

# The health implications of an expanded EU: Threats or opportunities?

Richard Murrin

## Background

In the UK, the 9 May 2005 was an uneventful day. As it transpired, this year's Europe Day ironically found itself lost amidst the introspective media maelstrom surrounding the General Election.

It is now 55 years since Robert Schuman, the French Foreign Minister of the time, appealed for integration amongst European countries that would provide a basis for peace and international security. The horrors and destruction of the Second World War provided the necessary political motivation to ensure that this ambitious proposal would eventually become realised in the form of the European Union (EU).

In its original form, the EU was a sextet comprised of Belgium, Germany, France, Italy, Luxembourg and The Netherlands. The United Kingdom, with Denmark and the Republic of Ireland, joined in 1973. Eight years later Greece became the next incumbent, followed by Spain and Portugal in 1986. In 1995 there was a further intake of three countries (Austria, Finland and Sweden), thus giving a total membership, at that time, of 15 nations (EU15).

Less than a decade later, 10 new Member States were admitted simultaneously by means of the Accession Treaty of 1 May 2004. This event was indeed unprecedented in the history of the EU, representing as it did its largest expansion both in terms of geography and cultural diversity. These 'Accession Countries', namely Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, the Slovak Republic (Slovakia) and Slovenia, also represented the acquisition of 100 million new EU citizens. Although many such individuals rejoiced in their new-found status, others were far less enthusiastic. For example, some of those who had experienced life behind the Iron Curtain feared that pooled sovereignty, enshrined within the EU constitution, might be associated with both the erosion of individual identity and the autocratic policies of the former Communist Bloc. Such pessimism was not only expressed in political demonstrations, but also in opinion polls. The latter indicated that only 60% of Latvians and Estonians were in favour of joining the EU. Surprisingly, however, the greatest

protest was seen in Malta, with half of its population being against EU membership.

Of course, concerns regarding the 'EU25' also originated from within the EU15 establishment itself. The British 'red-top' newspapers predicted a bleak future, characterised by the instability of the domestic job market through the influx of a cheaper labour force and, as a result of the health needs of such economic migrants, an overwhelmed National Health Service.

## Reality

Since the end of the Cold War, the European Union has enjoyed increasing influence on the world stage, having occupied, and expanded within, the political vacuum created through the collapse of the Soviet Union. With the surviving superpower as its model (and, in some ways, its counterbalance), the new, enlarged 'EU25' can aspire to American economic success ascribed to its federal infrastructure and the existence of a large single market.

Nevertheless, the 370 million citizens of the EU15 may be justified in their cautious welcome towards the latest additions to their family. Not only might the financial returns from human investment on such a mammoth scale prove disappointing in the short term, but also any resulting peace and diplomatic stability within its expanded boundaries may come at a price that may prove too high to collectively afford.

Health and wealth, as macro-economic concepts, are inextricably linked. This is clearly demonstrated by the fact that all 10 Accession Countries (very much the European family's 'poor relations') all have a 'GNP per capita' of less than half the EU average of US\$ 22,000. Naturally, financial comparisons between Western and Eastern Europe can prove complicated, but the striking correlation of reduced male life expectancy in all of the newest Member States, cannot be easily explained away. A nation's expenditure, per capita, on health yields additional insights into such matters. Data from the World Health Report (2003)<sup>1</sup> and the European Health for All database (2004)<sup>2</sup> illustrate that all 10 Accession Countries spend far less than their EU15 counter-

**Richard Murrin**

MRCP MRCPATH,  
Consultant  
Haematologist,  
Sandwell and West  
Birmingham  
Hospitals NHS  
Trust, Birmingham

This conference  
was held at the  
Royal College of  
Physicians on  
10 March 2005

*Clin Med*  
2005;5:385-9

parts. That said, it is therefore surprising that World Health Organization (WHO) statistics show that the doctor/population ratio (number of physicians per 100,000 population) in Lithuania in 2001, a figure of 403.04, was inferior only to 2001 data from Greece and Belgium (451.28 and 418.77, respectively). Furthermore, Hungary (1999 data) and the Czech Republic (2001 data) showed a superior ratio to many of their Western European neighbours, such as France, The Netherlands, Austria (all 2001 data), Spain and Portugal (both 2000 data). Interestingly, similar analysis according to the nurse/population ratio gives a different pattern of results in which, with the exception of the 2001 data from Lithuania and the Czech Republic, there is a much greater proportion of the Accession Countries amongst those nations whose population has the least nursing coverage.

Taken together, these statistics seem to suggest that the health inequality of the new EU Member States cannot solely be an issue of funding. Indeed, imbalances and misdistribution of skills are probably more significant than any absolute shortage in the numbers of health professionals. This, in turn, is likely to reflect fragmented strategic health planning, even in those countries where such government bodies actually exist.

All cohesive communities are characterised by a commitment towards mutual welfare and, albeit on a larger scale, the EU, in its latest incarnation, should aspire to the same. Laudable as such aims are, the magnitude of the task should not be under-

estimated. Furthermore, it is essential that health strategies are firmly based on an appreciation of the significant inequalities that exist between the EU15 and many of its 10 newcomers.

Recent surveys confirm the Baltic States to have the lowest life expectancy of the EU25, as well as the highest premature (less than 65 years old) mortality rates from cardiovascular disease and other smoking-related causes. It therefore comes as no surprise to discover that, based on 2004 WHO data, around 50% of Latvian and Lithuanian men smoke and (from 1999 WHO information sources) Lithuania and Latvia are amongst the top four European countries in terms of fat consumption, at 44% and 42% of total calorific intake respectively. These two countries also find themselves among seven of the new Member States (the others being Hungary, Malta, Poland, Slovakia and Slovenia) with a projected population prevalence of diabetes mellitus of greater than 10% within the next decade. Lithuania also has the highest rate of suicide, amongst young men, in Europe. In common with that from many of its neighbours, this statistic highlights the high proportion, roughly 25%, of the total long-term disability/morbidity arising out of neuropsychiatric diagnoses in the EU25. As one last example, Hungary has the unwanted distinction of the highest mortality figures due to lung cancer, five times higher than those of Sweden.

However, despite the above analyses, we should be careful not to conclude, as a generalisation, that the burden of illness within the EU25 largely arises within the boundaries of its most recent

## Conference programme

■ **EU enlargement and health: an introduction and overview**  
Professor Martin McKee, European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine

■ **New and emerging infections – Europe is not immune**  
Professor Peter Borriello, Director, Health Protection Agency Centre for Infections

■ **Perspectives on the trends in non-communicable diseases**  
Dr Imogen Sharp, Head, Health Improvement and Prevention, Department of Health

■ **Health professional mobility – challenges and opportunities**  
Professor James Buchan, Queen Margaret University College, Edinburgh

■ **Closing the gap; health and wealth in a divided Europe**  
Professor Witold Zatonski, Maria Sklodowska-Curie Memorial Cancer Center, Warsaw

■ **Global health issues and foreign policy**  
Mr Hasan Bakhshi, Deputy Chief Economist, Head of Global Economy Group, Foreign and Commonwealth Office

■ **Health Protection Agency: response to communicable disease threats**  
Professor Angus Nicoll, Director, Communicable Disease Surveillance Centre, Health Protection Agency Centre for Infections

■ **Prevention of obesity and smoking. Lessons from initiatives for healthy living**

Professor Peter Kopelman, Barts and The London School of Medicine and Dentistry, Queen Mary, University of London

■ **HIV/AIDS and TB in Europe: a World Health Organization perspective**

Dr Gudjón Magnusson, Director Technical Support, World Health Organization Regional Office for Europe, Copenhagen

■ **European Commission perspective on health: objectives and current priorities**

Dr Bernard Merkel, Head of Unit, Health and Consumer Protection and Directorate-General, European Commission

■ **Department of Health perspective on the opportunities and challenges of an enlarged Europe for health policy**  
Mr Nick Boyd, Head of International Affairs, Department of Health

■ **Milroy Lecture – Winners and losers: the health effects of political transition in Eastern Europe**

Professor Martin McKee, European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine

incumbents. In fact, by means of illustration, the UK and the Republic of Ireland have the highest rates of respiratory illness in Europe.

Furthermore, there are those health issues that are of pressing importance for both established and new Member States alike – such as obesity and smoking. Nearly a quarter of European schoolchildren are overweight, with its attendant risks of diabetes (and other complications) in later life. The UK annual cost of obesity, £1 billion direct and £4 billion indirect, serves to emphasise the magnitude of the problem. Here, the Foods Standards Agency is actively promoting the sale of healthier foods, an improvement in nutritional standards and increased levels of physical activity. Such initiatives, however, may find themselves ‘swallowed up’ by the promotional/advertising activities of fast food restaurants, ready-meal manufacturers and soft drink companies, whose combined expenditure of £743 million, in 2003, in the UK was over 100 times that spent by the Government in food campaigns and related matters, within the same 12 months.

Smoking, pathologically synergistic with the effects of obesity, is also a huge problem for the new EU, both at home and abroad. General Household Survey data demonstrated that, since 1973, smoking prevalence has been inversely proportional to socio-economic advantage and that, whereas 1998 figures had shown a general fall in overall prevalence over 25 years, a disproportionately small reduction had taken place in the most deprived social groupings. Currently, one-fifth of all UK deaths can be attributed to smoking and, with 2,300 people losing their lives in this way every week, it represents the largest avoidable cause of premature mortality. To maintain current levels of profitability in the face of such rates of attrition amongst its consumer base, cigarette manufacturers need to constantly recruit new customers amongst the young. It should be stated that smoking rates in British 11- to 15-year-olds have remained at a level of around 10% for many years with similar, if not higher, statistics seen on the continent. Tobacco control policies have, based on the recent experiences of several countries, brought about a reduction in smoking prevalence of the order of 4%. Such strategies must be strengthened in scope, and applied over a wider geographical context internationally, to counter the immense threat posed by the expansion of the tobacco industry's business interests into its potentially lucrative markets in Eastern Europe.

### Rhetoric

For some time prior to the Accession Treaty, the Euro-sceptic elements of the British media, appealing to the xenophobic sensitivities of their readership, predicted a huge influx of health professionals from the new Member States, into the UK. However, events post-May 2004 have failed to match expectation. Although the General Medical Council (GMC) saw, in 2004, a total of 900 new entrants from the countries of Poland, the Czech Republic and Hungary, 2003 data from the Open Society suggested that less than 20% of such medical practitioners, expressing an intention to work in the UK, had made

any definite plans to do so. Furthermore, towards the end of 2004, a mere 53 nurses from the new Member States had actually come to the UK to work, far less than the initial unofficial estimates had suggested.

The political influence of the 10 Accession Countries within the latest conformation of the EU is probably, like the scenario of a mass exodus of migrant workers amongst their respective health worker populations, an exaggeration of the true situation. Despite these newcomers having, by virtue of being considered for EU membership, successfully satisfied the Copenhagen Criteria (which include democracy, rule of law, human rights legislation, respect for minorities, a functioning market economy, a capacity to cope with competitive pressures and an ability to take on the obligations of membership), recent amendments to the Council voting process will tend to favour the historical pre-eminence of most of the founder states (and maintenance of the status quo), rather than promote new alliances and models of international collaboration. Seven countries of the EU25 have populations of under 6 million, giving a mean value of 18 million overall, a reduction from the 25 million average that characterised the EU15. Although not strictly proportional, the number of votes allocated to a given EU member does, in broad terms, reflect the number of its inhabitants. From 1 November 2004, four nations – Germany, France, Italy and the UK – had, at 29, the largest number of votes to cast individually. Although, alongside Spain, Poland can boast the next highest quota of 27 votes, only two of the other new Member States – the Czech Republic and Hungary – have been granted more than 10 votes each. Lithuania and Slovakia will each cast seven votes; Slovenia, Estonia, Latvia and Cyprus, four; Malta, the lowest, at three votes. The corollary is that, of a total of 321 votes in the EU25, the Accession Countries can only lay claim to 84. Such mathematics, within the ‘qualified majority voting (QMV) scheme’, ensures that in order to achieve the minimum majority vote of 72.3%, the EU15 ‘establishment’ will retain the balance of power over the new EU ‘10’. The latter, comprising only 21% of the total EU25 population, might also experience difficulties, even with unanimous agreement between themselves, in recruiting the additional 41% of population (amongst the EU15) to achieve a minimum ‘population’ vote of 62%, the final requirement prior to any EU Council majority determinations being adopted.

### Threats

The recent unprecedented expansion of the EU has brought with it, inevitably, many potential disadvantages that threaten its membership's collective prosperity, well-being and security – the very issues that the acquisition of the ten Accession Countries had been assumed would safeguard, rather than jeopardise. There is now a larger-than-ever internal European market, whose commodities, in addition to workers, services, goods and capital, also include micro-organisms and criminality; the latter two elements require preventative strategies to be employed both within, and beyond, the frontier boundary delineated by the EU25.

Our new Eastern neighbours, in particular, pose a substantial danger. Russia and the Ukraine have seen higher growth rates of HIV infection than anywhere else in the world. If much-needed public health measures are not undertaken, and the current trends were to continue, then there would be an estimated 5.4 million cases of HIV, representing 3.7% of these populations, by 2020. In contrast to its epidemiological features in Western Europe, HIV infection in Russia is mainly acquired as a consequence of intravenous drug abuse and the vast majority (75–85%) of individuals contracting the virus are male. Between 30 and 70% of patients affected by this retrovirus are less than 25 years old. The demographic impact of this is likely to prove profound, deepening the financial crises facing these already frail economies. Multi-drug resistant tuberculosis (MDR-TB), whose incidence is rapidly growing in Russia, the Ukraine and Belarus, has markedly increased mortality amongst these countries' immunosuppressed patient groups. Such mycobacteria, also being detected more frequently in individuals from the Baltic States, now have a foothold within the EU's new perimeter.

The spectre of other infectious diseases, such as hepatitis B and C, also looms large. Furthermore, in the Baltic countries, Russia and the Ukraine, fragmentation of public health initiatives has led to a massive rise in vaccine-preventable conditions. However, both here and in the Candidate Countries of Bulgaria, Romania, Turkey and Croatia, high levels of corruption comprise a formidable barrier to policies aimed at tackling these, and similar, medical concerns.

Notwithstanding the effects of contagious and malignant diseases, the world's population growth continues at an alarming pace. In 1950, planet earth had 2.5 billion inhabitants; 4 billion in 1975; 6 billion in 2000; and a projected number of over 8 billion in 2030, the year in which Turkey's population is predicted to rise to 94 million, bigger than any other member country of the EU25.

Furthermore, from a more global perspective, the recent SARS crisis emphasised the fact that, through modern-day international travel, we are all inhabitants of the 'world village', in which infection can promptly cross several time zones, placing several susceptible continents under threat from a contagious illness simultaneously.

## Opportunities

There is, nevertheless, some room for cautious optimism. The European Union has an impressive track record with regard to its public health role (eg the European Centre for Disease Control) and, through well-organised surveillance schemes, in partnership with specialised microbiological laboratories located within the EU25, can further plan and implement coordinated interventions.

In seeking further progress in the sphere of public health, the new EU will be able to draw upon the substantial experience and success of Poland's domestic policies; especially those of tobacco control and dietary improvement, instrumental in reducing the nation's cardiovascular mortality, and thus improving life expectancy by four years (thus matching figures amongst the EU15), in both men and women.

It is therefore essential that, within the expanded labour market of the EU25, Western Europe's recruitment of health sector workers, especially from the new Member States, does not compromise the economic, nor national, well-being of such countries, by accentuating skill shortages. The latter would be keenly felt by many of the Accession Countries, as their models of healthcare continue to evolve from state-led, social insurance-funded schemes. A significant financial commitment will be required from the EU to protect, and promote, such medical services in transition.

With the recognition that peace, security and health are interdependent variables, the EU has, via the Global Opportunities Fund, set up the Reuniting Europe Programme, to 'bolster and extend the success of EU enlargement by supporting countries throughout the EU integration process, particularly in the field of good governance'. Of its many projects, action against border crime and trafficking (of goods and people) is high on the list of priorities. This is vital, given the huge increase in smuggling from Eastern Europe – not only narcotics and tobacco but also women, taken to the West for forced prostitution. Such problems are rife in South Eastern Europe, documented in detail in the publication *Healing the crisis*.<sup>3</sup> Health, indeed, can be a bridge to peace; this can be seen clearly in the success of programmes in Bosnia-Herzegovina, where improvements in the provision of medical care have led to political stability and social cohesion.

## The way forward

In July 2005, the UK assumes the Presidency of the European Union, with the responsibility of chairing all Council Meetings, promoting legislative and political discussions and, perhaps most important of all, brokering compromises between individual Members in order to achieve a consensus view on issues of mutual interest.

As part of its presidential agenda, the UK will have amongst its major themes improvement of health across the new EU, with every citizen aspiring to well-being as a basic human right. Fundamental to such policies is the acknowledgement that British commercial interests are ultimately linked to the prosperity and stability of other European countries. That said, the pursuit of short-term financial advantage may often conflict with the principles underpinning the longer-term interests of good diplomatic relations and international cooperation. In the search for balance between such competing demands, an ideal example would be to reinforce, through legislation, the World Trade Organisation directive, Trade-Related Aspects of Intellectual Property Rights, which makes provision for less affluent countries to import cheaper, generic preparations under compulsory licensing, if it can be shown that such nations lack the facilities to manufacture such drugs themselves.

UK-directed debates on EU Health Policy should allow for, and may depend on, engagement with Accession Countries at an early stage, especially in important areas such as patient safety (eg the Crossing Borders initiative) and methods of reducing inequalities between EU15 countries and the newest Member States.

The new political alliances that emerge will inevitably alter the UK's medical horizons in terms of the potential for shared knowledge, transfer of skills and joint training opportunities. Various EU instruments will be required to ensure that recruitment of healthcare workers, between EU States, firmly adheres to ethical standards. Furthermore, such provisions should account for, and perhaps compensate, a country in which health service delivery would be adversely affected by the efflux of a given number of its medical professionals. Such nations will probably require, in addition, aid from their fellow Members to adopt and maintain EU standards concerning the delivery of healthcare.

As described already, the welfare of EU citizens will ultimately be governed by events outside, as well as inside, its collective borders. The EU Justice and Home Affairs Council has long recognised the importance of coordinated cooperation between the national courts and police forces in criminal matters. In addition, the Foreign and Commonwealth Office has committed itself, via the Drugs and Crime Fund, to reduce the supply of, and demand for, Class A drugs in the Balkans and Turkey. This will be achieved through the support of, and close liaison with, regional law enforcement agencies.

A Pan-European approach to health promotion is also essential. The Presidency of the EU will give the UK a valuable opportunity to formulate a concerted approach against the hazards of (as examples) smoking and alcohol, not only amongst its 24 fellow Members, but also Candidate Countries and their Eastern neighbours. In response to the current epidemic of HIV infection in Russia (where only 8% of infected patients currently

receive anti-retroviral therapy – similar figures to those of sub-Saharan Africa), it can be argued that the long-term health of EU25 citizens can only be safeguarded through prompt, EU-generated, medical aid as part of a committed international initiative.

Although the European Union was initially established for the purpose of international trade, it now finds itself increasingly concerned with matters of direct importance to the individual, such as human rights, security, justice, job creation, regional development and environmental protection. Success in these and other areas will only be achieved through a renewed spirit of tolerance, solidarity and optimism amongst the citizens and political leaders of the new EU.

## References

- 1 World Health Organization. *World Health Report, 2003*. Geneva: WHO, 2003.
- 2 World Health Organization. *European Health for All database*. Regional Office for Europe. Geneva: WHO, 2004.
- 3 *Healing the crisis. A prescription for public health action in South Eastern Europe*. A Public Health Programs Publication. New York: Open Society Institute, 2003.