Championing cancer care in an age of austerity: an interview with the European Health Commissioner

Vytenis Andriukaitis talks to *Cancer World's* Anna Wagstaff about what Europe needs to do to safeguard and extend access to high-quality cancer care in challenging times.

How can European countries provide a rapidly rising number of patients and survivors with the treatment and care they need when governments are cutting health spending? They can't, says European Health Commissioner Vytenis Andriukaitis.

A surgeon by profession, and former Lithuanian Health Minister, he says he is unhappy that, in response to the financial crisis, some governments raided their health budgets as part of their efforts to cut public spending, and argues that such a policy is counterproductive.

"The message is clear: The healthcare system creates conditions for jobs and the economy to recover, and spending on health must be seen as an investment… Investment, investment, and once again investment is the way to fight against cancer," he told *Cancer World*.

It's an important message to get across, particularly as these healthcare cuts are often perceived as a response to pressure from Europe, which in the wake of the financial crash is taking a tougher line on policing the size of the budget deficits run by Member States.

Less widely known is that the Commission now also makes an annual review of how governments' economic plans align with the EU 2020 strategy for "a smart, sustainable and inclusive economy" – and since 2012, this review has included health spending. This means that the Commission can, and does, now make explicit recommendations in relation to national health systems, which gives added weight to the strong message from the Health Commissioner about increasing investment.

The Vilnius Declaration

Though Andriukaitis only joined the Commission in 2014, he nonetheless played a key role in discussions about what type of health services recommendations from the Commission should be aiming for.

In his capacity as Health Minister, he hosted a European conference in Vilnius during the 2013 Lithuanian EU presidency, which issued a call for European leaders to work with governments and civic society to "help ensure that European health systems are people-centred, sustainable and inclusive and deliver good health for all".

The Vilnius Declaration called for: increased investment in health promotion and disease prevention; universal access to high-quality, people-centred health services; and healthcare policies that are based on evidence and focus on cost-effectiveness, sustainability and good governance.

Having now become one of those European leaders to which the Vilnius Declaration was directed, Andriukaitis says that the Commission did respond to the call for action and took up many of the Vilnius recommendations in its 2014 'Communication on effective, accessible and resilient health systems'. For him personally, the declaration, he says, served as a source of inspiration when framing his own priorities as Health Commissioner – particularly his focus on "Prevention, promotion and protection."

Equal access

For people with cancer, however, particularly in countries with the poorest outcomes, it's the Vilnius call for "universal access to high-quality, people-centred health services" that is of real interest. What can Andriukaitis do for them?

"That part of the Declaration

Taking on the challenge. Andriukaitis answering questions from MEPs last September, during the parliamentary hearing to confirm his appointment as Commissioner for Health and Food Safety

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"The health system creates conditions for the economy to recover; spending on health is an investment"

"The high costs of personalised medicine pose a serious challenge to the principle of equal access"

was primarily addressed to Member States," says the Commissioner, "because access to healthcare falls mainly under their competence." There are, however, ways in which the Commission can help, he adds. "Inequalities between social groups both within and between Member States, lie behind a lot of the gaps in outcomes. From our side, the Commission is ready to be more active in cooperating with Member States in raising issues, especially relating to social determinants, advising them to pay more attention to disadvantaged groups, to evaluate needs and properly implement their national cancer programme."

There are funds available to help with this, he adds. "You can use European social and investment funds for activities that reduce health inequality between regions and social economic groups, including the development of healthcare infrastructure, health promotion, e-health solutions and better training for the health workforce."

He mentions also the proposal for European Reference Networks, which should improve access to expert care for people with more rare cancers.

Andriukaitis recognises, however, that the high costs of 'personalised medicine' pose a serious challenge to the principle of equal access, and stresses the need to find a way of dealing with this "without discrimination against patient access to healthcare or undermining the cost-effectiveness, resilience and sustainability of Member States' health systems".

The Commission, he says, is backing efforts to generate reliable, timely, transparent and transferable information that Member States can use to evaluate the cost-effectiveness of new therapies. It will shortly be introducing a permanent mechanism to oversee this work, which, since 2006, has been led by EUnetHTA on a project-by-project basis.

Affordability

Better health technology evaluation, however, cannot by itself resolve the problem that the prices of many new therapies are simply unaffordable for many European healthcare systems – what can the Commission do about that?

"Negotiating prices of medicines and their inclusion in health insurance systems is the responsibility of Member States," Andriukaitis responds, and "any action on this front will be done voluntarily and without prejudicing international competencies." He adds, however, that he is "keen to foster discussions and support cooperation between Member States in these areas, so as to make medicine more accessible to patients."

He mentions, in particular, moves by Belgium and The Netherlands to start exchanging information about the prices they pay for drugs. Luxembourg is now interested in joining the initiative, says Andriukaitis, and the government has indicated that it is keen to address the cost issue within the wider discussions it is promoting on personalised medicine during its EU presidency, which will continue until the end of 2015.

Andriukaitis mentions also discussions between Romania and Bulgaria about cooperating to address the cost of drug prices, and says he is optimistic about making progress. "When I started in debates with Member States in 2012 and 2013, there was a lot of resistance from many, many countries [about cooperating over negotiating drug prices]. But after 2013, I see the hesitation is rapidly changing, especially relating to new medicines, which are attractive but very costly… I would like to propose an open method of cooperation in this field, and to encourage Member States to be more active."

Reducing the burden

Important though all these measures are, Andriukaitis argues that the biggest contribution to improving access to high-quality care will have to come from effective action on prevention, which will free up resources by reducing the overall burden of ill health.

He suggests that it is in the preventive setting that the personalised approach to medicine could have the greatest impact, by improving targeting of actions. "Personalisation will change prevention programmes for obesity and cancer," he says, and mentions, in this respect, the work being done by

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the current Joint Action on Cancer Control, which includes looking at public health genomics and the use of genetic testing in population screening.

He also stresses the importance of including health considerations in every aspect of government policy: education departments should be investing in PE teachers, transport departments in improving bike lanes – while departments of industry should include the health costs of alcohol, tobacco and unhealthy foods when calculating the overall economic contribution from these industries.

"We are ready to discuss with Member States our ideas on a comprehensive approach to managing alcohol, tobacco, nutrition, overweight, obesity, and other risk factors within some framework of actions, and encourage Member States to cooperate on this between themselves and with the Commission," he says.

He is aware, he adds, of the concerns that have been expressed by some health NGOs, including the European Public Health Alliance and the Standing Committee of European Doctors, that the current Commission is prioritising the interests of economic growth over health – concerns that came to a head in June when the NGOs walked away from the EU Alcohol and Health Forum, calling it "a free PR front for the industry".

Steps have since been taken to improve the way the Forum functions, says Andriukaitis, and the Commission fully backs the work of the Committee on National Alcohol Policy and Action, and the Joint Action to Reduce Alcohol-related Harm. He mentions, too, the EU Health Policy Forum, which he is in the process of relaunching, and which will provide a valuable platform for

"Effective action on prevention will free up resources to improve access to high-quality care"

Yet, by the end of the eight weeks, desensitised had taken on an entirely different meaning for some students. These were the students who would begin handling their cadavers with the delicacy of a rag doll, who would make inappropriate jokes during the genitourinary section, and who ultimately would treat their 'first patient' like one would an object that had never been alive.

The language of medicine

Todd Olson, PhD, an anatomist at Albert Einstein College of Medicine, said that "anatomy is the foundation for the language of medicine: the language health-care professionals use for communicating about patients." Dr Olson was most likely referring to the basic anatomical vocabulary of medicine, the *terminologia anatomica* that one first learns in the anatomy lab and that subsequently forms the foundation of concise and accurate discourse between physicians about the health and disease of patients. Yet, in the wake of recent attention on how doctors speak of patients, generated by a conversation secretly recorded by a sedated patient undergoing a colonoscopy, one cannot help but wonder about the other possible meanings of the statement.

Is the language of medicine that is learned in anatomy lab limited to anatomical vocabulary, or does it extend to our less technical conversations about patients, and even the extent to which our words respect and humanise the people in our care?

This question is often left out of debates about the need for cadaver dissection in medical training, yet it represents some of the most important lessons and formative experiences of anatomy lab. In interactions with their 'first patient', some students discover a profound appreciation for humanity and a humbling reminder of the unique privileges and responsibilities we shoulder as physicians. Others merely learn mechanisms of coping during this encounter with death, how to suspend their emotional reaction and physical repugnance while distancing themselves from any sense of the human life that the cadaver once had.

Regardless of what we take with us from anatomy lab, apart from the smell of formaldehyde, the experience imparts much more on our language and training than the names of anatomical structures, and this contribution to our medical education deserves both caution and attention.

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Armaan Rowther is currently studying toward a combined MD-PhD in public health under the Johns Hopkins University Medical Scientist Training Program

WE'RE REACHING OUT TO MEDICAL STUDENTS

ESO has teamed up with ESMO to help convince more of the brightest and best young medical students to go into medical oncology. A newly launched summer course, held in the Spanish town of Valencia, offers students in their fourth or fifth year of medical school the chance to spend an intensive five days interacting with international experts; learning a practical approach to cancer diagnosis, staging, prognosis and therapy; getting to grips with the basic principles of medical oncology; and discussing how to plan their careers.

The first course, held this July, had such a high standard of applicants that 50 of the nearly 300 who applied were given a place, rather than the 40 that had initially been envisaged.

Encouraging more medical students to consider a career in medical oncology will be essential to ensure that the patients of tomorrow will have enough top-quality doctors to care for them and to keep pushing up standards of clinical practice.

Applications for the 2016 course open in September 2015. For further details check out the ESMO and ESO websites, www.esmo.org and www.eso.net