Disuguaglianze di salute: politiche sanitarie e non sanitarie

30 maggio 2019

organizzato da

ISTITUTO SUPERIORE DI SANITÀ
Centro Nazionale per la Salute Globale

e

ASviS – Alleanza Italiana per lo Sviluppo Sostenibile
UN IMPATTO DEVASTANTE IN POCHI ANNI

40 million died

40 million live with HIV
Trends in Annual Rates of Death from Leading Causes of Death Among Persons 25-44 Years Old, USA
Antiretroviral Therapy for HIV Infection in 1996
Recommendations of an International Panel

Charles C. J. Carpenter, MD; Margaret A. Fischl, MD; Scott M. Hammer, MD; Martin S. Hirsch, MD; Donna M. Jacobson; David A. Katzenstein, MD; Julio S. Montaner, MD; Douglas D. Richman, MD; Michael S. Saag, MD; Robert T. Schooley, MD; Melanie A. Thompson, MD; Stefano Vella, MD; Patrick G. Yeni, MD; Paul A. Volberding, MD; for the International AIDS Society–USA

Objective.—To provide clinical recommendations for antiretroviral therapy for human immunodeficiency virus (HIV) disease with currently (mid 1996) available drugs. When to start the therapy, what to start with, when to change drugs, and what to change them to were addressed.

Participants.—A 13-member panel representing international expertise in antiretroviral research and HIV patient care was selected by the International AIDS Society–USA.

Evidence.—Available clinical and basic science data, including phase 3 controlled trials, clinical endpoint data, virologic and immunologic endpoint data, interim analyses, studies of HIV pathophysiology, and expert opinions of panel members were considered. Recommendations were limited to drugs available in mid 1996.

Process.—For each question posed, 1 or more member(s) reviewed and presented available data. Recommendations were determined by group consensus (January 1996); revisions as warranted by new data were incorporated by group consensus (February–May 1996).

Conclusions.—Recent data on HIV pathogenesis, methods to determine plasma HIV RNA, clinical trial data, and availability of new drugs to the need for new approaches to therapy. Therapy is recommended based on CD4 cell count, plasma HIV RNA level, or clinical status. Preferred initial drug regimen includes nucleoside combinations; at present protease inhibitors are probably best reserved for patients at higher progression risk. For treatment failure or drug intolerance, subsequent considerations include resistance to initial therapy, available drug options, disease stage, underlying conditions, and concomitant medication(s). Therapy for primary (acute) infection, high-risk exposure to HIV, and maternal-to-fetal transmission are also addressed. Therapeutic approaches need to be updated as new data continue to emerge.

From Brown University School of Medicine, Providence, RI (Dr Carpenter); the University of Miami (Fla) School of Medicine (Dr Fischl); Harvard Medical School (Dr. Hartman); University of Cincinnati, Cincinnati, Ohio (Dr Richman); Stanford University Medical Center (Dr Richman); St Paul's Hospital, Vancouver, British Columbia (Dr Hammer); University of California San Diego, and San Diego Veterans Affairs Medical Center (Dr Richman); the University of Alabama at Birmingham (Dr Saag); the University of Colorado School of Medicine, Denver (Dr Schooley); AIDS Research Consortium of Miami (Dr Thompson); Instituto Superiore di Sanita', Rome, Italy (Dr Vella); Hopital Richelieu-Guillaume Pasteur, Strasbourg, France (Dr Yeni); and the University of California San Francisco (Dr. Volberding).

Financial disclosures appear at the end of this article.

Reprints: International AIDS Society–USA, 363 Kearny St, San Francisco, CA 94108.
Mortality vs. HAART Utilization

Deaths per 100 Person-Years

% of Patient Days on HAART

Palella F et al, HOPS Study
Per Stefano Vella la prospettiva di cura è in un cocktail di farmaci dai costi devastanti.

Ma la terapia sarà solo per pochi.

GIANGIACOMO ACCOLPI

E una lezione a battesimo politico. Allo Stato, in nome del ministero della Salute, andrà ceduto un elenco dei farmaci che possono aiutare a lottare contro la tubercolosi. E dovrà essere assicurato che questi farmaci siano disponibili in tutto il mondo, in modo che possano essere presi in considerazione dalle politiche sanitarie di tutte le nazioni.

La terapia di cura per la tubercolosi implica un processo lungo e costoso. Ogni farmaco deve essere prescritto a dosi precise in un determinato ordine, per assicurare l'efficacia del trattamento. Ma il costo di questi farmaci è altissimo, soprattutto per le nazioni povere.

E così che la prospettiva di cura per la tubercolosi può diventare un'illusione. Ma non è solo la questione della disponibilità dei farmaci che è da considerare. È anche questione di come questi farmaci vengano finanziati.

La soluzione è in mano alla comunità internazionale. Occorre collaborare per trovare soluzioni che considerino sia l'efficacia del trattamento, sia la possibilità di finanziarne il costo per le nazioni povere.
YEAR 2000: difference in mortality between the rich north and the poor south
Durban 2000: Community mobilization
Global March for access to HIV treatment
Treatment Access Campaign (and others)

EVERYONE HAS THE RIGHT TO HEALTH!

All people with HIV/AIDS have a right to access treatments in addition to health care, employment, education, clean water, adequate nutrition, and housing. Denying people with HIV/AIDS access to affordable medicines in order to protect profits or intellectual property rights, is tantamount to genocide.
Kofi Annan, UN Secretary General:
Call for 7 – 10 billion war chest against AIDS and the creation of the Global Fund (launched Jan 2002) “… we must put care and treatment within everyone's reach”.

UNGASS AIDS, June 2001
Declaration of Commitment:
“… make every effort to provide … the highest attainable standard of treatment for HIV/AIDS, including … the effective use of quality-controlled anti-retroviral therapy …”

Schwartländer et al, Science, June 2001
UNGASS 2001:
THE GLOBAL FUND WAS BORN

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

17.5 MILLION
PEOPLE ON ANTI-RETROVIRAL THERAPY FOR HIV
79.1 MILLION
HIV TESTS TAKEN
9.4 MILLION
PEOPLE REACHED WITH HIV PREVENTION PROGRAMS & SERVICES

27 MILLION LIVES SAVED

5 MILLION
PEOPLE WITH TB TREATED
102 THOUSAND
PEOPLE WITH DRUG-RESISTANT TB ON TREATMENT

US$ 4.2 BILLION
GLOBAL FUND GRANTS DISBURSED

197 MILLION
MOSQUITO NETS DISTRIBUTED
108 MILLION
CASES OF MALARIA TREATED

US$ 205 MILLION
SAYINGS GENERATED BY POOLED PROCUREMENT

Lives saved are cumulative since 2002. All other results were achieved in 2017 in countries where the Global Fund invests.
Time to act: global apathy towards HIV/AIDS is a crime against humanity

Robert Hogg, Pedro Cahn, Elly Katabira, Joep Lange, NM Samuel, Michael O’Shaughnessy, Stefano Vella, Mark Wainberg, Julio Montaner
Response to the AIDS Pandemic — A Global Health Model

Peter Piot, M.D., Ph.D., and Thomas C. Quinn, M.D.

JUST OVER THREE DECADES AGO, A NEW OUTBREAK OF OPPORTUNISTIC INFECTIONS AND KAPOSI’S SARCOMA WAS REPORTED IN A SMALL NUMBER OF HOMOSEXUAL MEN IN CALIFORNIA AND NEW YORK.¹ ² This universally fatal disease, which was eventually called the acquired immunodeficiency syndrome (AIDS), was associated with a complete loss of CD4+ T cells. Within the first year of its description, the disease was also identified in patients with hemophilia, users of injection drugs, blood-transfusion recipients, and infants born to affected mothers. Soon thereafter, a heterosexual epidemic of AIDS was reported in Central Africa, preferentially affecting women.³-⁴ Little did we know at the time that this small number of cases would eventually mushroom into tens of millions of cases, becoming one of the greatest pandemics of modern times.

Within 2 years after the initial reports of AIDS, a retrovirus, later called the human immunodeficiency virus (HIV), was identified as the cause of AIDS.⁵ Diagnostic tests were developed to protect the blood supply and to identify those infected. Additional prevention measures were implemented, including risk-reduction programs, counseling and testing, condom distribution, and needle-exchange programs. However, HIV continued to spread, infecting 10 million persons within the first decade after its identification.

The second decade of AIDS was marked by further intensification of the epidemic in other areas of the world, including the southern cone of Africa, which saw an explosive HIV epidemic. Asia and the countries of the former Soviet Union also reported a marked increase in the spread of HIV. However, by the mid-1990s, with the discovery of highly active antiretroviral therapy, rates of death in developed countries started to decline. The use of antiretroviral drugs during pregnancy also resulted in a substantial decline in mother-to-child transmission of HIV in high-income countries. However, without access to antiretroviral drugs in low- and middle-income countries, rates of death and mother-to-child transmission continued to increase, with 2.4 million deaths and more than 3 million new infections reported in 2001. Of these new infections, two thirds occurred in sub-Saharan Africa.⁶

INTERNATIONAL RESPONSE TO AIDS — A GLOBAL HEALTH MODEL

It was not until the third decade of the epidemic that the world’s public health officials, community leaders, and politicians united to combat AIDS. In 2001, the United Nations General Assembly endorsed a historic Declaration of Commitment on HIV/AIDS, a commitment that was renewed in 2011.⁷ These actions resulted in the formation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which was established to finance anti-AIDS activities in developing countries. In 2003, President George W. Bush announced the President’s Emergency Plan for AIDS
THE RISE OF LIFE EXPECTANCY

Life expectancy globally and by world regions since 1770

Source: Life expectancy – James Riley for data 1990 and earlier; WHO and World Bank for later data (by Max Roser)
THE DRIVERS......1. CLEAN WATER

WORLDWIDE, 1 OUT OF EVERY 5 DEATHS OF CHILDREN UNDER 5 IS DUE TO A WATER-RELATED DISEASE.
THE DRIVERS......2. SOCIAL DETERMINANTS

- Healthcare
- Physical activity
- Environment
- Nutrition
- Education
- Equality
- Working conditions
- Unemployment
- Gender roles
- Social networks
- Marketing and advertising
- Organic farming
- Chemistry and pesticides
- Industrialization of food production
- Social innovation
- Urban development
- Demographic change

HEALTH & WELLBEING
Addio Millennio
La medicina/Vaccini, antibiotici e soprattutto l’uso di acqua pulita: così il 900 ha allungato la durata della vita umana. Ma non nei paesi poveri!

IL NUMERO di anni che, in media, arriveremo a vivere alla fine del secolo prossimo dipende in gran parte da alcuni fattori. L’ascolto può apparire di vi-
vare a persone interessati al futuro delle generazioni. Ogni tre anni, un paese adotta nuove tecnologie che migliorano la produzione di energia elettrica, per esempio, o cambiano il modo in cui viviamo, passando da una 45 anni nel 1900 ad oltre 70. Suggestioni nel venticinquesimo secolo le congetture esperimentali sono diverse e che la capacità della medicina avanzata di pervenire o evitare un imminente pericolo. Ero-secoli dal momento del 2000 in Italia potrebbe avere una diversa patologia di malattie potenzialmente mortali. Il fatto che il mondo nel secolo della terapia e della medicina è evidentemente migliorato, che più di la rabbia e la gioia, ma anche più di quanto accade tra di noi, il farmaco della via con il terreno di un paese. L’ultima è senza dubbio un anacronismo, ma è diventato qualcosa di un problema di salute molti più rapidamente che di solito. Certo, anche la revisione della vaccinazione e dell’antibiotico. La parola corrente non mette in bocca per nu-

Il controllo delle malattie infettive

Il controllo delle malattie infettive è un’opzione tra le situazioni più importanti comprese delle malattia e dei primi punti dove non si tratta la mani
cura delle malattie del terzo mondo. Lo sviluppo iniziano i Romanii, nella medicina e nell’ambito della salute pubblica, che per molti hanno dimostrato che la durata della vita umana può essere migliorata. Ma anche gli operatori sanitari che lavorano in molti paesi africani, includendo la Namibia e il Mozambico, si sono uniti per creare una nuova organizzazione di un’organizzazione mondiale della salute più collaborativa che collaborarsi di essere tra le principali cause di morte del terzo mondo. Il numero di morti di AIDS è cresciuto nel 1990 e 2000, da 1.000 a 1.500. E nonostante sia un problema, l’Agencia Italiana per la Salute della Bambina, si è accorta che la durata della vita umana non è stata modificata. "Ma non è stata modificata. La salute della bambina è stata migliorata, ma la durata della vita umana non è stata modificata."

CULTURA & SPETTACOLI
Nord e Sud, la salute non è uguale per tutti

di STEFANO VELLA
The unequal rise of «healthy» life expectancy
Acute myocardial infarction, 2009

Revascularization procedures, 2009

Giuseppe Costa

Fonte: FORASTIERE ET AL. 2011
Corte dei conti: “Conti sanità sotto controllo ma crescono le disuguaglianze”. Aumentano i
Premature mortality rates in 2016
(as measured by years of life lost per 100,000)

The Haves and the Have-Nots
Branko Milanovic
A Brief and Idiosyncratic History of Global Inequality
The Sustainable Development Goals are interlinked
Universal Health Coverage (UHC) means that ALL PEOPLE can obtain the quality health services they need without suffering financial hardship.
"No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means."

-Nye Bevan
First get a recommendation from your family doctor that your needs are urgent. Then hand that recommendation to any doctor with special qualifications (lists will be available) or to any ophthalmic optician taking part in the new service. If you need glasses, these will be provided without charge. For re-testing you can go direct to any of the doctors with special qualifications, or to an ophthalmic optician.

The National Health Service will provide several kinds of spectacles of different types. For specially expensive types you will have to pay the extra cost.

Dentists Specialist care clinics will be established as resources allow. At these you will get not only an expert opinion upon dentistry but also, if necessary, a 

new hearing aid invented by a special committee of the Medical Research Council. Production of these aids is now going on, but will not meet all demands at once. They will be supplied free, when ready, together with a reasonable allowance of maintenance batteries.

Home Health Your local County or County Borough Council will, as soon as it can, make special provision for: (1) advice and care of expectant and nursing mothers and children under five (for particulars ask your doctor, health visitor, or Welfare Centre); (2) midwifery (ask your doctor or Welfare Centre); (3) home nursing where there is illness in the family (ask your doctor); (4) all necessary vaccinations or immunisation (through your doctor or Welfare Centre); and (5) a health visitor service to deal with problems of illness in the house, especially tuberculosis.

Health Special premises known as Health Centres may later be opened in your district. Doctors may be accommodated there instead of in their own surgeries, but you will still have "your own doctor" to give you personal and confidential treatment. He will still come to your home as necessary. At the Health Centre he will be able to use equipment supplied from public funds. These Centres may also offer dentistry and other services on the spot.

WHAT TO DO NOW

1. Choose your doctor.
2. Get application forms from him or from the Post Office, Public Library, or office of the local Executive Council.
3. Fill one in for each member of the family.
4. Hand them to the doctor.

ACT AT ONCE

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.
TO REACH....

and the future of Health Systems and Services Research in Europe

This project has received funding from the European Union’s Horizon 2020 research and innovation programme under grant agreement No 733274.
TO-REACH is a Coordination and Support Action funded by Horizon 2020 Societal Challenge 1 coordinated by Istituto Superiore di Sanità (National Institute of Health), Italy.

Its goal is to pave the way to a joint European research programme aimed at producing research evidence to support healthcare services and systems so that they become more resilient, effective, equitable, accessible, sustainable and comprehensive in Europe and elsewhere.
The TO-REACH consortium

Chaired by Prof Walter Ricciardi, President of the Istituto Superiore di Sanità, the EU-funded TO-REACH project consists of 27 partners, clustered around three main types:

- **At the core are Ministerial and funding bodies from 15 EU Member States and 5 non-EU countries**, all seeking to fund research that has the potential to change how care is being provided in the near or distant future.
  
  a. the Istituto Superiore di Sanità (the Italian National Institute of Health), coordinator,
  b. Ministero della Salute, Italy
  c. Agenas, national Agency for regional health services, Italy;
  d. ZonMw (Netherlands Organisation for Health Research & Development), the Netherlands;
  e. Austrian Public Health Institute (GÖG), Austria
  f. Academy of Finland, Finland;
  g. IReSP/ITMO santé publique, France;
  h. Health Research Board, Ireland;
  i. Latvian Council of Science, Latvia;
  j. Research Council of Norway, Norway;
  k. Foundation for Science and Technology (FCT) Portugal;
  l. National Institute of Public Health, Slovenia;
  m. Forte, Swedish Research Council for Health, Working Life and Welfare, Sweden;
  n. Federal Office of Public Health (FOPH), Switzerland;
  o. Health and Care Research Wales, UK;
  p. Regional Agency for Public Health and Social Well-being (PHA) HSCNI, Northern Ireland UK;
  q. CIHR Institute of HSPR, Canada;
  r. Israeli Ministry of Health, Israel;
  s. Agency for Healthcare Research and Quality (AHRQ), United States.

- **National research organisations**, able to identify methodological guidance for a future research programme and mapping shared priority areas between countries and stakeholders in those countries.
  
  a. NIVEL, Netherlands organisation for health services research, the Netherlands;
  b. National Institute for Health and Welfare (THL), Finland;
  c. University of Riga (RSU), Latvia;
  d. University of Malta (UoM), Malta;
  e. Babeș-Bolyai University (UBBCU), Romania;
  f. Catholic University of Sacred Heart (UCSC), Italy.

- **European level bodies**, able to contribute to part of the scientific preparations as well as well-positioned to identify fellow bodies and initiatives which require alignment.

  a. European Observatory on Health Systems and Policies;
  b. European Health Management Association (EHMA);
  c. European Public Health Association (EUPHA).
<table>
<thead>
<tr>
<th>Preliminary list of candidates for European Partnerships in Pillar II, III and cross-pillar, and short description of what the partnership stands and aims for</th>
<th>Currently envisaged implementation mode(s)</th>
<th>Predecessors</th>
<th>Composition of partners</th>
<th>Relevance for clusters/ pillars</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. EU-Africa Global Health Partnership Increase health security in sub-Saharan Africa and Europe, by accelerating the clinical development of effective, safe, accessible, suitable and affordable health technologies as well as health systems interventions for infectious diseases in partnership with Africa and international funders.</td>
<td>Article 185 or Article 187 or Co-programmed or co-funded</td>
<td>EDCTP2 (Art.185)</td>
<td>MS/AC and 3rd countries (i.e. sub-Saharan African countries) Foundations/industry on an ad-hoc basis</td>
<td>Cl.1</td>
</tr>
<tr>
<td>2. Innovative Health Initiative A collaborative platform bringing the pharmaceuticals, diagnostics, medical devices, imaging and digital sectors together for precompetitive R&amp;I in areas of unmet public health need, to accelerate the development and uptake of people-centred health care innovations.</td>
<td>Article 187 or Co-programmed</td>
<td>IMD2 (Art.187)</td>
<td>Industry, other organisations on an ad hoc basis</td>
<td>Cl.1</td>
</tr>
<tr>
<td>3. European partnership for chemicals risk assessment Bring together the European risk assessment and regulatory agencies to implement a joint research agenda, to ensure their capacity to deal with persistent or emerging challenges. It will promote the uptake of new methods, tools, technologies and information in chemical hazard identification and risk assessment and as part of this, sustain the development and use of human biomonitoring capacities in Europe.</td>
<td>Co-funded</td>
<td>Human Biomonitoring and a number of other actions</td>
<td>MS/AC, National agencies, tbd the role of the corresponding EU agencies</td>
<td>Cl.1, 4, 6</td>
</tr>
<tr>
<td>4. Pre-clinical/clinical health research The partnerships aims for establishing and implementing a strategic research agenda and joint funding strategy between major European public funders in health research.</td>
<td>Co-funded</td>
<td>Around 10 previous and current ERA-NET actions</td>
<td>MS / AC / 3rd countries</td>
<td>Cl.1, 6</td>
</tr>
<tr>
<td>5. Large-scale innovation and transformation of health systems in a digital and ageing society Improving health and care models in an ageing, data-driven and digital society, shifting to holistic health promotion and person-centred care approaches through health policy and health systems research.</td>
<td>Co-funded</td>
<td>AAL2 (Art.185), JPI ‘More Years, Better Lives’ and others</td>
<td>MS / AC Civil Society organisations</td>
<td>Cl.1</td>
</tr>
<tr>
<td>6. Personalised Medicine To align national research strategies, promote excellence, reinforce the competitiveness of European players in Personalised Medicine and enhance the European collaboration with non-EU countries</td>
<td>Co-funded</td>
<td>ERA-PerMed and actions in support of ICPERMed</td>
<td>MS / AC</td>
<td>Cl.1</td>
</tr>
<tr>
<td>7. Rare Diseases To improve the integration, the effectiveness, the production and the social impact of research on rare diseases through the development, demonstration and promotion of Europe/ world-wide production, sharing and exploitation of research and clinical data, materials, processes, knowledge and know-bows.</td>
<td>Co-funded</td>
<td>EJP Rare diseases (until 2023)</td>
<td>MS/AC/3rd countries, civil society organisations, EU research infrastructures</td>
<td>Cl.1</td>
</tr>
<tr>
<td><strong>General Information</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preliminary title of the European Partnerships</strong></td>
<td>Large-scale innovation and transformation of health systems in a digital and ageing society: a European Partnership on Health and Care Systems Research and Innovation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Short description of the partnership</strong></td>
<td>A partnership with health and care systems owners/organisers and research funders to boost research in policy, uptake and scale-up of innovations to accelerate transformation of national/regional health and care systems.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Services directly involved</strong></td>
<td>RTD, SANTE, CNECT, ECFIN, ENV, REGIO, SRSS, JRC, EMPL, GROW, EAC, EUROSTAT.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Context and problem definition** | Health and care systems in the EU are globally recognised for making quality care available to citizens, and are a key asset for economic strength in the EU. Healthcare is an important economic sector in Europe, employing 8.5% of the workforce, and counting for almost 10% of the GDP in the EU. Nonetheless, health and care systems face serious challenges due to ageing population, increasing number of people with multiple chronic conditions, higher demand for healthcare by citizens, expensive innovative products and solutions, and health workforce shortages. Public spending on health and long-term care is steadily rising in the EU, which is expected to put additional pressure on the Member States given budgetary constraints and the need for fiscal sustainability. The key problem drivers are the following:  
- Lack of knowledge and good practice of how health and care systems research can support policy makers in management and design of health and care systems;  
- Lack of an operational platform that links researchers and innovators in the area of health and care systems with stakeholders from Member States and regional/local health authorities, technology and services providers, investors, patient/citizen and profession advocacy groups to define the unmet system needs and take collaborative R&I actions to address them;  
- Lack of communication channels between researchers and policymakers to take into account the research needs of policymakers, and ensure that solutions provided by researchers are uptaken into policy;  
- Underuse of local/regional stakeholder eco-systems that play a key role in communicating with and informing patients, in education and training for professionals, and in piloting and integrating innovative solutions in health and care services.  

The proposed partnership is being built with the support of a H2020-funded Coordination and Support Action (TO-REACH), which was created to prepare a Strategic Research Agenda towards a joint European research programme on Health Systems, and is composed of partners from 18 countries (IT, NL, FI, FR, IE, LV, MT, NO, PT, RO, SI, SE, UK, IL, AT, US, CH, CA). It has prepared the grounds for joint research activities and pooling of resources from EU and Member States within the European Partnership on Health and Care Systems Research and Innovation. This partnership will draw on specific aspects relevant to health and care systems research in FP7 and H2020 initiatives such as EIP AHA, AAL/AAL2 and MYBL, which are mainly focused on addressing challenges related to ageing population (detailed in the section on current active partnerships). |
| **Objectives and expected impacts** | The partnership has the following objectives:  
1. Provide science-based evidence for health and care systems innovations that support cost-effective and fiscally sustainable health policies and the needs of health authorities, health professionals, patients, citizens and other key stakeholders;  
2. Develop science-based frameworks for monitoring and evaluating the cost-effectiveness and budgetary impact of innovative solutions, including digital, new health promotion services and care models;  
3. Build knowledge on the conditions for transferability and up-scaling of innovative health and care solutions across and within EU countries; |
Source: Dahlgren and Whitehead, 1993
The concept of “public good”

non exclusive: anyone can use them

non competitive: their use will not limit others to use them
The concept of “public good”

Progress of medicine and essential medicines shall be considered as global public goods and be accessible to all human beings living on our planet