

# Gesundheit!

Stockholm Network Health and Welfare Newsletter

# 10

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## COMMENTARY

Helen Disney, chief executive of the Stockholm Network

“A comfortable old age is the reward of a well-spent youth. Instead of its bringing sad and melancholy prospects of decay, it would give us hopes of eternal youth in a better world”.

These words by Maurice Chevalier provide a suitable opening for this issue of *Gesundheit*, in which we examine the topic of Europe’s ageing population and ask how we can turn it to our advantage, rather than seeing it simply as a burden.

Rebecca Taylor, formerly a senior researcher at the International Longevity Centre (ILC\_UK), and a recent speaker at the Stockholm Network’s ageing roundtable in Brussels, kicks off by explaining the benefits of what she calls a “life course” approach to ageing and asks how we can change our mindset to begin to see the advantages that an older population could bring. Paul Healy, our own senior researcher follows up by looking at some of the suggested challenges of demographic change including the impact on welfare and healthcare systems, as well as the problem of age discrimination, and asks what policymakers could be doing to solve them.

No country in Europe will be immune to the effects of an ageing workforce and Germany has already started down the road to reform – at least in part – by enacting a series of reforms to the way it pays for medicines. But, as a recent Stockholm Network research intern, John Blagys explains, this is only part of the story and structural reforms cannot be far behind.

We also focus in on the issue of pharmaceutical pricing in our new research paper, *What price is right?* which is summarised in this issue along with a link to our new web section which rounds up our workstream on HTA and pricing.

The figures and projections on ageing make for some frightening reading and it is perhaps not surprising that we often run scared. None of us wants to confront the challenges of old age – either on a personal level or a political one. But if we want Europe’s economy to flourish and our societies to remain healthy and productive, we have no choice but to accept that old age will come to us all. Our responsibility is to turn that into something we can cherish rather than simply ignore.

## CHANGING OUR MINDSET: A LIFE COURSE APPROACH TO AGEING

Rebecca Taylor, former senior researcher of the International Longevity Centre – UK

### “Zero sum” and intergenerational conflict; the negative outlook

The challenges of demographic change, more often referred to as a demographic “time bomb”, are a frequent topic of contemporary debate, especially when it comes to pensions, health and social care. We frequently hear that in order to fund the pensions, health and social care of our current generations of older people, we working people and our children will have to work longer, pay more taxes and probably end up less well off than previous generations.

This view of the world panders to society’s obsession with youth; seeing younger people as productive and older people as unproductive. It paints a negative view of older people as frail, dependent and using up lots of healthcare resources. This “zero sum” approach also risks pitting different age groups against each other and engendering intergenerational conflict.

### The life course approach; the positive outlook

There is another more positive way of looking at things. The International Longevity Centre – UK (ILC-UK) prefers to take a different view, that of a “life course” approach. A life course approach recognises that people of all ages make a valuable contribution to society, albeit different contributions at different stages of life.

The life course approach challenges us to match our perception of older people with the reality. When we look around, we see that people are living longer and, in many cases, healthier lives. Many people in their 60s today are as healthy as 40 year olds, but often have more money to spend as consumers, especially if they have paid off their mortgage and no longer have children to support.

Despite this, many older consumers are badly served and some even find themselves with money to spend, yet unable to spend it because the market does not cater to their needs. In these tough economic times, you would think that the chance to find new consumers with money to spend would be attractive to most businesses. Apparently not if those new consumers are older people - although those businesses which make the

effort to attract older consumer groups (there is no single homogenous “older consumer”) do reap the benefit.

### Older workers: a valuable role to play

Changing demographics in Europe mean that despite high unemployment, some sectors have skills or labour shortages, which can be filled by older workers. Older workers can also be involved in training and mentoring their younger colleagues; the mix of the experience of age and the energy of youth can be highly effective. There is evidence that older workers, due to their longer professional and life experience are more relaxed and confident in customer service positions, especially when it comes to dealing with problems.

There is also evidence that older workers take less short-term sick leave i.e. they don’t call in sick after a night on the town. However, other studies show that when older workers take sick leave, it is for more serious health problems and can last longer. This means that organisations may need to take steps to support older workers returning to work after sick leave.

Despite the media and public in many countries believing that older people working longer means that they “take” or “block” jobs for younger workers, ILC-UK has yet to see concrete evidence of this. On the contrary, most studies addressing this area find that older workers are not a factor driving youth unemployment. There is greater discrimination in the workplace against older workers than their younger counterparts with the possible exception of the under 24s who have little or no professional experience.

Outside paid work, the voluntary sector depends heavily on older volunteers, even more so in the current economic climate. Many a charity shop would be understaffed and many meals on wheels might not get delivered if it were not for older volunteers. In addition, many working parents rely on their own parents for help with childcare, so this ‘silent’ contribution of grandparents to the economy should not be underestimated.

It is even possible to challenge the view that older people inevitably use more healthcare resources than their younger counterparts. People use the greatest amount of healthcare in the last two years of their life, regardless of the age at which they die. Epidemiological studies show that a 50 year old with no major risk factors for chronic disease has a very good chance of having another 25 years of healthy active life. An overweight 40 year old smoker could well use up more resources even in the short term, never mind the long term, than an active 70 year old with no chronic disease.

#### Addressing the challenges of demographic change

But this does not mean that ageing and demographic change do not present serious challenges to modern societies; they do, but there are sensible solutions to be found. When it comes to work and pensions, one way of encouraging people to continue working or at least persuading them not to retire early is to allow “gradual retirement”, whereby older workers are offered greater flexibility, typically by reducing working hours in the years prior to their eventual retirement.

This is a highly desirable solution for many older workers who do not feel ready to give up work entirely, but would like to work less, perhaps to spend time with their grandchildren, to do voluntary work or simply in order to have more leisure time to do things they enjoy. This has a benefit for society and the economy as the older worker continues to pay tax and social security contributions and they begin drawing their pension later.

However, gradual retirement requires a labour market and tax system which incentivises people to work longer or at the very least does not disincentivise them. Incentives could include lower tax or social security contributions and a higher pension for those who take it later. Obviously, careful calculations need to be undertaken to ensure that the cost of incentives does not outweigh the savings made by people working longer.

#### From treating sickness to promoting and supporting health

Current approaches to managing rising demand and the rising cost of healthcare, which is being brought sharply into focus by demographic change, concentrate mostly on cost control measures such as generic substitution,

de-listing, higher co-payments etc , but do not change the way healthcare systems operate. Our healthcare systems remain for the most part, sickness services rather than health services.

This is where a life course approach can play a role. A life course approach to health gives a stronger role to prevention and health promotion through all stages of life to support people to live healthier lives rather than wait until they become sick to intervene. This approach, naturally, does not begin when people get older, but applies at all stages of life.

Chronic diseases are more common in older people and do generate significant costs for healthcare systems. However, many of the risk factors that lead to chronic disease are known and can be identified and managed with appropriate support. The first step is to know risk factors e.g. your cholesterol levels, and the second step is to help people manage them, e.g. dietary changes and if necessary further measures such as cholesterol lowering margarine or using statins (heart medication).

Moving towards a more health-promoting rather than sickness-treating healthcare system will require changes including incentives for healthcare providers to undertake health promotion and preventative interventions, and for individuals to be more pro-active in managing their health. Incentives can be financial, but can also be structural.

In addition, assessing the cost-benefit of preventative interventions needs to take the broader context into account. For example, the benefits of giving up smoking accrue to the individual through less illness and overall better health, to the healthcare system as smokers often suffer serious and expensive to treat illnesses such as cancer, and also to society as a non-smoker is likely to be productive for longer.

ILC-UK considers that society has much to gain from taking a life course approach to ageing. Most importantly, this will require us to change our mind-set, particularly in relation to older people and to recognise that investment to support older people to remain healthy and active is not just for their benefit, but can benefit the whole of society.

## AGEING AND ITS CONSEQUENCES

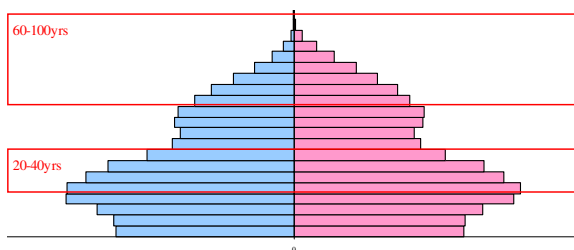
Paul Healy, senior researcher, Stockholm Network

When I attend events, such as the recent Stockholm Network roundtable on ageing in Brussels (see page 13), I am reminded of many other events that have danced around the issue of Europe's ageing society. Two things strike me the most. The first is the acceptance of the scale of the challenge that we are about to endure. It is sometimes rather unsettling to hear policymakers talk comfortably about a future that is projected to be both unprecedented and troublesome. Although I agree with many of these assessments, I mostly disagree with the pessimistic belief that these challenges are both inevitable and insurmountable. In fact, I have faith that society possesses the tools and skills to overcome the challenges that an ageing society presents.

### The scale of demographics

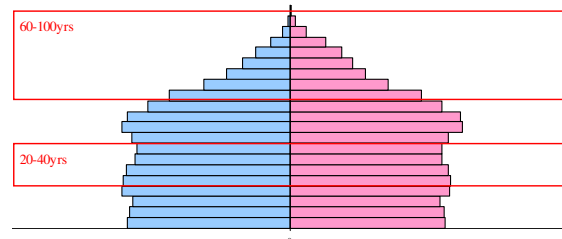
Let's start therefore with an assessment of the problem by looking at demographic trends over a 60 year period in the United States. The graph below shows the shape of the US population 30 years ago in 1980. It generally resembles a pyramid, albeit one with a basement. More importantly, we can see that most of the population is generally aged between 20 and 40 years old, in other words, the citizens who mostly work and rarely use public services. At the top, we can see a much smaller number of people are aged above 60 years old: citizens who rarely work and mostly do use public services.

US population pyramid, 1980



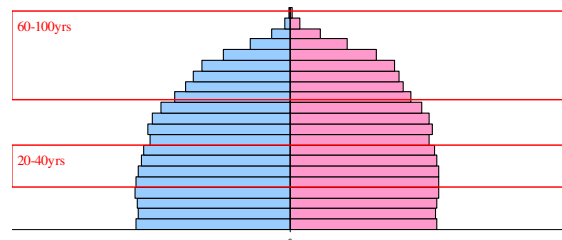
If we move forward to the present day, in the graph below, we can see that this bulge of people aged between 20 and 40 years old has been pushed up to the group of people aged between 40 and 60 years old. These people still generally work more than they access public services. At the top, we can see that there is an increase in the number of citizens above 60 years old, although it is not particularly drastic yet.

US population pyramid, 2010



Thirty years further on, however, in 2040 a very different picture emerges, one that barely resembles a pyramid and is more akin to a sausage. Here, we see that there will be many more citizens aged 60 and above, while this bulge of people who had been aged somewhere below 60 has now levelled out.

US population pyramid, 2040



The picture does generally vary across Europe, particularly towards the foot of the pyramid. The United Kingdom, for example, currently has a relatively high birth rate, while Germany's is rather low. Therefore, by 2040, you might expect the United Kingdom to have more people between 20 and 40 years of age and Germany to have less. Nonetheless, what varies much less is the problem at the top, in which many more people are able to live to 70, 80 and beyond.

### The challenges

So what are the four main challenges of ageing for society? The first is pensions and social security. When Bismarck established his welfare state in the 19th century, he hoped that few people would need to use it. The age established for retirement benefits, for example, was set loosely around life expectancy. It is reasonable to suggest that the State did not expect many people to be entitled. Ever since then, the link between retirement

and life expectancy has generally diminished and many governments continue today to circle around 65 years as an arbitrary figure for old age and retirement. Left unchanged, this would mean that future welfare states are likely to face the parallel challenge of increased recipients of welfare and diminishing contributors through taxation. The old-age dependency ratio estimates the number of people aged above 65 as a percentage of the people aged between 15 and 65. It shows that currently there is a recipient (i.e. a person aged over 65) for every four contributors (i.e. a person aged between 15 and 65). By 2050, this will double to one recipient per two contributors.

A similar story can also be told about the future of healthcare, with recipients of health services likely to increase at a time when contributors, through social insurance or taxation, decrease. Added to this, older people tend to develop diseases that are currently more difficult to treat and rely on medicines, such as cancer drugs, that are much more expensive.

Ageing also presents a significant challenge for society in regards to long-term care. Currently, the arrangements for long-term care in most European nations are inadequate and those that are more developed are often very expensive. Only 9% of Europeans currently believe that they will not be dependent on the help of others at some stage in their life because of their physical and mental condition, while 45% believe that this is either inevitable or likely. In addition, 93% of Europeans believe that public authorities should provide appropriate home care and/or institutional care for the elderly.

Finally, probably the most rarely mentioned challenge is the issue of age discrimination. At present, society tends to view ageing in a degrading sense. As a result, perceptions about the ability of older people are usually pretty poor. A *Eurobarometer* poll which asked how comfortable Europeans would be with a person aged over 75 in the highest political office found that the response was just 5.4%. This trend will not be unfamiliar to most, given the current wave of youthful and energetic people running for high office, nor is it specific to politics. In the workplace generally, older people are seen as more complacent and inactive, whilst younger workers, however unfairly, are viewed as enthusiastic and dynamic.

### The policy solutions

So what can we identify as potential policy solutions? In regards to pensions and social security, the most prominent solution is increasing the retirement age. At present, 14 OECD countries are undergoing reforms to increase the age at which citizens can access retirement benefits with some, such as the Germany and the United Kingdom, set to see retirement ages that go beyond the hallowed 65 figure to 67 years of age. There is also the potential to reduce the so-called "generosity" of these benefits and others, such as unemployment and incapacity benefits. Although fewer governments will keen to take these reforms on, given their unpopularity amongst voters, some are currently revisiting the criteria for entitlement and in some cases removing people's entitlements to certain benefits.

In healthcare, the most sensible solution in many cases would be structural reforms that would offer more consumer choice and provider competition. In many cases these could reduce the cost of services and empower patients to manage their healthcare in a more cost-effective way. In reality, however, most governments have focused on cost-containment as a solution, particularly through mechanisms such as health technology assessment. The drawback of this is the necessity of having to deprive some patients of treatments that are not deemed cost-effective.

The challenges posed by ageing to the sustainable provision of long-term care have so far been the most neglected. Governments are unlikely to be able to effectively manage the pressures of many more citizens looking to public services for long-term care without some sort of insurance system that allows citizens themselves to prepare for it. In the United Kingdom for example, policymakers have flirted with such insurance schemes as well as considering what critics have termed "death taxes", in which the State recoups some of the costs from the estates of deceased recipients.

The final challenge, age discrimination, has a number of possible solutions. In terms of government, equality legislation needs to ensure that older people cannot be unfairly treated in favour of younger people and mechanisms such as mandatory retirements need to be outlawed entirely. However, most solutions to age discrimination should come from society itself. We need to transform our perception of ageing and encourage a

new attitude that doesn't treat old age as a disadvantage. Instead we should embrace the fact that people are living longer and capitalise on the opportunity that this presents.

Whether we call it "active ageing" or "healthy ageing", we should acknowledge that being old today does not mean people should become excluded whether from politics, the economy or society more broadly. Old people: "Your country needs you!"

## HEALTH OF THE NATION – GERMANY

*We continue our “Health of the Nation” section which explores individual healthcare systems throughout Europe, with a look at Germany by John Blagys, former research intern of the Stockholm Network.*



Since 1883, Germany has provided its citizens with access to a national healthcare system. Fully public, multi-payer, and universal in nature, the service was first theorised in 1881 by the then Chancellor Otto von Bismarck. By 1889, with the help of Bismarck's influence, the German Parliament passed health, accident, old age, and disability insurance for German citizens in need. Despite countless reforms to Bismarck's model, the founding principle of social solidarity remains the defining feature of Germany's healthcare system today and implies that medical treatment should be administered on roughly equal terms, financed on the basis of an individual's ability to pay.

Under the mandate of German law, all citizens must be medically insured, although there are many options by which they can comply. Statutory Health Insurance schemes (SHIs), of which there are around 240, are financed by mandatory payroll taxes that are paid equally by both employees and employers. For most people, SHIs are mandatory, although some will also purchase supplemental insurance while others are able to opt-out entirely in favour of private insurance. Around 72 million citizens are covered under the public insurance system and another 8.5 million are covered privately, with 99% of the total German population covered by a healthcare plan.

Contributions made through payroll taxes are collected centrally and distributed to a national health fund, which then distributes money to over 200 private, non-profit, and highly-regulated organisations, known as sickness funds. These organisations receive government funding based on risk-adjusted amounts for each patient and are incentivised to care for chronically-ill patients. Citizens are free to insure themselves with any of the various sickness funds, thus creating some sort of competitive market. In general, the system is built upon the principle of self-governance, allowing sickness funds to collectively bargain with providers over prices although bodies such as the Federal Joint Committee (G-BA) and the Federal Health Ministry (BMG) remain influential over how services are provided.

Under the SHIs, patients are not required to begin their medical treatment with a general practitioner (GP), opting against the gatekeeper system common in the UK and Scandinavia. Instead, patients can see any doctor or specialist they choose, although by forgoing a GP they may be subject to a small co-payment charge. Similarly, patients under SHIs are free to visit any public or non-profit hospital they choose and are covered for basic dental, optical, and mental health needs. Overall, the healthcare industry employs a total of 43 million workers and contributes 11% to Germany's total economic output.

### CHALLENGES

#### Healthcare funding

Germany ranks among the highest in the world in healthcare expenditure, allocating just under 12% of GDP spending to healthcare. Only France, the Netherlands, and the United States designate more. Since contributions to SHIs are mainly made by employees and employers, healthcare funding is dependent on high levels of employment. Despite being Europe's strongest economy, Germany still has an unemployment rate of 7% which, when coupled with stagnant wage growth, poses a serious problem for the future sustainability of the healthcare system. Moreover, the tendency among high-end earners to opt out of the SHIs in favour of private insurance makes financing even more difficult.

One consequence of this has been a gradual growth in the health spending deficit, which currently stands at around €11 billion. In order to address this, the German parliament recently passed a mandatory healthcare premium increase, which effective from January 2011 saw the mandatory health insurance charge rise from 14.9% to 15.5% of gross wages. This charge is evenly split between employees and employers, but all future increases will be paid solely by employers. Moreover, the reform calls for cost reductions for doctors, hospitals, and insurers, but has proved extremely unpopular among trade unions, insurers, and opposition

parties who claim that employers have been unfairly targeted.

#### Demographic Change

Germany's shrinking population is beginning to become a major obstacle for the future sustainability and effectiveness of the German healthcare system. Advances in medical treatments and technologies have allowed the German population to live longer than ever before. In 2009, over 20% of the population was over the age of 65 and by 2035, this number is predicted to swell to an incredible 30% of the population.

Though the German government has already taken steps towards addressing this issue, such as passing legislation to increase the retirement age from 65 to 67 in 2012, the dwindling German workforce still seems incapable of permanently supporting a growing number of retirees. These future challenges will not be helped by the current low birth rate among Germans, which has fallen by over 100,000 per year since 1999. In fact, 2009 marked the lowest German birth rate since 1945. If this trend persists and life expectancy rates continue to grow, the workforce will become increasingly incapable of supporting the growing demands of healthcare consumers.

#### Drug pricing reforms

Passed by the German parliament in November 2010, the Act for the Restructuring of the Drug Market (AMNOG) took effect in January 2011. The primary purpose of AMNOG is to ensure that benefits derived from new medical products are deserving of SHI funding. In order to make this determination, the act stipulates that pharmaceutical manufacturers will be required to provide the G-BA with a dossier that explains their product's added value, among other features. When the G-BA concludes that there is sufficient added benefit, the pharmaceutical manufacturer will generally enter into negotiations over price or else be permitted to price their product freely. All SHIs are required to comply with the price agreed upon and are charged by means of rebate on the pharmaceuticals selling price. If a product is deemed to have no additional benefit, the G-BA will instead include them within a reference price framework whereby products that treat the same condition are grouped and

priced based on a reference price, usually the average or cheapest price within the group. If the product is then priced higher than this reference, the patient will be required to cover the difference by means of copayment.

These so-called "jumbo groups" are, of course, controversial because whilst some may be willing to accept the interchangeability of pharmaceuticals that have identical active ingredients, i.e. branded medicines with their generic equivalents, there is strong opposition, often from patients themselves, to the idea that one pharmaceutical can be alternated with another because it treats the same condition. Overall, the BMG believes that these reforms will cut €2 billion from the healthcare budget.

#### CONCLUSION

The German healthcare system prides itself on its tradition and longevity and it has acted as a model for social solidarity across Europe, where its influence is challenged possibly only by that of the Beveridgean model in the UK. Yet, Germany finds itself on the cusp of a challenging period in which its ability to provide sustainable and effective healthcare will be confronted by rising costs and an ageing population. Increasing healthcare premiums may ease solvency problems in the interim, but tax increases alone are an inadequate response to ensuring a sustainable system. Instead, structural issues will need to be addressed.

## RECENT DEVELOPMENTS



## EUROPEAN UNION

EU commissioner John Dalli has announced swift and determined action to tackle antibiotic resistance, which the European Centre for Disease Prevention and Control suggests costs Europe over 1.5 billion Euros in care and productivity losses.



## AUSTRIA

A recent study has shown that four in ten Austrians are opposed to recent suggestions by health minister Alois Stöger that single women and lesbian couples should be allowed to undergo IVF.



## BELGIUM

A report has published that more than half of Belgian patients are happy with the performance of their healthcare system, although many are concerned with the costs of treatment.



## BULGARIA

The Economist Intelligence Unit has pinpointed Bulgaria's healthcare system as well-placed to develop its medical tourism industry, with many dentists offering special packages to foreign patients.



## CYPRUS

The recent EU report into antibiotic resistance has identified Cyprus as the member state with the highest resistance, with around 54.5 percent compared to under 5% in some other states.



## CZECH REPUBLIC

The Czech lower house of parliament has pushed through reforms to the healthcare system that aim to separate publicly insured medical treatment from premium care and will see the amount charged for an overnight hospital stay increased from CZK 60 to CZK 100 a day.



## DENMARK

The world's first tax on fatty foods has been introduced and will see all foods with more than 2.3% saturated fats receive an additional surcharge of 16 Kroner (£1.84) per kilogram of saturated fat.



## ESTONIA

Experts have warned that the economic crisis may be sparking a rapid spread of HIV infections in countries such as Estonia, where increased infections have been reported by the European Monitoring Centre for Drugs and Drug Addiction.



## FINLAND

Four neighbourhoods in Helsinki have begun a trial programme that will see regular drinkers offered blood sugar and blood pressure tests, in an attempt to identify those with type 2 diabetes.



## FRANCE

A new report from French researchers has suggested that patients who are socially disadvantaged or who lack social support tend to be less satisfied with the healthcare they receive.



## GERMANY

Manufacturers of Trajenta, a drug to treat diabetes, have decided to delay its launch in Germany despite receiving European approval because of concerns about new pricing regulations.



## GREECE

Austerity measures continue to affect health services in Greece with only 30% of the €1.2bn owed by public hospitals from the start of last year being paid and just 1% of the debt accrued since 2011 settled.



## HUNGARY

Prime minister Viktor Orbán has said that reductions in healthcare will form the main part of his government's budget deficit targets.



## IRELAND

Health and dental costs have been calculated to have dropped by an average of between 3 and 10 percent in Ireland, although wide variations in cost savings have been shown for different treatments and depending on where the treatments were being received.



## ITALY

In face of mounting economic troubles, Italy's Association of Medical Oncology has warned that up to 80 percent of cancer units are now in deficit.

## LATVIA

The Latvian government has designated an extra 6.1 million lats (8.7 million euros) to healthcare, which will be used to pay outstanding bills particularly in outpatient care.



## LITHUANIA

A report has suggested that an increase in the compulsory sickness insurance contributions has triggered a four fold increase in emigration in 2010.

**LUXEMBOURG**

Researchers at Oxford University have estimated that dementia costs in Luxembourg are the highest in the European Union.

**MALTA**

The chairman of the Paediatrics Department has said that breastfeeding rates, which had been comparatively low, have doubled in Malta over the last ten years with nearly 70 percent of newborns breastfed when discharged from hospital.

**NETHERLANDS**

Doctors in Netherlands have set a precedent by allowing a patient with senile dementia to be euthanised without requiring her to make her wishes clear. 95% of Dutch people are judged to support euthanasia, although only 33% of doctors are believed to agree with the practice.

**POLAND**

Poland took over the presidency of the EU looking to put an emphasis on reducing the gaps in health status of the EU's population and to continue actions aimed at preventing and treating brain and neurodegenerative diseases.

**PORTUGAL**

The National Federation of Doctors, one of two doctors' unions in Portugal, have joined nurses' unions and taken part in a nationwide general strike to defend the National Health Service and protest against salaries and bonus cuts proposed by the government's 2012 budget.

**ROMANIA**

Health minister Ladislau Ritli has said that legislation will be soon proposed that will allow private insurers to compete in the health insurance market, which is currently controlled by public bodies.

**SLOVAKIA**

Prime minister Iveta Radicova has met with doctors' unions to improve relations with health professionals and stave off a threatened strike in the healthcare system.

**SLOVENIA**

The National Institute for Health and Disability, the health insurance institute in Slovenia, has adopted an austerity budget that aims to cut spending by 14.4 million Euros. The government abstained in voting to approve the measures and health minister Dorjan Marusic expressed doubts about whether they were suitable.

**SPAIN**

It is unclear as yet as to how the new Spanish government's plans to cut public spending will affect healthcare policy, although the People's Party has pledged that private sector involvement, through public-private partnerships, will rise sharply under their watch.

**SWEDEN**

An audit of the Swedish healthcare system will be conducted after suggestions that care is not being given on equal terms and that services are currently fragmented.

**UNITED KINGDOM**

A parliamentary committee has demanded reform of EU rules that afford foreign doctors the right to practice medicine without first needing to take a language test.

## STOCKHOLM NETWORK EVENT

### IS AGEING GOOD FOR US?

Many of us are conditioned to think of old age as a bad thing. We may see it as a time of declining health, reduced mobility and freedom. Commentators also blame a host of problems on Europe's ageing population including our pension crisis, healthcare budget deficits and the burden on family members of caring for the elderly. But what if ageing as we think of it is about to change? Already, those who were once considered pensioners have been re-branded as 'silver surfers', who actively use the internet, travel the world and increasingly remain involved in the working and social life of their communities.

Indeed, the next generation of medicines and healthcare treatments will enable us all to live longer and more productive lives and change the notion of what it means to be old. So what impact will this have on Europe's welfare systems and labour markets and should a Europe which needs to expand its labour force start to see active ageing as a blessing rather than a curse? This roundtable, hosted in Brussels, looked at the issue of ageing and its policy consequences.

Participants included:

**Rebecca Taylor**, who joined the International Longevity Centre - UK in February 2010 as a senior researcher with over 10 years experience in EU and UK public affairs mainly in the health sector. She has previously worked for PGEU (European pharmacists), the NHS, two pharmaceutical industry associations (PPTA Europe and IFAH), and at Fleishman-Hillard Brussels.

**Peter Wintlev-Jensen** is the head of sector in the European Commission DG Information Society and media responsible for development of policy and research strategy related to Information and Communication Technologies and demographic ageing. He has been involved in this field for the last five years, including the preparation of the new European joint research programme on ambient assisted living, development of the ICT research agenda on Ageing in the 7th Framework Programme and the recent EU action plan on ageing well in the Information Society.

**Dr. Meir Perez Pugatch** is a senior lecturer at the University of Haifa in Israel, where he is also the chair of the division of Health Systems Administration at the School of Public Health. Since 2005, Dr Pugatch has been the director of research of the Stockholm Network and he is also a visiting professor at the postgraduate programme on IP law and knowledge management at the University of Maastricht.



## STOCKHOLM NETWORK PUBLICATION

WHICH PRICE IS RIGHT? REGULATING THE COST OF PHARMACEUTICALS  
IN EUROPE AND NORTH AMERICA

By Paul Healy

Our latest publication on Health Technology Assessment (HTA) and pharmaceutical pricing, *Which Price is Right?* is an extensive study into pricing regulations in Europe and North America. It identifies a pricing spectrum that balances between controlled prices set by healthcare payers and market-based prices set by manufacturers.

It argues that Europe currently finds itself in a position where it is getting "more for less" in regards to pharmaceuticals, although in doing so it relies on more market-based environments, such as the United States, to progress research into much-needed innovations. This is ultimately identified as problematic for two reasons:

It puts European nations in a position where they can be accused of "free-riding" on patients in the US and thus not paying their fair share towards the current cost of developing medicines that are of value to the entire globe, not least to their own patients. And it also means that European nations have surrendered some autonomy over their healthcare systems by placing the burden for medical innovation on the shoulders of others, whilst leaving themselves susceptible to changes in pharmaceuticals regulations over which they have no authority.

Among the paper's many conclusions, it maintains that pricing policy should not be a race to the bottom. Whilst payers do have a duty to manage their budgets in an effective manner, they should take care when contemplating price controls and consider them as part of an overall approach, which understands the efficiency of healthcare systems in a dynamic way. Short-term measures to reduce pharmaceutical prices artificially are, firstly, unlikely to deal with rising healthcare budgets but are also likely to hamper innovation further down the road.

To view the publication, please visit:

<http://tinyurl.com/bwpk7e3>

For an executive summary, please visit:

<http://tinyurl.com/cfsuoap>

To read an comment piece about the paper featured on *Public Service Europe*, please visit:

<http://tinyurl.com/d75x5b7>

For more information on the Stockholm Network's new work programme on HTA and pricing, please visit:

<http://tinyurl.com/cdcy9bm>

