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European Health Forum Gastein 2025

› Rethinking solidarity in health: Healing Europe´s fractured social contract

- Solidarity and innovation go hand in hand
- Investing in women’s health research and innovation
- Social, green, and arts prescriptions
- Mental health support during crises
- End-of-life care and the social contract
- Strengthening primary healthcare
- Hospitals of the future
- Transparency of public contributions to drug development

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Journal of the
European Observatory on Health Systems and Policies
Eurostation
Place Victor Horta/Victor Hortaplein, 40/30
1060 Brussels, Belgium
T: +32 2 524 9240
F: +32 2 525 0936
Email: contact@obs.who.int
http://www.healthobservatory.eu

SENIOR EDITORIAL TEAM
Sherry Merkur: +44 20 7955 6194 s.m.merkur@lse.ac.uk
Gemma Williams: + 44 20 7107 5304 g.a.williams@lse.ac.uk

FOUNDING EDITOR
Elias Mossialos: e.a.mossialos@lse.ac.uk

LSE Health, London School of Economics
and Political Science, Houghton Street,
London WC2A 2AE, United Kingdom
https://www.lse.ac.uk/lse-health

EDITORIAL ADVISORY BOARD
Reinhard Busse, Ewout van Ginneken, Suszy Lessof,
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DESIGN EDITOR
Steve Still: steve.still@gmail.com

PRODUCTION MANAGER
Jonathan North: northj@obs.who.int

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List of Contributors

Oihane Abiega ◆ Andalusian Public Foundation Progress and Health and Regional Ministry of Health and Consumer Affairs of Andalusia, Seville, Spain

Alaa Alnasser ◆ International Federation of Red Cross and Red Crescent Societies (IFRC), Regional Office for Europe, Budapest, Hungary

Amanda Amigues ◆ International Federation of Red Cross and Red Crescent Societies (IFRC), Regional Office for Europe, Budapest, Hungary

Clemens Martin Auer ◆ European Health Forum Gastein, Bad Hofgastein, Austria

Oriane Bodson ◆ University of Liege, Belgium

Elettra Carini ◆ National Agency for Regional Healthcare Services, Rome, Italy

Julien Carretier ◆ Université Claude Bernard Lyon 1; University of Lyon, France

Ana M. Carriazo ◆ Regional Ministry of Health and Consumer Affairs of Andalusia, Seville, Spain

Nigel Edwards ◆ European Observatory on Health Systems and Policies; University of Birmingham, UK

Stefan Eichwalder ◆ Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, Vienna, Austria

Daniel Fabian ◆ Austrian Institute for Health Technology Assessment (AIHTA), Vienna, Austria

Sandra Gallina ◆ Directorate-General for Health and Food Safety, European Commission, Brussels, Belgium

Dorli Kahr-Gottlieb ◆ European Health Forum Gastein, Bad Hofgastein, Austria

Ewout van Ginneken ◆ European Observatory on Health Systems and Policies, Brussels, Belgium

Romana Höltschl ◆ Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, Vienna, Austria

Pia Kreutzer ◆ Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, Vienna, Austria

Christos Lionis ◆ University of Crete, Greece; University of Limassol, Cyprus

Alison Maassen ◆ EuroHealthNet, Brussels, Belgium

Giovanna Marsico ◆ French National Center for Palliative and End-of-Life Care (CNSPFV), Paris, France

Pedro Morera ◆ Andalusian Health Service, Seville, Spain

Basilio Muiruri ◆ International Federation of Red Cross and Red Crescent Societies (IFRC), Regional Office for Europe, Budapest, Hungary

Ülla-Karin Nurm ◆ Northern Dimension Partnership in Public Health and Social Well-being, Stockholm, Sweden

Dimitra Panteli ◆ European Observatory on Health Systems and Policies, Berlin, Germany

Iva Perhavec ◆ International Federation of Red Cross and Red Crescent Societies, Regional Office for Europe, Budapest, Hungary

Elena Petelos ◆ University of Crete, Greece; Maastricht University, The Netherlands

Dheepa Rajan ◆ European Observatory for Health Systems and Policies, Brussels, Belgium

Paola Sillitti ◆ University of Lausanne, Swiss Centre of Expertise in the Social Sciences, Swiss Centre of Expertise in Life Course Research, Lausanne University Hospital (CHUV), Lausanne, Switzerland

Ffion Storer Jones ◆ DSW, Brussels, Belgium

Sebastian Tornero-Patricio ◆ Andalusian Health Service, Seville, Spain

Aneta Trgachevska ◆ International Federation of Red Cross and Red Crescent Societies, Regional Office for Europe, Budapest, Hungary

Greisy Massiel Trejo ◆ International Federation of Red Cross and Red Crescent Societies, Regional Office for Europe, Budapest, Hungary

Claudia Wild ◆ Austrian Institute for Health Technology Assessment (AIHTA), Vienna, Austria

Juliane Winkelmann ◆ European Observatory on Health Systems and Policies, Brussels, Belgium

Eurohealth editorial team

Sherry Merkur ◆ European Observatory on Health Systems and Policies, London, UK

Gemma A. Williams ◆ European Observatory on Health Systems and Policies, London, UK

Eurohealth Gastein commissioning team

Chloe Maher ◆ European Health Forum Gastein, Bad Hofgastein, Austria

Dorli Kahr-Gottlieb ◆ European Health Forum Gastein, Bad Hofgastein, Austria

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FOREWORD

Solidarity has long been the foundation of the European social model and access to affordable healthcare for all citizens is deeply embedded in our social contract.

Almost 20 years ago, EU Member States agreed on common values and principles for EU health systems, which include “universality, access to good quality care, equity and solidarity”.* Solidarity and access to healthcare is also enshrined in the EU Pillar of Social Rights (Principle 16). The Commission will present a new Action Plan on this Pillar later this year, to reconfirm our unwavering commitment to these principles.

In recent years, immense public health challenges have tested us to the limit. In the face of a pandemic, climate change, zoonotic risks, workforce pressures and medicine shortages, it may have been tempting to retrench behind national lines. However, these challenges have also been a stark reminder that health is not simply a national concern, but a shared responsibility, without borders. Whether confronting new diseases, striving for equal access to medicines or grappling with the new realities of digitalisation, the most effective solutions can only be found by working together for the common good. That is why solidarity, fairness, equity and collaboration lie at the heart of the European Health Union, which we are now consolidating at great speed.

Our proposed reform of the EU’s pharmaceutical legislation, along with the Critical Medicines Act, will help to ensure access to affordable, safe and effective medicines for all Europeans, by boosting EU competitiveness and diversifying supply chains. The upcoming Biotech Act will accelerate biotech innovations from lab to market, strengthening Europe’s leadership in this sector and improving the treatments on offer to our citizens. With the Health Technology Assessment Regulation, we have a collaborative, transparent framework to evaluate the value of new treatments, thereby supporting equitable access to care while stimulating innovation. Meanwhile, the European Health Data Space will empower citizens with control over their health data, improve continuity of care across borders and unlock secondary use of data for research, innovation, policy making and regulatory activities.

Vulnerable groups are hardest hit by shocks in our societies and new health threats. Within our Health Union, we pay special attention to tackling social disparities, in line with our social contract. Europe’s Beating Cancer Plan is already delivering results, by addressing the inequalities in cancer care across Europe. Our upcoming Cardiovascular Plan will also seek to tackle health problems that are too often driven by socio-economic factors. The EU4Health programme has funded vital actions to safeguard solidarity in public health, while the Recovery and Resilience Package includes investments to improve accessibility of healthcare, including through digitalisation, better regional distribution of health services, and strengthening primary care.

In short, the EU’s health policy is rooted in solidarity – focussed on universal access to quality, affordable care, in line with our social model. Recent challenges have highlighted the need for cross-border cooperation and shared responsibility. Through our reforms, digital health initiatives and targeted programmes, the European Health Union will continue to work on reducing inequalities and strengthening resilience for all citizens.

Sandra Gallina,
Director General for
Health and Food Safety
(DG SANTE),
European Commission

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* Official Journal of the European Union. Council Conclusions on Common values and principles in European Union Health Systems, 22 June 2006. https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF

GUEST EDITORIAL

Rethinking Solidarity in Health:
Healing Europe's Fractured Social Contract

The 2025 **European Health Forum Gastein** (EHFG) convenes at a pivotal moment as Europe grapples with pressures that threaten the foundations of its post-war social contract grounded in solidarity, equity, and collective responsibility. Rising defence and climate expenditures, demographic shifts, economic polarisation, and rapid technological change are straining welfare systems. Health, as a visible and valuable expression of this contract, is under stress. This special issue of Eurohealth brings together diverse perspectives on how solidarity in health can be renewed and reimagined.

EHFG President Auer opens with a stark warning: that labour market shifts and new financing models are eroding solidarity. Auer calls for capturing untaxed digital revenues, and ensuring innovation serves human dignity. Storer Jones argues that the social contract has failed to deliver for women. Because gender health disparities persist, gender perspectives could be embedded in research, closing knowledge gaps, and boosting female leadership in science. Maassen and Nurm explore social prescribing, which links people to community activities. But to succeed, these programs must be inclusive, culturally sensitive, and sustainably funded.

Good mental health enables people to participate in society, trust others, and uphold shared responsibilities. Perhavec and colleagues share insights from the Red Cross and Red Crescent's Ukraine response. Their work exemplifies solidarity and underscores the need to integrate mental health into mainstream systems. End-of-life care reflects Europe's values: Sillitti and co-authors highlight the gap between people's preference to die at home and the reality of institutionalised and medicalised deaths.

Primary healthcare (PHC) is a vital entry point to care and a practical embodiment of solidarity. Abiega et al. showcase an initiative which strengthens PHC across Europe by transferring best practices across national contexts, focusing on multidisciplinary teams, digital integration, and community orientation. Winkelmann and co-authors examine hospitals' transformation into integrated care networks pointing to decentralisation, strategic planning, and digital innovation. Transparency in drug development is addressed by Wild and Fabian. With new EU legislation requiring disclosure of public funding, they argue transparency must be linked to fair pricing and equitable access.

Collectively, this issue shows that rethinking solidarity in health is a societal imperative. It requires inclusive design, sustainable financing, community-centred care, and transparent governance. Health is both a pillar and beneficiary of Europe's social contract. By acting decisively, Europe can mend its fractures and reaffirm solidarity as a defining value for the 21st century.

Dorli Kahr-Gottlieb,
Secretary General,
European Health Forum
Gastein

Ewout van Ginneken,
Director,
European Observatory on
Health Systems and Policies

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RETHINKING THE SOCIAL CONTRACT: SOLIDARITY AND INNOVATION GO HAND IN HAND

By Clemens Martin Auer

OPINION PIECE

Summary: Europe's post-World War II social contract, based on solidarity, social justice, and redistributive welfare, is under existential threat. With rising defence and climate costs, ageing populations, and AI-driven labour automation, traditional tax-based funding for social systems is eroding. This article asserts that a paradigm shift is needed to ensure fairer taxation and to balance innovation with human dignity. AI will transform societies, but may also devalue human labour, deepening inequality and creating instability. Without political action to renew the social contract, Europe risks undermining its democratic values and social cohesion.

Keywords: *Social Contract, Innovation, Competitiveness, Artificial Intelligence, Financing*

> #EHFG2025 – PLENARY 1:
Rethinking solidarity in health – Healing Europe's fractured social contract

Clemens Martin Auer is President of the European Health Forum Gastein; former Director General and Special Envoy of Health for the Austrian Ministry of Health, Vienna, Austria; former Vice-Chair of the Executive Board of the World Health Organization, Geneva, Switzerland. Email: clemens.auer@ehfg.org

Introduction

We are living in a time of dynamic political change in Europe. Governments are being encouraged by external forces to substantially increase public budgets for defence to as much as 5% of GDP. The costs of addressing the climate crisis are similarly high. This additional government spending, coupled with the unpredictable impact of AI-driven automation across nearly all sectors of the economy, its consequences for the labour market as well as the demographic ageing of Europe, directly influences the sustainable financing of solidarity systems in Europe.

All of these developments will also have a massive impact on health systems and long-term care. This makes it increasingly urgently to rethink the social contract that has underpinned European societies since the end of World War II.

At this pivotal moment in history, what is at stake is the legacy of a post-war political consensus: the creation of social justice through the legal frameworks of welfare states and the introduction of progressive income taxation. Over the last eighty years, the political centre has successfully implemented social justice – not merely as a voluntary charity or moral appeal, but as a legally enshrined state responsibility.

The welfare state, particularly in the Western European tradition, has transformed social rights into codified entitlements in the major areas of healthcare, pensions, family support, education, and unemployment insurance. The Social Security Code creates the central lever for the implementation of at least optimised equality of access to and participation in the overall economic prosperity of society and in the fight against poverty.

The level of current government spending of plus/minus 50 percent GDP on health, to an increasing extent on pensions, on education, against unemployment and for other forms of transfer payments (families, children, social welfare, etc.) together with progressive income taxes and social security contributions, is an expression of the political will to bring about the democratically legitimised redistribution of assets and income in the economy in favour of social participation and the establishment of social justice. That is the core of the social contract. It is an expression of socially and politically induced integration. The market economy and the Social Security Code, i.e., the social market economy, are the foundations of this understanding of social justice. Here, the humane principle prevails that those who cannot or can no longer contribute to the prosperity of a society still have a legal claim to share in it and not just a moral claim.

> legally enshrined state responsibility

This principle of solidarity now faces challenges from the dynamic growth in additional government spending. In an interview before the NATO summit in The Hague in June 2025, NATO Secretary General Mark Rutte unequivocally summed up his picture of the future: Europeans, he warned, could continue to prioritise spending on health and pension systems, but without also investing substantially in defence, "we might as well start learning Russian".[1]

Similarly, Germany's former foreign minister, Joschka Fischer, himself a veteran of the Green Movement, said at a Swiss foreign policy conference in June 2025 that Europe has the potential to defend itself, especially though its strengths in education and research. Yet he also asserted that Europe's most important resources are its values: freedom, democracy, and the rule of law. When asked about concerns such as climate and social policy, Fischer said that while they matter, "Safety comes first".[2]

In this situation, securing the Sustainable Development Goals (SDGs), particularly universal health coverage, including long-term care for an ageing population, becomes imperative to uphold the justice of a new social contract. Fulfilling these emerging state tasks in the areas of climate, decarbonisation, migration, rearmament and military defence, requires a comprehensive political paradigm shift in the social contract.

On the one hand, achieving security based on social justice can only be achieved at the level of the nation state through a political debate about a significantly broader tax base on disproportionately high incomes and wealth. To avoid distortions due to different tax rates in individual European Union (EU) countries, there is an argument that the EU needs to harmonise its ranges of tax rates within its territory. On the other hand, the increasing burden of new state tasks also demands the rapid development of a multilateral tax framework. This could encompass global economic activities that have thus far largely escaped national taxation due to deregulated capital mobility and the globalised trade in goods and services, especially digital services. Until now, actors responsible for social or ecological damage have been able to externalise the associated costs of their actions, shifting the financial burden to national taxpayers while making little to no contribution through taxation. This is especially true of the globalised tech giants. The raising of funds for armaments expenditure in the EU can only be financed by common financial instruments at the European level, but in any case, requires the establishment of a common EU capital market.

Artificial Intelligence versus Social Contract?

A basic principle of the functioning of solidarity systems is often overlooked in the general debate: The financing of Europe's solidarity systems – and especially the health systems – are based mainly on taxes and levies on work performance and employment. There may be differences in the organisation of the solidarity system, such as self-administration in public social insurance financed by levies, or state forms of organisation financed by wage and income taxes. But essentially, the solidarity system is paid for mostly by taxes and contributions on earned income or income derived from work, such as pension income.

This basic principle has so far been one of the strengths of the solidarity system in economic systems with a broad middle class, the "high-income countries". The financial resources grew along with the income from work, and rising employment rates, especially with increasing employment rate among women over time. However, this basic principle and thus the inflow of funds for universal health coverage or pension systems is not secured in the long term. Already in the last twenty years, earned income in the Western industrialised countries has stagnated compared to capital income, which is decoupled from contributions to solidarity systems. The ongoing deindustrialisation in Europe by relocating production to low-wage zones leads to a loss of well-paid industrial jobs, compared to jobs in the service sectors (especially retail and tourism) and the rapidly growing logistics industry. In the immigration countries in Europe, the employment rate for migrant women is lower than non-migrant women and men.

At the same time, age-related developments in the population pyramid are leading to a rapid exit of the baby boomer generation from the active labour market. For the EU, the Draghi Report "The Future of European Competitiveness"[3] expects the workforce to shrink by close to 2 million workers a year by 2040. Over the same period, the ratio of the working population to pensioners in the EU will fall from 3:1 to 2:1. All these factors naturally slow down the development of contributions to and tax revenue for the solidarity systems, especially for social health insurance systems, because the increase in earned income is no longer a given and the loss of jobs reduces the basis for contribution income overall.

The biggest political and social challenge for solidarity systems, however, lies in rapid digitisation and AI, especially in their potential impact on the labour market. These challenges are of interest to anyone who cares about the social contract and health systems. The very foundations of that contract will change drastically, even be obliterated. The revolutionary dimension of digitalisation, but above all of AI, the associated automation of (work) processes, is comparable to the invention of the steam engine by James Watt and the first industrial revolution in economic and production processes in the decades after 1830. The initial fears of Gerhard Hauptmann's play "The Weavers" that their already poorly paid jobs at the looms would be destroyed by the steam engine may have come true for these weavers. Overall, however, the explosion of the labour market due to industrialisation and the proportional increase in prosperity in Western society brought about by labour disputes is an enormous achievement of civilisation in the historical context. The industrial revolution is what allowed solidarity systems to be created in the first place.

However, the difference between the invention of the steam engine and the invention of AI is clear: The steam engine had the potential to multiply the work output of human muscles as an aid. AI has the potential to completely replace human work. Historically, the steam engine contributed to the development of solidarity systems because of the enormous increase in human output and income it brought about. Bots can potentially replace human work and the income linked to it, which in turn would reduce the basis for financing solidarity systems.

Naturally, historical predictions are difficult, especially when it comes to the development of employment and the labour market. So far, technical progress since the invention of the steam engine and the increasing automation of production processes have led to restructuring in the labour markets, but the number of employees has grown enormously during this time. The political and social question in the context of AI bots therefore lie in the critical assessment of whether this AI merely replaces individual tasks in the context of work processes or takes over the entire workflows and thus human workplaces.

If AI takes over entire workflows and thus workplaces, we must remember that solidarity systems so far have been linked to the strengths and weaknesses of labour markets. This could change because of the enormous capital investments in new technologies. These investments in turn would shift the importance from human labour to profit-making capital, which would be a further step toward the dehumanisation of the purpose of capital. This scenario is not disputed in the more or less whispered conversations of the big tech investors: The macroeconomic calculation of the return on investment can only work out if the automation stimulated by AI leads to a broad reduction in labour costs, i.e., to a significant loss of jobs. The decision on how much capital to invest in these developments is made by financial investors who hope for a profit from them.[4] However, there is no political discourse on how far the dehumanisation of these technical developments should extend. The social and human costs, which investors in AI simply externalise, are not a perceptible political issue in the political centre. In the EU, political decisions are being made about legal provisions for protective and security measures when it comes to the use of data. However, the main focus of politics is on supporting investments from the point of view of geopolitical competitiveness. No one is saying anything about the social consequences of AI for society.

From the perspective of solidarity and a new social contract in society, the question of "cui bono?" arises or to be more specific: Does this development benefit society as a whole? Economists have so far assumed that the use of AI in specialised jobs creates a benefit, both in the productivity of service provision and in new employment opportunities. This applies at least to job creation in the technology industry itself and in the broad field of research, especially in life sciences. In these areas, especially in medical research, AI will bring enormous benefits. The situation is different in the logistics industry, where automation bots can largely replace human work. However, skilled industries such as banking, finance, legal and all consulting services also face challenges. AI is even transforming the education sector. This development only intensifies the rift between the educated and the less educated. The Draghi Report quotes studies that the automation of production processes in the US has contributed to a 50 –70% increase in income inequality since 1980.

However, these assumptions by the OECD, for example, about the impact of AI on labour markets may be shortsighted.[5] Eric Schmidt, the former CEO of Google and a major investor in AI, assumes that in the next five to eight years, i.e., time horizon of 2030 to 2033, the codes used in AI will have reached a quality corresponding to 80 to 90% of the skills and knowledge of the top experts in their respective fields.[6] He assumes that even the best programmers and mathematicians will become superfluous because of these self-learning AI systems. However, Schmidt, as one of the great drivers of AI, also believes that these developments are completely "underhyped" in the broad social and political debate. Sam Altmann, CEO of OpenAI, takes a similar view, noting that we must have a debate about the impact of this development on the social contract. For him, ChatGPT will soon be more powerful than any person who has ever lived.

For politics, for the social debate about a social contract and its implication for the financial base of health systems, this raises the urgent question of whether a positive balance of justice for the labour market will still be possible in the era of AI. This question goes far beyond the necessity of personal (protective) rights and security necessities in the digital data world. It is an existential question for a society: can it enable social and economic participation by the broad social classes. In any case, the sustainability of solidarity systems is threatened at its core by this development and cannot be rendered future-proof unless the basis for funding these systems changes.

The Social Contract in the EU: Solidarity and Competitiveness Go Hand in Hand

The European Commission, appointed in 2024 under President Ursula von der Leyen, has declared that it has two main tasks: to secure the Union’s geopolitical competitiveness in relation to the US and China, and to overcome stagnating economic growth. The blueprint for achieving these goals is outlined in the Draghi Report “The Future of European Competitiveness”. It states that no economic growth in the EU will be possible without a significant increase in productivity. In terms of the European understanding of a new social contract, the Draghi Report states that even if the EU follows the example of the US and increases productivity and growth, it must avoid the negative social consequences associated with the American model. “A European approach must ensure that productivity growth and social inclusion go hand-in-hand”.[7]

To put this issue in the context of a new social contract, it is important to note that the European solidarity system cannot be maintained without economic growth in the EU. The same is true of averting the climate crisis and maintaining the strength of the education and health systems. The Draghi Report calculates that in order for the EU to remain geopolitically competitive, requires additional annual investment equivalent to 5% of GDP in order to be able to invest comprehensively in digitalisation, decarbonisation, its defence capability and its security and economic independence. This enormous economic effort requires an increase in productivity and, in turn, massive investment in Europe’s innovative power, i.e. support of European digital technology.

In the context of formulating a new and revitalised social contract for European societies, it is politically imperative not to focus solely on the competitiveness of the European economy. Equally and at the same time, we must discuss and politically initiate steps to protect the solidarity systems in the long term and ensure the social and economic participation of as many segments of the population as possible. The political call of the economic elite to strengthen Europe’s innovative power as forcefully as possible will come to nothing if, at the same time, we ignore the political concern that the innovations of the tech industries have the potential to dehumanise economic activity and weaken human labour and the associated systems of solidarity. The desired innovation is currently driven by the use of capital, not labour. In the centre of all this are the potential negative effects on the sustainability of the health system.

Politics must go hand in hand with better governance to reach the goals of innovation and productivity growth and must prioritise decisions to reformulate the tax base. This is especially true when it comes to substituting stagnant tax revenues from labour income, which have thus far been the prime source for solidarity and health systems. OECD works on such frameworks for the reformulation of tax codes.[8] Globalisation of trade, digitalisation and automatisation call for multilateral tax agreements to secure fairness for “robot taxes” or taxation of AI and digital systems or the usage of data. The national tax regulators have only a few possibilities for taxing the profits stemming from digital commerce and the digital economy, which when implemented, are strongly countered by the new geopolitical pressures exerted by the current US government. Nevertheless, such political decisions are urgently needed to counterbalance the social costs of inequality deriving from the vast and fast technological revolution we are witnessing.

The rise of right- and left-wing political populism, which seeks to hit existing systems with big wrecking balls, can be traced not only to the paralysis of fear about the consequences of migration, but above all to the social insecurity among the broad base of voters due to modern innovations they view as threatening. A serious debate about a social contract as a humane balance to the capital-driven intention to promote technological innovation is one of the last chances to protect the liberal democratic state under the rule of law from both authoritarianism (right or left) or (big tech) business oligarchies.

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INVESTING IN WOMEN'S HEALTH RESEARCH AND INNOVATION:

A PRESCRIPTION TO HEAL OUR FRACTURED SOCIAL CONTRACT

By: Ffion Storer Jones

Summary: Investing in women's health research and innovation (R&I) offers an opportunity for the European Union (EU) to mend its fractured social contract. Political momentum and EU initiatives offer hope that women's health is finally on the agenda, but funding and policy commitments remain inconsistent. Placing women's health at the heart of its renewed efforts to strengthen Europe's R&I ecosystem is an opportunity for the EU to show leadership in closing the gender health gap. By adopting a comprehensive approach to advancing women's health globally, Europe can provide a blueprint for shaping a social contract that delivers for all.

Keywords: *Women's Health, Gender Equality, Research and Innovation, Social Contract*

Introduction

It was only in 1993 that the inclusion of women* in clinical trials was mandated by the United States' (US) National Institute of Health (NIH). The NIH is one of the largest public funders of health research globally, whose efforts on this front are a target of the Trump administration, including a "Ctrl Alt F–Delete" approach to eradicating any reference to, and jeopardising efforts to improve the health of women. From historic exclusion to ongoing, and growing attacks, the politicisation and rollback of women's health rights stands in the way of not only improving the lives of billions of individuals across the world but also serves up a substantial bill for healthcare systems, erodes trust in public institutions, deepens inequities and threatens to erode social cohesion.

The social contract – an agreement that organises how individuals relate to each other and to the state, balancing the needs of the public sphere (collective welfare and governance) with those of the private sphere (individual rights and autonomy) – has thus far failed to deliver for women, across multiple domains. To fulfil the promise of the social contract for all, the women's health gap must be addressed in a comprehensive approach that drives action across both spheres: from public policies, research, and healthcare delivery that

> #EHFG2025 – SESSION 1: Women's health 2030 – Closing the gender gap

Ffion Storer Jones is Senior Advocacy Officer for the global health NGO DSW. Brussels, Belgium.
Email: ffion.storerjones@dsw.org

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* The use of women in this article is done with recognition of diversity.

Box 1: How has R & I failed to account for women?

Biomedical research is androcentric, with a disproportionate focus on male cells, animals and humans throughout the research pipeline. In early research, up to 75% of research articles do not report on the sex of the cells used. Where cell sex is specified, studies show that female cells account for only 5% of cells used.[1] In pre-clinical animal studies, rodents are most often used as models. Between 1990 and 2009, studies show that 80% of all mouse/ rat studies used only male animals.[2] While the NIH mandated the inclusion of women in clinical trials in 1993, clinical trials are far from representative, and pregnant and lactating populations continue to be routinely excluded from research.

adequately address women's unique health needs, to better recognition and support for women's roles and needs within the private sphere; including bodily autonomy, caregiving and access to building blocks of good health, such as nutritious food or safe housing.

> failed to deliver for women

Persistent and pervasive disregard

In a 1997 report [3] on the state of women's health in the European Community, 62% of women considered themselves to be in good or very good health. Skip to the present day, and the European Institute for Gender Equality's index [4] reports that the figure is now at 65% – compared to 70% of men. Progress has therefore been slow. This is reflected globally, with the 2025 edition of the Hologic Women's Health Index [5] highlighting that women have experienced losses compared to previous years across all five dimensions covered: preventive care, emotional health, opinions of health and safety, basic needs, and individual health. In 2006, concluding on the aforementioned women's health report,[6] the Council of the EU acknowledged 'the need for gender-related biomedical research as well as research on socio-economic determinants', recognising the distinct and intersecting role of sex and gender as biological and social variables in the poorer health outcomes reported by women.

Are words finally being translated into action?

Almost 20 years later, the EU Roadmap for Women's Rights [7] again highlights the persistent gender health gap and the need to prioritise gender-sensitive medical research and clinical studies. While there is strong political momentum on women's health in the current EU mandate, including the appointment of four prominent Members of Parliament as co-Chairs of an Interest Group on Women's Health – bringing growing attention to, and action on the topic – empty promises can no longer be afforded. Literally. Closing the gender health gap has been estimated to potentially boost the global economy by over €800 million annually by 2040.[8]

Tackling the deficit of women-specific knowledge in science and investing in research and innovation (R&I) on women's health are key to seizing this wealth of opportunity. R&I are core tenets of the social contract, with citizens supporting public investment in activities to drive societal progress, including public health, through funding (taxes) and participation. It is perhaps one of the most striking examples of the disregard of women's health needs; a collective investment in research whose results, including new knowledge and health technologies, while expected to benefit society as a whole – continue to fail women (**see Box 1**). At a critical juncture in Europe's history, and entering a new budgetary cycle, the flurry of initiatives looking to reinforce the European R&I ecosystem must be mobilised to close the gender health gap.

Science and technology: an engine of change

The integration of the gender dimension as a mandatory criterion in the most recent EU research framework programme (Horizon Europe) has been a significant move in improving the consideration of gender in research, as have the major strides that the EU has taken in advancing women in science.[9] Promoting women's leadership in Science, Technology, Engineering, and Mathematics (STEM) has shown to ensure research reflects women's needs and priorities. While there are more women in science, science for women, meaning research (in the health field) that is focused on topics that affect women differently, exclusively or disproportionately, shows slower progress.

Earlier this year, the European Commission shared [10] that over €2 billion has been invested in more than a thousand projects focused on women's health since 2014 (estimates show cancer received over €4 billion during the same period), targeting, among others, cardiovascular disease, reproductive and maternal health and personalised medicine. The projects extend from support for basic research via the Health Cluster to late-stage clinical trials via the Global Health EDCTP3 Joint Undertaking. There's no lack of instruments in the EU's arsenal that could contribute to closing the gender health gap, but investment has thus far been inconsistent and unpredictable.

The need for an overarching strategy and coordinated agenda

DSW has been calling [11] for the establishment of an expert group on women's health R&I, to promote a more comprehensive and integrated approach to the EU's actions in the area of women's health. This would help build expertise, identify gaps and foster collaboration between the EU, its member states and international actors on women's health policies, interventions and investments. The expert group should be tasked with leading the development of a research agenda, to maximise investments and guide actions that yield interventions that are suitable, deliverable, and acceptable to women globally, increasing access and equity.

To deliver on this agenda, a partnership for women's health, modelled on the European Rare Diseases Research Alliance could serve to bring under one roof a multi-stakeholder ecosystem; so that discoveries move from the bench side to the bedside and beyond, faster and more efficiently. Achieving such a critical mass through the joint implementation of research agendas and establishing structured R&I ecosystems enable speedier and more substantial results, as recognised by the EU's new Life Sciences Strategy.[12]

Unlocking investment for impact

Despite the near-total absence of intersectional sex and gender considerations, the Life Sciences Strategy holds promise to advance women's health efforts in Europe, not only through identified actions linked to artificial intelligence and digital twins, but particularly pertaining to its ambitions to drive investments in unlocking the potential of the EU's life sciences sector. Public support mechanisms are critical to de-risking investments to attract follow-on private capital, and support via the European Investment Fund should be scaled up for women's health, particularly given the barren and misogynistic investment landscape that FemTech founders face. Currently, 70% of FemTech startups are female-founded, but those that are male-founded raise significantly more capital – with female-founded FemTech startups on average raising €3.9 million, compared to €7.8 million by male-owned companies.[13]

The EU's pharmaceutical legislation, currently under revision, sets out to incentivise investment in areas of unmet need. While it feels like an oxymoron to describe the health of more than half of the world's population as an area of unmet need, the reality is so. Only 7% of biomedical research funding is directed towards conditions that exclusively affect women.[14] While in the final stretch of negotiations, the legislation looks set to miss a rare opportunity to introduce regulatory or financial incentives for women's health. These are critical levers to accelerating innovation in this field, as recommended by the World Economic Forum. The Forum's recommendations for increased government funding through grants, prizes and dedicated women's health research initiatives should be duly considered as the Commission shapes its future research programmes. Fostering a coherent, efficient and flexible political and financial framework to support an end-to-end approach to women's health R&I is needed.

> empty promises can no longer be afforded

For many conditions that affect women exclusively, there is still substantial basic research needed to properly understand these conditions before clinical development of any health intervention can meaningfully advance. This realistically means that any new health tools are years, if not decades from entering the market. In an analysis [15] of research investment in sexual and reproductive health, over half of the funding for endometriosis, menopause and preeclampsia, and more than 70% of the total funding for uterine fibroids, preterm labour and polycystic ovary syndrome went to basic research. The fact that menopause – a natural stage in a woman's reproductive life, but one that has potential to be far better managed – sits in this group is further still a glaring sign of the neglect of women's health and well-being.

Mind the gap – digitalisation, disinformation and discrimination

One area of significant unmet need in the arena of sexual and reproductive health is contraception, for all genders. Unmet need for contraception is estimated to extend to 257 million women globally.[16] The current ageing array of women-led contraceptive options are largely rejigged versions of the hormone-based breakthroughs of the 1950s. Today, there are only two approved options for men: the condom or a vasectomy. Despite a global commitment via the Beijing Declaration and Platform for Action [17] to provide financial and institutional support for research on safe, effective, affordable and acceptable methods and technologies for the reproductive and sexual health of women and men, governments continue to fall short.

Tech-based solutions (such as period tracking apps) aimed at plugging the gap are not without risk: from misinformation, in part due to a lack of oversight and reliable information, to dangers associated with data protection (or lack of).[18] Furthermore, the digital ecosystem is stifling innovation and endangering access to vital health information through routine censorship on social media and other large online platforms.[19] The EU Digital Services Act should deliver on its commitment to hold accountable platforms if activities pose risks to public health.

The EU also has an expansive mandate via which to tackle the data gaps that lead to the dismissal and discrimination that women routinely face in seeking healthcare. For example, women with symptoms of cardiovascular disease are too often sent away by doctors because of pervasive gender biases that "women don't get heart disease" – resulting from a dearth of research that addresses sex- and gender-specific differences in disease and treatment. A lack of representative clinical trials increases the risk of adverse drug reaction in women, further driving an erosion of trust in a system that is supposed to protect us. The European Medicines Agency could mandate sex-disaggregated data in clinical trials and submissions, ensure proportional inclusion of participants and mandate reporting on sex-based differences in efficacy and side effects. Any EU funded research could be required to report sex and gender disaggregated data – with the SAGER guidelines [20] offering a comprehensive framework for action.

Driving democracy, solidarity and sustainability

The EU's claims that 'Europe's high standards for quality, safety, and efficacy in the life sciences underpins public trust and ensures that innovations deliver real value to patients, consumers, and society', are not strictly true. Europe has the potential, given its steadfast commitment to academic freedom, diversity, and inclusion to be a world leader in closing the gender health gap. In a rapidly changing world marked by demographic shifts, digital transformation, and geopolitical uncertainty, investing in women's health is a strategic imperative.

Spurring research into historically underfunded areas will lead to the development of cutting-edge diagnostics, pharmaceuticals, and digital health solutions, positioning Europe as a global leader in medical innovation. Such investments will aid earlier intervention and improve preventative care, delivering a lower healthcare bill in the long term; and reduce absenteeism. A win-win for Europe's 'competitiveness' agenda. It is well established that healthier women result in healthier families, economies and societies.

In an increasingly polarised world, as young men's and women's world views pull apart, signalling that deeper divisions lay ahead, reimagining a health system grounded in equality is not only a matter of justice, but a fundamental pillar to fulfilling the social contract. To deliver its promise for the whole of society and safeguarding our democracy. Without an overarching approach, the EU's well-founded efforts to close the gender health gap will be too slow and piecemeal to deliver meaningful change. Another 30 years of the same will not suffice.

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SOCIAL, GREEN AND ARTS PRESCRIPTIONS FOR HEALTH: HARNESSING THE POWER OF COMMUNITY INTERVENTIONS FOR WELL-BEING

By: Alison Maassen and Ülla-Karin Nurm

Summary: Social prescribing connects people to community activities, like arts, creative events, or nature walks, aiming to enhance their health and well-being. It addresses health determinants, offers a person-centered, health-promoting approach, and helps reduce pressure on health systems. By increasing engagement, fostering trust, and strengthening social connections, social prescribing can contribute to better health outcomes. When designed inclusively, it can advance health equity by reaching underserved groups. Although interest is rising across Europe, long-term success relies on consistent funding, seamless integration into health and social systems, and investment in community resources to generate widespread and lasting positive effects.

Keywords: *Social Prescribing, Cohesion, Equity, Integration*

> #EHFG2025 – SESSION 4:
Social, green, and arts prescriptions for health – Harnessing the power of community interventions for well-being

Alison Maassen is Programme Manager, EuroHealthNet, Brussels, Belgium; **Ülla-Karin Nurm** is Director, Northern Dimension Partnership in Public Health and Social Well-being, Stockholm, Sweden.
Email: a.maassen@eurohealthnet.eu; ulla-karin.nurm@ndphs.org

Introduction

Europe faces complex health and societal challenges. Health systems are under pressure, and social cohesion is weakening. Polarisation, loneliness, and declining trust in institutions strain the social contract. Yet health is a foundation for economic security and societal resilience, not a luxury. Health systems are among the most frequent touchpoints between citizens and the state. Ensuring their sustainability and responsiveness can help rebuild public trust and enhance preparedness for future crises.[1]

The understanding of health has expanded beyond hospitals and medications, embracing a more holistic view that includes the social, environmental, and creative dimensions. Targeting wider health determinants – like social support, environment, and meaningful activity – can improve well-being and reduce demand on strained health services.

Social prescribing (SP) has emerged as a promising approach to complement traditional healthcare. It connects individuals to community resources such as social groups, nature activities, and creative programmes.

Understanding Social Prescribing: Mechanisms and current landscape

SP enables professionals to co-create non-clinical "prescriptions".[2] While national contexts vary,[3] many SP models share common features. A central element in nearly all models is the link worker – based in primary care, community or social services – who understands individuals' needs and connects people to appropriate community resources.

SP typically begins with a referral from a general practitioner, nurse, or social worker, although some countries have implemented specific social prescriber roles, and self-referral in other countries is growing.[3] Link workers help address issues such as loneliness, housing, or low physical activity by connecting individuals to relevant support, like walking groups or arts classes.

> promising approach to complement traditional healthcare

SP is gaining policy attention for its potential to reduce over-medicalisation, improve care coordination, and deliver more sustainable, preventive models. Growing SP fields are green and arts prescriptions. Green prescriptions involve nature-based activities that promote well-being while also supporting planetary health.[4] Arts prescriptions utilise creative practices to improve mental health, build confidence, and strengthen social connections.[5] Examples of types of SP are presented in **Table 1**.

Table 1: Examples of Social, Green, and Arts Prescribing Activities

Category	Type of Activity	Examples
Social Prescribing	Community groups	Attending peer support groups, parenting classes, bereavement support
	Volunteering	Opportunities to give back to the community, build purpose, and reduce loneliness
	Physical activity	Exercise referral schemes, walking groups, sports clubs
	Educational activities	Literacy classes, budgeting workshops, IT skills training
	Social clubs / cafés	Coffee mornings, hobby groups, intergenerational activities
Green Prescribing	Nature walks & green gyms	Guided nature walks, outdoor fitness
	Allotment & gardening projects	Community gardens, horticultural therapy
	Conservation & environmental volunteering	Tree planting, wildlife surveys, maintaining nature trails
	Outdoor mindfulness / nature-based therapy	Forest bathing, ecotherapy, wilderness therapy sessions
	Green education & skills training	Workshops on sustainability, permaculture; ecological crafts
Arts Prescribing	Performing arts	Music, dance, acting classes, performances
	Visual arts	Painting, drawing, crafting, sculpture, photography
	Attending cultural events, museum or gallery visits	Cultural outings, art appreciation tours, concerts
	Digital arts	Animation, film making, photography
	Literature	Reading, creative writing, storytelling

Source: Authors' own

Social prescription for supporting the social contract

SP can go beyond individual health benefits to strengthen social cohesion. Community-based prescriptions – like nature walks, arts classes, and gardening – foster networks, interpersonal trust, intergenerational interaction, and a sense of belonging, key elements of healthy, equitable societies. They promote cultural expression and build social capital, particularly 'bridging capital' connecting people across social divides.[6]

When designed and delivered equitably, SP can help rebuild trust in public services and address complex needs not met by mainstream care.[4] [5] [6] [7] However, if SP is not deliberately inclusive, it risks reinforcing inequalities. To fulfil its promise, SP must be tailored to reach and empower those in vulnerable situations.

Groups such as migrants, older people, young people, LGBTQ+ individuals, and those with chronic conditions often face barriers to accessing care, cultural activities, and social networks. They may also distrust institutions, limiting engagement even when services exist.

Tailored SP approaches can address these challenges. The SP-EU project is co-designing models with underserved communities. They will test their effectiveness to improve access to health and social care through a multi-country randomised controlled trial (RCT), and qualitative studies across five European hubs.[4]

Similarly, the RECETAS project co-develops and evaluates nature-based SP across six global cities, focusing on vulnerable populations.[8] At country level, the Irish “Healthy Communities” project targets disadvantaged areas with SP services.[7]

Arts on Prescription (AoP) is a model of social prescribing that connects people to a range of non-clinical services in the community to improve their well-being. It enables health professionals or other referral channels to refer individuals to a range of creative and participatory activities to promote their mental health and social inclusion.

The programme is group-based and facilitated, consisting of varying arts categories, which means the participants engage with different genres during the programme. Piloted in five Nordic and Baltic countries, it is being evaluated for impact and cost-effectiveness.[9] However, these programmes may favour individuals with fewer access barriers, widening health inequalities.[10] Addressing this requires confronting limited access, inconsistent referrals, and underrepresentation of certain groups. This requires implementers to move beyond classic “consultation” approaches to participatory action research and genuine “co-creative” processes, particularly targeting those at risk of being excluded.[4] This approach fosters agency, dignity, and belonging, all of which support health and social resilience.

> “unites health, social, and cultural sectors

System change: Embedding SP in Policy and Financing

Countries are adopting various models to integrate SP into health systems:

In England, SP is central to the National Health Service (NHS) Long Term Plan. Over 3,500 link workers are funded and integrated into primary care – supporting over 2.5 million referrals – and demonstrating SP’s scalability when backed by policy, investment and infrastructure.[7] In Catalonia, Spain, SP is integrated into electronic health records, enabling health professionals to refer patients to community-based activities, supporting efficiency and normalising non-clinical approaches in primary care.[7] The Portuguese Social Prescribing Network unites health, social, and cultural sectors through collaborative, community-based care models, and is expanding to municipalities nationwide.[11]

Wales’ National Framework for Social Prescribing has blended governance. NHS Wales works through regional Partnership Boards to deliver integrated health and social care services, and invests in SP through the Health and Social Care Regional Integration Fund.[7] Similarly, EU-funded projects such as Invest4Health are exploring new financing models to scale initiatives like SP.[12]

SP is also expanding beyond primary care into acute and secondary settings. In London, Barts Health NHS Trust developed a toolkit to embed it into hospital services.[13]

Success across diverse models hinges on cross-sectoral collaboration, supportive funding, integration into routine services, and investment in link workers. Existing models provide valuable insights for other countries to embed holistic, community-based approaches into their health systems.

Addressing criticisms and challenges

While SP gains traction, challenges remain. Critics warn of ‘outsourcing care’ to overstretched and underfunded voluntary and community sectors. Others argue that SP is largely tokenistic, calling instead for systemic reforms to health and social services.

Beyond achieving equity for underserved communities, there is the challenge of providing SP equitably across urban and rural areas and among different socio-economic groups. Those most likely to benefit from SP are often least able to access or engage with it due to barriers like service gaps, time constraints, digital exclusion, or low health literacy.

Another concern is that methods for measuring and assessing SP’s impact are weak and metrics and definitions remain un-standardised.[4] Social prescribing is sometimes called a ‘practice in need of a theory’ as, without understanding its impacts more clearly, it is difficult to refine and enhance its effects.[10] The initiatives referenced above incorporate a strong focus on measurement and evaluation to help correct for existing evidence gaps.

To address these realities, SP must complement, not replace, clinical care. Consistent data collection, improved assessment and evaluation approaches, and regular community consultation help ensure SP services meet real needs, reach those at most risk, and measurably contribute to better health outcomes.

SP could be integrated into broader health system reform, via primary care pathways and health promotion strategies. This requires sustainable funding, like long-term, ring-fenced investment – not just in link workers, but in the community and voluntary services to which people are referred. For instance, Ireland’s Sláintecare Integration Fund provided €20 million to test integrated service delivery, including community infrastructure financing.[14] Health professionals also need adequate training to address non-medical needs and enhance cross-sectoral engagement.

Conclusion

The future of resilient health systems lies in integration, prevention and participation. SP provides practical tools and signifies a shift toward a relational and responsive model of care where individuals co-create well-being instead of being passive service recipients. SP bridges clinical care and everyday life. Designed and implemented equitably, it can improve trust, social cohesion, and health outcomes, particularly for vulnerable individuals.

However, SP is not a quick fix. It relies on sustained political commitment, long-term investment, adequate capacity building for all involved, and genuine cross-sectoral collaboration. Efforts must avoid tokenism, ensure community services are equipped and empowered to meet demand, and tailor interventions to users' needs. Strong European-level frameworks help overcome these barriers. EU programmes like EU4Health, Horizon Europe and Interreg enable transnational learning, build a common evidence base, and support joint investment in SP infrastructure.

In an era marked by fragmentation and mistrust, social, green and arts prescriptions offer a hopeful, evidence-based pathway to greater connection, inclusion, and sustainability.

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From ideas to reality: An introduction to generating and implementing innovation in health systems

By: Nick Fahy, Nicole Mauer, Dimitra Panteli

Published by: World Health Organization, 2025 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

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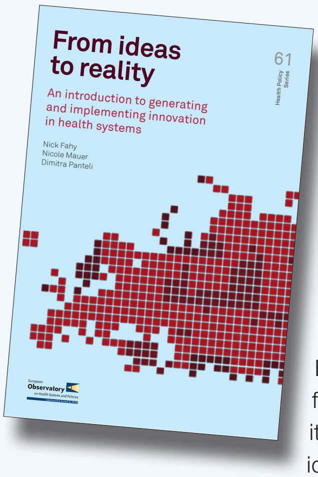
Freely available at: https://eurohealthobservatory.who.int/publications/i/from-ideas-to-reality-an-introduction-to-generating-and-implementing-innovation-in-health-systems

This book explores how innovation and implementation intersect in health systems, offering practical insights into how we can bridge the gap between promising breakthroughs and real-world impact. While medical advances have transformed care and saved lives, their rising costs and the complexity of implementing new delivery models pose major challenges.



The book examines why some innovations thrive while others fail, and how to ensure that valuable, evidence-based practices are adopted across Europe. Drawing on lessons from the COVID-19 pandemic, it provides a roadmap for identifying, supporting, and scaling innovations that truly meet population health needs and strengthen system sustainability.

MENTAL HEALTH SUPPORT DURING CRISES: LESSONS FROM THE RED CROSS RESPONSE TO THE CONFLICT IN UKRAINE

By: Iva Perhavec, Greisy Massiel Trejo, Aneta Trgachevska, Amanda Amigues, Basillio Muriuri and Alaa Alnasser

Summary: In response to the mental health needs arising from the international armed conflict in Ukraine, the International Federation of Red Cross and Red Crescent Societies, in partnership with the European Commission, launched one of the most extensive mental health and psychosocial support (MHPSS) responses in humanitarian history. Integrating mental health into broader health systems and policy frameworks is aligned with humanitarian and development principles and the broader global commitment to equitable, people-centred health services. It fosters long-term impact and quality of MHPSS services, enhances preparedness for future emergencies, and supports the creation of resilient, inclusive health systems.

Keywords: *Displacement, Mental Health and Psychosocial Support, Psychological First Aid, Ukraine*

> #EHFG2025 – SESSION 8:
Solidarity in action on mental health and psychosocial support – Learnings from people affected by the conflict in Ukraine

Iva Perhavec is Consultant, **Greisy Massiel Trejo** is Coordinator, Mental Health and Psychosocial Support, **Aneta Trgachevska** is Project Manager, **Amanda Amigues** is Project Officer, **Basilio Muiruri** and **Alaa Alnasser** are Project Coordinators, International Federation of Red Cross and Red Crescent Societies (IFRC), Regional Office for Europe, Budapest, Hungary. Email: aneta.trgachevska@ifrc.org

Introduction

The International Federation of Red Cross and Red Crescent Societies (IFRC) recognises mental health and psychosocial support (MHPSS) as a crucial cross-cutting area of life-saving emergency response. In 2022, only months after the escalation of the international armed conflict in Ukraine, in partnership with the European Commission and with the support of the International Red Cross and Red Crescent Movement MHPSS Hub, the IFRC launched a dedicated project to provide quality and timely psychological first aid to affected people.[1] The project initially involved National Red Cross Societies* in Ukraine and five countries neighbouring Ukraine. By 2024, the project had expanded to include 28 National Societies across Europe, recognising the immense need for MHPSS services for people displaced due to the conflict. The project represents one of largest responses to mental health needs in emergencies ever implemented, emphasising the importance of solidarity in supporting those affected by conflict. It also presents valuable insights for mainstreaming MHPSS into health systems and future intersectoral crisis responses.

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* National Societies are the local, independent Red Cross or Red Crescent organisations in nearly every country worldwide.

Mental Health Impacts of Conflict

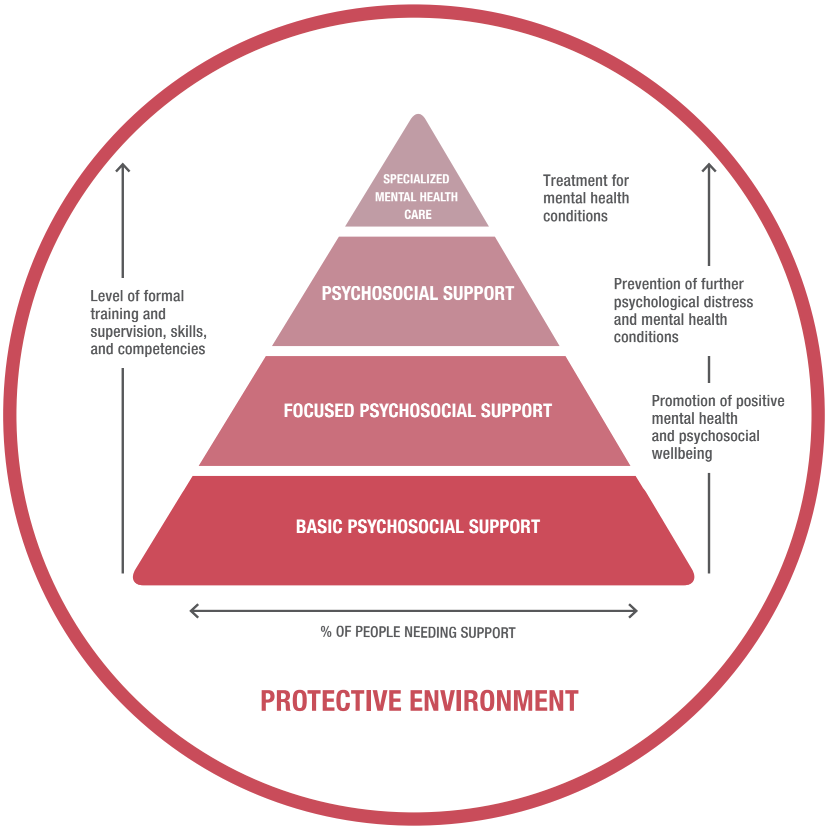
The mental health toll of conflicts is profound. The World Health Organization (WHO) estimates that nearly all those affected by humanitarian emergencies experience psychological distress. In conflict-affected areas, one in five people experience a mental disorder – ranging from mild depression or anxiety to severe conditions such as psychosis – and nearly one in ten lives with a moderate to severe mental disorder.[2] Yet mental health services are among the most under-resourced areas of humanitarian and development responses.

Due to the conflict, which has caused the largest displacement in Europe since the Second World War,[3] millions of people from Ukraine have experienced violence, loss of loved ones, destruction of homes, separation from families, erosion of support systems and economic insecurity – experiences and stressors that can lead to a wide range of mental health conditions. An overwhelming majority – over 90% – of those displaced by the conflict are women, children, older adults, and persons with disabilities.[4] In addition, pre-existing inequalities and protection risks have been exacerbated by the conflict, especially for people who already had a mental health condition or physical disability, and other groups at risk of exclusion, such as the Roma community.

Findings from needs assessments carried out by National Societies in 2022,[5] [6] corroborated by research,[7] have shown that mental health needs were widespread, with many reporting symptoms of anxiety and depression, sleep problems and psychosomatic symptoms.[7]

However, access to mental healthcare services was limited, and vulnerable groups, in particular, faced significant barriers to accessing much needed support. Barriers included language, the stigma of mental health conditions, limited access to public healthcare systems in host countries, lack of information on available services and limited number of qualified mental health professionals.

Figure 1: Red Cross Red Crescent MHPSS Framework



Source: [10]

Assessments nevertheless highlighted strong coping capacities of people affected by the crisis, demonstrating self-organisation, resourcefulness and mutual support. They showed that affected people had a strong preference for face-to-face MHPSS services and group activities, which serve as safe spaces for sharing concerns and fostering peer support. The need for continuity of care was evident, with respondents expressing a clear preference for regular support, including through ongoing phone sessions, and for services provided by Ukrainian mental health professionals, with language being a key factor in building trust.

A Needs-Based, Coordinated MHPSS Response

Building on the insights of needs assessments, under the project, National Societies have been delivering a multi-layered MHPSS approach, ranging from providing basic psychosocial support to facilitating access to specialised mental healthcare. A variety of channels were employed to reach people in need of support, including helplines staffed with Ukrainian- and Russian- speaking psychologists, in-person individual counselling, psychoeducational workshops, mobile clinics and a range of community-based MHPSS activities.

Through the project, by 31 March 2025:

- Over 600,000 instances of MHPSS services were provided to people affected by the conflict in Ukraine
- 40,000+ first line responders were trained in psychological first aid and MHPSS, including 9,500+ professionals (e.g. teachers and health workers) and 2,000+ Ukrainian- /Russian-speaking providers, and
- 29,000+ psychosocial support activities were conducted to enhance staff and volunteers' well-being.

Community-based approach

Community-based MHPSS activities have played a particularly important role in strengthening long-term resilience and coping mechanisms among affected communities. Unlike psychological first aid, which focuses on addressing immediate problems and basic needs in the short-term, community-based MHPSS is a longer-term approach aimed at building sustainable support systems within communities. It includes recreational and social activities, such as art-based well-being sessions, women's groups and activities for children, along with psychoeducational activities designed to address the stigma of seeking traditional psychological support. By actively involving community members, the approach helps break down barriers to access timely MHPSS. It is grounded in the belief that when communities are empowered to care for themselves and one another, both individual and collective self-efficacy and resources are strengthened. An example of such activities is in Slovak Red Cross community centres.[8] It also helps build positive relationships with host communities, and this, in turn, supports the integration of displaced people into their new environment and strengthens their sense of belonging.[9]

Another example is evidenced by the Belgian Red Cross which has shown some key impact indicators that reflect the strong performance of MHPSS activities. Some 99.7% of training participants rated the sessions as good or excellent (out of 691 people who completed a training evaluation forms); psychosocial tools (e.g., game cards, online platforms) are now used regularly by responders and team leaders; and supervisory support systems are in place for over 100 MHPSS volunteers who provide MHPSS through the new Integrated Model of Supervision. Moreover, psychological first aid has been embedded into institutional training structures, increasing sustainability.

Innovative and Integrated Approaches to MHPSS provision

National Societies have been delivering varied and complementary MHPSS, ranging from providing basic psychosocial support to facilitating access to specialised mental health care, in accordance with the International Red Cross and Red Crescent Movement's Mental Health and Psychosocial Support Framework The Framework recognises that individuals, families and communities in different contexts have different needs and require various types of support provided as part of a multi-layered approach (**see Figure 1**).

In addition, tailored activities have been developed for individuals in vulnerable situations. Given the significant impact of conflict and displacement on children's mental health, the project introduced a dedicated component building the capacity of educators, health professionals, and social workers in child-focused psychological first aid. This ensures that those closest to children are equipped to recognise and respond to their distress.

To expand reach and provide flexibility, digital tools were deployed. Examples include Buddy Bot, a chat-bot developed by Red Cross of Montenegro, and a digital well-being website rich with mental health resources by the Danish Red Cross. Meanwhile, mobile MHPSS clinics made it possible for individuals in remote areas or with limited digital literacy, especially older people, to access needed support. These innovations point to the importance of hybrid models that combine face-to-face services with digital accessibility.

A key added value of the project has been the recognition that MHPSS is integral to the overall operations of National Societies, and that it should be embedded across all services provided to people affected by crises. A notable example is the integration of psychological first aid into standard, physical first aid training, which can significantly enhance the ability of responders to support people in distress, both physically and emotionally.

Simultaneously, recognising the emotional toll of responding to crisis and emergencies, the well-being of frontline responders was prioritised. Such support has been especially vital for many Red Cross staff and volunteers and other professionals who are themselves from conflict-affected communities. Initiatives to support them included setting up peer support systems, regular supportive supervision, and training in stress management. An innovative Platform was developed by the Hellenic and Portuguese Red Cross – a virtual peer support group for health mediators from Ukraine providing space for cross-border sharing of experiences and challenges that may be emotionally overwhelming.[†]

Partnering for Scalable and Sustainable Services

At the heart of the response were partnerships, involving a range of actors including migration and health authorities, civil protection organisations, municipalities, schools and community-level, non-governmental and international organisations. Partners helped scale up services, enabling broader access to MHPSS and strengthening community-level mental healthcare. Local partners were also involved in extensive training efforts made possible thanks to the project. This has built MHPSS capacity within their own organisations and helped communities to continue supporting mental health initiatives independently.

Placing Communities at the Heart of Interventions

Importantly, National Societies actively involve community members in the planning and implementation of MHPSS activities, fostering strong connections with communities they serve and promoting their agency at the community level. People with lived experience offer invaluable insights that shape the design and delivery of effective, relevant MHPSS services. Given the significant positive impact of social networks and connectedness on mental health, the project actively fosters strong community partnerships and involves host communities in the delivery of community-based MHPSS activities.

Integrating MHPSS in Systems and Policy Frameworks

The approaches implemented through the project reflect the growing consensus that MHPSS is not an optional add-on, but a core component of crisis response and health system strengthening. This is aligned with multiple frameworks at national, regional and global levels,

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[†] The support group meets online monthly and is accompanied by a mental health professional, who ensures a safe environment and provides guidance throughout the discussion.

including the European Union (EU) Comprehensive Approach to Mental Health, which emphasises parity between mental and physical health, the European Preparedness Union Strategy and the EU's Health Emergency Preparedness and Response Authority (HERA). It is also consistent with the WHO Comprehensive Mental Health Action Plan 2013–2030,[11] which promotes integration, prevention, and community participation.

Although mental health continues to receive disproportionately low funding across health budgets – undermining the principle that *there is no health without mental health* – there are increasingly diverse mechanisms available to support its integration. These include EU4Health, Horizon Europe, NextGenerationEU, national Recovery and Resilience Plans, the Temporary Protection Directive, and the European Pillar of Social Rights. These frameworks offer practical entry points to embed MHPSS across health, education, migration, and social sectors. To be effective, such funding streams must promote integrated approaches where mental health is recognised as a cross-cutting enabler of public policy and resilience.

The Red Cross and Red Crescent Movement's Resolution 2,[12] adopted by States Parties to the Geneva Conventions in 2019, reinforces this imperative, calling for MHPSS to be embedded across all sectors and levels of crisis preparedness and response.

The MHPSS model applied through the Red Cross response to the international armed conflict in Ukraine provides a replicable and scalable approach, rooted in evidence and adapted from other large-scale humanitarian responses, including the regional Syria crisis. Its success is built on the unique positioning of National Societies: as part of their communities, they can co-create sustainable, culturally relevant MHPSS systems that bridge humanitarian action and development goals. This model can be applied in other contexts at national, subregional, and regional levels. Strategic inclusion of mental health components – such as psychological first aid, community-based MHPSS, or first responders' well-being – adds tangible value to any policy or funding proposal. This large-scale model not only serves as a response record, but also as a roadmap for integration, guiding how MHPSS can be embedded as a priority in national systems and EU-wide strategies.

Conclusion

The protracted nature of the conflict in Ukraine, coupled with uncertainty about the future, are expected to have a significant and lasting impact on the mental health of the Ukrainian population both within and outside Ukraine.[13] The response to the crisis has shown that integrating MHPSS into broader health and crisis response systems is not only feasible but essential. Unmet mental health needs risk long-term societal and health system strain if not addressed with integrated, accessible services. Grounded in solidarity and health equity, MHPSS services must be accessible to all, including individuals impacted by crises and displacement. Early and sustained MHPSS interventions planned as a continuum address the enduring mental health impacts of crises and emergencies, save lives and promote individual and community resilience. They contribute to more efficient healthcare systems by reducing the risk of more severe mental health conditions developing over time that require resource-intensive specialised services.[14]

Reducing distress of displaced people strengthens their ability to cope with challenges more effectively, which also supports their integration into host communities. It ultimately helps restore a sense of hope, self-efficacy, and resilience that is essential for long-term health outcomes.

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WHAT PEOPLE WANT OUT OF END-OF-LIFE CARE: IS THE SOCIAL CONTRACT FAILING?

By: Paola Sillitti, Dheepa Rajan, Julien Carretier, Oriane Bodson and Giovanna Marsico

Summary: End-of-life care embodies the social contract in its most essential form, yet inequalities in access, quality, and care setting persist across and within countries. Despite rising needs driven by population ageing and increasing chronic diseases, many people – especially those facing socioeconomic hardship – lack adequate care in their final months. Using data from 28 European countries, this article highlights disparities in who receives care, where care occurs, and what kind of care is delivered. Emerging challenges are explored, including assisted dying and workforce shortages. Addressing these inequalities is essential to rebuilding a fairer, more compassionate and equitable end-of-life care system for all.

Keywords: End-of-life Care, Inequalities, Palliative care, Social Contract, Participation

> #EHFG2025 – SESSION 21:
End of life, end of autonomy? Examining the reality of the current end-of-life paradigm

Paola Sillitti is Researcher and PhD candidate, Faculty of Business and Economics (HEC), University of Lausanne, Swiss Centre of Expertise in the Social Sciences (FORS), Swiss Centre of Expertise in Life Course Research (LIVES), and Lausanne University Hospital (CHUV), Lausanne, Switzerland; **Dheepa Rajan** is Health Systems Adviser, European Observatory on Health Systems and Policies, Brussels, Belgium; **Julien Carretier** is Public Health Project Manager, French National Center for Palliative and End-of-Life Care (CNSPFV), University of Lyon, and associate researcher, Health Systemic Process (P2S) laboratory, Université Claude Bernard Lyon 1, France; **Oriane Bodson** is Researcher, Department of Public Health, Faculty of Medicine, University of Liege, Belgium; **Giovanna Marsico** is Director, French National Center for Palliative and End-of-Life Care (CNSPFV), Paris, France. Email: paola.sillitti@unil.ch

Rethinking end-of-life care in Europe: a broken social contract?

Population ageing is one of society's greatest accomplishments, yet there is an increasing recognition that longevity in itself is not enough. As a greater proportion of Europe's population is reaching older ages, ensuring a good quality of life in the later years and until the end has become a central responsibility of governments in safeguarding the well-being of their citizens. This responsibility stems from the social contract, the fundamental agreement – implicit or explicit – that governments will act in the interests of their citizens' welfare. This is especially so in democratic societies.

Governments currently approach end-of-life care (defined in **Box 1**) primarily as a responsibility delivered through services provided in the health system. However, health system actors in Europe still view end-of-life care as mainly a medical matter, with care focused on hospital-based processes aimed at prolonging life and reducing system liability. The human, spiritual, and emotional dimensions of dying are often treated as secondary or overlooked, despite being the aspects that matter most to people as they die. This raises important questions about how far the social contract is adequately fulfilled at life's end.

The social contract at the end of life

The social contract extends to the end of life. In fact, this is when that contract is tested most profoundly. Supporting people in their dying days is not only a matter of medical care; it is about respect, compassion, and ensuring that no one faces death alone or unsupported.

International institutions have formally recognised this responsibility. WHO, through its 2014 resolution at the 67th World Health Assembly, called for the integration of palliative care into national health systems and declared it an ethical obligation.[3] Similarly, countries like Belgium, France, Italy, and Portugal have passed legislation making access to palliative and end-of-life care a legal right.

Yet, legal recognition does not automatically translate into practical delivery. Too often, the actual experience of end-of-life care falls short, especially for those who are disadvantaged. The gap between principles and practice is wide, and the consequences are starkly human.

Box 1: What is end-of-life care?

End-of-life care refers to the care services provided to individuals approaching the final stage of life. While definitions and timeframes vary across jurisdictions, a universally accepted definition has long been lacking. The Organisation for Economic Co-operation and Development (OECD) conceptualised end-of-life care as all types of care that people receive at the end of their life, including the terminal stage of palliative care, as well as including some elements of curative care and help with mobility limitations.[1] The World Health Organization (WHO) puts end-of-life care under the umbrella of palliative care, with the following features:

- Provide relief from pain and other distressing symptoms
- Affirm life and view dying as a normal process
- Neither hasten nor postpone death
- Integrate psychological and spiritual aspects of care
- Offer support so patients can live as actively as possible until death
- Offer a support system to help families cope during the illness and in bereavement
- Use a team approach, including bereavement counselling if indicated

The WHO definition[2] specifically puts an emphasis on a holistic approach to death, viewing the end-of-life period as a societal issue *within which* medical care is provided, rather than predominantly a medical issue *per se.*

What people want at the end of life – and what they actually receive

Despite the growing recognition of end-of-life care as a right, many people die without receiving the support they need or want. Most individuals desire a peaceful, dignified death surrounded by family, with minimal pain, and ideally at home. However, current systems often deliver something very different: institutionalised, medicalised dying, with limited attention to emotional, spiritual, or social well-being.

Across OECD countries, there were approximately 11 million deaths in 2019. Of these, it is estimated that 7 million people did not receive but could have benefited from palliative or end-of-life care.[1] Studies consistently show that people prefer to die at home or in a familiar environment.[4–6] However, this rarely happens – existing analyses have highlighted a mismatch between people's preferences for place of death, and the reality of where death occurs.[7] The mismatch between preferred and actual place of death is a key indicator of end-of-life care quality, as person-centred end-of-life care should provide people with the possibility to receive adequate care in line with their preferences, in the place of their choice, whenever possible. These figures suggest a profound unmet need and are an indication of systems not being aligned with public preferences. For example, **Figure 1** reveals that most people in Europe still die in hospitals, even though this setting often runs counter to their desires.

This institutional bias is reinforced by funding priorities. In many OECD countries, between one-third and two-thirds of public health spending in the final year of life is allocated to hospital and acute care, limiting the availability of community- and home-based services that would enable an approach in line with people's preferences.[1]

End-of-life care inequities: who gets support – and who doesn't

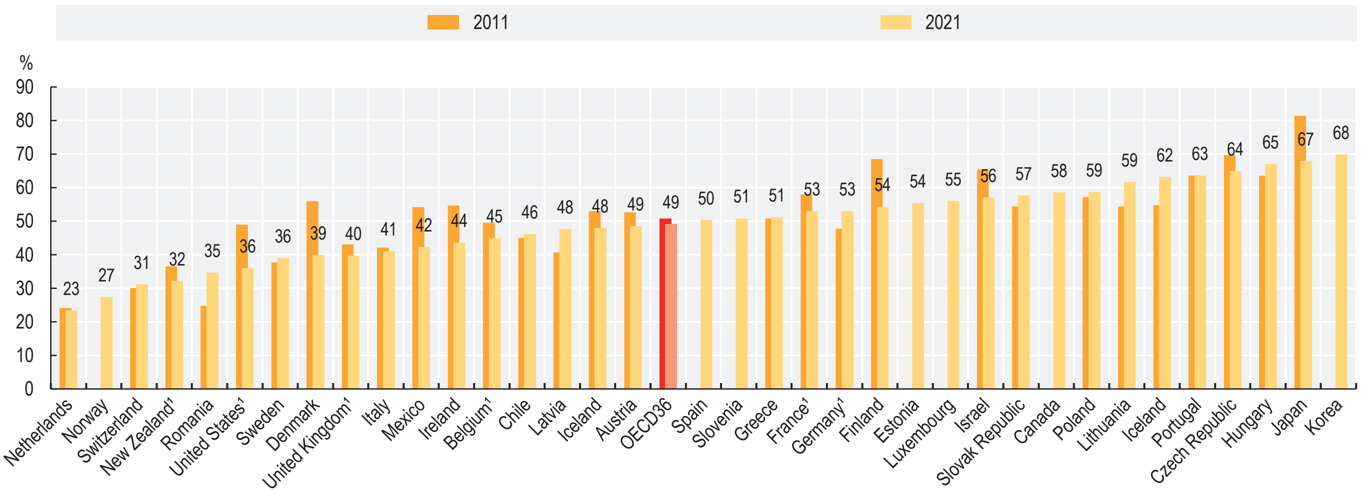
The inequities in access to end-of-life care are profound. Globally, only around 40% of people who need palliative care toward the end of their lives actually receive it.[1] This shortfall is not random, it mirrors existing socioeconomic inequalities that shape access to health and social services more broadly.

The Lancet Commission on Global Access to Palliative Care and Pain Relief introduced the concept of serious health-related suffering (SHS) to quantify the global need for end-of-life care. Between 1990 and 2021, the global burden of SHS rose by 74%, reaching 73.5 million people in 2021.[9] While low- and middle-income countries carry the highest SHS burden, high-income countries are far from immune. Inequities also exist within European countries, driven by factors such as income, education, and geography.

> a moral and political imperative

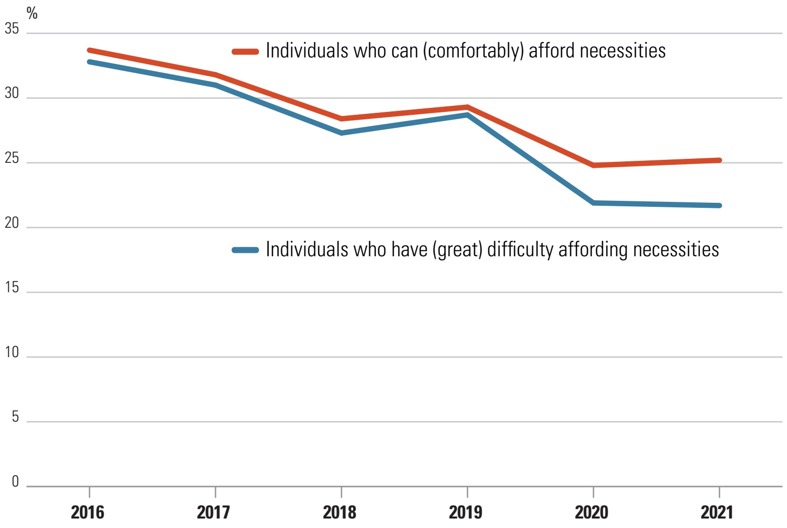
Evidence from the Survey of Health, Ageing and Retirement in Europe (SHARE), covering 28 countries, reveals how these disparities in Europe worsened during the COVID-19 pandemic.[10] From 2016 to 2021, access to palliative care in the last four weeks of life declined, especially among those facing financial hardship. Among economically vulnerable individuals, the probability of receiving palliative care dropped from 28% to 21% between 2019 and 2020, compared to

Figure 1: Percentage of deaths which occur in hospital across OECD countries (2011 and 2021, or nearest year)



Source: [8]

Figure 2: Predicted probabilities of receiving palliative care in the last 4 weeks of life in 28 European countries (2016–2021), by financial security



Source: [9]

Note: *Individuals who can (comfortably) afford necessities* and *individuals who have (great) difficulty affording necessities* were identified through self-reported measures, based on whether respondents to the Survey of Health, Ageing and Retirement in Europe reported having difficulty making ends meet during their last interview before death.

a smaller decline (from 29% to 25%) among those who were financially stable (**see Figure 2**).

These disparities not only determine whether people get care, but also what kind of care they receive and where they die. People with lower socioeconomic status are more likely to live with multiple chronic conditions and disabilities. They face greater difficulties navigating complex care systems and are less likely to engage in advanced care planning. As a result, they are often more reliant on emergency services and more likely to receive intensive, unwanted interventions near the end of life.[1]

A societal conversation: social participation platforms to underpin the end-of-life care debate

Addressing end-of-life care isn't just about policy – it's about values. The decisions we make as a society about how we care for the dying reflect who we are and what we prioritise. As the topic grows more visible and contentious, governments need to foster an ongoing, inclusive dialogue with citizens about what compassionate, equitable end-of-life care should look like.

For example, in France, the Citizens' Convention on the End of Life recently spanned a two year process (2022–23).[11] Organised by the French Economic, Social and Environmental Council (CESE) at the request of President Emmanuel Macron, it involved 185 randomly selected citizens representing the French population who deliberated over nine weekends with expert testimonies, ethical debates, and discussions on palliative care and assisted dying. The outcome demonstrated a majority which supported legalising assisted dying under certain conditions. A strong emphasis was also placed on improving access to palliative care and reducing inequalities. The Citizens' Convention helped shape the national debate and laid the groundwork for proposed legislation on assisted dying.

Another example comes from Malta, where the government launched a national public consultation on Assisted Voluntary Euthanasia for individuals with terminal illnesses, running from May to July 2025.[12] The country invited stakeholders – patients, healthcare professionals, ethicists, and citizens – to submit feedback on a proposed legal framework allowing terminally ill individuals to request assisted dying under strict eligibility criteria.

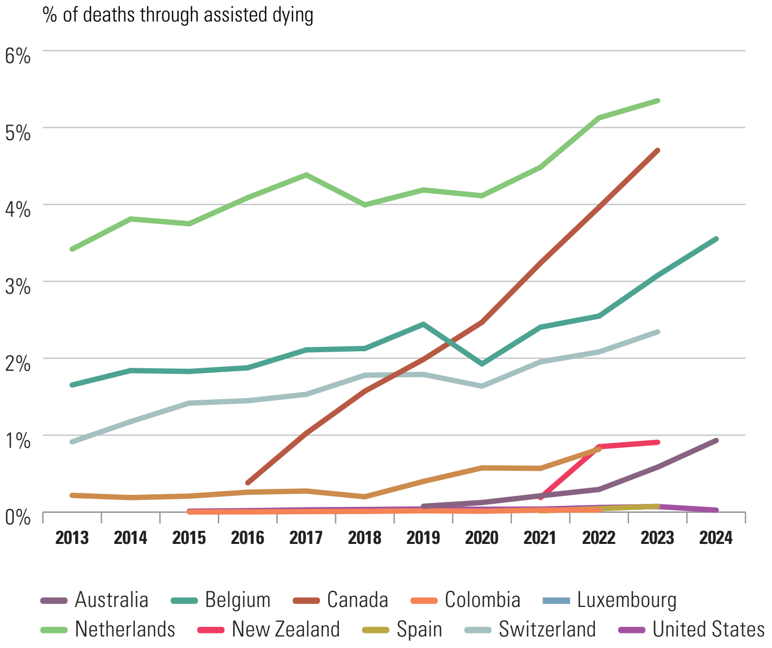
Is the social contract particularly fractured on the sensitive topic of assisted dying?

One reflection of this growing public engagement is the rising demand for assisted dying legislation. As of May 2025, at least 12 countries have legalised some form of assisted dying, including Australia, Austria, Belgium, Canada, Colombia, Cuba, Luxembourg, the Netherlands*, New Zealand, Spain, Switzerland, and parts of the United States. These jurisdictions account for more than 200 million people worldwide.[13 – 15] Several others – including France, Germany, Ireland, Italy, Portugal, Slovenia, and the United Kingdom – are currently debating or advancing legislation.

> “people feel unheard in their end-of-life choices

While views differ on assisted dying, its growing acceptance reveals a broader frustration: people feel unheard in their end-of-life choices. The popularity of assisted dying in some contexts reflects a desire for control and dignity, not necessarily a desire to end life prematurely. Governments must recognise that improving end-of-life care more broadly – including better communication, palliative options, and emotional support – can address many of the concerns currently channelled into these debates.

Figure 3: Trends in assisted deaths as a share of total deaths by country (2010–2023)



Source: Author’s analysis based on national statistics.

A call to action: ensuring equity, dignity, and compassion

The need for end-of-life care will continue to grow. Projections indicate that by 2050, the number of deaths from conditions that would benefit from palliative care will rise to nearly 10 million across OECD countries – up from 7 million in 2019.[1] At the same time, health systems are facing growing workforce shortages, geopolitical pressures, and the fiscal impacts of climate change and conflict.

Without deliberate policy action, these forces threaten to worsen existing inequalities. But with smart investment and social participation, governments can still realign end-of-life care with the social contract. Priorities as expressed by various citizen consultations and surveys across Europe include:

- expanding access to timely, high-quality palliative and end-of-life care for all, with a special focus on vulnerable and disadvantaged groups.
- investing in community- and home-based care models, reducing overreliance on hospitals and aligning care delivery with people’s preferences.
- addressing the social determinants of health, recognising that end-of-life disparities begin long before the final stages of illness.
- ensuring fair distribution of public funding across care settings, with adequate support for informal carers and community services.
- investing in social participation platforms which offer continuous dialogue with citizens about death, dying, and dignity.

Conclusion: healing the social contract at the end of life

How a society treats people at the end of life is one of the clearest expressions of its values. In Europe today, too many people die in pain, alone, or without their wishes respected – not due to a lack of resources or know-how, but because this issue has not yet been prioritised as a moral and political imperative.

Restoring trust in the social contract means ensuring that everyone – not just the affluent, well-educated, or well-connected – can die with dignity. That requires equitable policies, inclusive systems, and a renewed commitment

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* Note that the Netherlands (Kingdom of) comprises six overseas countries and territories and the European mainland area. As data for this publication refers only to the latter, the publication refers to it as the Netherlands throughout.

to compassion. It also requires constant dialogue with people, communities, and civil society to gauge changing end-of-life needs and expectations. Only by bridging the gap between what people want and what systems currently deliver can the promise of care, solidarity, and justice at life's end be truly upheld.

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How can health care facilities reduce their environmental footprint and contribute to more sustainable health systems?

Authors: Nicole Mauer, Béatrice Durvy and Dimitra Panteli

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Climate change and health systems are deeply interconnected: while climate impacts human health and healthcare demand, health systems themselves contribute around 5% of global greenhouse gas emissions. To mitigate their environmental footprint, health systems must promote health promotion and disease prevention, reduce low-value care, and adopt greener delivery practices.

This brief explores actions towards environmentally friendly delivery of care that are particularly relevant for the health care facility level. Key strategies include sustainable procurement, energy-efficient infrastructure, low-emission transport, improved waste management, and fostering green skills among healthcare workers. The brief highlights case studies from countries including Ireland, Austria, and Spain that are leading efforts to green their health sectors.


HEALTH SYSTEMS AND POLICY ANALYSIS

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How can health care facilities reduce their environmental footprint and contribute to more sustainable health systems?

Nicole Mauer
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Dimitra Panteli

It also shows that international support is vital. The EU's Green Deal and funding instruments — such as LIFE, Cohesion Policy funds, and Erasmus+ — can aid national efforts. WHO also provides frameworks, training, and global collaboration platforms. Together, these initiatives highlight the importance of political will, technical expertise, and financial resources in transforming health systems into climate-resilient and environmentally sustainable entities.

STRENGTHENING EU PRIMARY HEALTHCARE: TRANSFERRING INNOVATIVE PRACTICES SUPPORTS SOLIDARITY IN HEALTH

By: Oihane Abiega, Elena Petelos, Elettra Carini, Pedro Morera, Sebastian Tornero-Patricio, Christos Lionis, Ana M. Carriazo and CIRCE-JA Consortium

Summary: Primary health care (PHC) is the cornerstone of equitable, resilient, and person-centred health systems. The Joint Action on Transfer of Best PraCtices In PRimary CarE (CIRCE-JA), was launched in 2023 to transform the European PHC landscape. Six innovative practices on digital tools and integrated care models are being transferred to 40 sites, with 14 European Member States coming together to strengthen PHC delivery and health system resilience. CIRCE-J Ademonstrates Europe's commitment to health solidarity, offering a scalable blueprint for future reforms. Ultimately, it reinforces the role of PHC to restore trust, protect the social contract, and advance universal health coverage (UHC).

Keywords: *Primary Health Care, Solidarity, Implementation Research, Evidence-informed Policymaking*

> #EHFG2025 – SESSION 2:
Strengthening primary healthcare in the European Union – Transfer of best practices supporting solidarity in health

Oihane Abiega is Scientific Project Manager, Andalusian Public Foundation Progress and Health, Seville, Spain; **Elena Petelos** is Deputy Scientific Coordinator for CIRCE-JA, 7th Health Region of Crete, Senior Lecturer and Researcher at the University of Crete, Greece; **Elettra Carini** is Medical Doctor, National Agency for Regional Healthcare Services, Rome, Italy; **Pedro Morera** is Family physician-Advisor, Andalusian Health Service, Seville, Spain; **Sebastian Tornero-Patricio** is Coordinator for CIRCE-JA, Head of Operational Planning Service, Andalusian Health Service, Seville, Spain; **Christos Lionis** is Scientific Coordinator for CIRCE-JA, 7th Health Region of Crete, Professor Emeritus of General Practice and Primary Health Care at the School of Medicine, University of Crete, Greece; **Ana M Carriazo** is Co-Coordinator for CIRCE-JA, Senior Advisor, Regional Ministry of Health and Consumer Affairs of Andalusia, Seville, Spain. Email: anam.carriazo@juntadeandalucia.es

Introduction

Health, complete physical, mental and social well-being, is a fundamental human right. Everyone has the right to achieve the highest attainable level of health.[1,2] This is the core premise of primary health care (PHC). According to the World Health Organization (WHO), PHC is a whole-of-society approach to organise and strengthen health systems bringing care closer to communities. These aspects were recognised in the political declaration of the high-level meeting on universal health coverage (UHC) of 2019. It recognised that PHC brings people into first contact with the health system and is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being. It further stated that PHC is the cornerstone of a sustainable health system for UHC and health-related Sustainable Development Goals (SDGs).[1,3,4]

The Global Context and Evolving Relevance of PHC

The critical importance of PHC was internationally acknowledged in 1978 through the Alma-Ata Declaration [1] and later reaffirmed in 2018 by the Astana

Declaration,[3] which underscored the urgent need to build sustainable PHC systems. Governments are ultimately responsible for the health of their populations, which necessitates strong political commitment alongside appropriate health and social measures. A crucial global objective is to achieve a standard of health that allows all people to lead economically and socially productive lives – an objective where PHC plays an indispensable role.

Box 1: Innovative Best Practices Selected for Transfer under CIRCE-JA

1. **Integrated Health Association (Wallonia, Belgium):** Multidisciplinary PHC centres providing medical, nursing, physiotherapy, and psycho-social services, with community health project planning tailored to individual needs.
2. **TELEA: Home Telemonitoring in Primary Care (Galicia, Spain):** A telemedicine platform integrated with electronic health records, enabling home monitoring of chronic patients to improve care quality and resource efficiency.
3. **Integrated Care for Complex Chronic Patients – Personalised Action Plans (Andalusia, Spain):** Multidisciplinary teams develop individualised care plans for complex chronic patients, based on comprehensive assessments and patient priorities, ensuring coordinated care across the health system.
4. **Essencial Project – Adding Value to Primary Care Practice (Catalonia, Spain):** A knowledge transfer initiative promoting evidence-based recommendations to reduce low-value practices in primary care, addressing overdiagnosis, overtreatment, and overuse.
5. **Health Action for Children and Youth at Risk & Health Action for Gender, Violence and Lifecycle (Portugal):** Multisectoral teams in primary care and hospitals deliver early intervention and protection for vulnerable children and adults, working in coordination with hospitals, social services, and law enforcement.
6. **Health Promotion Centres (Slovenia):** Multidisciplinary PHC teams offering free programmes on nutrition, exercise, mental health, and substance use, with a focus on reaching vulnerable populations.

> advancing PHC strengthens health systems

The COVID-19 pandemic reinforced PHC's critical role in managing sudden surges in demand and ensuring continuous care, maintaining the resilience of health systems. When regional effective, accessible, and adequate PHC systems are in place, with multidisciplinary teams, digital tools, and community integration, pressure on hospitals is reduced and outcomes are improved.[5]

PHC as a key component of the Social Contract

PHC also represents a core public service, integral to the social contract, the implicit agreement between citizens and the state built on mutual obligations, involving responsibilities like taxation, public service support, and collective caregiving. However, this contract is under strain from polarisation, misinformation, and rising individualism. Defending it requires a deliberate response: Strengthening PHC therefore becomes not only a healthcare priority but also a defence of democratic solidarity, an essential value of the European Union (EU),[6] which not only supports social cohesion, but can reinforce resilience and preparedness.

Diversity of PHC Systems in Europe

Europe has historically played a significant role in shaping global health agendas and systems.[7] Interestingly, within Europe itself, PHC systems are quite diverse. Both Beveridge and Bismarck systems coexist, leading to considerable variation in how healthcare is funded, organised, and accessed across EU Member States. When exploring ways to consider how to best re-orient health systems to deliver person-centred care, including the PHC level, due consideration is needed to the heterogeneous context, particularly in cases where PHC is largely decentralised. In this scenario, local and regional authorities need to be placed at the forefront of organising, delivering, regulating, and financing care. Therefore, every effort to implement innovative solutions, including best practice transfer, requires a robust approach encompassing implementation research: one that assesses transferability and scalability, while ensuring context relevant, evidence-based decisions and policymaking at all levels.

Despite its strengths, PHC in Europe faces persistent challenges like an ageing population, workforce shortages, unequal access, rising incidence in non-communicable diseases (NCDs) and financial constraints. In response, the EU is investing in strengthening PHC and reforming health systems. These efforts include offering policy guidance, technical support, and funding, and facilitating cross-border knowledge exchange. Key focus areas include digitalisation, collaboration, interprofessional cooperation, and reforms to increase system resilience.[8]

National strategies, often supported by EU funding instruments, emphasise the need to duly consider service integration, community engagement, and robust data monitoring systems. An active effort is being made to preserve and scale up the innovations developed during the pandemic to tackle ongoing issues like population ageing and NCDs prevalence.[9]

The first Joint Action on Primary Care in Europe: CIRCE-JA

Recognising PHC's strategic importance, the 2020 European Semester and the COVID-19 pandemic prompted Country-Specific Recommendations for Member States to enhance the resilience and accessibility of their health systems. A key need emerged: to reinforce PHC through innovation in an evidence-informed and sustainable manner.

In response, the European Commission published a call under the EU4Health funding programme that resulted in the Joint Action on the transfer of best praCtices In pRimary CarE (CIRCE-JA). This Joint Action was launched in February 2023 and will run until November 2026. It represents the EU's most ambitious project to improve European PHC to date.

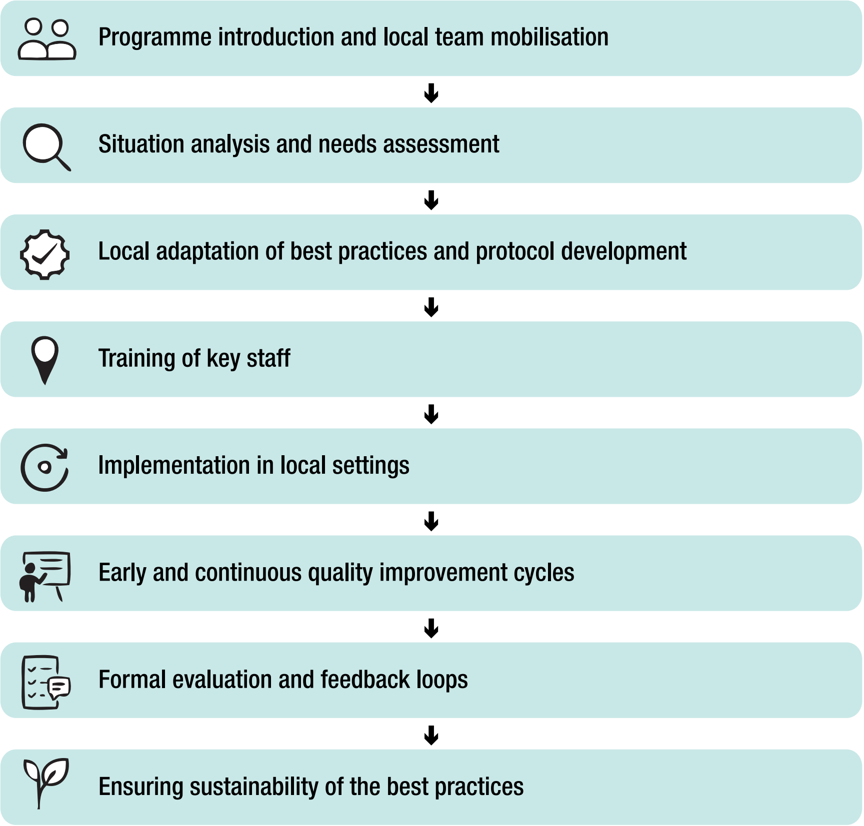
CIRCE-JA brings together 14 Member States, with a €12 million investment, co-funded by the European Commission. It aims to effectively transfer (i.e., implement, validate, and sustain) six innovative primary care best practices across 40 sites in 12 different Member States, each characterised by diverse health system structures. Aligned with the EU's broader aims, CIRCE-JA promotes structured integration of health promotion into PHC, strengthening links with social services, applying value-based care principles, and employing digital tools to deliver care remotely. Emphasis is placed on an integrated, patient-centred approach during a time when these goals remain particularly challenging.[10]

In December 2020, the European Commission launched a call to collect good practices in PHC, selecting those with proven impact, transferability, and sustainability. Six of the most successful practices were chosen by Member States during a 2021 Marketplace event. These were the ones selected for transfer in CIRCE-JA, originating from Belgium, Portugal, Slovenia, and Spain; they are listed in **Box 1**.

The CIRCE-JA transfer methodology

CIRCE-JA aims to document the processes and lessons learned in transferring these innovative best practices across countries. This includes generating actionable evidence to encourage health authorities to adopt and implement these new models in PHC. Key components of this process include structured training, knowledge sharing, and capacity building – essentials for fostering more resilient, adaptable, and responsive health systems in the EU.

Figure 1: The transfer methodology of CIRCE-JA



Source: authors' own

Successful implementation requires understanding the local challenges and developing tailored strategies to address each specific barrier in the PHC setting. Within CIRCE-JA, the transfer of the innovative best practices to the implementation sites is achieved following an eight-stage transfer methodology, aimed at exposing and mitigating these barriers (**see Figure 1**).

Lessons in Collaborative Implementation

The synthesis of the evidence so far has led to the development of recommendations to address key barriers at all levels of the action. These levels include regional health organisations, best practice owners, and local health centres responsible for implementation. The main recommendations to boost implementation and target the actors involved in the transfer process are summarised in **Box 2**.

Importantly, these recommendations underscore the essential need for coordinated collaboration at all levels, along with sustained efforts to foster motivation among all professionals involved. The successful transfer of innovative best practices to new settings within CIRCE-JA offers a unique opportunity to address common challenges and shared needs through solidarity and cooperation. CIRCE-JA is, at its core, is a large-scale collaborative learning process with a shared understanding: that advancing European PHC is a common priority and one that can only be achieved by working together. In this endeavour, regions are no longer the last mile of implementation, but the first mile of innovation.

Box 2: Key Recommendations to Support Implementation of Best Practices

1. **Develop detailed implementation guides** for each best practice to assist implementing sites, with a strong emphasis on clarity and practical guidance.
2. **Collect and distribute graphic materials** useful for patients and medical specialists.
3. **Leverage existing tools** by building on instruments already used by organisations at any level to support local implementation.
4. **Collaborative planning** through the development of workplans that promote the use of shared tools and methods.
5. **Addressing barriers collaboratively** across all levels of the consortium.
6. **Ongoing knowledge sharing** by regularly exchanging materials and holding working sessions to discuss local plans and challenges.
7. **Translating materials into multiple languages** to enhance accessibility for future European projects.
8. **Adapt to local specificities** to enable better implementation and to allow scalability and adaptability across diverse settings.

Conclusions

CIRCE-JA tackles some of the most pressing issues facing the future of PHC. By successfully transferring innovative practices to new contexts, it demonstrates not only the feasibility of these approaches but also that scaling up and adapting innovative practices is a realistic and effective path to strengthen PHC systems across Europe. Looking ahead, this work will be further supported by the creation of a European Primary Health Care Observatory capturing a vision to re-orient health systems and transform practice, research and decision-making for PHC in Europe. This platform will be open to all stakeholders and build on existing European initiatives to help support implementation, scale up innovations, ensure practice-based research, promote continuous learning, and build new and stronger partnerships.

PHC is built on trust, the trust between the healthcare system and the people it serves. In many places, that trust has been shaken. Investment alone is not enough. Healthcare delivery must be transformed: by strengthening the workforce, ensuring access to all communities, (urban and rural) enhancing efficiency, sustainability, and resilience, guaranteeing equity to ensure universal access, and emphasising personalised care, dignity, and compassion.

The overarching goal remains clear: to reinforce PHC and strengthen health systems. PHC serves as a protective umbrella, shielding the social contract that binds the citizens and their institutions. Ultimately, health will be the foundation on which we rebuild trust – in our systems, in our societies, and in each other.

Acknowledgments

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TRANSFORMING HOSPITALS FOR RESILIENT, PEOPLE-CENTRED HEALTH SYSTEMS

By: Juliane Winkelmann, Dimitra Panteli, Stefan Eichwalder, Pia Kreutzer, Romana Höltschl and Nigel Edwards

Summary: Hospitals across Europe are undergoing transformation to meet shifting demographics, the growing burden of chronic diseases, and rising public expectations for integrated, people-centred care. Once standalone institutions, they are now key components of coordinated health networks that support equity, resilience, and community-based services. This article highlights policy priorities and key levers of change such as digital innovation, governance reform and decentralised care delivery. It outlines strategic directions for hospitals to serve not just as centres of excellence, but as proactive partners in health system transformation, focused on improving access, outcomes, and public trust.

Keywords: *Hospitals, Transformation, Integration, Decentralisation, Hospital at home*

> #EHFG2025 – SESSION 3:
Hospitals of the future – Investing in transformation to meet tomorrow's needs

Juliane Winkelmann is Technical Officer, European Observatory on Health Systems and Policies Brussels, Belgium; **Dimitra Panteli** is Hub Coordinator, European Observatory on Health Systems and Policies, Berlin, Germany; **Stefan Eichwalder** is Deputy Director-General, Public Health and Health Systems Division, **Pia Kreutzer** is Policy Officer and **Romana Höltschl** is Policy Officer, Department of DRG, health and pharmacoeconomics, Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, Vienna, Austria; **Nigel Edwards** is Senior Expert Advisor, European Observatory on Health Systems and Policies and Honorary Visiting Professor, Health Services Management Centre, University of Birmingham, United Kingdom. Email: winkelmannj@obs.who.int

Introduction

Hospitals across Europe are undergoing a process of strategic transformation in response to evolving demographic trends, notably population ageing, alongside the growing burden of chronic conditions and a rising demand for integrated, person-centred care.[1] These shifts are occurring within a context of constrained public finances, health workforce shortages, and mounting pressure to rebalance service delivery towards prevention and early intervention. As a result, many health systems are reorienting service delivery to strengthen the role of primary and community care, reducing avoidable admissions to hospitals, and strengthening care coordination across sectors. In addition, the growth of technology increases the ability to treat patients and to organise and coordinate care more effectively. Looking ahead, hospitals are expected to focus increasingly on complex and acute care, supported by digital innovation and infrastructure, while the management of chronic diseases and routine services continues to transition to outpatient and home-based settings.[2]

To respond to these multiple challenges and to ensure timely access to high-quality and person-centered services, countries are transforming their hospital landscape towards a more strategic and structured specialisation and to improve quality of care. Indeed, hospital reforms are among the top health-system reforms undertaken in recent years across Europe.[3] The rationales for shifting inpatient care to ambulatory, community-based care

Box 1: Hospital transformation in Germany: the new hospital reform aims to reduce hospital activity and boundaries between inpatient and outpatient care

Germany has among the highest hospital activity rates and the most expansive hospital system in Europe with continuously rising costs. The former government therefore passed a major hospital reform, effective from January 2025, to enhance care quality, reduce costs and improve efficiency. Under the new hospital reimbursement system, hospital funding will partly be based on flat fees that will cover up to 60% of operating costs. This flat fee partly replaces the previous DRG-based payment system. The provision of a significant portion of upfront funding aims to remove incentives for unnecessary procedures and to ensure that complex treatments, such as cancer care, are carried out only by well-equipped, high-capacity hospitals following the new strict quality standards for hospitals to receive funding for these interventions. In addition, a new type of hospital in the German context, cross-sectoral care facilities, aim to integrate services traditionally divided between outpatient and inpatient sectors. These facilities will be able to provide both outpatient and inpatient care, such as outpatient and short-term inpatient care for older people, outpatient hospital services (e.g. day surgery), and some inpatient treatments to secure access to basic services, especially in rural areas.[4] A recent analysis of hospital claim data indicated that approximately 20% of hospital treatments – equating to over 2.5 million cases in 2021 – could be effectively managed in outpatient settings.[5] Overall, the restructuration of Germany's approximately 1900 hospitals will also imply mergers and closures of hospitals. A €50 billion transformation fund supports this restructuring and helps cover the associated costs.

settings are to reduce unnecessary hospitalisations and curb costs while at the same time improve quality and appropriateness of care and increase patient choice. Most European countries have expanded forms of hospital care in which patients can be treated as outpatients (day surgery, hospital at home (HAH), outpatient hospital departments), as evidenced by the increase of surgical procedures performed on an outpatient basis in most European countries over the last decade.[6] At the same time, many countries are consolidating hospital services by merging or closing smaller hospitals and concentrating complex procedures in larger, better-equipped centres to improve safety and care outcomes and ensure efficiency and sustainability in light of workforce shortages and budget constraints. Hospitals are also being restructured to ensure closer collaboration with primary care, long-term care, social care, and mental health services by emphasising prevention and patient pathways with the aim to reduce the need for patient referrals to hospitals.[2] The example of Germany's major hospital reform exemplifies these efforts (**see Box 1**).

Hospital transformation requires a multi-layered approach

To make hospital transformation successful, it needs to be supported by processes and interventions at various levels. At the system level, hospital planning needs to shift away from traditional planning based on individual institutions and bed capacity, towards planning based on an analysis of needs and the capacity that is required to meet those needs. Planning will need to take into account the potential changes in delivery models and incorporating a high level of flexibility to allow for the associated high levels of uncertainty. Patient pathways, population characteristics, burden of disease(s), travel times or distances, technological advances and the wider resources of the catchment area are important for future hospital planning. Traditional metrics like bed numbers are insufficient; instead, capacity planning should model patient flows, population health needs (demographics, epidemiology), service integration, and potential decentralisation.[2]

> “a strong focus on staff well-being ensures more equitable access to care

Digital technology plays a pivotal role in transforming hospital systems. By leveraging these technologies, hospitals can streamline operations, facilitate better decision-making, and ensure more equitable access to care. For example, technologies such as telehealth, data analytics, and interoperable information systems support remote service delivery, data-driven planning, and seamless information exchange.

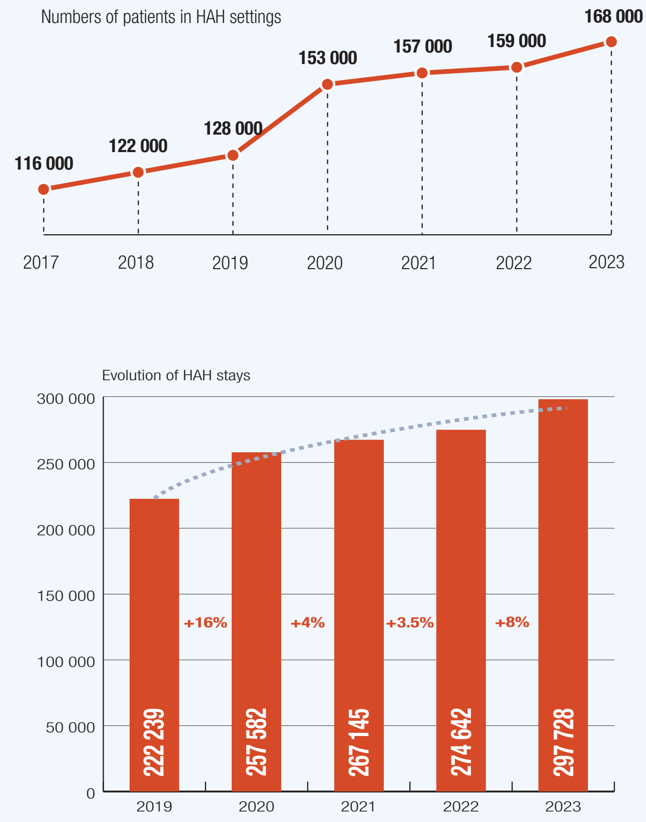
Regarding human resources, improved recruitment and retention strategies at the national and regional level are needed to make hospital care an attractive area to work and workforce planning needs to ensure that there are sufficient staff who are trained with the required competences to deal with a rapidly changing environment. Hospitals must themselves adapt training and recruitment strategies to support implementation of new and evolving roles such as clinical care coordinators, community paramedics or advanced practice nurses that are needed to support transformation, especially as decentralised services demand broader competencies. Developing multidisciplinary teams and involving clinicians in leadership roles are critical for successful health system transformation. Equally important are flexible skill-mix optimisation and a strong focus on staff well-being, both of which are essential to strengthening hospital performance and overall health

Box 2: France saw a significant increase in hospital at home activity in recent years

Hospital at home (HAH) provides nursing and other care with the aim of preventing admission to hospital, to allow early discharge and/or to provide palliative or end of life care. These may be operated by hospitals, residential care homes or homecare providers.[6] In recent years, France saw a significant increase of HAH activity from 2% of all short and medium-term hospitalisations in 2006 to 6% in 2019.[8] Between 2022 and 2023, HAH activity increased by almost 6% in terms of number of days and number of patients, and by more than 8% in terms of number of HAH stays (**Figure 1**).[7] Palliative care and complex dressing represent a major share of HAH activity (each about 30% of stays), followed by complex nursing care, pain management, and IV treatments. Delivery of chemotherapy at home is growing rapidly, reaching 214,000 days in 2023 – a 58% increase over five years.[9]

In 2023, France adopted a bill defining HAH as a standalone care activity, subject to authorisation, that provides continuous and coordinated medical and paramedical care in a patient's home. The HAH bill lays down conditions for setting up HAH facilities, stressing the importance of providing care 24/7, seven days a week, and ensuring intervention by a care team and access to timely medical advice. The HAH bill is part of the general reform of authorisations of healthcare activities in France that aims at restructuring healthcare services in an integrated model involving local services through to specialised and highly complex care – organised at different territorial levels.[10]

Figure 1: Numbers of patients in HAH settings and HAH stays in France saw continuous increases over the last years



Sources: [11] [12]

system resilience. Payment systems will need to incentivise population health and high-value healthcare that is more integrated with primary care, home-based care and long-term care. This means developing blended methods of payment that are aligned to these policy goals, as well as providing data and costing systems with higher levels of transparency and accountability on resource allocation and utilisation. [2]

At the local level, new ways of working will be needed between hospitals and providers of primary care, home-based care, long-term care, palliative care services, rehabilitation and other parts of the local health system – regardless of their ownership status. This includes developing shared pathways for common conditions, ways to provide support to primary care providers – such as e-referral, email consultation and telemedicine – and positive action by hospitals to develop outreach and other services. And lastly, at the hospital level, leadership and management need to have the ability to set strategy, as well as determining priorities, budgets and staffing profiles.[2]

Redefining hospital functions through integrated care and bringing them closer to communities

While some hospitals and specialised services are subject to centralisation to improve quality and efficiency, opportunities still remain to bring other hospital services closer to the communities they serve. Doing so can reduce the need for patients to travel and strengthen links with primary care. Decentralised models, including HAH, virtual wards, and outpatient care, allow hospitals to extend their reach into communities. These approaches can reduce pressure on acute services and align with patient preferences. Countries such as France, Israel, Spain and the United Kingdom have scaled-up such models during and after the COVID-19 pandemic.[7] In particular, the example of France (**see Box 2**) highlights how Hospital at home (HAH) services have evolved and expanded in recent years.

At the same time, hospitals are increasingly embedded in clinical networks, working collaboratively across hospital and outpatient sectors to deliver care pathways.[2] Centralisation and coordination of complex services can enhance outcomes and efficiency, while decentralisation and ambulatory models improve accessibility. Effective coordination between hospitals and primary care, including through tools such as teleconsultation and shared pathways, is essential for managing chronic conditions, ensuring care continuity

Box 3: Clinical stroke networks across sectors ensure rapid access to emergency and specialist care in London

London's stroke care transformation exemplifies a shift towards integrated, patient-centred models that bridge hospital and outpatient services. In 2010, the city restructured its stroke services by establishing eight Hyper-Acute Stroke Units (HASUs) to provide specialised care during the critical first 72 hours following a stroke. This replaced a fragmented system in which 30 local hospitals managed acute stroke care. This centralisation improved clinical outcomes and reduced mortality rates.

Complementing the HASUs, patients receive ongoing care in local stroke units and community settings, ensuring a seamless transition from acute treatment to rehabilitation. This hub-and-spoke model facilitates coordinated care across the stroke pathway, from emergency response to long-term recovery. The London Stroke Network's integrated approach has become a blueprint for national initiatives like the Integrated Stroke Delivery Networks aimed at replicating these successes.[13] [14] [15]

and reducing unnecessary admissions. Examples such as London's stroke network (**see Box 3**) illustrate how regional planning and integrated governance can enhance care delivery.

> reduce pressure on acute services and align with patient preferences

Conclusion

Hospitals of the future will be defined by their ability to adapt, connect, and lead within broader health systems. As strategic partners in health system transformation, they must strike a balance between specialisation and accessibility, innovation and sustainability, and efficiency and equity. To do so, hospitals need agile approaches that enable innovation in situations where payment, regulatory or structural barriers, can hinder progress. Policymakers have a critical role to play in supporting this evolution through governance reform, investment in digital and physical infrastructure, and inclusive planning. Hospitals that embrace this role can help restore public trust in health systems and reinforce the social contract for health and well-being across Europe.

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TRANSPARENCY OF PUBLIC CONTRIBUTIONS TO DRUG DEVELOPMENT

By: Claudia Wild and Daniel Fabian

Summary: The revised European pharmaceutical legislation (Article 57) will require market authorisation applicants to publicly declare any direct financial support received from public authorities for Research and Development (R&D) activities. Public contributions to drug R&D are numerous but remain poorly documented. Aligned public policies that enforce transparency in R&D investments are essential for implementing the transparency clause effectively. Although frameworks and methodologies for identifying and documenting public contributions to product R&D have been developed and applied in multiple case studies, the use of such data in price-setting and negotiations remains exploratory. Further policy options still need to be developed.

Keywords: *Pharmaceutical Pricing, Transparency, Public return on public investment (pRopI), Research and Development (R&D)*

> #EHFG2025 – SESSION 5:
Transparency of public contributions to drug development – Exploring policy options for fair pricing

Claudia Wild is former Director, **Daniel Fabian** is Researcher, Austrian Institute for Health Technology Assessment (AIHTA), Vienna, Austria. Email: Claudia.wild@aihta.at

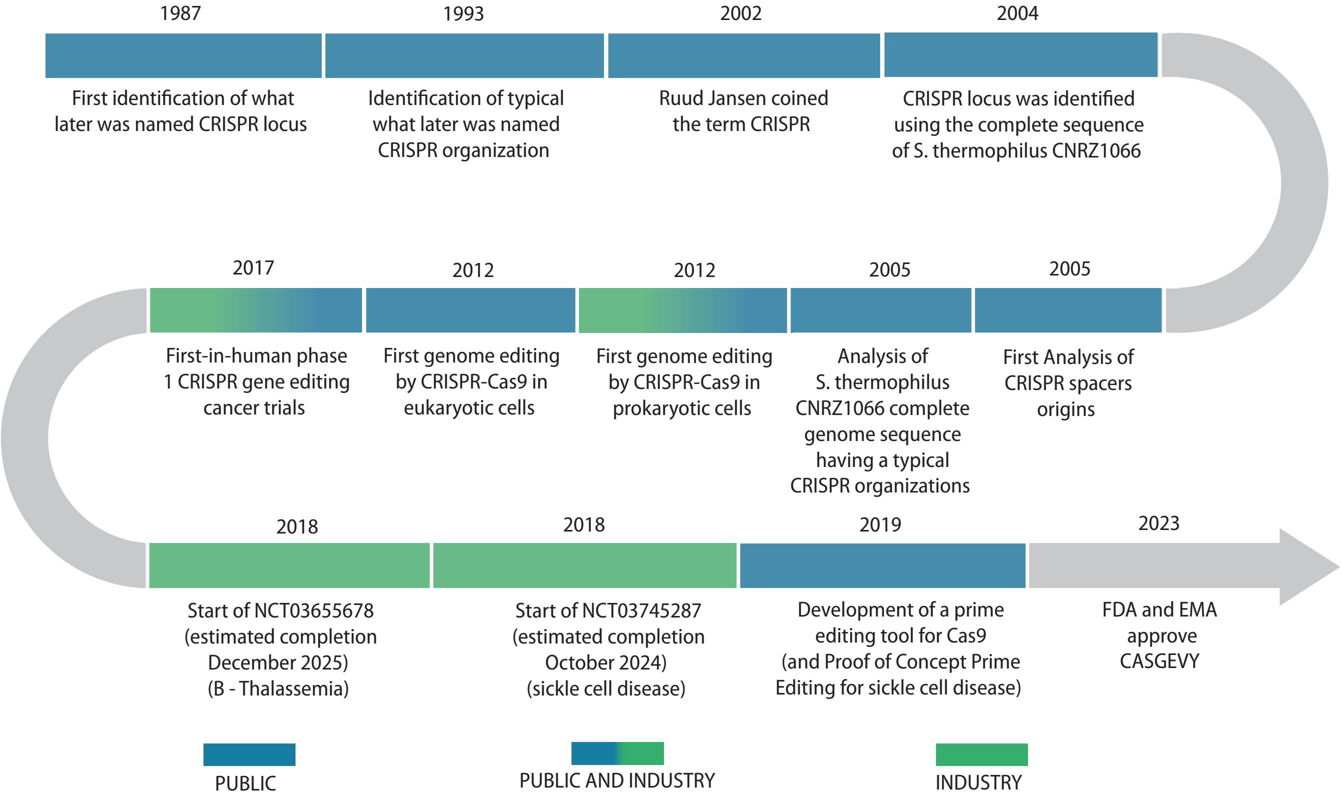
Background

Public contributions to the development of medicines have been the subject of growing debate, not only since the publication of Mariana Mazzucato's *The Entrepreneurial State: Debunking Public vs Private Sector Myths,*[1] but also due to the often-exorbitant prices of new medicines. These public, as well as philanthropic, contributions to medical product development are widely acknowledged and frequently highlighted in the media under headlines such as "The public pays twice" and "Risks are socialised and profits privatised".[2] Despite mounting evidence, there remains a lack of effective measures to translate these realities into corresponding policy actions.

Article 57 in the Directive of the new (draft) Pharmaceutical Legislation

In 2019, the World Health Assembly (WHA) emphasised in a resolution the need to 'improve the transparency of markets for medicines, vaccines and other health products'.[3] In April 2023, the European Commission (EC) published a proposal to revise the legislation on medicinal products (consisting of a directive and a regulation [4] [5]), which is now under negotiation. The directive contains a transparency obligation regarding public financial support for research and development (R&D) activities for a medicinal product. Article 57 of the proposed directive requires applicants and marketing authorisation holders to disclose any 'direct financial support received from

Figure 1: Developmental milestones in product development



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Source: [7]

Note: This example relates to a gene therapy that uses innovative technology to treat sickle cell disease and transfusion-dependent beta thalassemia.

a public authority or publicly funded body in connection with activities relating to the research and development of the medicinal product for which a national or centralised marketing authorisation has been granted, regardless of which legal entity received this support'.

> The public pays twice

The focus on 'direct financial support' is argued as follows in the recitals: 'given the practical difficulties in determining how indirect public funding instruments such as tax incentives have supported a particular product, the reporting obligation should only apply to direct financial contributions from public funds, such as direct grants or contracts'. The scope of the obligation is very broad, covering *all* direct financial contributions to R&D activities related to the development of the medicinal product. The reporting requirement does not specify a time frame, meaning that financial contributions received during basic research, preclinical, and clinical phases are also included.

Within 30 days of receiving authorisation, the authorisation holder must prepare an electronic report containing the amount of financial support received, the date of receipt, the authority or public institution that provided the financial support, and the legal entity that received it. The report must (i) be audited by an external auditor, (ii) be publicly available on a dedicated website, and (iii) be updated annually.

HI-PRIX developed a framework to support the search for public contributions

R&D encompasses a wide range of activities and different objectives. It begins with basic research to understand the disease mechanism and includes preclinical research to develop new molecules. Development involves refining manufacturing processes, and clinical research focuses on providing evidence of the efficacy and safety of the therapy to support market approval and benefit assessment. The aim of the HI-PRIX* project was to create a framework for standardised reporting and to clarify the interpretation of 'direct' and 'indirect' public contributions. A comprehensive category system will collect evidence

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* A European Commission funded project by Horizon Europe Grant Agreement 101095593, https://hiprixhorizon.eu/

(data and factual information) to derive political strategies for using knowledge in price negotiations.

Previous research and detailed analyses of pharmaceutical product development histories, based on individual case studies (**see Figure 1** for an example), reinforce a consistent pattern: high-risk basic research typically begins in academic settings. Promising developments then lead to the creation of university spin-outs or small biotech companies, which advance preclinical research supported by significant public innovation and regional funding, alongside private investment – particularly venture capital. Successful projects or entire portfolios are acquired by larger companies through mergers and acquisitions (M&A), gain value on the investment market, and are often resold multiple times at increasing prices, reflecting their perceived market potential. The process of acquiring academic knowledge and transforming it into profitable therapies using private equity, driven by financial market incentives, is commonly referred to as ‘financialisation’.[6]

Categories of public funding

Categories of public funding [8] [9] include funds and grants for basic research, preclinical research and applied (or translational) research, as well as institutional support for patent applications and technology transfers. Legal, technical and financial support for spin-outs from universities or newly founded small and medium-sized enterprises (SMEs) are also part of public subsidies. However, they are more challenging to research because this information is less readily available, less transparent and less frequently accessible to the public than research funding.

Changes in ownership that lead to large increases in value almost always result in no corresponding financial returns for the originators and are therefore not adequately considered. Public support for clinical trials of medicinal products is well documented in publications and registers. Finally, regulatory support – in the form of technical assistance with registration, methodological guidelines and the provision of priority reviews or vouchers – is considered a public investment due to its opportunity costs. Tax credits and (supply) data collection after market-launch – specifically real-world data (RWD) used to generate additional evidence – are also considered public contributions. We identified eight categories of (direct and indirect) public contributions to R&D for drugs and other health innovations.

> Political statement with no concrete impact?

There is considerable scepticism that the call for greater transparency in development spending is merely a political statement with no concrete impact. To counter this justified scepticism regarding the lack of practical implications and the perceived irrelevance of the proposed reporting system, several ideas and proposals are presented.

Exploring policy options to unlock the potential of increased transparency

The question is not why public contributions should be considered, but how to capture the considerable public funds, especially from European and American public institutions. The proposed directive contains the requirements for transparency. However, the conditions that enable verification and monitoring are currently insufficient. However, as shown here, indirect public contributions are just as relevant as direct ones.

1. Uniform, transparent reporting on public contributions for R&D and innovation support of regional agencies is necessary to verify the information provided by the pharmaceutical industry; an easily accessible website at the national and EU level is needed where every citizen can easily find all direct subsidies. This standardised disclosure of all public and non-profit contributions would also have to make the results sold (patents and licensing, M&A) to industry or to company spin-offs transparent, thus enabling more detailed insights into the subsidised projects and their return on investment. All licence agreements, patent sales and collaborations between universities and pharmaceutical companies should be disclosed.
2. To date, only a few countries (i.e., Austria, France, Italy) have imposed transparency requirements for reimbursement applications. However, these remain voluntary as long as no sanctions (such as deferrals until data is submitted) are imposed. Compliance with transparency requirements will become mandatory due to the implementation of the (new) EU Medicines Regulation. It can be assumed that other countries will also want to use the information in price negotiations. Here, an exchange of experiences – similar to that on Managed Entry Agreements (MEA) – should be organised to accelerate the operationalisation of the transparency clause.

Since the pharmaceutical industry has so far declared its expenditure without a standardised definition of R&D, a generally applicable definition is necessary to compare public and private R&D expenditure. The Frascati Manual, developed by the OECD,[10] provides a rather broad definition whereby R&D is seen as ‘creative and systematic work undertaken to increase the stock of knowledge, including knowledge of humanity, culture and society – and to devise new applications of available knowledge’.

3. Binding requirements for R&D reporting in industry with clearly defined inclusion and exclusion criteria (e.g., it is unclear whether the purchase of knowledge through M&A or licensing costs can be declared as R&D expenditure, whether ‘seeding trials’ to increase market share are considered R&D etc.) are recommended for better comparability between public and private R&D expenditure. The public availability of these R&D reports is crucial: the reports provided by pharmaceutical companies must be made available to the public and

allow access to the data in an easily filterable and easy-to-edit format that makes it easier for users/researchers to download, analyse and review the files.

Detailed contractual options for the conditions and requirements for public funding of R&D are necessary. These conditions attached to public contributions have not been sufficiently thought through and must be addressed as a key policy measure.

4. Conditions can, for example, stipulate a fair price via a 'fair price clause', open access to intellectual property rights (open access pool for academic research results to promote genuine competition instead of monopolistic marketing), profit sharing upon reaching sales thresholds, or the repayment of the initial investment upon reaching sales thresholds or licence fees to the public. Reinvestment obligations and controls (instead of naive trust) are also requested.

Finally, the role and willingness of political decision-makers to use all transparent information about public contributions must be emphasised. Otherwise, the transparency clause will remain a 'dead paper' instead of promoting a paradigm shift. Since the pharmaceutical industry no longer calculates prices based on research expenditure, but rather on market value determined by the financial markets and their investors (often euphemistically referred to as 'value-based pricing'), it is essential to dispel the myth that commercial companies are the sole innovators.

5. The further development or revitalisation of public infrastructure,[11] not only for research, but also for the development and approval of medicines, is now a widely discussed means of choice to counter the powerful position of the pharmaceutical industry and the failure of the market to provide essential medicines such as antibiotics.[12] This would result in public institutions acting confidently as innovators.

Conclusion: Social contract between governments, organisations and private economic actors revised

Public and private funding of drug development are complementary activities based on a division of labour [13] and involve high levels of risk capital on both sides, the public and the private. Public R&D spending has macroeconomic effects on gross domestic product (GDP) and microeconomic effects on corporate revenues. However, the strategic objectives of public R&D in the fields of health, life sciences and biotechnology must serve the interests of public health first and economic interests second. Complementarity is based on an implicit agreement (the so-called 'social contract') between governments, citizens, organisations and private economic actors that there are mutual obligations between the contracting parties. In the context of medicines (and other medical products), companies commit to bringing medicines to market that meet health needs in exchange for profits that compensate for their investments. The role of governments within this social contract is to create the legal and regulatory framework. If therapies are unavailable due to unaffordable prices, this system of complementarity must be considered as a failure.

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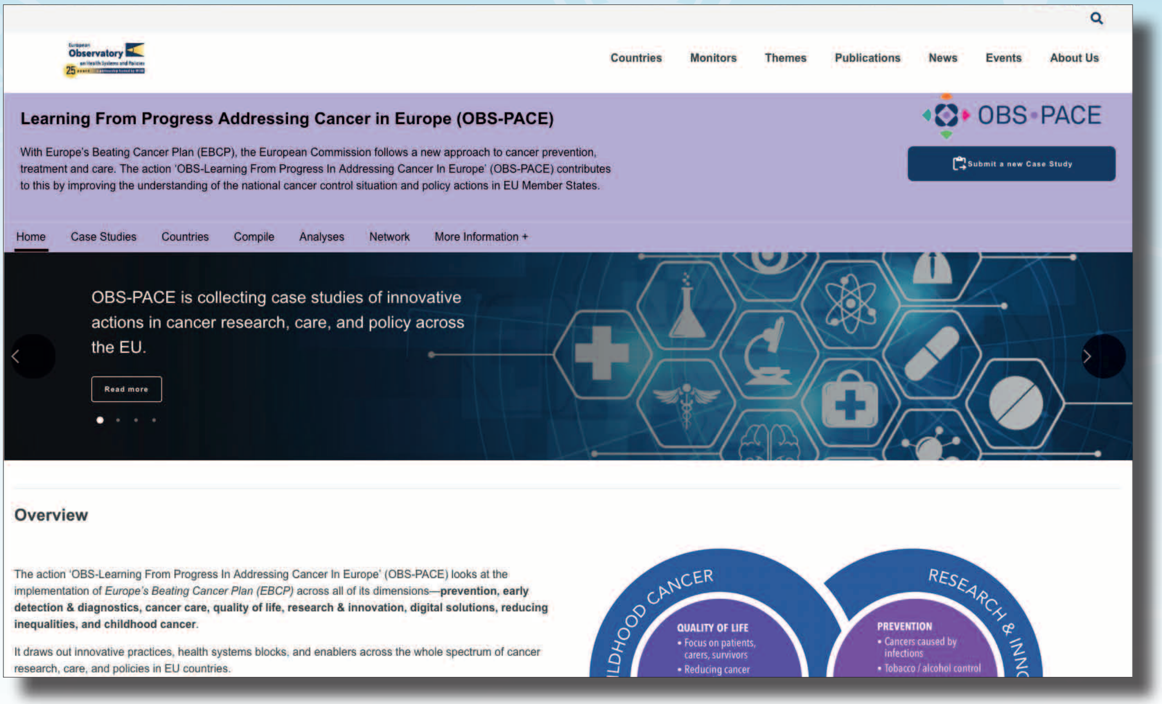
DISCOVER OBS-PACE, AN INITIATIVE DEDICATED TO ADVANCING CANCER RESEARCH, CARE, AND POLICY ACROSS EUROPE.

OBS-PACE is a joint undertaking of the European Observatory on Health Systems and Policies and the EU's Directorate General for Health and Food Safety (DG SANTE), looking at the implementation of Europe's Beating Cancer Plan (EBCP) across all of its dimensions: prevention, early detection & diagnostics, cancer care, quality of life, research & innovation, digital solutions, reducing inequalities, and childhood cancer.

At the core of the action is a network of national cancer experts from across the EU who provide case studies on initiatives tackling cancer at the local, national, and international level. These draw out lessons on the implementation of innovative practices, including health systems blocks and enablers, addressing the entire cancer continuum. Analyses across case studies are also conducted, highlighting the value of cross-country learning.

All case studies and cross-cutting analyses are available on the new OBS-PACE website, with more upcoming; a video tutorial guides you through the website.

Have a look to learn more about how EU countries are innovating to better tackle cancer!



Learning From Progress Addressing Cancer in Europe (OBS-PACE)

With Europe's Beating Cancer Plan (EBCP), the European Commission follows a new approach to cancer prevention, treatment and care. The action 'OBS-Learning From Progress In Addressing Cancer In Europe' (OBS-PACE) contributes to this by improving the understanding of the national cancer control situation and policy actions in EU Member States.

OBS-PACE is collecting case studies of innovative actions in cancer research, care, and policy across the EU.

Overview

The action 'OBS-Learning From Progress In Addressing Cancer In Europe' (OBS-PACE) looks at the implementation of *Europe's Beating Cancer Plan (EBCP)* across all of its dimensions—**prevention, early detection & diagnostics, cancer care, quality of life, research & innovation, digital solutions, reducing inequalities, and childhood cancer**.

It draws out innovative practices, health systems blocks, and enablers across the whole spectrum of cancer research, care, and policies in EU countries.