UK health challenges: can the EU make a difference?

Robert Madelin

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The role of the European Commission is not healthcare provision – it never will be and it is not our ambition – but rather to see if ways can be found in which Europe can make a positive contribution while leaving the necessary autonomy at local, regional and national levels.

Following the high profile and successful UK Presidency of the Council of Ministers in the health field, now is a good time to reflect where to go next. We are also 20 years from the Single European Act when the need for European legislation to incorporate health protection was explicitly acknowledged for the first time. Behind the headlines that say Europe is about markets and competitiveness against social goods or public goods, the same European Council is adopting Healthy Life Years (the sustainable health and well-being of individual citizens) as a key performance indicator for its competitiveness agenda. I think this is a sign for optimism. If we wanted to be pessimistic, we would then poll the heads of states and governments to determine whether they are conscious this is what they had decided.

The UK health agenda is indistinguishable from the European Union (EU) health agenda: inequalities, obesity, alcohol, the challenges of providing high quality health services with a constrained budget, rising salaries (perhaps not fast enough) and rising costs of technology. These challenges are faced in different measure by every member state, every local land or regional health authority and every hospital manager across Europe. Of course the figures are different. In health inequalities, for example (to choose the most striking), there is a difference of prevalence of tuberculosis of one to 17 and a difference of life expectancy of up to 12 years in the widest gap (between Sweden and Lithuania). Fundamentally, though, the agenda is the same.

What is the mandate?

The mandate is not to manage healthcare but to exert a supporting role from two perspectives: integration and support.

Integration

The Treaty on European Union (the Maastricht treaty) built on the Single European Act by introducing a specific article for EU action on public health. This is now in the Treaty; it came at the same time as many other additions motivated by the great strides on economic integration made since the Single European Act. With a more efficiently functioning market and a more integrated European society, there was agreement around Maastricht (something not seen around the Constitution) that this market needed accompanying measures to balance priorities other than health, such as the environment and consumer protection. From the Single European Act, which said that measures to put in place the single market should take as a base a high level of health protection, we moved to the treaty of Maastricht. This stipulated that a high level of human health protection shall be ensured in the definition and in the implementation of all Community policies and activities.

For me, that clause really says that the beginning of health in Europe is outside health as a policy area. Health has been accepted since the Treaty of Rome as a reason for one country to stand apart from single market measures. Progressively through the Single European Act, through the treaty of Maastricht, we see European policy actively being directed to pursue good health outcomes.

First, it is therefore possible to look across the range of EU action to identify many areas which demonstrate that Europe is determining the parameters for some of these non-health drivers for health outcomes: water, food safety, product safety. All these environmental standards are being set largely by regulation or self-regulation negotiated at the European level.

Secondly, in the first instance national regulations remain paramount for health professionals, but freedom to move from country to country and to practise are based on EU directives on mutual recognition.

Thirdly, pharmaceuticals: the European Medicine Evaluation Agency (based in London) does the essentials of licensing – although there are some national checks in terms of packaging and information. There is now a research programme for medical technologies (currently 3.2 billion euros); we are looking for higher funding under the seven year EU Framework Programme for Research and Technological Development.

The first point to come out of any sensible reading

of the treaty of Maastricht and the Healthy Life Years objective must be that there is potential to try to use non-health policies at the European level: not just to make sure they are doing no harm but to try to make them vehicles for leading towards more rapid change in the right direction.

Support

Europe offers support as a meeting place with limited financial backing. Essentially, Europe offers a place for people to come together, either because they want to or, on occasion, because the Commission suggests it: to debate and define common objectives, and then sometimes, given the meagre public health budget, to have some common financing actions at a European level. This is the basis on which sustained programmes on HIV/AIDS, cancer and health promotion have been established in the last 5–8 years.

Despite this apparently limited financial mechanism there have been sustained success stories in areas like cancer; over time, networks can be seen to be stabilising and growing, with improved support.

The current expenditure on public health is only 14 cents of a euro per annum per citizen – say, 10 pence per citizen per year – a tiny fraction of 1% of national expenditure even in the poorest member states. A similar sum has been settled on for 2007 to 2013.

Subsidiarity tests

We are looking at a world where those within the process can perceive a system that has proved its worth over 5–8 years, one which we want to enlarge, and one in which we are moving from 15 to 27 member states over a short period of time.

The next question is where to apply these techniques: where and why should this be done at EU level rather than at national level? I would suggest four subsidiarity tests:

- if there is an economy of scale
- if information can be gathered at EU level to inform local policy making that is not available at the same cost or not at all to the national policy-making community
- if technical or political support or other tools for tackling health issues can be developed through cooperation where there is already a national will but perhaps not a critical mass of momentum
- if there are areas where there is a need to act to ensure positive health impacts – more of these non-health determinants.

Economy of scale

The most exciting area is where there is an EU economy of scale. Through recent discussions with national authorities in Brussels we are beginning to identify such areas.

There are four *health technology* assessments. There could be 25 different assessments of every new piece of technology or innovative technique. There probably needs to be some review at national level to take account of particular collective preferences and sometimes particular health situations, but the evidence at the heart of decent health technology assessment will not vary much from England to Scotland to France. There is increasingly a willingness to look at how such a network on health technology assessment can be established – not to do it in Brussels, not to set up a European clinical assessment body, but increasingly to share common methods and mechanisms. We have established a pilot EU network on this that could serve as a basis for the future.

For a leading practitioner country like the UK, the immediate net benefits may be less evident than for a beginner in such a field but, over time, it would be a good insurance policy for the policies that are made and defended in one country to be recognisably based on the methods being used next door. Also, over time, genuine savings may be found to cut the cost of decision making, either if expertise can be bought in where it has proved successful elsewhere or where the completed work can be passed on, thus reducing the costs of the business.

Rare diseases – There is considerable interest in rare diseases which, by definition, can be a critical mass disease in half a billion population of the Union but not in one member state. It would be helpful to have some sort of network of centres of excellence across Europe and some established practice and protocols for how these centres of excellence could work together in terms of diagnostics and perhaps treatment.

Influenza – It must be in the interests of every member state (even those with insular geography) to ensure that pandemic preparedness, for example for influenza, is also high in other countries. We have been grateful for the professionalism that the Health Protection Agency has shown in helping to coordinate some of our preparedness exercises in the autumn. Clearly, influenza will continue to be one focus, but pandemic preparedness in general should be another – again, it stretches beyond the health community.

If there is a serious pandemic, at one level there cannot be much cooperation and sharing because every national and local system will be overwhelmed. At another level, in terms of social and economic disruption, a coordinated approach is needed in order to maximise the effectiveness and minimise the costs of such disruption. Different decisions cannot be taken in relation to Schiphol and Heathrow, and a common policy for both ends of the Channel Tunnel is vital.

Tobacco products and other areas – Another sort of problem concerns tobacco products, alcoholic drinks and front-of-pack labelling for food – areas where the existence of a single market provides an opportunity to create more widespread good signals in the market around such products and foods.

The economies of scale test, if quite vigorously applied, will enable aspects to be identified where it makes sense to have some cooperation and to winnow out other areas where it does not.

Information

Information was the key for the Europe Against Cancer programme which ran from 1987–2002. There were 340 small projects with an average cost of about 300,000 euros (some projects are still ongoing). Good comparative data were produced for one or two of them on outcomes for different cancers across Europe, leading to quite fundamental changes in UK cancer services in particular.

If it could be said that some cancer outcomes have been improved by paying 300,000 euros, this would be one example of a broader need for comparative data. Finding a structured safe way of getting into those data, having validated data, is an important potential value added for Europe.

Later this year the EU Health Portal will be launched – an internet-based tool to give access to validated data of this sort. It will not create all the data sets that are needed but it addresses the need to roll out this sort of example more generally, giving local policy makers access to broader comparative data.

Support for national initiatives

Obesity – Every member state faces rising trends in excess weight, inadequate physical activity and clinical obesity, and many different experiments are ongoing. Some member states tell the European Commission that what is done in Brussels will help to build political profile for this issue at national. A country like the UK does not need Brussels to tell it that obesity, nutrition and physical activity are important issues. However, I think that the strength of the response from the UK community to our Green Paper on promoting healthy diet and physical activity suggests that even here there is a willingness and a desire to be part of the debate (even if the UK may be contributing to the debate rather than learning much from it at this stage).

Patient safety – Safety of patients is clearly an example where the UK has been one of the countries leading Europe in the debate. Considerable progress has been made, again indicative of the sorts of tools that can be made available. By bringing the debate to Europe somewhere between the World Health Organization and the national level, a much more widespread and substantial consensus was created. I hope that this will enable member states who do not have such a strategy to build one, enabling all the member states to decide whether some elements of the strategy can best be done at local level while some require EU level cooperation.

Already we are launching projects to develop strategies for sharing data and best practice. If a particular problem that can endanger patient safety arises in one country, we should not wait to repeat the accident somewhere else before all can learn the lesson.

A positive EU impact on health?

Can actions be taken at EU level to maximise the positive impact of the EU on health? Within the better regulation work that is so popular in Brussels we are trying to develop a better technique for the assessment of both health impact and health services.

Health impact

The UK is more advanced than many member states in the use of data about disability-adjusted life-years (the value of a statistical life) to measure the impact on health of policy options. Following the publication of the White Paper on Tobacco in England and Wales I was impressed by the open debate both about valuation of life and in terms of the lives that would be saved under the different options. For me, that seems to be state-of-the-art impact assessment.

There is no consensus yet across the EU that lives can be talked about in this way. Paradoxically, in a field such as health it is only when lives are talked about in this manner that we can begin to speak the language of those whose policies are more economic than social in orientation and who therefore respond more to the idea of money than of lives. This is an important area where we have to learn to do better in order to maximise the impact of other policies on health.

Healthcare services

There are policies relevant to health in all the areas which can pass the subsidiarity tests – and where we are passing those tests – areas where a positive difference can be made if member states choose that Europe should be involved. However, Europe cannot enforce anything: even if the possibility of binding law does exist, the core Treaty mandate on health is to support co-operation, not to make legislation. So, both for healthcare services and more generally, the choice to be made by each national player is whether Europe is a field on which to play the game or a partner in the game you are playing, or neither.

The controversy around the European Working Time Directive reflects what can happen if such choices are not made consciously and at an early stage. Part of the current problems can be explained by the fact that, during the legislative process, healthcare implications were not adequately explored. Healthcare managers were not sufficiently engaged in the process at that early stage. Afterwards, the need to implement the Directive was not actively owned by that same constituency of people actually providing healthcare.

It may be that the first problem could be fixed by prior assessment of possible impacts on health systems, but a surer solution is engaging more fully with the people who manage these issues.

This is an important lesson which applies not just to damage limitation in difficult pieces of legislation like working time but also to all the rest of the positive health agenda that I have laid out. The key test for EU action is the extent to which a positive difference can be made to meeting national health challenges, but to pass that test the national experts have to be fully involved. This is not just an issue for the European institutions. Ultimately, our interlocutors are set down in the Treaty – the Parliament and the Council. Involving the right people therefore must happen within national systems and debates – which

means that the wider health community must also have Europe on their radar.

Health Services Directive

The proposition of a specific initiative on health services has now been endorsed by the European Council. The Health Directorate-General and my Commissioner, Markos Kyprianou, must decide what this means. The Commission said in Parliament that we will reshape the approach taken in the Services Directive, because the market-based approach which works well for simpler services may work less well for health provision.

This EU initiative on health services will be anchored at three points:

1 The issue of legal clarity – necessary for those responsible for healthcare systems.
2 What do the patients need? An EU-wide network of patients' organisations is emerging. Some of them go to the European Parliament and to Brussels and explore their rights, seek clarity about what happens when moving abroad for treatment or request more information.
3 The scope of things to be done at EU level that would help health service funders and providers to meet what are essentially common challenges.

Can EU law be used at all if health is not a market? In simple terms, health is not a market because:

- there is no perfect knowledge
- no one is a rational decision maker when sick or when their family is sick
- real competition is usually lacking, especially if competition is regarded as bounded geographically.

Health is not a market, but there is a quasi-market approach to health. This is in the sense, first, that healthcare is paid for by somebody, whatever the structure of provision and, secondly, people are increasingly moving to regard the market as a concept underpinning some of the mechanisms they want to introduce into health services as a means of delivering better health.

At the European level, I do not think we want to get into a debate about whether or not health is market based and whether we want different rules for private provision. We would much rather not look at high principles but ask:

- What do health systems need in terms of clarity?
- What do patients need as citizens?
- What are patients asking for?
- Is there anything that health systems can usefully do together?

The zero option is also there: the option of doing nothing or muddling through, which would probably mean that Brussels would do nothing and you would muddle through. If that is what happens, it will mask a missed opportunity.

Believing in Europe

My final point is to say that what I like about working in health as a European believer is that people believe in health.

Why do people not love Europe? The answer is of course that, as with herbicide-resistant, genetically-modified crops, individuals do not like Europe because they cannot see the direct benefit to them. If Europe wants to be loved, it has to be relevant. This should be easy in the health field, but it is not. Everything we do – food safety regulation, consumer protection, public health policy – really matters to people, but we are not yet making it clear enough that there is a common view of what Europe can do that is useful. My belief is that it is important to do this work and to continue to grow. The zero option, in terms both of health policy and of health services, does not seem to me a good option either for health or for Europe.