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COVER NOTE

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To:	Mr Uwe CORSEPIUS, Secretary-General of the Council of the European Union
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COMMUNICATION FROM THE COMMISSION

On effective, accessible and resilient health systems

1. Introduction

Health systems[1] play a central role in modern societies in helping people maintain and improve their health. Health systems should be able to add more years to life, but also to add more life to years.

Health systems in EU Member States are varied, reflecting different societal choices. However, despite organisational and financial differences, they are built on common values, as recognised by the Council of Health Ministers in 2006:[2] universality, access to good quality care, equity and solidarity.

EU health systems increasingly interact with each other. The entry into force of Directive 2011/24[3] was a key step in increasing this interaction. Strengthening cooperation between health systems should help them function better when faced with the increasing mobility of patients and healthcare professionals.

Over the last decade, European health systems have faced growing common challenges: increasing cost of healthcare, population ageing associated with a rise of chronic diseases and multi-morbidity leading to growing demand for healthcare, shortages and uneven distribution of health professionals, health inequalities and inequities in access to healthcare.

Moreover, in recent years, the economic crisis has limited the financial resources available and thus aggravated Member States' difficulties in ensuring their health systems' sustainability.[4] In turn, this jeopardises Member States' ability to provide universal access to good quality healthcare. Health systems need to be resilient: they must be able to adapt effectively to changing environments, tackling significant challenges with limited resources.

Increasing interdependence and common challenges call for closer cooperation. In 2006, Member States agreed upon common objectives on the accessibility, quality and financial sustainability of health care in the context of the Open Method of Coordination for social protection and social inclusion[5]. In 2011, the Council of Health Ministers established an EU-level reflection process to help Member States provide modern, responsive and sustainable health systems.[6] It recognised that '*whilst ensuring equitable access to high quality health care services in circumstances of scarce economic and other resources has always been a key question, at present it is the scale and urgency*

[1] In this Communication, health systems are defined as those systems that aim to deliver healthcare services to patients – be they preventive, diagnostic, curative, and palliative – whose primary purpose to improve health.

[2] Council Conclusions on Common values and principles in European Union Health Systems, OJ C 146, 22.06.2006

[3] Directive 2011/24/EU, OJ L 88, 04.04.2011.

[4] This is also highlighted in the Council conclusions on the Economic Policy Committee (EPC) – European Commission Joint Report on health systems in the EU (7 December 2010).

[5] Joint Social Protection Committee / Economic Policy Committee Opinion on the Commission Communication "Working together, working better: proposals for a new framework for the open co-ordination of social protection and inclusion" endorsed by EPSCO on 10 March 2006.

[6] Council Conclusions: Towards modern, responsive and sustainable health systems (6 June 2011).

of the situation that is changing and, if unaddressed, it could become a crucial factor in the future economic and social landscape of the EU'.

In December 2013, the Council of Health Ministers endorsed the progress made and called for further work in this area, in its conclusions on the 'reflection process on modern, responsive and sustainable health systems'.[7]

In the 2014 Annual Growth Survey[8] (AGS) "the top priority now is to build growth and competitiveness" in order to build a lasting recovery. With this goal in mind, the AGS emphasises the need to improve the efficiency and financial sustainability of healthcare systems, while enhancing their effectiveness and ability to meet social needs and ensure essential social safety nets. It also acknowledges the importance of the healthcare sector in tackling the social consequences of the economic crisis, stressing that healthcare services are an area that will generate significant job opportunities in the years to come. It recommended that active social inclusion strategies should be developed, including broad access to affordable and high-quality health services.

This had previously been stressed in 2013, when eleven Member States[9] received a recommendation for reform in their health systems as part of the European Semester. Most of these recommendations focused on the sustainability and cost-effectiveness of health systems, calling for reforms in the hospital sector, in the pricing of health services, out-patient care and primary care. Three recommendations also called for maintaining or improving access to healthcare.

Besides being a value in itself, health is also a precondition for economic prosperity, as recognised in the Commission staff working document 'Investing in health', which is part of the Social Investment Package.[10] People's health influences economic outcomes in terms of productivity, labour supply, human capital and public spending. The healthcare sector is strongly driven by innovation, and has major economic significance: it represents 10% of the EU's GDP. Moreover, it is a highly labour intensive activity and one of the largest sectors in the EU: the healthcare workforce accounted for 8% of all jobs in the EU in 2010.[11]

Capitalising on experience and work carried out over recent years, and with a view to further developing approaches at EU level, this Communication focuses on actions to:

1. Strengthen the effectiveness of health systems
2. Increase the accessibility of healthcare
3. Improve the resilience of health systems

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[7] Council Conclusions on the Reflection process on modern, responsive and sustainable health systems (10 December 2013).

[8] COM(2013) 800.

[9] Austria, Bulgaria, Czech Republic, Germany, Finland, France, Malta, Poland, Romania, Slovakia and Spain.

[10] COM(2013) 83.

[11] SWD(2012) 93, accompanying COM(2012) 173.

2. Strengthening the effectiveness of health systems

Effectiveness, safety and patient experience are key components of healthcare quality, an important element of health systems' performance. Work on patient safety is ongoing at EU level,[12] while patient experience is a key area which will require further attention in the future.

This Communication focuses on effectiveness: health systems' ability to produce positive health outcomes, i.e. to improve the health of the population.

Measuring the effectiveness of health systems will become increasingly important, especially as health systems are not the only factor in improving our health. Although large variations in life expectancy still persist between Member States, overall we are living longer and in better health than previous generations. This is not least because of the significant achievements made in public health and from outside the health system. Future improvements are also to be expected, for example from fewer people smoking, lower alcohol consumption, better nutrition, and greater uptake of physical activity. There is a general consensus that the healthcare sector's contribution to a healthy population has increased dramatically in the last fifty to sixty years.

Gathering information on the comparative effectiveness of health systems is still at an early stage. The examples presented below show areas where the contribution of health systems to the improvement of health is most evident, backed by available EU-wide indicators (i.e. perinatal mortality, amenable mortality, incidence of vaccine-preventable diseases and cancer screening). This comparison reveals large variations between EU Member States.

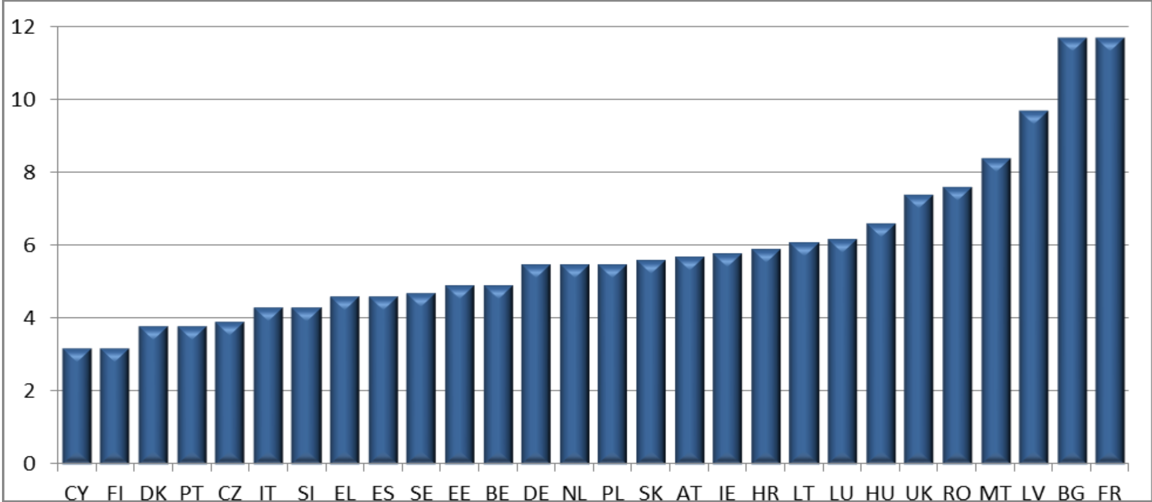
Perinatal mortality

Perinatal mortality is calculated as the sum of late foetal mortality (after 28 weeks' gestation) and early neonatal mortality (within seven days after delivery). Compared to infant mortality,[13] it is less strongly associated with socioeconomic factors and hence a more reliable indicator of health system effectiveness.

[12] Council Recommendation of 9 June 2009 on patient safety, including the prevention and control of healthcare associated infections, OJ C 151, 03.07.2009.

[13] Infant mortality is the number of deaths in children within the first year of life per 1 000 live births.

Figure 1: perinatal mortality rates per 1 000 total births (2011 or most recent data)



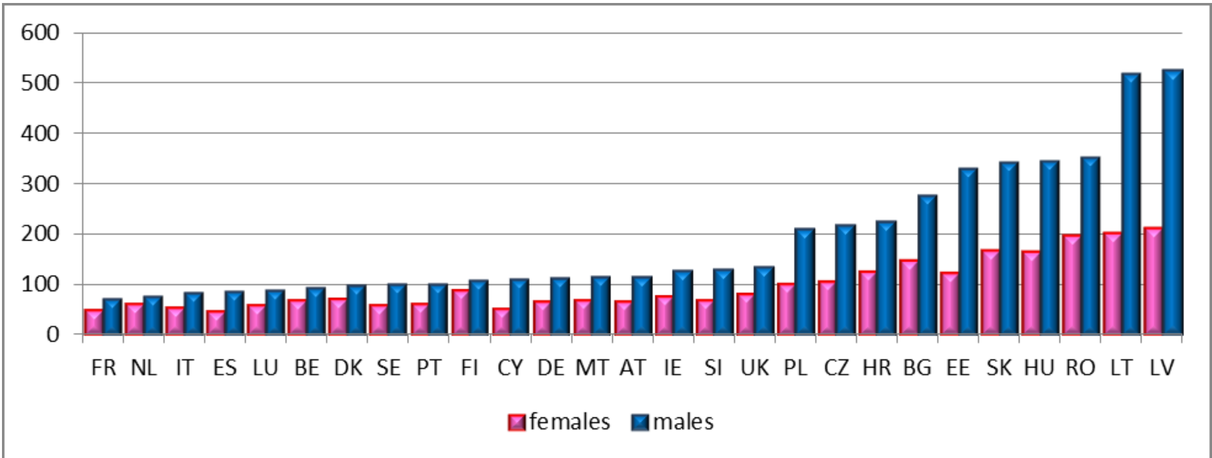
Data source: Eurostat database, Europeristat project (developed by Commission staff)

The perinatal mortality rate declined in the last five years in the majority of Member States, although some countries saw the rate increase during this period.

Amenable mortality

Amenable mortality is defined as premature deaths that should not occur if timely and effective healthcare is provided. It is a fundamental indicator used to explore the contribution of health systems to health outcomes.[14] Amenable mortality combines the standardised mortality rates for a selected set of diseases on which healthcare is estimated to have a direct impact.

Figure 2: amenable mortality, standardised death rates per 100 000 inhabitants — 2010



Data source: Eurostat (data for Greece not available)

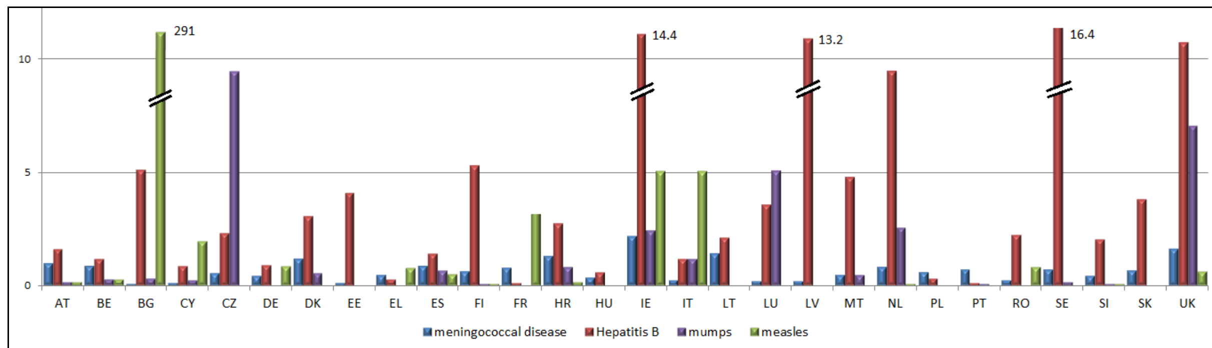
Virtually all Member States have been able to reduce the rate of amenable mortality between 2000 and 2010, though the rates of decrease vary considerably among them.

[14] Arguably, 'amenable mortality' comparisons need to take disease incidence into account and not just deaths relating to the relevant diseases. However, availability of comparable data is not ensured.

Communicable diseases

The incidence of particular communicable diseases is directly affected by the provision of appropriate healthcare services: immunisation campaigns have dramatically reduced the incidence of vaccine-preventable diseases (even though in some countries there are worrying signs of falling vaccination rates).

Figure 3: incidence of vaccine-preventable diseases — confirmed cases per 100 000 inhabitants — 2011



Data source: ECDC Annual epidemiological report 2012

Even focusing on a small set of vaccine-preventable diseases (meningococcal disease, hepatitis B, mumps, and measles), incidence rates across Member States shows a significant difference.

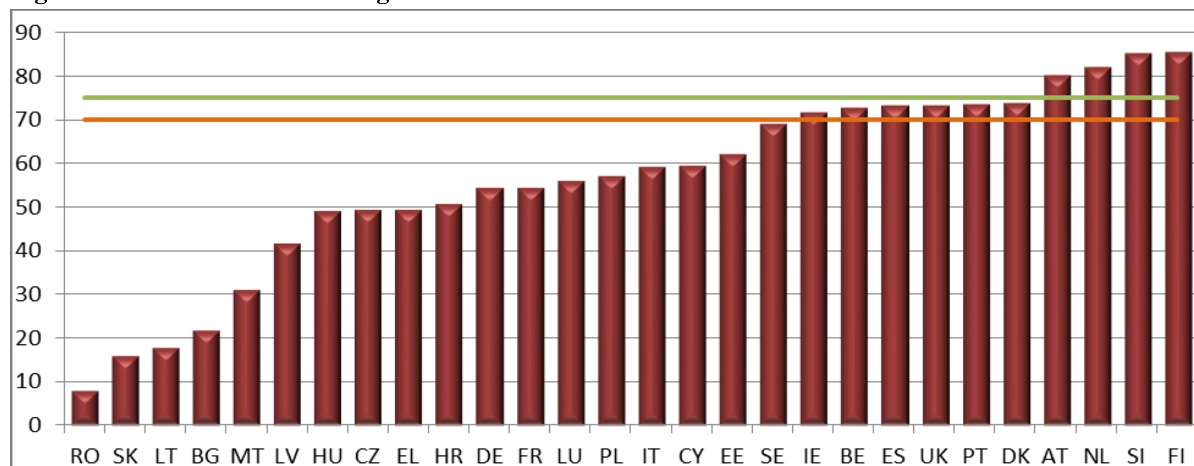
Cancer screening

Early diagnosis of colorectal, cervical, and breast cancer through organised population-based screening programmes is a useful proxy for the effectiveness of the healthcare system in addressing sectors at risk. The Council recommended implementing such programmes in accordance with European quality assurance guidelines.[15]

Breast cancer is the area where most progress has been made. National screening programmes generally meet EU guidelines in defining target age-groups (women aged 50-69) and on recommended time intervals between mammography screenings. However, while European guidelines identify a desirable target screening rate of at least 75 % of eligible women (and an acceptable level of 70 %), only a few Member States reached this rate in 2010.

[15] Council Recommendations of 2 December 2003 on cancer screening; OJ L 327, 16.12.2003. See also European guidelines on quality assurance in colorectal cancer screening and diagnosis, cervical cancer screening, and breast cancer screening and diagnosis.

Figure 4: breast cancer screening — % of women 50-69 screened



Data source: OECD health at a glance Europe 2012, national statistics

Main findings

Some initial observations can be made in relation to these specific indicators, although they are not representative enough to support a broad evaluation of health systems. They illustrate large variations between EU Member States. They also show that health outcomes are multidimensional and difficult to define. In general, assessing the effectiveness of health systems is a complex process: healthcare measures may only show their effects after long periods, and comparability and reliability of data is a challenge. However, work to improve this is being carried out.

The Commission has supported the development of the European health core indicators (ECHI), a set of indicators to monitor the health of the population and the performance of health systems. Several reports have also been issued, assessing European health systems. Particularly valuable examples are the joint EPC-European Commission report on health systems, published in 2010, and the 'Health at a glance Europe' series, published by OECD and the Commission.

Another important step has been undertaken in 2013: the Social Protection Committee developed a joint assessment framework on health, intended to act as a first-step screening device to detect possible issues in Member States' health systems. It constitutes a key contribution to the comparative assessment of health systems' performance, taking into account the availability of data at EU level. Finally, the framework programmes for research and for technological development funded several projects to develop indicators and methodologies to assess the performance of health systems.[16]

3. Increasing the accessibility of health systems

Health systems must be accessible. This is one of the principles stated in the European Social Charter,[17]which emphasises the importance of transparent criteria for access to medical treatment,

[16] See for instance the ECHO (http://www.echo-health.eu), Eurohope (http://www.eurohope.info), and EuroREACH (http://www.euroreach.net) projects.

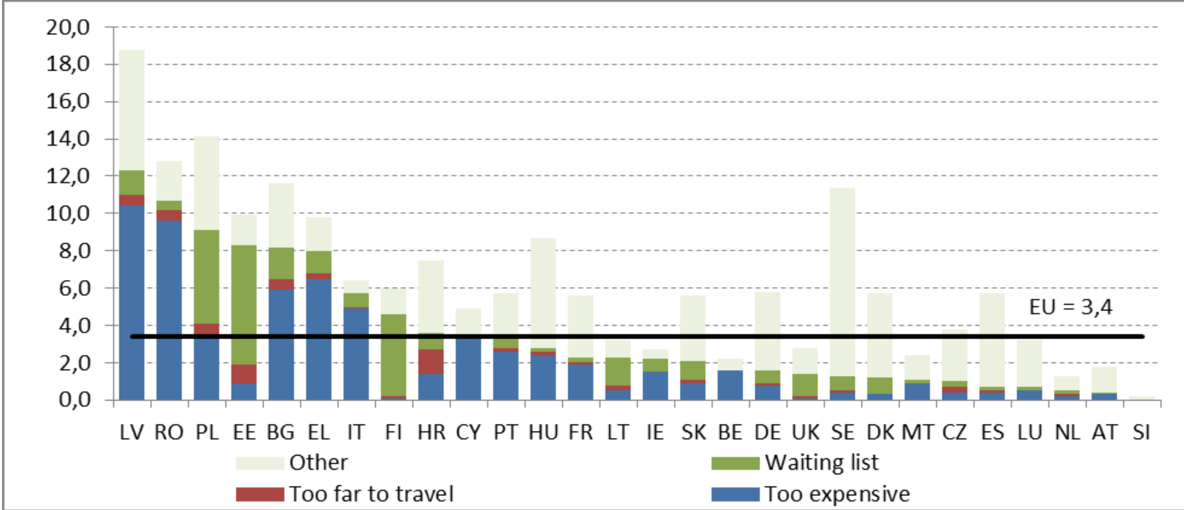
[17] Revised European Social Charter, Strasbourg 3 May 1996.

and the obligation for States to have an adequate healthcare system which does not exclude parts of the population from receiving healthcare services.

However, access to healthcare is difficult to measure and there is no EU wide detailed methodology to monitor it and promote best practice. This would be an important step to reduce health inequalities.[18]

A commonly used indicator is the variance across the EU in the percentage of residents reporting difficulties in accessing medical care for reasons related[19] to the accessibility of health systems: waiting time, travelling distance and cost sharing. However, these findings derive from self-reported needs and may therefore suffer from cultural bias when compared across countries.

Figure 5: Self-declared unmet needs for medical examination by reason, proportion of population (%)



Source: Eurostat, Statistics on Income and Living Conditions 2012 (2011 data for AT and IE)

Access to healthcare is the result of interaction between different factors, including health system coverage (i.e. who is entitled to healthcare), depth of coverage (i.e. what are citizens entitled to), affordability and availability of healthcare services. Healthcare access is also directly affected by the organisation and management models used in health systems. Patients may find healthcare more difficult to access if health systems are complex and lack transparency.

Population coverage

[18] COM(2009) 567.

[19] Note that the 'other reasons' classification in this survey relates to reasons not linked to local health systems, e.g. 'no time', 'fear of doctor', etc.

Health services are mostly financed from public sources in virtually all EU Member States. Healthcare coverage is universal or almost universal in all Member States; however, some people from disadvantaged backgrounds are still excluded from adequate health coverage.

Depth of coverage

Publicly financed healthcare treatments differ between national health systems. For example, dental care, eye care services and some state-of-the-art treatments are covered only in some Member States. In several Member States there is no explicit definition of publicly financed treatments. This complicates comparison and analysis which could contribute to a consensus on minimum or optimal levels of care provision.

Affordability

People are often asked to contribute financially towards the service they require, in the form of cost-sharing or co-payment. This can help ensure that health services are used responsibly; at the same time, however, this co-payment should not represent an obstacle or a deterrent to people getting the healthcare they need. Cost-containment measures in health systems, meant to promote more rational use of healthcare, should not unduly reduce access to high-quality healthcare.

Availability (health workforce, distance from point of care, waiting times)

Patients should have reasonable access to healthcare services: they should not have to travel too far or wait too long to access the service they need. This is a particularly serious challenge in rural and remote areas.

Problems relating to distance could be overcome through more integrated models of care, which improve contact between patients and the health system, and through wider uptake of eHealth solutions.

There is no EU-wide definition of how to measure waiting times, even though this is a significant concept in Regulation 883/04[20] and Directive 2011/24. This might change as Directive 2011/24 improves health system accountability for access to care, through increased transparency on the concept of 'undue delay' when waiting for treatment.

Ageing population and the rise in multiple chronic diseases require different skills mixes, with implications for the content of medical training programmes. The separation between professions is likely to become less rigid through the creation of multidisciplinary teams. Demand for skills and competences in the healthcare sector is changing constantly and roles and professions are likely to evolve in order to meet population needs. For instance, given the high rates of physical inactivity in the EU and the associated health risk factors, health professionals have a key role to counsel patients on the importance of physical activity, working with other sectors such as the sports sector.[21]

[20] Regulation 883/2004 of 29 April 2004 on the coordination of social security systems, OJ L 166, 30.04.2004

[21] Council Recommendation of 26 November 2013 on promoting health-enhancing physical activity across sectors, OJ C 354, 4.12.2013.

In order to be ahead of these developments, medical training planning systems have to be smarter, respond more quickly and be in a better position to attract students to the specialities that are needed most.

In addition, evidence shows that attention should be paid to medicines, as the share of private expenditure in medicines is markedly higher than for other types of publicly covered healthcare.

National decisions on pricing and reimbursement have direct and indirect impacts on the accessibility to medicines across the EU: innovative products are not always made available at the same time in all Member States, and in some countries they may not be available at all.

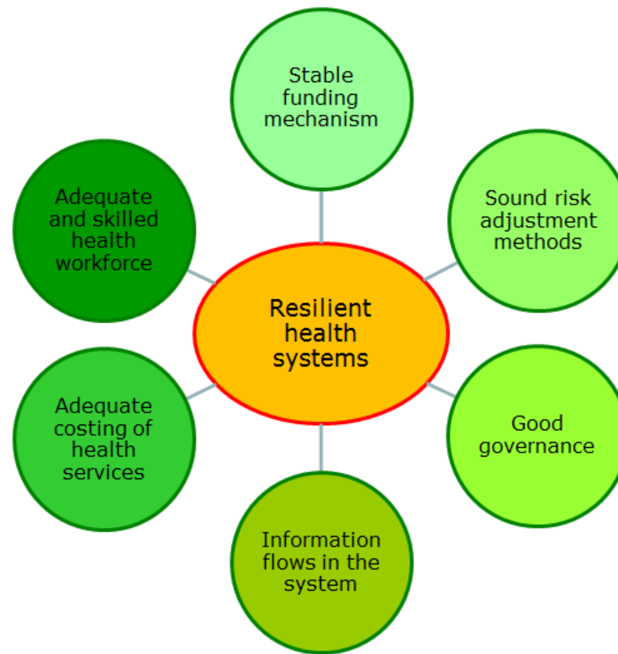
A first step to improving this was made through the process on corporate responsibility in the pharmaceutical field, which encouraged discussion between competent authorities responsible for pricing and reimbursement and other interested stakeholders, and supported the transparent exchange of information on how to achieve better access to medicines.

4. Improving the resilience of health systems

Modern health systems need to remain accessible and effective while pursuing long-term sustainability. To do this, they have to remain fiscally sustainable. The Commission supports Member States in this work, providing analysis and forecasts, and recommending reforms as part of the European Semester process.

Health systems should also look at non-fiscal factors. They must be able to adapt effectively to changing environments and identify and apply innovative solutions to tackle significant challenges — shortages of expertise/resources in specific areas, unexpected surges in demand (e.g. owing to epidemics), etc. — with limited resources. In other words, they need to build and maintain resilience.

EU health systems have not coped equally well with the economic crisis and some have had to implement major and sometimes painful reforms in a very short time. Building on experience of recent reforms, the Commission has identified the following resilience factors that helped some health systems safeguard accessible and effective healthcare services for their population.



Stable funding mechanisms

Stable funding allows effective investment planning and smooth continuity of services in organising and managing care delivery. Health systems whose financing is based on less stable sources of revenue are more prone to suffer from external shocks: e.g. systems relying mostly on employment-based contributions for funding are more exposed to the consequences of a rise in unemployment. Reserves or other countercyclical formulas for government budget transfer may help ensure stability of funds.

Sound risk adjustment methods

A consistent system of risk adjustment and risk pooling is a key tool to ensure that resources are spent according to needs. For example, when several social health insurance companies collect social contributions or insurance premiums, a risk-adjustment/risk-equalisation mechanism is used to take into account the size, age-gender structure and a proxy of the morbidity patterns of the individuals insured in each fund. This is to avoid patient selection, discrimination and ensure funding is adjusted to need.

Good governance

Governance is about well-defined responsibilities in running the health system and its main components, together with strong leadership, sound accountability mechanisms and a clear organisational structure. This enables systems to adapt quickly to new objectives and priorities and enhances their ability to respond to major challenges by identifying and putting in place the measures necessary to support smart investment decisions.

Information flows in the system

A sound knowledge of strengths and weaknesses and the ability to monitor information, including at the level of individual patients or healthcare providers, enable health systems managers to make tailored, evidence-based decisions in specific sub-sectors.

EHealth-based information systems facilitate and support the strengthening of information knowledge systems. Furthermore, eHealth can deliver more personalised healthcare, which is more targeted, effective and efficient and helps to reduce error and to minimise the length of hospitalisations.

Adequate costing of health services

It is essential for understanding the complexity of the processes leading from costs to outcomes: how costs correspond to human and physical resources, how resources contribute to activities (e.g. surgical interventions, diagnostic tests), how activities group into care interventions, and finally how care interventions impact on health.

Health technology assessment is key for ensuring a common method for evaluating efficacy of interventions and proper costing of services and hence to allow decision makers to allocate resources in the most efficient way.

The ability to cost healthcare services accurately is not only necessary for controlling expenditure, but also a prerequisite for effective decisions on investment and prioritisation.

A health workforce of adequate capacity and with the right skills

A highly qualified and motivated health workforce of adequate capacity and with the right skills is essential for finding innovative solutions through organisational and technological change. Having an effective structure of incentives is vital to improving the performance of health professionals and ensuring the focus is on direct provision of healthcare.

5. An EU agenda for effective, accessible and resilient health systems

The primary responsibility for health systems rests with the Member States. The EU has taken a number of actions that can support Member States', in particular by providing guidelines and as monitoring or evaluation tools.

The Commission has set up an independent expert panel to provide advice in relation to investing in health.[22] This panel will provide analyses and recommendations to the Commission on a number of the issues discussed.

Supporting the strengthening of the effectiveness of health systems

Health systems performance assessment (HSPA)

[22] Commission Decision of 5 July 2012 on setting up a multisectoral and independent expert panel to provide advice on effective ways of investing in health, OJ C 198, 06.07.2012.

The Council of Health Ministers invited Member States to use HSPA for policy-making, accountability and transparency, and invited the Commission to support Member States in using HSPA.

In response to this invitation, collaborative work on HSPA will provide Member States with tools and methodologies, including:

- capitalising on EU-funded research on performance assessment measures and indicators;
- defining criteria and procedures for selecting priority areas for HSPA at national and EU level;
- developing a tailored reporting system; and
- intensifying cooperation with international organisations, in particular the OECD and the World Health Organisation.

This collaborative work may also allow more targeted work at EU level to reduce inequalities by providing support to Member States that are performing below the EU average to help improve their situation. It could also prove instrumental in helping Member States meet requirements under Directive 2011/24 for information on quality and safety.

Quality of care, including patient safety

In spring 2014, the Commission intends to present its second report on the implementation of the Council recommendation on patient safety.[23] On the basis of the findings of this report, the Commission intends to discuss action to further improve patient safety and to reduce unwarranted variation between and within Member States.

The findings of the recent public consultation on patient safety and quality of care show that there is a high interest in developing a broader EU agenda to address the issues that impact on quality in healthcare. The Commission intends to follow up appropriately.

Integration of care

Integration of care should take place both between different levels of healthcare (primary care, hospital care, etc.) and between health and social care, particularly with regard to elderly people or people with chronic illnesses.

Member States' reforms, to reduce the reliance of their health systems on hospital-based care through better integration of care, provide an opportunity to exchange learning experiences in key areas and to answer the following questions:

- Which patients can be treated better or equally well outside hospital?
- How can avoidable hospitalisations be successfully reduced?

[23] The first report was published in 2012: COM(2012) 658.

The expert panel on investing in health has published a report on primary care and integration of care, on which the Commission has launched a public consultation to identify new areas for reflection.

Increasing the accessibility of healthcare

The EU health workforce

Significant gaps have been identified in Member States' capacity to plan for future health workforce resource requirements, relating to both overall volume and required skills mixes, in order to meet expected healthcare needs efficiently.

The outcomes of the action plan on the health workforce[24] will help to better predict future skills needs and provide important insights to train future generations of healthcare professionals with the right skills. Improving available data to enhance national planning systems can also help address the challenges posed by health workforce mobility and find solutions that take into account the right to move freely in the EU.

Health workforce planning efforts should develop sustainable solutions at EU level to ensure sufficient numbers of adequately trained health professionals with the right skills to provide care to all who need it. To avoid future shortages and skills mismatches, the Commission intends to work further with Member States on developing recommendations, common tools, indicators and guidelines, strengthening EU support for Member States' planning.

Cost-effective use of medicines

The EU needs a competitive pharmaceutical industry. With this background, Member States and the Commission should reflect further on how to reconcile the policy objectives of ensuring accessible healthcare for all EU citizens with the need for cost containment. Consideration should be given to improved cooperation on building mechanisms for increased transparency and better coordination to minimise any unintended effects that current national pricing systems may have in terms of accessibility throughout the EU.

Optimal implementation of Directive 2011/24

Directive 2011/24 broadens patient choice in healthcare and helps them avoid undue delay in receiving the treatments they need. The Directive will improve transparency by requiring the Member States to set up national contact points to provide information to citizens, including on their rights and entitlements, patient safety and quality of care standards. It also calls for a better understanding of baskets of healthcare. Member States should ensure that all the provisions of the Directive are properly implemented. The Commission will closely monitor how the concept of undue delay is applied in Member States.

Reference networks will promote cooperation among highly specialised providers across Member States, allowing patients with low prevalence, complex or rare diseases to access high quality care.

[24] SWD(2012) 93, accompanying COM(2012) 173.

The Commission intends to launch calls for expressions of interest in becoming European reference network members, who could also provide training for health professionals and support in defining common quality assurance requirements.

Improving resilience of health systems

There is an urgent need for further investigation into resilience factors for health systems and ways to build these. Member States should develop better analyses of these factors on the basis of their national experience. This should be complemented by EU work on sharing best practice and on designing policy measures. The following approaches will be beneficial to improve the resilience of health systems in the European Union.

Health technology assessment (HTA)

HTA is a scientific approach to evaluate the relative effect a particular health technology has on a medical condition by answering questions like:

- Is the technology effective?
- For whom does it work?
- What costs are entailed?
- How well does it work compared to alternative technologies?

HTA has proved to be an efficient tool for improving access to innovative technologies for patients and for supporting more efficient allocation of funds.

Member States cooperate on HTA within a network established in Directive 2011/24. The Commission supports an ambitious goal for the HTA network, namely that jointly produced HTA information should be re-used at national level. This will reduce duplication of work by regulators, HTA bodies and the HTA industry, and will lead to a shared understanding of the clinical aspects of health technologies (i.e., their relative safety and efficacy/effectiveness).

In future years, a more ambitious and stable structure to support scientific cooperation on HTA will be developed. In collaboration with the HTA network, the Commission is working on possible proposals on this.

Health information system

Any intervention to increase the resilience of the health system must take account of the system itself. Decisions on investing or disinvesting in specific sectors need to be based on an understanding of the processes governing those sectors and the impact of the interventions on health and economic parameters.

Member States should therefore invest in developing their information flows to, for example, ensure that patient-level information flows are channelled appropriately to all necessary healthcare

providers, or that more effective and sustainable reorganisation of health systems and services are supported.[25]

The Commission is considering supporting Member States on establishing a sustainable and integrated EU health information system, exploring in particular the potential of a comprehensive European research infrastructure consortium (ERIC) on health information.

eHealth

The Commission strongly encourages cooperation between Member States on eHealth and supports them in developing and implementing cost-effective and interoperable eHealth solutions to improve health systems.[26] As required by Directive 2011/24, the Commission supports the eHealth network, which works to deliver sustainable benefits from European eHealth systems and services and interoperable applications. The 2012-2020 eHealth action plan also emphasises the benefits of eHealth services for citizens, patients and healthcare providers, and proposes specific actions to lower the barriers to deploying these services.

Further efforts are needed to develop effective and interoperable telemedicine services. European reference networks will represent an ideal opportunity to introduce and test telemedicine in the EU.

6. Conclusions

The 2013 Annual Growth Survey recognised that "in the context of the demographic challenges and the pressure on age-related expenditure, reforms of healthcare systems should be undertaken to ensure cost-effectiveness and sustainability, assessing the performance of these systems against the twin aim of a more efficient use of public resources and access to high quality healthcare".

Member States' future ability to provide high quality care to all will depend on making health systems more resilient, more capable of coping with the challenges that lie ahead. And they must achieve this while remaining cost-effective and fiscally sustainable.

While this is primarily a task for the Member States, this communication highlights a number of initiatives through which the EU can support policy makers in the Member States. The EU will have to develop these initiatives and build on them to ensure that citizens' aspirations to high quality care can be met. The focus will have to be on methods and tools that will allow Member States to achieve greater effectiveness, accessibility and resilience of their health systems, in line with reform recommendations addressed to Member States in the context of the European Semester. To implement reforms identified in these recommendations, Member States are also encouraged to use European funding instruments.

[25] See the conclusions of the e-health task force report entitled 'Redesigning health in Europe for 2020', which calls upon policy makers to use the power of data: http://ec.europa.eu/digital-agenda/en/news/eu-task-force-ehealth-redesigning-health-europe-2020.

[26] COM(2012) 736.

EU agenda for effective, accessible and resilient health systems

Strengthening effectiveness	Increasing accessibility	Improving resilience
Health systems performance assessment	Planning of EU health workforce	HTA
Patient safety and quality of care	Cost-effective use of medicines	Health information system
Integration of care	Optimal implementation of Directive 2011/24	eHealth