European Parliament **EU health values as a guide for future policy challenges**

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Interventions from the floor

Prof Evis Sala, Health and Social Welfare Minister, Albania

Three short points (more to say on a later occasion)

On critical medicines, AAA(Q), none of the 'As' fully exist in Albania (which is well on the way to becoming an EU Member State). What constitutes a 'critical medicine'? For example, is an oncology medicine 'critical'? She would argue yes, because the patient needs access to it or their health will deteriorate quickly. Affordability is key: in small states, there is not much purchasing power.

On AI and digitalisation, so much to say (!) The European Health Data Space is clearly very important, but what is probably more important even at national levels is inter-operability. States build data management systems within their healthcare system which work vertically, but not transversally. Without interoperability, a healthcare system is paralysed. Furthermore, the timeline for EU investment is too slow for tech.

On healthcare professionals, this is a key issue for countries like Albania, which de facto produces nurses for countries like Germany, and indeed the rest of Europe. Germany has a very effective system where a nurse trained in Albania is supervised in Germany for a year. So, we really need balance on that policy. Of course, Albania has incoming medical tourism in dentistry and plastic surgery. On 'AI doctors', there is recent research showing that a well-programmed AI doctor can be more compassionate than a human doctor who has been working a 12-hour shift. For remote and rural areas, especially, it may be worth looking at this as part of a reorganisation of deployment of healthcare professionals.

Tomislav Sokol MEP

Innovation is essential (and obviously we need a balance between innovation and access). It relates to quality and to access. In the context of 'America first' and indeed 'China first', where Trump is putting huge pressure on the industry to reshore into the US, including research capacity, the EU has to respond. Innovation outside Europe will have an impact on access to healthcare within Europe. It's not the case that 'capital has no borders' – the COVID-19 pandemic taught us that, if we didn't already know. The EU pharma package legislation and the Critical Medicines Act will be adopted because of the need to respond to Trump's 'America first', and the need to enable equality of access to medicines (including generics) on one side as well as incentivize innovation and production on European territory on the other.

Also, we note that there is currently no health programme in the European Commission proposal for the next Multiannual Financial Framework. The European Parliament will ask for 10 billion Euros to be earmarked for health. Argument is that health is not a cost, it is an investment.

Sabrina Montante, European Commission Unit C3 DG SANTE

The discussions today very much match the work that is happening in DG SANTE. On healthcare professionals, the Commission is supporting Member States through initiatives aimed at strengthening the health systems resilience. Following on from COVID-19, 27 Member States were given country specific recommendations under the European Semester, resulting in funding for their healthcare systems, many on healthcare workforce – through the Recovery and Resilience Facility. Also, the EU is funding collaborative projects through the EU4Health Programme. Of course, the EU institutions need to respect national competences.

Nathalie Moll, EFPIA

Appreciate the opportunity to think about values. Have seen lots of changes over the last 30 years. COVID-19 saw the value of solidarity most challenged, when Member States closed borders and medicines couldn't get through. Solidarity is needed in access to medicines; in healthcare professionals; and amongst healthcare stakeholders, where we need to work together. We need to think about what universal access to healthcare means in this new deglobalized world which we barely understand yet, with budget constraints. We urgently need to reframe health as an investment and an asset, not as a cost. If this doesn't happen at national level, what happens in Brussels is peripheral. Health comes first – there is a cycle – we need all the elements – patients, professionals, industry – no one actor or group of stakeholders is more important than the others.

Stefaan Callens, KU Leuven and lawyer at the Brussels bar

In articulating the over-reaching values, it would be useful to have a preamble and/or examples. Please pay attention to care for healthcare professionals – that should also be covered as there are far too many burnt out healthcare professionals in Europe (see also Quintuple Aim). Also, make a link between non-discrimination and access to healthcare. We should avoid a 2-tier system. A lot of private equity is investing in one-day clinics. Those who have resource, and are not too sick, go there and get fast access to (good) care, whereas poor people or the elderly will go to public hospitals with insufficient capacity and long waiting lists. To avoid a 2-tier healthcare, public hospitals should receive enough financial means to guarantee (on time) access to good care for everyone, including the elderly and sick people.