Time to unlock the Potential of Health Promotion and Disease Prevention

AIM Position Paper

AIM is the umbrella organisation of health mutuals and health insurance funds in Europe and in the world. Through its 63 members from 28 countries, AIM provides health coverage to 240 million people in the world and 209 million in Europe through compulsory and/or complementary health insurance and managing health and social facilities. AIM strives to defend the access to healthcare for all through solidarity-based and non-for profit health insurance. Its mission is to provide a platform for members to exchange on common issues and to represent their interests and values in the European and international Institutions.

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AIM
Healthcare and social benefits for all

Executive Summary

In the European Region, the largest proportion of mortality is created by non-communicable diseases, which constitute a real challenge to healthcare systems. Apart from the problems they cause to individuals on a personal basis, these diseases have a significant economic impact, costing EU economies an estimated €192 billion per year. Moreover, demographic challenges such as the ageing population or the migrant crisis exacerbate the issue.

Yet, research shows that a large proportion of premature mortality is preventable. Risk factor modification seems to be key to prevention, and population-based strategies can enable healthy behaviours to become social norms. In this view, many actions can be encouraged both at Member State and Union level to tackle this ever-growing challenge.

AIM members have a broad mandate and responsibility as far as prevention is concerned. Members of AIM are not (only) insurers in the classical (and limited) sense. They do not limit themselves to the "actuarial approach", which would balance financial risks and uncertainty with revenues to maximise profits. AIM members have no aim of 'profit'. They have a broad responsibility to contribute to the long-term sustainability and affordability of healthcare systems and above all to the wellbeing of their affiliates. From that perspective AIM wants to contribute to the shaping and implementation of the prevention agenda and calls on others to do the same. Therefore, AIM:

Tobacco

- Encourages MS to implement the council recommendations from 2003
- Encourages MS to go further and introduce fully standardised packaging of tobacco products
- Calls for the end of EU subsidies to tobacco crops
- Calls on the Commission to ensure high taxation rates in its revision of the tobacco tax directive
- Calls on Member States to allocate the resources obtained from this taxation to campaigns or actions to reduce tobacco use

Alcohol

- Calls on the Commission to come forward with a comprehensive long-term strategy to tackle the impacts of alcohol on health
- Calls on the Commission and MS to increase alcohol excise rates
- Encourages MS to establish a Minimum Unit Price (MUP), as a measure to minimise the damage from alcohol consumption and help reduce health inequalities
- Calls on the Commission to enact stricter legislation regarding health information and warning labelling of alcohol products
- Calls on the Commission further to restrict alcohol advertising

Physical inactivity and unhealthy diet

- Encourages the Commission and Member States to restrict the advertisement of unhealthy products, especially to children and adolescents
- Calls for the establishment of maximum EU sugar or trans-fatty acid levels
- Encourages Member States to increase taxation rates for unhealthy products and to make healthy choices better available
- Calls for the development of labour and workplace policies which promote physical activity

Pollution

- Calls for the alignment of EU air quality standards with the health-based recommendations made by the World Health Organization
- Encourages the Commission to promote and incentivise clean air across all policies
- Calls for the setting of more ambitious and binding commitments for emissions reductions for the years 2020, 2025, 2030 (under the National Emissions Ceilings Directive)

Psychosocial risks

- Welcomes the framework issued by the Joint Action on mental health and well-being and calls for its practical implementation
- Encourages Member States to develop and implement national action plans on mental health and well-being
- Encourages the Commission to promote mental health in all policies, as the responsibility extends well beyond health authorities
- Calls for comprehensive and coordinated policies both at EU and national level to implement the active inclusion of people affected by mental illness

Low socio-economic status and low health literacy

- Encourages the Commission to tackle health inequalities as a policy priority both at Community level and in all Member States
- Calls on the Commission to mobilise all relevant policies to contribute to reducing health inequalities

AIM also:

- Calls for a greater allocation of public spending on health promotion and disease prevention
- Calls for health determinants to be addressed across all relevant policies and for more formal commitment to develop concrete strategies on health promotion and disease prevention
- Calls on the Commission to strengthen scientific and empirical bases for policies by facilitating collaboration between Member States
- Calls on the Commission to prioritise the facilitation of evidence-based decision-making regarding the introduction of new or underutilised vaccines
- Encourages the Commission to further develop ICT solutions and projects not only for the treatment but also for the prevention of diseases and the promotion of healthy lifestyles
- Calls for the Commission to handle international agreements such as TTIP and CETA in a way which safeguards EU high standards and so as to make no obstacle to Member State actions in the field of health promotion and disease prevention.

Introduction

Non-communicable diseases, a growing threat to public health

In the European Region, the largest proportion of mortality is created by non-communicable diseases (NCDs); the burden of chronic and disabling diseases and conditions poses a serious challenge to health systems. Two disease groups, cardiovascular diseases and cancer, cause almost three quarters of mortality, and three main disease groups, cardiovascular diseases, cancer and mental disorders, cause more than half the burden of disease.[1] They represent a growing threat and an underestimated cause of poverty which hampers economic development in many nations. [2]

Apart from the problems they cause to individuals on a personal basis, these diseases have a significant economic impact. Cardiovascular ailments cost EU economies an estimated €192 billion per year. To the growing costs for health care systems must also be added broader effects. "Employers carry a burden of absenteeism, decreased productivity and employee turnover, while individuals and their families face reduced income, early retirement, increased reliance on welfare support and a burden of health care costs (direct and indirect)." [3]

On the other hand, new emerging demographic challenges exacerbate the issue. The ageing population, with an expected increase of 50% in the share of people above 80 years old within the EU during the next two decades, raises not only the issue of sustainability of our health systems as a whole, but also of higher prevalence of chronic conditions, including mental ill-health. Migration into and within the European Region is also increasing. Migrants usually have a lower income, greater health needs and are more exposed to NCD risk factors.[4] In addition, they have less access to social protection and health care. Social inequity within and between Member States is increasing, with the consequent and proven negative effects on the health and well-being of vulnerable groups. [5]

As dramatic as this scenario may seem, the situation is not yet out of hand. Indeed, estimates indicate that much premature mortality is avoidable. Research shows that "at least 80% of all heart disease, stroke and type 2 diabetes and at least one third of cancer cases are preventable". [6] Common risk factors like tobacco use, high blood pressure and cholesterol are globally the root of more than three-quarters of cardio-vascular diseases and are not infrequently the cause of chronic disease deaths. Some of the disease burden associated with diseases such as cardiovascular conditions, cancers, mental disorders, chronic respiratory conditions and diabetes can be avoided through health promotion and disease prevention. [7]

Risk factor modification is thus the key to prevention. It has already been proven to reduce clinical events and premature death in people with established cardiovascular diseases, but also to promote sustainable development and reduce inequities in society. On the other hand, population-based strategies enable making healthy behaviour a social norm, thus lowering risk in the entire population.[8] Although it is true that governments retain the power to decide on the allocation of health resources, it is nevertheless a whole-of-society responsibility to improve health promotion and disease prevention strategies for the benefit of all citizens.

1 WHO, The New European Policy for Health, Copenhagen: 2012.
2 WHO, Geneva, 2005.
3 European Observatory on Health Systems and Policies Series, New York: 2015.
4 Read AIM Declaration on access to medically necessary healthcare services for refugees
5 WHO, The New European Policy for Health, Copenhagen: 2012, p. 65.
6 WHO, The New European Policy for Health, Copenhagen: 2012, p. 70.
7 European Observatory on Health Systems and Policies Series, New York:2015
8 WHO, Geneva, 2007.

The role of mutuals and health insurance funds in fostering health promotion and disease prevention

Mutuals and health insurance funds have a clear role to play when it comes to the promotion of healthy lifestyles and the prevention of diseases. More specifically, mutual and health insurance funds can be seen as:

Health educators
Mutuals and health insurance funds are trusted by their affiliates and the prevention messages and actions they disseminate are considered trustworthy and are taken seriously.

Front-line collaborators with healthcare providers
Mutuals and health insurance funds support general practitioners in order to facilitate and encourage health promotion and disease prevention. On the other hand, prevention has more chances of being effective when it involves actors from a wide variety of sectors (social services, advisors, carers, etc.). They can thus benefit from their large network.

An epidemiological source
Through their systems, mutuals and health insurance funds have access to an large amount of data and information which can be used to develop and evaluate health promotion and disease prevention.

Promoters of research in health promotion
Mutuals and health insurance funds have the capacity to carry-out useful research in the field of health promotion, by attracting collaboration from all types of stakeholders (providers, etc.) and professionals in the field of epidemiology and evaluation.

Coaches
Mutuals and health insurance funds also play a role in tertiary prevention by improving the quality of life of patients and their adherence to treatments. They can also play a vital role in raising awareness among affiliates of their responsibility regarding their health.

Important actors in the political dialogue
Mutuals and health insurance funds actively take part in the policy dialogue concerning healthcare as a whole and healthcare budget allocation more particularly. They are conscious of the weight of influence they can represent and always work for the cause of citizens' health.

AIM members are conscious of the important role they play in the field of health promotion and disease prevention and, as will be described further on in this paper, they develop campaigns and activities in the area. AIM hopes that decision-makers will, for their part, apply the necessary resources and attention to the issue.

Preventing diseases by tackling risk factors

In the following chapters, the health and economic burdens represented by some preventable risk factors will be scrutinised and strategies to mitigate each one of them will be identified. Some of the conditions highlighted are not 'risk factors' in the traditional sense but nevertheless entail a higher exposure to ill-health. For each section, concrete examples of AIM members' activities will be given ("AIM members take action" section) and recommendations to European Institutions will be made. As background information, a non-exhaustive list of European 'actions' in each field will be provided.

Smoking and Tobacco Use

Tobacco use is responsible for the death of approximately six million people across the world each year – including 600 000 persons who are estimated to die from the effects of second-hand smoke. The WHO European Region has one of the highest proportions of deaths attributable to tobacco, with 16% deaths attributable to its use. Tobacco is the only legal drug that kills its consumers when used as intended by producers. But not only is it lethal to users, it also has a large impact on the people exposed to it unbeknown to themselves.

In terms of prevention, many actions can be adopted to hold back the advance of this scourge, most of which are included in the so-called WHO MPOWER package introduced in 2008: measures to protect people from tobacco smoke; offer support to stop smoking; raise awareness about the dangers of first-hand and second hand smoke and use; enforce the bans on tobacco advertising, promotion and sponsorship, and promote plain packaging. [1] These measures have already proved to be effective and need to be further implemented. Furthermore, increasing taxes on tobacco might also lead to successful results when combined with other measures including those mentioned above. These increases will be all the more effective if the resources gathered are then spent on campaigns or actions to reduce tobacco use.

1 World Health Organisation, WHO global report on trends in prevalence of tobacco smoking 2015, Geneva: 2015

AIM members take action:

eCoaching to stop smoking

"Krankenkassen" from the German umbrella organization Vdek, offer a coaching application to stop smoking. The eCoach supports people through the phase of withdrawal, strengthens their willpower and shows alternatives to cigarettes. It analyses smoking types, dependence levels and life circumstances and develops highly individualised recommendations, creating an individual plan with daily tips and information for giving up smoking.

Social support and special attention to the development of a healthy lifestyle are also parts of the strategy. For assistance and guidance, ex-smokers-to-be always have the possibility of contacting experts by email. The coach-application also includes a «savings-o-meter» which keeps count of the money saved.

Background: Actions at EU level

In April 2014, the Tobacco Products Directive (TPD), the transposition of which must be done by the end of May 2016 in each Member States, entered into force. The Directive notably prohibits cigarettes and roll-your-own tobacco with characterising flavours; requires that health warnings appear on packages of tobacco and related products; and bans all promotional and misleading elements on tobacco products.

The Audiovisual Media Services Directive (2007/65/EC) bans the advertising and sponsorship of tobacco products in all forms of audiovisual commercial communications, including product placement. The Council Recommendation (2003/54/EC) on the Prevention of Smoking and on Initiatives to improve tobacco control, additionally, recommends that Member States prohibit other forms of tobacco promotion, such as promotional items, posters or cinema advertisements.

The Council Recommendation on smoke-free environments adopted in 2009 called on European Member States to adopt and implement laws fully to protect citizens from second-hand smoke exposure in public places; to enhance smoke-free laws; and to strengthen EU collaboration. 17 EU countries currently have comprehensive smoke-free laws in place, some of which (like the UK and Greece) include a complete ban on smoking in enclosed public places, on public transport and in workplaces.

Finally, Directive 2011/64/EU on excise duty on tobacco amends the structure and rates of duty with public health goals in mind. This Directive is to be revised in 2016.

Recommendations: AIM...

- Encourages Member States to implement the council recommendations from 2003
- Encourages Member States to go further and introduce fully standardised packaging of tobacco products
- Calls for the end of EU subsidies to tobacco crops
- Calls on the Commission and Member States to ensure high taxation rates in the revision of the tobacco tax Directive
- Calls on Member States to allocate the resources obtained from this taxation to campaigns or actions to reduce tobacco use

Harmful use of Alcohol

Background: Actions at EU level

The EU alcohol strategy adopted in 2006 is intended to help national governments and other stakeholders coordinate their action to reduce alcohol related harm in the EU. It established on the one hand the Committee on National Alcohol Policy and Action (CNAPA) which gathers representatives from national government and aims to enhance the sharing of information, knowledge and good practice on reducing harmful alcohol consumption; and on the other hand the European Alcohol and Health Forum (EAHF), a platform where bodies active at European level can debate, compare approaches and act to tackle harmful levels of alcohol consumption.

The European Union Information System on Alcohol and Health (EUSAH) monitors trends and developments in alcohol consumption and alcohol-related harm in EU.

The Joint Action on Reducing Alcohol Related Harm (JA RARHA) is a 3-year action (2014-2016) aiming to support EU Member States in addressing and reducing the harm associated with alcohol. The Joint Action focuses on the priorities established by the 2006 strategy: to strengthen the evidence base and raise awareness of alcohol related harm and consumption patterns.

The Audiovisual Media Services Directive (2007/65/EC) prohibits audiovisual commercial communication about alcoholic beverages aimed specifically at minors. It also forbids the encouragement of immoderate consumption of such beverages. The Council Recommendation 2001/458/EC encourages Member States to work together with retailers and producers of alcoholic products towards an agreement on alcoholic promotion, marketing and retailing.

As far as taxation is concerned, the EU legislation on excise duties for alcohol and alcoholic beverages was introduced in 1992. Directive 92/83/EEC sets out the minimum rates that must apply to each category of alcoholic beverage.

In April 2015, members of the European Parliament passed a resolution calling on the European Commission to come forward with a comprehensive new long term strategy to tackle the impacts of alcohol on health.

Harmful use of alcohol is identified as one of the main factors contributing to premature death and disability and to more than 60 diseases and conditions.[1] About 5.9% of all global deaths and 5.1% of the global burden of disease and injury were attributable to alcohol consumption in 2012.[2] The European Union itself is the region with the highest alcohol consumption in the world, with 11,9% premature alcohol-related deaths.[3]

Given the scope and nature of alcohol-attributable disease and the alcohol-related social harm ensuing, increased leadership and involvement should be shown at Member State and European level. Restricting access to alcohol by making alcoholic drinks less affordable through tax increases and the establishment of minimum unit pricing; increasing the access to affordable and effective preventative care services for people affected and their relatives; and supporting initiatives for screening and brief interventions for hazardous and harmful drinking in primary health care and other settings are only a few of the measures which should be promoted in order to tackle the issue.[4]

AIM members take action:

Physicians to support Alcohol-drinking cessation

Mutuals provide information on the consequences of alcohol consumption, to their affiliates via conferences, brochures, or through their webpages. For example, some members of the German umbrella organization 'vdek' have taken a step further by involving doctors, enabling affiliates to get detailed advice and support from participating physicians to reduce their drinking risk. Doctors guide them through their personal project and remain available for constant assistance. Follow-up is individualised, the individual's health status taken into account, and tips and up-dated information provided.

1 WHO, NMH Fact Sheet: Harmful Use of Alcohol, June 2009.
2 WHO, Global Status Report on Alcohol and Health 2014, Geneva: 2014.
3 WHO, Alcohol in the EU, Copenhagen, 2012
4 European Observatory on Health Systems and Policies Series, New York: 2015.

Recommendations: AIM...

- Calls on the Commission to come forward with a comprehensive long-term strategy to tackle the impacts of alcohol on health
- Calls on the Commission and Member States to increase alcohol excise rates
- Encourages Member States to establish a Minimum Unit Price (MUP), as a measure to minimise the damage from alcohol consumption and help reduce health inequalities
- Calls on the Commission to enact stricter legislation regarding health information and warning labelling of alcohol products
- Calls on the Commission to further restrict alcohol advertising

Physical Inactivity…

Insufficient physical activity is one of the ten leading risk factors for death worldwide and is a key risk factor for NCDs such as cardiovascular diseases, cancer and diabetes. By contrast, regular physical activity is highly beneficial to health as it reduces the risks of most chronic NCDs and contributes to mental health and overall well-being.[1] With more than 80% of the world's adolescent population insufficiently physically active, the promotion of physical activity – e.g. through labour and workplace policies - should be a priority. Mass media campaigns and more targeted interventions (e.g. in the workplace) have already proved to be cost-effective and relatively inexpensive. As the WHO recommends, national policies and plans on physical activity should involve multiple strategies aimed at supporting the individual and creating supportive environments for physical activity to take place.[2]

A healthy lifestyle does not depend solely on people's individual choices. A person's whole physical and social environment affects their healthy or unhealthy choices. The current world encourages little exercise, overeating and sedentary behaviour. An environment that makes it easy and natural to make healthy choices must be aimed for. Healthy habits are adopted more quickly if such an environment encourages healthy eating, sport and exercise. The layout of neighbourhoods and districts can have a major impact on nutritional and exercise habits with positive effects not only on health but also on the quality of life and on social cohesion.

1 WHO, The New European Policy for Health, Copenhagen: 2012.

2 WHO, Geneva : 2010.

… and unhealthy diet

Overeating and overconsumption are important determinants of ill-health. They lead to unfavourable metabolic changes, such as increased blood pressure, raised cholesterol levels and insulin-related disorders, leading to higher risks of coronary heart disease and many forms of cancer. On the other hand, malnutrition and undernourishment also have a significantly negative impact on people's health and well-being.

Government action, in partnership with multiple stakeholders, to lower blood pressure and cholesterol by reducing salt content, saturated fats and trans-fat contents of processed foods on a population-wide basis would achieve substantial health benefits. The European Commission should encourage the food industry to produce healthier and more balanced food products, and a critical look at the marketing and advertising of food products is of great importance. Developing policies aiming at making healthy food and vegetables available for example in schools and workplaces; establishing food labelling schemes; educating and raising public awareness; and drawing up national food and agricultural policies consistent with the protection and promotion of public health are other measures which should be implemented.

AIM members take action:

FNMF changes French habits

Sports workshops, meetings with dieticians, fun parkours on eating habits... From 1 to 30 April 2015, the operation «In April, eating, moving, is easy», organised by the French federation of mutuals 'FNMF', organised 137 local actions to raise public awareness of the importance of diet and physical activity to health. In total, nearly 5,000 people were informed on various topics and 3,000 exchanged messages about nutrition with a prevention professional, through surveys and quizzes.

Free and open to all, these events took place throughout France, in primary care structures, dental centres and mutual medical centres, multidisciplinary health centres, as well as mutual pharmacies and municipal health centres.

The participants, of whom 90% were mutual members, were satisfied with the information received: 36% of them were willing to change their eating behaviour and 41% to increase their physical activity.

SVB's children summer camps

SVB, the Austrian social insurance focussing on the agricultural sector, offers children and adolescents attendance at "health" camps during the summer holidays to improve their health status. With a 19 day-stay and a three-day follow-up, obese children and adolescents have the opportunity to learn and practice proper eating habits.

Swimming, ball games, cycling and Nordic walking are included in the programme. The children are supervised by doctors, nutritionists, dieticians and psychologists. Parents are involved during the information and exchange days and their presence is required during the follow-up.

Benenden's online tools

Benenden, AIM's British member, has been active in communicating very clearly the impacts of an unhealthy diet to its members. Because people need very visual examples of how sugar and unhealthy foodstuffs can affect their health, Benenden developed two online tools accessible to the whole population in the UK. The 'sugar bowl' is a tool highlighting which parts of the human body are affected by sugar consumption. The other tool, the 'UK basket of goods' monitors the quantity of sugar in the average UK basket of goods – for 2016 it identifies an increase of 28.7g of sugar compared to 2015. At a policy level in 2016, Benenden also sponsored a report promoting healthy eating by the specialised think-tank the Food Foundation.

Background: Actions at EU level

The Commission's Strategy on Nutrition, Overweight, and Obesity-related Health Issues established in May 2007 addresses the issues of overweight and obesity through the adoption of a white paper which highlights actions to be taken at local, regional, national and European level to reduce the risks related to poor nutrition and limited physical exercise.

Regulation (EU) No 1169/2011 on the provision of food information to consumers entered into application on 13 December 2014, with the obligation to provide nutrition information to be applied from 13 December 2016. It requires for example certain nutrition information for a majority of prepacked processed foods, the mandatory notification of origin information for fresh meat from pigs, sheep, goats and poultry, and the same labelling requirements for online, distance-selling or buying in a shop.

Regulation (EC) No 1924/2006 establishes Union rules on nutrition and health claims, with the aim of ensuring that any claim made on a food's labelling, presentation or advertising in the European Union is clear, accurate and based on scientific evidence. It prohibits food bearing claims that could mislead consumers. In October 2015, the Commission published a roadmap on the evaluation of the EU Nutrition and Health Claims legislation.

On 3 December 2015, the Commission adopted a Report to the European Parliament and the Council regarding trans fats (TFA) in foods and in the overall diet of the Union population which highlights possible actions to be carried out at EU level in order to reduce TFA consumption in the EU such as "the introduction of a EU mandatory TFA content declaration, a EU legal limit on the TFA content of food, voluntary agreements towards reducing TFA in foods and diets at EU level, or EU guidance for national legal limits on the TFA content of food."

The 2013 Council Recommendation on promoting Health-Enhancing Physical Activity across sectors encouraged Member States and the Commission to work towards effective health-enhancing physical activity policies by developing a cross-sectoral approach involving policy areas including sport, health, education, environment and transport. Following these recommendations, the EU Work Plan for Sport (2014-2017) promotes a cooperative and concerted approach among Member States and the Commission, aiming to deliver added value in the field of sport at EU level over the longer term.

The EU Action Plan on Childhood Obesity (2014-2020) aims at demonstrating the shared commitment of EU Member States, addressing childhood obesity; setting out priority areas for action and a possible 'toolbox' of measures for consideration and proposing ways of collectively keeping track of progress.

The Council Conclusions on Nutrition and Physical Activity encourage Member States to "continue keeping healthy diet and regular physical activity a top priority for the coming years in order to reduce the burden of chronic diseases and conditions, thus contributing to better health and quality of life of EU citizens and the sustainability of the health systems"; and welcomes the promotion of policies and initiatives to that end.

Recommendations: AIM...

- Encourages the Commission and Member States to restrict the advertisement of unhealthy products, especially to children and adolescents.
- Calls for the establishment of maximum EU sugar or TFA levels
- Encourages the Commission to increase taxation rates for unhealthy products and to make healthy choices better available
- Calls for the development of labour and workplace policies which promote physical activity

Pollution

Air pollution has a negative impact on the lives of hundreds of millions of people and creates a heavy disease burden as well as economic costs. According to WHO figures, in 2012 outdoor urban pollution (outside) caused 3.7 million deaths a year, that is 6.7% the total number of deaths. Almost 600 000 deaths are due to air pollution in Europe and the health-related costs to society from exposure to air pollution in the European Union were estimated in 2013 to be in the range of €330-940 billion per year. Tackling environmental chemical hazards and improving air quality can reduce healthcare and other costs associated with respiratory illnesses and improve citizens' health condition.

As evidence increases, so does the list of diseases linked to exposure to air pollution, including lung cancer and diabetes. Therefore, more ambitious and binding commitments for emissions reductions for the years 2020, 2025, 2030 (under the National Emissions Ceilings Directive) should be set, and EU air quality standards should be aligned with the health-based recommendations made by the World Health Organization.

AIM members take action:

A Belgian Intermutualist Working Group

Mutuals also have the mission to inform their members about health and notably about environmental health. They also have broad databases which allow them to make studies on various issues. Their "lobby" role towards institutions and authorities is crucial.

In 2010, an intermutualist working group on environmental issues was founded at Belgian level. A year later, the group published a common brochure on indoor pollution and how to avoid it in the three national languages. The emphasis was on the sources of pollution in houses and the aim was to show the (partial) improvement that people can make on some of these.

In 2012, a project was initiated to perform bio-monitoring in the Flemish population. The study aims to examine the presence of various environmental blood contaminants, by detecting morbidity through reimbursement data collected about drugs, healthcare, etc. The project is a good examples of how mutuals can play a relevant role in the field of environment and health by researching the links between environmental factors and health conditions.

Background: Actions at EU level

The 2004-2010 Environmental and Health Action Plan is the first cycle in the Environment and Health Strategy. It focusses on the causal links between environmental risk factors and priority diseases: respiratory diseases, neuro-developmental disorders, cancer and endocrine-disrupting effects; and aims at improving the information chain, understanding the links between sources of pollution and health effects; filling the knowledge gap by strengthening research, and addressing the emerging issues on environment and health.

The Commission also works in partnership with the WHO by supporting its work on indoor air quality, injury prevention and physical activity the implementation of the WHO Europe – children's environment and health action plan (CEHAPE).

Recommendations: AIM...

- Calls for the alignment of EU air quality standards with the health-based recommendations made by the World Health Organization
- Encourages the Commission to promote and incentivise clean air across all policies
- Calls for the setting of more ambitious and binding commitments for emissions reductions for the years 2020, 2025, 2030 (under the National Emissions Ceilings Directive)

Psychosocial risks

According to EUROSTAT, 28% of European workers reported exposure to psychosocial risks, work-related stress being the second most frequently reported work-related health problem in Europe, with 50 to 60% of all lost working days attributable to work-related stress. Mental illnesses are among Europe's most burdensome yet least addressed groups of diseases. According to estimations by the World Health Organisation (WHO), they affect every fourth citizen at least once during their life and concern more than 10% of the European Union population. WHO's 2012 estimates show that 12% of the reduction in 'disability-adjusted life years' is a direct result of mental problems, a figure which represents over half the impact of cancer or heart disease and more than four times that of diabetes. Moreover, stress worsens or increases the risk of conditions like obesity, heart disease, diabetes, or depression. It can push people into adopting unhealthy habits like smoking and eating badly, which in turn are risk factors for cardiovascular diseases.[1]

1 For more information, please read our Position on mental health promotion and well-being

AIM members take action:

"Transferring a business – a matter of health"

The German Social Insurance for Agriculture, Forestry and Horticulture (SVLFG) developed a seminar regarding the impact of agricultural business-transfer on health. Scientifically supported and positively evaluated by the Institute of Quality Assurance in Prevention and Rehabilitation (IQPR), the pilot seminar's positive results turned the programme into a standard offer.
Participants in the seminar were subsequently interviewed by scientists from the IQPR, and the German Sport University's institute conducted an accompanying study on behalf of the Bavarian Health Ministry. Almost all interviewees believe that the issues addressed were of "great significance". The comparison of ideas from potential business-transferors and business-successors and the discussion of their mutual expectations were regarded as very fruitful. The positive response was understood as a call for further action in this direction, by providing more needs-based programmes in order to support the succession-management processes having an effect on health.
The seminar is part of the SVLFG health programmes which promote good health by providing customised health offers to insured people alongside standard benefits. The health programmes also include for example: "a week for recovery and training for the nursing of relatives" and a seminar on "sensitive dialogue facilitation to traumatised persons".

MSA National strategy to combat suicide in the Agricultural sector 2011-2014

With over 10,000 deaths per year in the overall French population, suicide is the primary cause of death in the 35-44 age group. The rate for farmers is the highest of the socio/professional categories – 32/100,000 compared with 28/100,000 for blue collar workers (workers) and 8/1000 for white collar workers (managerial or professional occupations). The launch of this national suicide prevention plan was prompted by the abnormal death rates in the overall population due to

suicide, with higher rates at work and even higher again in the agricultural sector. Suicide prevention was declared a "National cause" in France at the beginning of 2011. A national suicide monitoring group was created, which pilots a multi-agency initiative made up of experts in the field, institutions and associations. The MSA National Suicide Prevention strategy started in October 2011. CCMSA, the French mutual for farmers and employers in the agricultural sector, was given the task of implementing the strategy. This plan aimed at promoting a better understanding of the reality of suicide in the agricultural sector, introducing a telephone support line for farmers in distress and setting up suicide prevention groups in each MSA branch to identify farmers in difficulty.

Background: Actions at EU level

The European Strategy on Safety and Health at Work (2014-2020) aims at improving the implementation of existing health and safety rules, in particular by enhancing the capacity of micro and small enterprises to put in place effective and efficient risk prevention strategies; improving the prevention of work-related diseases by tackling new and emerging risks without neglecting existing risks; and taking into account of the ageing of the EU's workforce. EU-OSHA, the European Union information agency for occupational safety and health, contributes to this Strategy.

In 2005, the Commission published a Green Paper on Improving the Mental Health of the Population, which acknowledges the need for a European action on mental health. It proposes a strategy which focusses on the promotion of mental health, preventive actions, social inclusion, and the protection of the rights of people with mental disorders, as well as on developing a European mental health information system.

In 2008, the European Pact for Mental Health and Well-Being was launched, encouraging the promotion and implementation of mental illness and mental health promotion interventions, by addressing Member States' governments, regional and local authorities, non-governmental actors and civil society organisations, whose decisions might have an impact on mental health policies.

In 2016, the Joint Action on Mental Health and Well-being was launched, which issued a European Framework for action on mental health and well-being, which identifies areas for further actions and which is to be implemented by Member States.

The Joint Action is followed by the European Compass for Action on Mental Health and Well-Being, a mechanism to collect, exchange and analyse information on policy and stakeholder activities in mental health. It focusses on seven priority areas: better access to mental health services; providing community-based mental health services; preventing suicide; mental health at work; mental health in schools; and developing integrated governance approaches.

Recommendations: AIM...

- Welcomes the framework issued by the Joint Action and calls for its practical implementation
- Encourages Member States to develop and implement national action plans on mental health and well-being
- Encourages the Commission to promote mental health in all policies, as the responsibility extends well beyond health authorities
- Calls for Comprehensive and coordinated policies both at EU and national level to implement the active inclusion of people affected by mental illness

Low socio-economic status and low health literacy

The greatest burden of health risks is often borne by the most disadvantaged people in society, that is, those with little education, fewer resources, and low-status occupations. As a consequence, when tackling behavioural risk factors, a debate arises over individual responsibility versus public-sector intervention. This debate only makes sense when individuals have equitable access to a healthy life, and are supported in making healthy choices. [1]People may develop an addictive behaviour, either because they choose to enjoy their life today or because they dismiss future risks, but they can also lack the information or the resources necessary to make rational and efficient choices. As stated by the WHO, "The world is living dangerously – either because it has little choice, which is often the case among the poor, or because it is making the wrong choices in terms of consumption and its activities."[2] The exposure to health-damaging conditions, vulnerability and lack of resilience is influenced by societal processes and is unequally distributed in society according to socioeconomic position and/or other markers of social position.

Health literacy is thus another critical factor in enabling healthy choices. Evidence shows that people with a higher educational status have healthier eating habits and are less inclined to develop addictive behaviours.

The social and economic environment of individuals is thus key to identifying the causes of lifestyle differences and as such, these are also to be addressed. Empowering people to take control of their lives and health by providing them with the tools to self-manage their condition is of vital importance and leads to benefits at biological, mental and societal level.

Other actions advisable to undertake include the design of policies which take into account the contextual determinants of health; the elimination of inequalities in the field of health; and the increase of public funding for health which would enable achievement of reasonable levels of financial protection (as developed further on in this paper).[3]

1 WHO, Geneva, 2005.

2 WHO, Sadag: 2002.

3 WHO, The New European Policy for Health, Copenhagen: 2012.

AIM members take action:

Estonian campaign:
"Sensible Drug Use"

In Estonia, pharmaceuticals are often said to be too expensive. What is usually meant is that the share of the cost covered by the patient is excessive. Generally, the approach to the problem is too simplistic, merely suggesting that the proportion paid by the Health Insurance Fund should be increased. Technically this would be the simplest and fastest solution, but in reality it would mean a reversal of the reforms in the pharmaceuticals' sector, whether by reducing the reference prices or increasing the reimbursement level. Either way, the additional funds would have to come from the Government's taxpayer-funded health insurance budget.

In 2009 the Pharmaceutical Department of the Estonian Health Insurance Fund proved that a more reasonable use of pharmaceuticals would allow the patients' out-of-pocket expenses to be considerably smaller. In subsequent years the Health Insurance Fund and the Ministry of Social Affairs launched several activities aimed at promoting more reasonable use of pharmaceuticals.

Given that it is the patient who eventually makes the choice in the pharmacy, the Health Insurance Fund has since 2010 been organizing campaigns aimed at increasing the self-confidence and awareness of the users. These measures have produced good results. Out-of-pocket expenses

have dropped from a peak in 2009. To improve people's awareness, in the first and second half year a campaign of "Sensible drug use" reached the population, with a renewed message and visuals aiming to raise awareness about the choice of prescription drugs and to enhance the number of people using the service of 'prescription view' of the State portal 'eesti.ee'. This assisted people to make reasonable choices to reduce their expenses on purchases of prescription drugs, thus improving patient compliance by enabling them to afford full dosages. The visibility of the campaign among the population was 85%, and as a result of the campaign, the number of viewers of prescriptions on the State portal increased.

Empowering patients through individualised communication

The Belgian «National Union of Socialist Mutual Benefit Societies» (NUSMBS) communicates directly with its affiliates on diseases like back pain, diabetes or COPD via weekly electronic newsletters providing practical and scientifically sound information and answering patients' questions. The knowledge of techniques and resources resulting from this exchange contributes to a considerable reduction of the burden of disease and helps patients to cope better with stress and anxiety.
On top of that, the NUSMBS also sends personal letters to people with diabetes or shortness of breath, informing them about the good monitoring of their condition; promoting healthy lifestyles; and emphasising the importance of proper medical follow-up. Studies reveal the positive impact of these campaigns, with people becoming more conscious and aware of their conditions and the care they require; taking concrete actions like deciding to visit healthcare professionals; and developing healthy eating habits.

Background: Actions at EU level

In 2009, the Commission published its Communication - Solidarity in Health: Reducing Health Inequalities in the EU, which sets out actions to be taken by the European Commission to help address health inequalities. These include for example the assessment of the impact of EU policies on health inequalities to ensure that they help reduce them where possible and regular statistics and reporting on the size of inequalities in the EU and on successful strategies to reduce them.

The EU third Health Programme (2014-2020) puts forward, as key objectives, complementing, supporting and adding value to the policies of Member States for the reduction of health inequalities. It is aligned with the EU Sustainable Development Strategy, which also sets as an objective "reducing health inequalities within and between Member States by addressing the wider determinants of health, and appropriate health promotion and disease prevention strategies".

Projects like the HEPP (Maintaining a focus on health inequalities) have been developed for this purpose. The pilot project to be finalised in 2018 will contribute to maintaining an EU and Member State focus on health inequalities and will help to 'mainstream' measures to address them, with a particular focus on alcohol, nutrition and physical activity, related to the socio-economic gradient and disadvantaged areas.

Recommendations: AIM...

- Encourages the Commission to tackle health inequalities as a policy priority both at Community level and in all Member States
- Calls on the Commission to mobilise all relevant policies to contribute to reducing health inequalities

Other general actions to be encouraged

Public spending on health and on health promotion and disease prevention in particular is dramatically low. According to WHO figures, spending on health is at or below 10% of total government spending in one third of the countries in the European Region, when it is estimated that ensuring sufficient financial protection is difficult below 12%. Low levels of health spending hinder the availability of key medicines and the often necessary reorganisation of structures in order to achieve a more people-centred system, **leaving prevention with very few resources available**. An increase in budget allocation to health and disease prevention would bring not only well-being gains for societies but also economic growth, notably by creating a healthier workforce and decreasing the prevalence of NCDs.

Many of the determinants of NCDs cross borders – e.g. food products or tobacco – and so do some of their potential solutions. Therefore, **international and intersectoral collaboration** are key and should be strengthened in order to reduce major extraneous risks to health, improve risk management and increase public understanding of those risks. Promoting health and equity in all policies and actions across sectors, by ensuring that every sector is committed to act for better health and is aware of its responsibilities, will undoubtedly produce benefits for health and health equity. This requires not only a close collaboration between ministries but also the engagement of stakeholders outside the government -such as professional associations, NGOs or international bodies - and between government, community and individual levels. Lack of commitment by Governments has held back the development of public health and of more concrete strategies on health promotion and disease prevention in particular. A more systematic and integrated approach is thus needed to ensure 'whole-of-government' working and to achieve health in all policies.[1]

Scientific and empirical bases for policies also need to be strengthened. Risk prevention policies should be based on sound scientific research and improved surveillance systems should be put in place. For those policies to be efficiently implemented, data which would allow international comparison should be available. Cost-effectiveness analysis should also be used to identify "high, medium and low rated" priority interventions. This should also enable a focus on actions which are both cost-effective, affordable and which lead to the greatest possible improvements in public health for the resources available. "Evidence is a key input to the final decision about the best combination of interventions."[2]

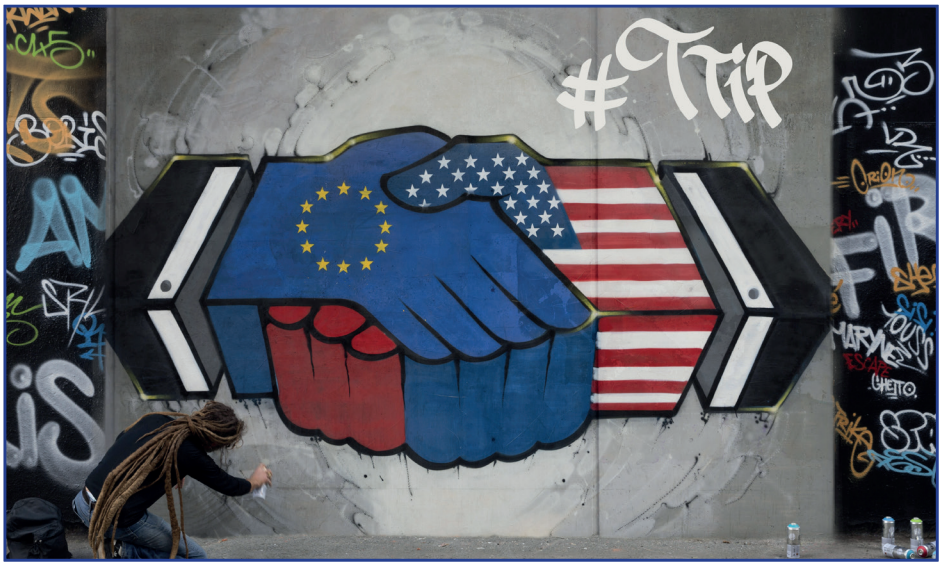
In terms of prevention, **screening and early detection** can be crucial in increasing the efficiency of certain treatments. In 2012, The WHO claimed for example that about one third of cancer cases can be cured if they are detected and effective treatment is started early enough.[3] However, caution is necessary and screening programmes can be economic only when their effectiveness has been demonstrated –e.g. for bowel and cervical cancer, when the available resources enable the coverage of nearly all the target group, and when the disease is prevalent enough to justify the effort and costs of screening -just as suggested by the WHO.[4]

Vaccines have been the most cost-effective preventative intervention and have enabled a dramatic decrease in mortality among children, especially in the second half of the 20th century. Nevertheless, adding new vaccines to routine infant immunisation schedules requires careful consideration: priorities must be carefully set, funding plans need to be developed in order to ensure sustainability, and close monitoring and evaluation should be carried out. The difference between countries' capacities and resources must be taken into account when making decisions and implementing the introduction of new or underutilised vaccines, as the most vulnerable populations might otherwise see their access to preventive interventions delayed or even denied. Therefore, "facilitating the evidence-based decision-making regarding the introduction of new or underutilised vaccines" should be a priority. [5]

'eHealth' has a clear potential for strengthening health promotion and disease prevention without further threatening the sustainability of the EU healthcare systems. It can deliver substantial benefits to patients while at the same time increasing the quality of care, which becomes more patient-centred and individualised. 'eHealth' and 'mHealth'[6] make prevention

1 WHO, The New European Policy for Health, Copenhagen : 2012.
2 WHO, Sadag : 2002.
3 WHO, The New European Policy for Health, Copenhagen : 2012.
4 http://www.who.int/cancer/detection/en/
5 WHO, Copenhagen : 2012, pp. 79-80.
6 Mobile health (mHealth) covers "medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants, and other wireless devices". See Commission's Green Paper.

more accessible to the wider public, regardless of their socio-economic status, for example enabling the improvement of care by 'empowering' people suffering from chronic diseases. Moreover, these initiatives can undoubtedly compensate for low health literacy and promote healthy lifestyles.



Trade agreements have been negotiated at international level in order to remove barriers to trade in services and goods. The EU and the US in particular are promoting bilateral FTAs implementing existing international trade rules. The most recent negotiations are the trade agreements between the EU and Canada, known as CETA (Comprehensive Economic and Trade Agreement) and between the EU and the USA, called TTIP (Transatlantic Trade and Investment Partnership). If not handled carefully, these agreements could have a tremendously adverse impact on the health of European citizens and could, more precisely, hamper the efforts of Member States in health promotion and disease prevention. In the agro-food sector for example, the EU has very high hygienic standards for every production stage whereas the USA only applies disinfectants at the end of the chain. Similarly, TTIP could further expose EU citizens to unhealthy food products. CETA's current text would already allow a Canadian company to use 'Investor-State Dispute Settlement' (ISDS) procedures to sue Member States' governments and ask for compensation if they consider their profits to be affected by, for example, a reinforcement of anti-tobacco prevention. To give a final example, TTIP and CETA would both weaken the ambitions of EU 'climate policies'.
Therefore, it is vital to ensure the preservation of European standards in those negotiations and to safeguard the health of Europeans, more precisely through the deletion of the ISDS clause and of the subsequent «Investment Court System», and the introduction of social and environmental clauses which would guarantee the precautionary principle. Human rights must not subordinated in favour of trade.

Recommendations: AIM...

- Calls for a greater allocation of public spending to health promotion and disease prevention
- Calls for the promotion of health and equity in all policies and actions across sectors and for more political commitment to develop concrete strategies on health promotion and disease prevention
- Calls on the Commission to strengthen scientific and empirical bases for policies by facilitating collaboration between Member States
- Calls on the Commission to prioritise the facilitation of evidence-based decision-making regarding the introduction of new or underutilised vaccines
- Encourages the Commission to further develop 'ICT' solutions and projects not only for the treatment but also the prevention of diseases and the promotion of healthy lifestyles
- Calls for the Commission to handle international agreements in a way which ensures high EU standards and so as to make no obstacle to Member State actions in the field of health promotion and disease prevention

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