably optimise the health of people, animals and ecosystem. This article reflects on the roles of Association of Schools of Public Health in the European Region (ASPHER) and European Health Management Association (EHMA) and the concrete steps needed to address skills for One Health.

Keywords: One Health, Workforce, Capacity Building, ASPHER, EHMA

Introduction

An increasingly recognised phenomenon in public health and healthcare is that of a 'new normal' which has been and will continue to be shaped by demographic and socioeconomic shifts, scientific and technological developments, political strife, upheaval and migration, climate change and environmental degradation, natural disasters, food and water insecurity and the COVID-19 pandemic.[1] Although these major global challenges constitute a continuous state of risk, necessitating a state of 'preparedness' for change which cannot be fully contained or overcome, they call for recognition and regulation.[1][2] In turn this 'new normal' must shape our thinking and actions in relation to the scope and remit of our public health and healthcare workforces, with specific attention to the skills, competencies, and levels of preparedness in this constant state of change.

This 'new normal' does not discard the traditional tenets of public health and healthcare. However, it must extend its brief to incorporate the digital transformation of society and how this impacts on health; capitalise on big data and artificial intelligence (AI); adapt to diversity and intersectionality; cater for the needs of vulnerable groups; recognise the political and commercial influences on public health; and foster leadership and decision-making. Thus, an interdisciplinary approach to the public health challenges of our time is necessary.

An interdisciplinary approach

The public health and healthcare workforces constitute heterogeneous groups from diverse professional backgrounds who are involved in protecting and promoting the health of populations.[3] As contexts and complexity increase, it is imperative to address the

readiness of the public health workforces locally, nationally, and globally to manage current challenges and to anticipate and prepare for future challenges. Current and future public health challenges cannot be solved by one discipline or profession alone, but require multiple sectors, disciplines, and professions to work together, exchanging and combining their knowledge, expertise, and methods.[3]

> require multiple sectors, disciplines, and professions to work together

The Association of Schools of Public Health in the European Region (ASPHER) recognises the challenges posed by the 'new normal' for public health education, training and practice. Adhering to its mission to *"improve and protect the public by strengthening the education and training of public health professionals for practice and research"* ASPHER, in collaboration with the World Health Organization (WHO) Regional Office for Europe, has undertaken to investigate public health curricula and consider how best to address the competencies required and expected of current and future public health professionals. Inherent in ASPHER's approach is the need to prepare a multidisciplinary workforce to work in interprofessional and cross-sectoral contexts recognising the skills, values, languages and methodologies of other disciplines.[1] One Health is one such context.

One Health: Concept and Approach

Although the term 'One Health' is recent, the concept has been recognised for centuries. In the 1800s, scientists noted similarities in disease processes in animals and humans, but human and animal medicine were practiced separately until the 20th century. Recently, the One Health concept has gained more recognition in public health and animal

health communities.[4] Recognising that the health of people is closely connected to the health of animals and our shared environment, One Health is an integrated epidemiological and economic approach that aims to sustainably balance and optimise the health of people, animals, and ecosystem.[5] The concept of One Health was developed to approach the complex interconnectedness and interdependence of all living species and the environment, thereby having a multiplicative positive effect in public health control efforts.[6]

The COVID-19 pandemic emphasised the vulnerability of human populations globally to emerging infectious diseases. Increasing impacts of climate change and environmental degradation have stimulated interest in institutionalising a One Health approach to contribute to global health security. One Health frameworks reject a reductionist view of health as a solely biomedical phenomenon, rather requiring closer cooperation between the human, animal, and environmental health sciences, contextualised politically, historically, and geographically for the health of the biosphere, as well as the importance of dismantling disciplinary and professional silos.[6]

Suitable capacity building with training in One Health must be integrated into the public health and health workforces. Plenary session 3 of the EUPHA conference brings together ASPHER and the European Health Management Association (EHMA), two key organisations mandated to sustain and enhance capacity building for public health and healthcare workforces in Europe, to reflect on the roles they play and the concrete steps being taken to address training and skills for One Health.

Action by ASPHER

A multidisciplinary approach in public health, is recognised as fundamental by ASPHER. This was reaffirmed at the Association's 50th anniversary[7] and a cross-sectoral and cross-disciplinary approach has been confirmed through ASPHER's collaborative work with WHO to professionalise the public health workforce in Europe.[8]

A 2021 survey to profile public health education and training offers of ASPHER member schools and institutions found One Health to be a key emerging interest of several members. Many members already function within a multidisciplinary context in teaching, research and other activities and are actively seeking to increase cooperation across disciplines. In some cases, this is strategic positioning of programmes within university structures, in faculties of psychology, applied sciences or social sciences. In others, relationships are forged with faculties of agriculture and veterinary medicine, or ecology and environmental sciences departments.

The ASPHER Core Curriculum Programme (CCP)

An important role of academic public health institutions is to serve local, national, and global communities, from educating the public, politicians and the media about important public health issues to collaborating with health departments on just-in-time trainings to providing expert guidance for decision-makers in government, non-profit, and for-profit sectors. The COVID-19 pandemic has put public health professionals in the public leadership spotlight, demonstrating the need to develop skills beyond the traditional public health education domains of epidemiology, biostatistics, health promotion, health policy, programme evaluation to be most effective in responding to crises.[9]

To respond to the needs of members, and increasing evidence for an interdisciplinary approach to public health, ASPHER in collaboration with WHO Regional Office for Europe has undertaken a wide-ranging review of public health curricula across member schools, in consultation with both established public health experts and early career professionals as a necessary step to a prepared public health workforce, and to ensure that ASPHER-member public health programmes are fit-for-purpose. One Health is a key subject area within this curriculum.

The Core Curriculum Programme (CCP) has established that One Health content in schools in which it is delivered falls

into five major themes: Human health; Animal health; Plant and food health; Climate health; and Practice. The detailed elements of each theme demonstrate a diversity of content spanning professionals from all relevant specialisms. Amongst schools that do not currently provide One Health content, almost 90% agreed that it was important to integrate these five thematic areas into public health curricula. Challenges include:

• sharing of content of current and future One Health curricula with schools and programmes who are constrained in the provision of this content; and

• integration into current One Health curricula of cross-cutting and interdisciplinary skills of digital literacy, communication, emergency preparedness, leadership, advocacy and ethics in practice.

" upskilling and reskilling the European healthcare workforce

Action by EHMA

EHMA serves as a membership organisation open to organisations committed to improving health and healthcare. It focuses its actions on health management capacity and capabilities in support of the implementation of health policy and practice. EHMA fosters an environment where evidence, challenge and experience are valued, and promotes complex debates on current topics such as One Health and the integration of concepts into the operations of the health workforce and stakeholders so as to better serve the health of patients and the environment in which they live.

In order to ensure the European health workforce is able to cope with future challenges and evolving societal expectations,[10] EHMA is coordinating

Box 1: The BeWell partnership

Comprising 24 organisations from 11 European countries, BeWell promotes the sustainable transformation of European health systems through four primary actions:

– Developing skills intelligence on the digital and green skills needs of the health workforce;

– Establishing the first Blueprint Alliance for the health ecosystem to create a skills strategy to implement at a local, regional, national and European levels;

– Launching a large-scale skills partnership under the Pact for Skills initiative;

– Conceiving and implementing a training programme on digital and green skills in the healthcare sector and for emerging occupational profiles.

BeWell is cross-collaborative aiming to advocate and provide a roadmap to lifelong learning and continuing professional development (CPD) upskilling and reskilling the European healthcare workforce across professions in green and digital skills. It takes health and care system needs into context – integrating critical areas such as One Health – for pandemic recovery and preparedness for future emergencies.

It calls upon policymakers to integrate the health and care workforce's needs – co-creating the design and implementation of policies.

the BeWell project – Blueprint Alliance for a Future Health Workforce Strategy on Digital and Green Skills – In partnership with education and training providers and in consultation with diverse stakeholders. BeWell strategises on upskilling and reskilling the European healthcare workforce across professions in green and digital skills (**see Box 1**) to cope with future challenges and evolving societal expectations.[11] One Health is key to inform green skills and must be a recognised component integrated into digital skills.

The first version of BeWell's Skills Strategy launched on 7 June 2023, during the EHMA2023 conference.[12] It emphasises development of training and CPD for lifelong learning in digital skills (e-health, big data and AI); green literacy and competencies incorporating climate change, sustainability and green logistics; but also soft-skills to work in multidisciplinary and multiprofessional collaboration critical for One Health principles. The Strategy acts as a roadmap to implementing actions at the local, national and European levels.

Conclusion

Working together, ASPHER and EHMA can advance the interdisciplinary agenda of public health and healthcare education, training, and practice as well as the preparedness of the public health and healthcare workforces. COVID-19 and other crises ushered in a 'new normal' as it relates to public health practice. It is incumbent upon us to evolve our educational programmes and CPD for current and future public health and healthcare professionals accordingly. Integrating concepts such as One Health into public health and healthcare curricula and lifelong learning is essential to equip graduates and upskill professionals to effectively navigate strategies and interventions in response to health crises in an ever-changing world, thereby protecting and promoting the health and welfare of the global population and planet.

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Making Health for All Policies:
Harnessing the co-benefits of health

By: Greer SL, Falkenbach M, Siciliani L, McKee M, Wismar M, Vissapragada P, Montás MC, Perroud J, Rockwell O, Figueras J

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This policy brief argues for health actors to adopt a "Health for All Policies" (HfAP) approach that focuses on co-benefits between sectors. HfAP offers an alternative approach to "Health in All Policies" (HiAP), which primarily focused on health sector gains and often failed to engage other sectors. HfAP recognizes the wide-ranging effects of health and health policy on societies, extending beyond the realm of good health. It emphasizes co-benefits, where health policies and actions produce positive outcomes that span multiple sectors and can contribute to meeting many Sustainable Development Goals (SDGs).

By using the SDGs as a framework, the brief identifies goals that can be pursued across sectors. This includes the impact of improved health status on other SDGs – for example, better health can lead to better educational and employment outcomes – as well as the impact of health systems and policies on other sectors, such as through being a major employer and driver of economic activity. The logic of Health for All Policies amounts to making a case for investment in health, but also for the health sector itself to do better in understanding and directing its impact on the world beyond the healthcare it provides.

LEAVING NO ONE BEHIND:

PRIORITISING DIGITAL HEALTH EQUITY ACROSS THE WHO EUROPEAN REGION

By: Keyrellous Adib, Natasha Azzopardi-Muscat and David Novillo-Ortiz

Summary: The 2023 World Health Organization (WHO) report on digital health for the WHO European Region demonstrates the accelerated progress in the adoption of digital health technologies (DHT) in recent years. However, there are growing concerns about the digital divide resulting from inequitable access and utilisation of DHT, particularly among older people and marginalised communities. This article sheds light on the advancements made by WHO Europe Member States and underscores the necessity to ensure access to devices and stable internet connection, as well as promoting digital literacy and user engagement, to overcome this digital divide.

Keywords: Digital Health Equity, Digital Divide, Digital Health Inclusion, Digital Health Literacy

> #EPH2023 – PLENARY 4:
On the path to an equitable and sustainable digital future for European health systems

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Introduction

As the integration of digital health technologies (DHT) within the healthcare system continues to expand, it's crucial to prioritise equitable access and utilisation. This goes beyond just ensuring the presence of suitable devices and stable internet connection; it also necessitates improving user engagement and promoting digital health literacy, enabling individuals to effectively use technology to access and understand health information.[1]

Transforming patient-provider engagement in healthcare

The rise in adoption of DHT is bringing numerous advantages and revolutionising the way patients and healthcare providers engage with the healthcare system. For instance, patient portals, which are online platforms, grant patients secure and real-time access to their personal health records from anywhere with an internet connection. Within the WHO European Region*, 71% of Member States have established a national digital health portal.[1] Among these Member States (**see Figure 1**), 78% utilise the patient portal primarily as an information centre, 72% enable patients to retrieve their health records through the portal, 53% have integrated functionalities for appointment booking, 56% have developed these

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*   All 53 countries of the WHO European region took part in the survey on which the report on digital health for the WHO European Region is based. However, responses to questions in the survey were not mandatory and so response rates were not uniform across all questions.

Figure 1: Uses of National Digital Health Portals in the WHO European Region

Percentage of Member States (%)
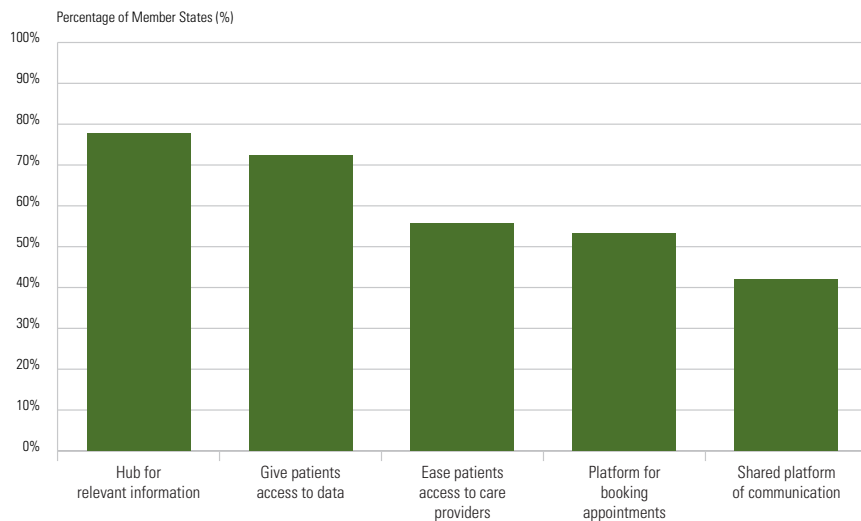
Source: [1]

Figure 2: Types of mHealth programmes and services for healthcare in the WHO European Region

Percentage of Member States (%)
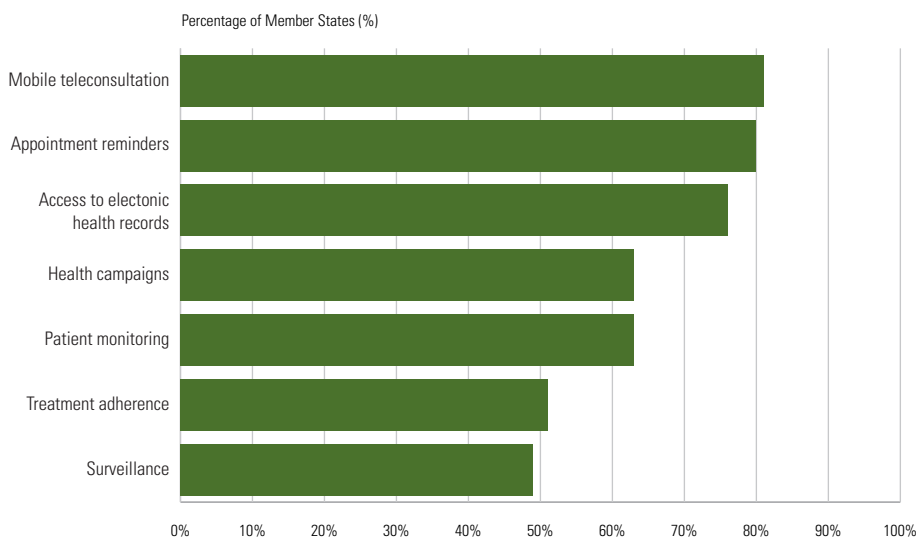
Source: [1]

portals to ensure that patient information is readily available to healthcare providers, and 42% have embedded communication features into their portals.[1]

Telehealth has the potential to bridge geographical and socio-economic barriers, ensuring that individuals in remote or underserved areas have access to quality healthcare services. In the WHO European Region, 84% of Member States reported using teleradiology.[1] Additionally, 77% utilised telemedicine or remote patient monitoring. More than half of the Member States reported using teledermatology and telepsychiatry.[1] However, telehealth services' distribution varies across the WHO European Region, with northern and western Europe showcasing a broad range of telehealth services, whereas western Asia and central Asia have a more limited range of services.[1] Teleradiology is notably prevalent, with over 80% of Member States in all subregions, excluding central Asia, adopting this service.[1] Telemedicine or remote patient monitoring is highly used in southern Europe,

Europe, and western Europe by 90%, 91% and 100% of Member States, respectively.[1] In stark contrast, only 56% of the Member States in eastern Europe, and 25% of Member States in central Asia reported having telemedicine services.[1]

Mobile health (mHealth) services and applications leverage the capabilities of smartphones, transforming the healthcare landscape by facilitating immediate access, enhancing personal engagement, and streamlining remote healthcare services. Between 2015 and 2022, there was a noticeable increase in the number of Member States that reported having at least one government-backed mHealth service.[1] The percentage of Member States with such services surged from 49% in 2015 to 91% by 2022.[1] As shown in **Figure 2**, teleconsultations is the most prevalent mHealth service available in 81% of the Member States, followed closely by appointment reminders in 80% of the Member States, and access to electronic patient information from electronic health records in 76% of the Member States. Treatment adherence services, which can help increase patient compliance with medical regimens, were reported by over half of the Member States.[1] Additionally, 63% of Member States have reported having mHealth services for health promotion, community mobilisation, and risk communication. The same percentage also reported having mHealth programmes for patient monitoring, facilitating the capture and transmission of data for diverse medical conditions. Surveillance, an essential component for data collection, management, and reporting in healthcare, is facilitated through mobile devices in 49% of Member States.[1]

Demographics of the digital divide

Despite advances in digital transformation by the Member States of the WHO European Region, concerns arise regarding equitable access to DHT. WHO's recent scoping review provided consistent evidence indicating that there is a higher utilisation of DHT in urban areas compared to rural ones.[2] Moreover, individuals from ethnic minorities and those facing language barriers have lower DHT usage.[2] The review also found higher DHT use by individuals

Table 1: Most cited measures to ensure equity in accessing digital health services

MEASURE	NUMBER OF MEMBER STATES
Improvements in connectivity (broadband) and ICT infrastructure	22
Digital literacy and digital health promotion	21
Expanding geographical coverage and the range of care services using telemedicine solutions	19
Improving patient access to digital health data and health information	14
Assistance to vulnerable populations (aid to the elderly / physically impaired etc.)	5
Development of guidelines	1

Source: [1]

with higher educational levels, those of a higher economic status, and younger individuals. Furthermore, better access to DHT was prevalent among individuals without disabilities or complex health needs.[2] Additionally, the review pointed out that there is limited evidence on how DHT helps improve the health and well-being of groups that are often left out, like the homeless or those with substance use disorders.[2]

Eurostat data further highlight this digital divide. In the European Union (EU), 81% of urban residents access the internet daily, compared to 70% in rural areas.[3] Those employed exhibit superior digital skills than the unemployed.[4] Students stand out with 68.2% having more than basic digital skills.[4] Moreover, there is a salient disparity in internet connectivity among households based on income. While 99% of households in the highest income quartile have internet access, only 73% in the poorest quartile do.[4] Additionally, a striking difference in digital literacy exists between age groups: only 33% of those aged 55-74 years possess basic digital skills, compared to 80% of individuals aged 16-24 years.[4]

Digital health strategies and measures of equity

Digital health governance plays a vital role in promoting universal health coverage (UHC), emphasising inclusive healthcare for all. In the WHO European Region, 83% of Member States reported having a digital health strategy or similar policy.[1] Notably, 71% of Member States

have explicitly listed UHC as one of the strategic priorities of their digital health policies and strategies.[1] It is also noteworthy that almost all the responding Member States, except one, highlighted enhancing accessibility, quality, safety, and efficiency as their strategic priorities. These priorities align directly with the essential elements of UHC.[1]

Recognising the adverse consequences resulting from the digital divide, 75% of Member States with digital health strategies or similar policies, reported that their policies or strategies included measures to ensure equity in accessing digital healthcare services.[1] The majority of these Member States identified two measures: improving digital literacy among general public and health professionals and ensuring reliable internet connectivity. As shown in **Table 1**, 21 Member States prioritised enhancing digital literacy, while 22 Member States emphasised the importance of improving internet connectivity and ICT infrastructure.[1] These priorities underscore the critical challenges faced by Member States in bridging the digital divide in healthcare: ensuring not only the availability of technology but also equipping their populations with the skills to utilise it effectively.[1]

Digital health literacy and inclusion plans

Digital health literacy refers to the capacity to seek, locate, comprehend, and evaluate electronic health information and apply the knowledge to address health concerns.[1]

WHO/Europe Resolution (EUR/RC69/R9) on health literacy that was adopted at the WHO Regional Committee for Europe in 2019, put emphasis on DHT and digital health literacy, and improving digital health literacy is one of the strategic areas of the Draft WHO European roadmap for implementation of health literacy initiatives through the life course.[5]

Digital health literacy encompasses a variety of individual and societal factors, as well as technological constraints, that influence people's ability to effectively use digital technologies for searching, acquiring, understanding, appraising, and communicating health-related information to maintain or improve their health and quality of life.[1] Therefore, promoting digital health literacy in the general population is critical to ensuring health equity and access to high-quality healthcare services and information for all. Low levels of digital health literacy can lead to misinformation and confusion, resulting in poor health management, delayed treatments, and higher healthcare costs.

Plans and strategies for digital health education and digital inclusion are essential to ensure that everyone, regardless of background, has access to and can effectively use digital technologies. Digital inclusion plans, policies and strategies aim to bridge the digital divide between people who have access to and can use digital technologies and those who do not and ensuring people who lack access to digital technologies or the ability to use them do not fall through the cracks. Within the WHO European Region, 52% of Member States reported having digital health education policies or strategies.[1] Additionally, 56% of the Member States' inclusion plans or strategies, like a digital literacy program, are aimed at marginalised communities.[1] However, the adoption of these plans varies widely by subregion. As presented in **Figure 3**, all five central Asian Member States and eight out of the ten Member States in northern Europe reported digital inclusion plans, this was not the case in the remaining subregions where less than 50% of the responding Member States reported such plans. A similar uneven distribution

Figure 3: Digital health education action and digital inclusion plans
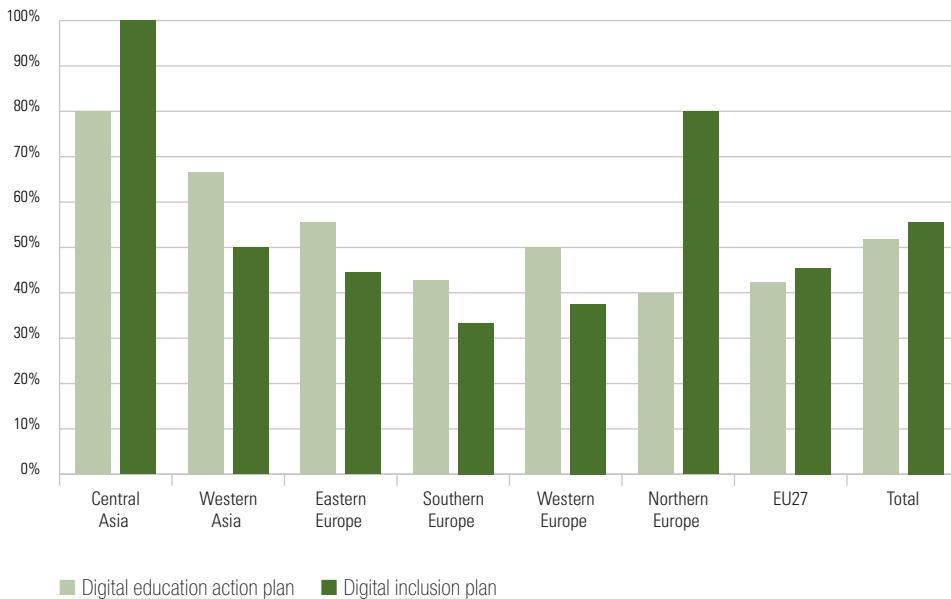
Note: For countries of the WHO European Region the geographic subregions are as defined by the United Nations Statistics Division and used in all United Nations publications and databases.

Source: [1] [7]

of digital health education plans, policies, and strategies also differs notably across subregion.[1]

The Digital Decade,[6] which outlines the EU's vision for digital transformation, includes indicators of digital skills as some of its key performance metrics. According to the Digital Compass, by 2030, 80% of EU citizens between the ages of 16 and 74 should possess at least fundamental digital skills.[6] However, the findings of WHO on digital health in the European Region show that less than 50 % of EU Member States have digital health education and inclusion plans.[1] To achieve this goal by 2030, these plans should be in place to ensure that we are bridging the digital divide and leaving no one behind.

Conclusion

The advancement and adoption of DHT across the WHO European Region offers promising avenues for more effective and accessible healthcare, particularly in the face of challenges like the COVID-19 pandemic. The growing adoption and utilisation of DHT such as patient portals, telehealth, and mHealth services reflects the region's commitment to leveraging technology to improve patient care.

However, alongside these advancements, persistent disparities in access and usage remain a concern. Factors such as geographical location, socio-economic status, age, and digital literacy contribute to the digital divide, potentially hindering the promise of UHC. Effective digital health governance and integrating digital and health literacy education into national health objectives is paramount. To bridge the digital divide, Member States should consider developing capacity-building and digital inclusion plans, policies, or strategies to ensure that everyone, regardless of background can access and effectively use DHT. These measures will accelerate action towards achieving UHC while leaving no one behind.

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LAUNCHING A PUBLIC DEBATE ON THE EUROPEAN UNION'S FUTURE HEALTH PRIORITIES: **HOW DO WE KEEP HEALTH ON THE POLITICAL AGENDA BEYOND 2024?**

By: Nicole Mauer and Matthias Wismar

Summary: In 2024, European citizens will vote for a new European Parliament. The ongoing political cycle has coincided with a health crisis that has reshaped the European Union's policies and opened a window of opportunity for health and health systems. There is now a unique opportunity to assess past achievements and consider future goals in the field of health. The European Observatory on Health Systems and Policies, in agreement with the EC Directorate General for Health and Food Safety (DG SANTE), has launched a public debate. This initiative invites input from different stakeholders and the public to inform future EU health priorities. The article highlights key events and milestones planned within this public discourse.

Keywords: European Health Priorities, Public Debate, European Union

> **#EPH2023 – PLENARY 5:**
Safeguarding health together: preparing the European Union's health priorities

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Introduction

The European Union (EU) response to the pandemic went beyond immediate firefighting. It strengthened the basis for coordination among European countries to protect people's health, both in normal times and in times of crisis. Key actions included crisis preparedness, a revision of the EU's pharmaceutical legislation, Europe's Beating Cancer plan,[1] and a comprehensive approach to mental health. The proposal for a European Health Data Space and the recently launched EU Global Health strategy [2] have also been part of this response. It has led to the creation of new institutional structures, the expansion of mandates of existing agencies, a substantial increase in the public health budget and the support of

health and health systems' development through new (temporary) financial instruments such as the Recovery and Resilience Facility.

Much has been achieved in a short period of time, but more can be done moving forward. The question is, what comes next? Was this a one-off response to an unprecedented crisis and should we focus on retaining and defending the achievements? Or is there scope and motivation for building on them? These next steps must also be considered against the backdrop of the EU's delimited mandate in the field of health and the implications of this for related EU priorities and actions moving forward.

What should the EU prioritise in its upcoming mandate?

With these questions in mind, the European Observatory on Health Systems and Policies (OBS) has launched a public debate in agreement with the European Commission's Directorate General for Health and Food Safety (DG SANTE). The aim of the public debate is to brainstorm ideas, options, and possible priorities ahead of the upcoming European elections in 2024. In a series of successive events leading up to the 2024 elections, the Observatory will engage with diverse stakeholders – from researchers, policy makers and representatives of civil society to the general public and the European citizens who are impacted first-hand by health policy decisions – to carve out key priority areas for EU action in health.

Beyond reflecting on the legacy of this legislature, the public debate serves to gauge public sentiments, gather experiences and expectations from different stakeholder perspectives on what should be prioritised as the EU enters a new political cycle. To set the scene for this debate, the Observatory has developed a discussion framework based on nine (non-exhaustive) priority areas (presented briefly in **Table 1**). This serves as the starting point to lead open and meaningful discussions on what needs to happen now to safeguard and further improve health in the EU moving forward.

Table 1: Building a framework for discussion: Nine priority areas to guide the public debate

Enhancing health security	Ensuring protection of people's health through prevention of, detection of, and response against threats or events that could harm it, including (re-)emerging infectious diseases, bioterrorism and the intentional release of biological agents, natural disasters and the release of chemical, radiological, or nuclear materials.
Addressing the determinants of health through Health in All Policies and Health for All Policies	Adopting systematic approaches that direct policies towards health by identifying the health impacts across different policies and maximise efforts to promote (or at least) avoid damaging health (Health in All Policies), as well as highlighting ways, in with health can contribute to other agendas (Health for All Policies).
Supporting health system transformation	Health system transformation is a critical process to meet new challenges and rising demands, which may require implementing different types of innovations. This process can be facilitated by creating supportive framework conditions, including targeted resources, a long-term vision, political commitment, and sustained investment.
Enhancing the labour market for health and care workers	Enhancing the working and framework conditions for health and care workers to counteract health worker shortages, medical deserts, attrition, and skill gaps, which are issues most countries are currently dealing with, and which will likely be exacerbated by demographic change and an ageing health workforce.
Achieving universal health coverage	Ensuring people have access to quality healthcare without facing financial hardship. Much progress has been made in European countries, but gaps in coverage and access still exist in many settings.
Implementing digital solutions and artificial intelligence	Maximising positive health outcomes and gains for healthcare delivery from using digital health solutions and artificial intelligence, while successfully mitigating risks and ensuring the safe use of these technologies.
Improving the performance and resilience of health systems	Strengthening the resilience and performance of health systems to maximise health outcomes and ensure health systems can rapidly adapt and meet their goals, including quality, access, equity, responsiveness, health improvement, people-centredness and financial protection.
Addressing long-term challenges such as population ageing and climate change	Understanding the stakes of long-term challenges such as population ageing and climate change for European health systems and building resilience to adequately detect, prepare for and act on challenges, ideally before they manifest as crises.
Strengthening the EU's global voice and leadership	Developing a common EU global voice and leadership to ensure coordinated action in international fora, in development assistance, in humanitarian aid and in civil protection efforts, as well as coherence with Member State policies to avoid fragmentation and duplication.

Source: authors' own, drawing from Observatory Briefing Papers

Box 1: Launching the Observatory briefing papers: bitesize information on key topical areas

Ahead of the events planned in this series, the Observatory has prepared nine briefing papers on the topical areas presented in **Table 1**. The briefing papers aim to frame the discussion and provide relevant background information to empower stakeholders and citizens engaging in the public debate.

The nine briefing papers are now available for download on the Observatory website.◢

Figure 1: Countdown to the European Elections: Timeline of key events foreseen within the scope of the public debate on future EU health priorities

September 2023: European Health Forum Gastein

YFG workshop

Conference session

Launch of briefing papers

November 2023: European Public Health Conference

Workshop

Plenary session

November/ December 2023: OBS webinar 1

November/ December 2023: OBS webinar 2

November/ December 2023: OBS webinar 3

January 2024: Stakeholder survey

February 2024: Summit workshop

March 2024: Final report on outcomes of the public debate

June 2024: European elections

Source: authors' own

Looking ahead to the European Public Health Conference and upcoming events in the series

The public debate was officially launched in September 2023 at the European Health Forum Gastein (EHFG) with three key events: 1) A workshop with young professionals forming part of the Young Forum Gastein network; 2) A conference session with Director General for Health and Food Safety, Sandra Gallina[3] and; 3) The launch of an Observatory briefing paper series exploring the nine topical priority areas included in the discussion framework (**see Table 1** and **Box 1**). The debate will be carried forward in November at the 2023 European Public Health Conference in Dublin. Taking stock of the wealth of ideas and impressions already collected during the first events, two conference sessions with different constellations of stakeholders and participants will serve to further spur the public debate. The first session is a workshop (**1.I. Keeping health at the forefront: A debate on health priorities of the European Union, Thursday 9th November at 9:00 – 10:00 am**), which will gather speakers from the European Commission, European Observatory, and the EUPHAnxt network of young professionals. The findings from this

workshop will subsequently be showcased and discussed in unison with insights garnered during Saturday's plenary session (**Plenary 5: Safeguarding health together: Preparing the European Union's future health priorities, Saturday 11th November at 10:30 – 11:30 am**).

> seeks to engage as many voices and collect as many inputs as possible

To render the debate as participatory as possible, the Observatory will also run a series of topical webinars later in the year, which will be open and just a click away for anyone willing to participate online. To complement these interactive events and gather additional inputs, the Observatory will cast its net even wider and run a stakeholder survey in the new year. A final summit workshop will serve to share and evaluate the outcomes of the

public debate, which will also be collected and analysed in a final summary report (**see Figure 1**).

Kickstarting the public debate and garnering first insights

During the first conference event of the series, Sandra Gallina was joined by representatives of different stakeholder groups, including civil society, the research community, and young Public Health professionals. Throughout the session, there was active participation from the audience who voiced their hopes and ideas for the future of the EU. First insights from this session are summarised in **Figure 2**.

Conclusions

As the European elections draw closer, there is growing public interest to discuss the future health priorities of the EU and to explore how it may support Member States in their efforts to strengthen health and health systems moving forward.

The public debate on the future health priorities of the EU is an iterative process which seeks to engage as many voices and collect as many inputs as possible. First impressions from these events also

Figure 2: Capturing first insights from the conference session

Source: Graphic Recording (c) Alexandra Brenner, www.blaugezeichnet.at

underline the usefulness of the discussion framework and the briefing papers in guiding a very complex and broad debate which brings together diverse interest groups and ideas. At the same time, ideas and proposals outside the scope of the framework have already been raised, which validate the open and participatory approach chosen to conduct this exercise. Over the coming months, the debate will continue to engage new stakeholder groups, gauge public sentiments, and distil key outcomes to inform the future mandate and the future health priorities of the new Commissioner for health.

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25 YEARS OF COLLABORATION BETWEEN EUPHA AND THE OBSERVATORY

By: Bernd Rechel, Martin McKee and Iveta Nagyova

Summary: The European Observatory on Health Systems and Policies was founded in 1998 at a time of transition, from communism in Eastern Europe and to new means of paying for and delivering healthcare everywhere. Since then, Europe has confronted both longstanding challenges and new ones, including wars, the financial crisis, the COVID-19 pandemic, and climate change. The Observatory and the European Public Health Association (EUPHA) have collaborated to address these public health challenges. Looking ahead, there is much to be done together to transform health systems and achieve the Sustainable Development Goals.

Keywords: European Observatory on Health Systems and Policies, EUPHA, Monitoring, Public health

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Introduction

In the 1990s, when the European Public Health Association (EUPHA) and the European Observatory on Health Systems and Policies were created, European health systems were in varying stages of transition. Those in Central and Eastern Europe were implementing new methods of financing and delivering care after half a century of communist rule and some were preparing for European Union (EU) accession. Meanwhile, in Western Europe, governments were considering how they would address what seemed inexorable cost pressures associated with ageing populations and scientific advances. While unexpected threats were always possible, the main challenges seemed clear even if the solutions were not. Now, 25 years later, Europe's future is less certain than ever. It is experiencing a major war and several conflicts and it has come through a global pandemic that cost the lives of millions and disrupted the lives of many more.

Public health challenges past and present

The World Health Report 1998 argued that humanity had many good reasons for hope in the future. And indeed, prospects were bright, with people living longer and in better health than ever before. However, it was also becoming clear that the burden of chronic diseases and multimorbidities were already growing and posing new challenges to health systems. In the past decade, progress in longevity and healthy life years has slowed and, in some countries, almost stopped, even prior to the COVID-19 pandemic.[1] The health inequalities that were already rising on the agenda have since widened markedly for some groups.

Human-made climate change had been recognised in the 1992 UN Framework Convention on Climate Change, but little serious policy action to address it had been taken by 1998, although the Kyoto Protocol entering into force in 1997 constituted progress, committing countries to reduce greenhouse gas emissions. The impact of climate change on health and health systems was only beginning to come into focus. Now, a generation later, the health impact of climate change has become a stark reality across the globe, forcing millions of people to move against their will at a time when Europe's borders are becoming ever more difficult to cross.

"

Europe has confronted both longstanding challenges and new ones

Economic crises had occurred throughout history but the global financial crisis in 2007–2008 still came as a surprise to most, resulting in the Great Recession and the European debt crisis. Governments decided to bail out banks and shift the costs on taxpayers while reducing public spending, including on public health, undermining pandemic preparedness prior to COVID-19.[2] [3]

The civil war in Syria and the "refugee crisis" it triggered in Europe in 2015 showed how interlinked developments in different parts of the world are. It also illustrated that solidarity can be extended to migrants, and health systems can be adapted to their needs when there is political will for doing so, benefiting both migrant and host populations.[4]

The COVID-19 pandemic caught most countries insufficiently prepared. It illustrated why governments must build strong, resilient and inclusive health systems and equitable societies

to protect against health threats and to secure progress in health and sustainable development.[5]

When the Russian Federation invaded Ukraine in February 2022, Europe was plunged into yet another crisis, with many lives lost, people displaced from their homes, and economies disrupted. The war led to new global food insecurities,[6] increased inflation, an added debt burden for many countries, growing military spending and disruption of global supply chains, with consequences for the global economy, all adversely impacting health.

The Observatory and EUPHA working in tandem

The European Observatory on Health Systems and Policies (Observatory) and the European Public Health Association (EUPHA), established just six years earlier in 1992, have worked in close partnership throughout the last 25 years, always complementing each other's work. EUPHA brings together public health associations and institutes in Europe, with a network of over 32,600 public health professionals. The European Journal of Public Health (EJPH) is a leading outlet for public health research in Europe, and the annual European Public Health (EPH) conference, attracts more than 2,500 participants each year. The Observatory, meanwhile, contributes to evidence-informed health policy making in Europe through country monitoring, health system performance assessment, a review of the evidence of what works, and knowledge brokering activities. It draws on its network of experts, many of whom are involved in EUPHA and its sections on specific public health themes.

The Observatory and EUPHA working on public health challenges

EUPHA and the Observatory have frequently worked hand in hand to identify how the many public health challenges described above affected the health of European populations and which policies would best address them. The Observatory's work was often developed in partnership with experts from EUPHA

and presented at EPH conferences, while discussions at EPH conferences gave rise to new Observatory areas of work.

The impact of the 2007–2008 global financial crisis on population health was explored in numerous scientific articles, workshops, and presentations at EPH conferences. The Observatory established a financial crisis monitor to track these research outputs and produced a series of books, policy briefs and reports on the topic, many again presented at EPH conferences and published in the EJPH.

Drawing on experts from across Europe, most involved in EUPHA, the book "Facets of public health in Europe"[7] assembled knowledge on public health practice in Europe, covering a wide range of key topics in public health, including screening, health promotion, occupational health, environmental health, nutrition, healthcare public health, tackling the social determinants of health, intersectoral working, public health research, and knowledge brokering in public health.

The Observatory's book on "Successes and failures of health policies in Europe", presented at an EPH conference, explored how progress towards better population health varied across countries. It identified the extent to which European countries differed in the implementation of health policies in ten different areas (tobacco, alcohol; food and nutrition; fertility; pregnancy and childbirth; child health; infectious diseases; hypertension detection and treatment; cancer screening; road safety; and air pollution).[8]

We explored some of these issues further in our study on the role of public health organisations in responding to the public health problems of obesity, alcohol consumption and antimicrobial resistance.[9] As in our earlier work, what stood out was how far countries differed in responding to these challenges, with some failing to recognise public health challenges as such, partly due to the influence vested commercial interests could exert on health policy making.

Migration and the health of migrants has received ever greater attention in the European public health community,[10] as evidenced by the EUPHA section on the topic and a number of pre-conferences. This 2015 "refugee crisis" gave rise to a new wave of research, including on how health systems can be adapted to meet the needs of refugees and other migrants,[4] and EUPHA statements brought attention to the inequities faced by migrants.

> ## EUPHA and the Observatory have frequently worked hand in hand

Delving deeper into the diverse structures, capacities and practices of delivering public health functions across Europe, we explored the organisation and financing of public health services and the public health workforce.[11] By the eve of the COVID-19 pandemic, we had found substantial scope for strengthening public health services and functions, including vaccination.[12]

The EPH conferences in 2020 and 2021 could only take place virtually, as the COVID-19 pandemic engulfed the world. The Observatory created the COVID-19 Health Systems Response Monitor (HSRM) to track how health systems responded to this challenge. It documented national responses in great detail, enabling cross-country comparisons and analyses. This gave rise to the "Public health in times of COVID-19" series developed in close collaboration with EUPHA, as well as special issues of the EJPH and Health Policy, summarising lessons from the pandemic. A new focus on health systems' resilience to cope with unexpected shocks emerged.[5]

What next?

As we are meeting again in person at the EPH conference in Dublin in November 2023, the war in Ukraine continues and the Middle East is once more engulfed in violence. The climate crisis is accelerating, with 2023 the hottest year ever recorded, while fossil fuel industries enjoy unimaginable profits and government subsidies worth trillions of euros. The challenges in achieving the Sustainable Development Goals are greater than ever, but it is not clear how to overcome them. Looking to the next 25 years, it seems that the Observatory and EUPHA will have their hands more than full in making the vision of the 1998 World Health Report come true.

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STRENGTHENING COMMUNITY HEALTH NURSING IN SLOVENIA VIA THE PROJECT:

THE UPGRADE AND DEVELOPMENT OF PREVENTIVE CARE PROGRAMMES AND THEIR IMPLEMENTATION IN PRIMARY HEALTHCARE AND LOCAL COMMUNITIES

By: Martina Horvat, Rade Pribaković Brinovec and Vesna Kerstin Petrič

Summary: Community health nursing in Slovenia operates within primary healthcare centres, offering preventive and curative healthcare services to diverse populations. Demographic and social changes have led to the evolution of this field. In 2015, the WHO recommended expanding community health nursing in Slovenia to address health inequalities, a pilot project in 2013 set the foundation, and a 2019 EU-funded initiative strengthened preventive care programs. The challenge now lies in securing sustainable funding and building an adequate workforce to continue promoting public health and reducing disparities. Effective collaboration is vital to extend healthcare outreach to homes and engage families and stakeholders in health improvement endeavours.

Keywords: Primary Health Care, Prevention, Community Nursing, Slovenia

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Background

Since its beginning, community health nursing has been an important part of Slovenia's healthcare system. It operates as an independent service or organisational unit within the primary healthcare (PHC) system in 61 PHC centres across the country.[1] According to data from the National Institute of Public Health, 893 community nurses were employed in 2021, with the average number of persons per community nurse-work district 2,605.[2] The concept underlying community health nursing is field work in a geographically defined district that encompasses provision of preventive and curative healthcare to patients in all periods of life. It is implemented at the patient's home, at PHC centres, in the local community or anywhere else in the field. Based on its focus on local community and its methods of work, community health nursing is considered as part of the PHC system.

Community nurses are the first to identify social changes and can respond to them quickly and effectively; ensuring provision of health-related nursing to a person, her/his family, and members of the community, where people live, learn,

play, and work. They actively follow-up health status of people in a designated medical district, provide health-promotion programmes and thereby encourage people to make the best possible decisions for their own health and that of their families.[3] Community health nursing includes the following areas of work: preventive and curative visits to individuals, families, and communities; healthcare to pregnant women, to women in the puerperal phase, newborns and babies at home; and home care.[4]

new upgraded preventive services in community nursing system

Demographic and social changes as well as changes within the healthcare system significantly impact the work of community nurses.[1] People's needs are changing, and community nursing must be adjusting accordingly in terms of content and staffing, supported by sufficient and sustainable financing.

In depth analysis of the health system in Slovenia,[5] performed in 2015 by WHO and the European Observatory for Health Systems and Policies in cooperation with the Ministry of Health of the Republic of Slovenia, identified the need to expand and promote the scope of community health nursing. Consequently, the Resolution on the National Health Care Plan 2016–2025 "Together for a Healthy Society" stated that the key to ensure access to high quality healthcare for vulnerable groups of the population and to reduce inequalities in health, entails further development of community health nursing.[6]

An opportunity to upgrade community health nursing and strengthen community nurses' roles had already emerged in 2013 with the "Towards better health and reducing inequalities in health"

pilot project as part of the programme financed through the Norwegian Financial Mechanism. Implemented in three local environments, this project aimed to upgrade preventive programmes for children, adolescents, and adults, decrease healthcare inequalities, ensure vulnerable groups are included in preventive healthcare, and strengthen health in the local community. The pilot project was completed in 2016 and showed that the new contents, tools, and approaches tested were effective in community health nursing.[7] Slovenia was ready for the implementation of new upgraded preventive services in community nursing system wide.

The aims, the objectives, the process, and the achievements of implementation

After evaluating and optimising the solutions tested in the pilot project, it has been proposed that they are implemented in a further 27 PHC centres and related local communities.[6] Slovenia was granted funds from the Operational Programme of the European Cohesion Policy for 2014–2020 for "The upgrade and development of preventive care programmes and their implementation in primary healthcare and local communities", a project that was dedicated also to strengthening community nursing. The project has been managed by the Ministry of Health. Expert support and guidance for the project's activities in PHC centres as well as substantive monitoring of the project has been provided by both the Ministry of Health and the National Institute of Public Health.[9]

The overall aim of the implementation project was to:

• strengthen the public-health role of PHC centres in preventing diseases, promoting health, and reducing health inequalities among people in the district in which they operate;

• reduce the burden of chronic diseases in children, adolescents and adults;

• include vulnerable individuals in preventive healthcare; and

• introducing the community approach model to promote health and reduce health inequalities in local communities.

The upgrading of preventive care programmes, in PHC and local communities, including upgraded preventive visits community nursing, was meant to be implemented first in 30 of a total of 61 PHCs.

The objectives for community nursing were to:

• increase, update, and harmonise the ways in which preventive services are performed by community health nursing;

• introduce planning of preventive services in community health nursing; and

• ensure sufficient staff and opportunities for training.

The following actions have been undertaken in the local environments, covered by the project: [8] [10] [11]

1. Providing home care for new-borns, babies, and puerperal mothers according to the upgraded programme:

The same preventive services have been provided to all puerperal mothers and children up to one year. During the child's first year, a community nurse performs at least eight preventive visits at the home of the new-born child and the mother, starting with the first visit within 24 hours of them arriving from hospital. Special attention is paid to mental health of the mother in the perinatal period, breastfeeding support, and safety at home. The programme also envisages interventions to address specific needs of the families with vulnerabilities, pregnant women and new mothers, and the new-born child. Based on the criteria that define the level of vulnerability, the community nurse might perform two to five preventive visits. In the framework of the promotion of early reading to children, she also distributes picture books and provides counselling.

2. Establishing contact with persons not responding to an invitation for a preventive check-up at the family medicine practice; identifying the reason for non-responsiveness and taking measures based on the reasons identified:

After sending a notification, a community nurse visits persons who have not responded to an invitation for a preventive check-up at the family medicine practice; they identify the reason for not responding and take measures according to the needs assessed. They also provide preventive check-ups according to the set algorithm for people incapable of visiting a family medicine clinic due to their vulnerability (people with various impairments, mental health issues, geographically dislocated people, vulnerable older people, migrants etc.). In addition, they include family members and important other persons in provision of care, especially when they can help with better understanding of the contents of services and thus improving effectiveness of preventive care. In people older than 65, community nurses assess the risk factors associated with falls and give advice on preventing falls of the elderly at home, based on the "Let's take a look and see if our home is safe" checklist.

3. Providing disease prevention and health promotion counselling in local communities:

Counselling services are intended for vulnerable people and are provided according to the agreed schedule to address specific health issues that occur frequently in local environments. Community nurses provide individual consulting and short lectures and workshops for groups. While performing these activities, they may cooperate with a health promotion centre (HPC) that operates within a primary healthcare centre (PHC). The main role of HPC is to ensure integration of all preventive services including with the specialist level and to provide lifestyle interventions against key risk factors for noncommunicable diseases by combining population and individual approaches.

Analysis of the district and the work plan

Community nurses can only effectively plan their work by considering the overall picture of the local community, facilitated by an accurate analysis of their district. The work plan thus consists first of an analysis of the district, followed by description of the work already performed, proposed measures, and an implementation plan of the preventive community health nursing programme to be undertaken by each community nurse. Based on the analyses of all districts and annual plans compiled by individual community nurses, the head of the community health nursing in the relevant PHC draws up both a document that encompasses the key findings and proposed measures as well as a plan for cooperation and networking with other stakeholders in the local community.

" how to ensure enough professionals in community nursing

Results of the project and the remaining challenges

The project was completed in 2019 and the data gathered during its duration enabled further development of community health nursing and provision of the upgraded health nursing also in the remaining 50% of healthcare centres that provide community health nursing. This has consolidated public health activities in community nursing.

Sustainable financing of those upgraded activities that have proven to work well after evaluation of the project remained a challenge after the project has been completed. In 2020, an agreement was adopted at national level that from 2021 all activities developed in the project would be financed through

obligatory insurance as part of the regular community nursing programme in all PHCs.

There were several other results of the project that contribute to the sustainability of the upgraded preventive care programme in community nursing. Directions on how to implement, monitor, and calculate services provided by community nurses developed in the project are being used to support planning, implementation and monitoring in community nursing. Trainings have been developed and performed including for the staff that have not participated in the project. New definitions of preventive work in community health nursing and long-term financing have ensured that all patients can receive equal preventive services, even if performed in their home environment.

The challenge remains, how to ensure enough professionals in community nursing to cope with additional responsibilities of implementing the upgraded preventive care and act as key promotors of health and equity in health in the local community. The strength of community nurses lies in their exceptionally good knowledge of the people living in their district and in their ability to identify social and health issues and to seek for solutions through their connections with the local community and non-governmental organisations. They are best placed to coordinate all types of services performed at people's homes and can act as a link between a person, their personal doctor, and other services. It has been demonstrated within the project that they can foster interdisciplinary cooperation and coordinate teams of different professionals in the community which has resulted in better integration of preventive services and reduced health inequalities.[11]

To enable effective work of community nurses and their role in introducing and implementing preventive programmes and activities for individuals, families and local environments, communication and connections with other implementers, such as social services and NGOs, should be systematically established and supported. There is enormous potential in community

nursing to further reach out of healthcare facilities to people's homes, and involving their families, neighbours and stakeholders in improving health, contributing to wellbeing, and reducing inequities in local communities, that needs to be further explored.

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