WHERE TO FOR EUROPEAN HEALTHCARE?


Organised by UCL European Institute and UCL Grand Challenges in collaboration with The Finnish Institute in London.
The Future of Healthcare in Europe project aims to address some of the key challenges faced by European healthcare systems today, discuss existing good practices and identify new policy strategies. With this pamphlet, we aim to offer readers an entry point to these discussion and to challenge them to think and act to find an answer to the question – how can Europe sustain and improve healthcare?

Healthcare systems throughout the world are endeavouring to rise to the challenges that result from an ageing population, the growth in chronic diseases, burgeoning technical possibilities and public expectation. To cope with such elements, an increasing proportion of GDP is spent on health in OECD countries, with Europe being no exception. The downturn in the world economy has increased concern about the sustainability of such a state of affairs.

The UK is contemplating the most radical reform of the NHS since the service was developed over sixty years ago in an attempt to optimise quality of care whilst seeking huge efficiency savings. A greater focus on prevention and public health, patient empowerment and out-of-hospital care is integral to the proposals. Other European nation states have proposed or are contemplating their own solutions to the challenge of meeting health care demands within constrained budgets, including for example the Netherlands and Switzerland.

Despite our differing histories and cultural diversity, European countries are characterised by social solidarity on issues such as health. Furthermore, amongst EU member states, healthcare professional and patient mobility can occur.

It thus seemed timely and highly appropriate to create a forum to examine the nature of the healthcare challenges we face, and to draw on European experience as well as policy makers and academic experts in the search for potential solutions. The future of healthcare in Europe and ultimately the health and wellbeing of European citizens will rely upon the right answers being found.

Professor Sir John Tooke is UCL Vice-Provost (Health) and Head of the UCL School of Life & Medical Sciences.
Some major health challenges...

Rising costs and inequality

In 2008, European Union countries devoted 8.3% of their GDP on average to health spending. Public expenditure on health and long-term care as a share of GDP could almost double between 2005 and 2050 on average across OECD countries.

Obesity

Obesity affects 30–80% of adults in the countries of the WHO European Region. The WHO predicts there will be 2.3 billion overweight adults in the world by 2015 and more than 700 million of them will be obese.

Physical inactivity

In recent studies, physical inactivity is estimated to cost each of the European Region’s countries about EUR150-300 per citizen per year.

Sexually transmitted infections

The steady decrease in the number of reported AIDS cases diagnosed in recent years in the EU has continued in 2008, apart from the Baltic States. However, between 2000-2008 in the 23 EU/EFTA countries that have consistently reported HIV data, the rate of reported cases of HIV infection has increased 33%.

Diabetes

Diabetes has rapidly become a global epidemic. WHO projects that diabetes deaths will increase by more than 50% worldwide in the next 10 years.

Ageing population

Europe’s population is ageing rapidly. In 2060, 30% of the EU27 population to be aged 65 or more. From 2015 on, deaths are projected to outnumber births.

Mental health problems

Depression is one of the main causes of disability in the EU. The European Commission estimates that one in four Europeans suffer from a mental health problem at least once during their life. It is estimated that 18.4 million Europeans aged 18 to 65 have suffered from depression in the last twelve months.

Cancer

Cancer incidence rates are higher for men than for women in all EU countries. Changes in lifestyle and improved prevention and screening policies could prevent up to 40% of all cancer cases.
There are three widely accepted goals in the organisation of health care in Europe: care should be of high quality, comprehensive and available without financial barriers to access. These are not the only important goals, but they define a set of core policy purposes. Public policy works well when it combines the three core purposes in acceptable ways, however achieving such combination becomes ever more challenging as the tensions between them increase under pressure of background trends such as an ageing population, technological innovation and a global rise in healthcare costs.

It is in the context of these three potentially conflicting policy desiderata and the ambition to combine them, that a set of common challenges is faced in very different institutional healthcare settings across Europe. The principal challenges can be defined as scientific/intellectual; economic/financial; organisational/administrative and cultural – roughly speaking, what we know or understand, what we can afford, what we can organise and what we value. How may we examine these challenges in light of the policy aim to provide high quality, comprehensive healthcare, without financial barriers to access?

Providing high quality care is related to underlying scientific developments but also to the economic and organisational capacity to translate those developments into improvements in practice, and to questions of social value, for example on cultural attitudes to end of life care or to the treatment of early neonates. Providing comprehensive care raises organisational and economic questions around the integration of social care, cultural questions around tackling environmental and lifestyle determinants of health, and ethical and cultural questions about what distinguishes the treatment of illness from the provision of enhancement. Securing care without financial barriers involves a values challenge about what level of healthcare a society should fund and an organisational challenge of how to design systems of co-payments which do not jeopardise access.

Within any one of the three policy goals, the force of the various challenges may shape our overall conception of what that goal consists in. For example in the case of high quality care, whilst scientific advancements may increase what is medically possible, doing whatever can be done may prove ethically and culturally controversial; we may decide that high quality care consists in more than high-tech medicine. How the policy goals are conceived may have some bearing on the tension between them, but the need to compromise will remain. So, doing all that is medically possible to achieve a certain conception of high quality care may be not only ethically and culturally controversial but also highly expensive, requiring compromise on one or both of the other two goals: one way of coping with cost pressures is to restrict comprehensiveness of care, another is to introduce co-payments.

A maximal view of comprehensiveness may mean trade-offs on quality of care, such as accepting longer waiting lists, and a view which regards any charge as a barrier to access may lead to financial pressures which bear negatively on both of the other policy goals. Whilst compromise between the three desiderata is inevitable, sacrifice is not, and the task is to find a reasonable balance among the values implied.
There are no shortages of challenges faced by the healthcare systems throughout Europe today. Governments are now tasked with providing additional services to an ageing population, with less money, for more demanding patients. However, the European Union – through its various institutions – is determining how it can bring added value to health systems and use these challenges to create opportunities for patients, healthcare professionals and industry stakeholders. The opportunities for improving the efficiency and efficacy of European healthcare institutions exist – the real challenge lies in utilising the capacities we already have and viewing the delivery of healthcare in a new way.

One of the first opportunities for all health stakeholders will be realised with the implementation of the Patients’ Rights in Cross-border Healthcare Directive. The newest piece of healthcare legislation makes clear determinations regarding reimbursements for patients seeking treatment in countries abroad and provides the foundation for cooperation amongst Member States in the realms of both eHealth and Health Technology Assessment (HTA).

Setting a new standard for patient-centred policymaking, the Directive creates a basis for further pan-European regulations to consider that the delivery of healthcare must begin to adapt to the patient.

With the establishment of the legislative basis for eHealth, Member States will also have increased opportunity to share knowledge and best practice about how to encourage the uptake of innovative technologies that assist in providing efficient and effective healthcare services. Waiting times for patients can be significantly reduced with telemedicine services and an electronic patient record can help both patients and professionals in monitoring care no matter where the patient travels or resides.

To safeguard patients, Health Technology Assessment (HTA) is now used as a method through which many Member States devise the medicines and technologies that are safe and effective for use in health systems. HTAs throughout the Member States have used differing procedures for approving medical products which has translated into a problem of accessibility for patients, professionals and industry. However, the new legal foundation for HTA will allow for additional cooperation between Member States with the aim of continuously increasing the presence of technology in the delivery of healthcare.

Though the challenges to health systems in Europe are great, there are many opportunities for policy solutions. The European Commission continues to develop partnerships and programmes to encourage the assistance of technology in reducing the challenges faced by healthcare systems. Together, policymakers, patients, healthcare professionals, industry and experts are facilitating improvements in the average patient experience and will continue to drive reductions in the challenges we all face as recipients of the most prized possession – quality health.

John Bowis OBE is Honorary President Health First Europe, former MEP, former UK MP and Minister of Health.
THE FUTURE OF HEALTHCARE IN EUROPE

Inequality in Healthcare Systems
by Professor Marina Erhola

“Equity as an indicator of healthcare performance is often poorly understood. Equitable access to health services is not only about normative ethical standards in healthcare systems. Breaches of equity are also sentinel indicators of serious flaws in the functioning of a healthcare system.”

With regard to the principles underlying the creation of the European healthcare systems of the future, the Governments of the European countries share the common values of solidarity, equity and participation, as set out in the Tallinn Charter issued by the WHO European Ministerial Conference on Health Systems in 2008. In most, if not all, countries these principles are regarded as major objectives for healthcare policy.

In this context the growing evidence of inequalities in access to and use of health services is disquieting. This is the case even in countries such as the UK and Finland, whose healthcare systems have traditionally been thought of as being modelled on the fair, egalitarian principle of ‘equal use for equal need’. Research shows geographical and socio-economic disparities in a wide range of healthcare services, including GP and specialist care, preventive services and elective surgery. Likewise, studies show inequities in care outcomes. In Finland, one shocking finding has been that, while mortality amenable to healthcare interventions is in general declining, socio-economic differences in mortality are increasing. This indicates that the increasing benefits of more effective health services are unfairly distributed.

In developing their healthcare systems, many countries have launched major initiatives to boost effectiveness and efficiency, but few governments have implemented effective policies to tackle inequities in access to health services. This is the case in Finland, too.

The healthcare debate, as well as policy initiatives and healthcare development actions, have mainly focused on costs and cost effectiveness. Although inequality in health services is widely recognized at the top political level, the only major healthcare reform during the last ten years which clearly focused on equity has been the expansion of public dental-care coverage. It is evident that major structural changes to tackle problems of inequity in healthcare system are politically difficult to carry out, as increasing equity can have a negative impact on the better-off groups.

Equity as an indicator of healthcare performance is often poorly understood. Equitable access to health services is not only about normative ethical standards in healthcare systems. Breaches of equity are also sentinel indicators of serious flaws in the functioning of a healthcare system. In the end, inequities reflect the existence of factors that block or delay the use of services by those with a justifiable need, and which consequently reduce the overall efficiency of the system. In the background to this there may be various healthcare-related determinants, such as ineffective structures, misallocation of resources, poor responsiveness, unbalanced cost sharing, inappropriate provider incentives, or faulty referral systems. Effective equity-driven healthcare reforms should address these frequently structural evils in systems. The urgent need for action is underscored by the rapid demographic and economic changes taking place in European countries, for instance, due to aging populations, increasing migration, and labour-market insecurity. These current societal trends will potentially increase the number of people at risk of being unable fully to access health services.

However, while inequality results from a badly constructed healthcare system, it is plausible that the structures that block and delay access to services by the disadvantaged also misdirect care for other patients, leading to compromised effectiveness and outcomes. Misallocated resources or inappropriate provider incentives that result in poor access to or underuse of services in some healthcare authorities or population groups may, and probably will, lead to overuse and inappropriate poor-quality care at the other end of the regional or socioeconomic gradient.

In conclusion, while future healthcare systems in Europe require sustainable financing, good management, and highly skilled professionals, they should also be created using building blocks that promote access to care according to need.

Professor Marina Erhola is Assistant Director General of National Institute for Welfare and Health of Finland.
In recent decades, European spending on health care has increased at a faster rate than economic growth and the great majority of this expenditure is found from public sources. While increasing government spending on health-care has sometimes been a deliberate policy few countries believe that they manage to obtain best value from this spend. Although only a small part of the public budget is spent on patented pharmaceuticals, the area has come under particular pressure. All countries must decide which new pharmaceuticals will be made available under a national health or insurance system, and value for money, explicitly or implicitly, will always be part of the calculation. Where, as in the UK, a formal body – the National Institute of Health and Clinical Excellence – has primary responsibility for deciding which drugs will be made available at public expense, it is not surprising that it attracts minute attention. In the case of NICE it has faced media criticism, legal challenge and political scrutiny.

In 2007 not only NICE but the entire system of pricing and dispensing drugs in the UK was examined by the Office of Fair Trading, which claimed to find two major sources of inefficiency. The first is that many doctors were said to prescribe expensive patented medicines even when cheaper generics are available. Doctors may be unaware of relative prices or therapeutic value, or reluctant to change, and so continue to prescribe drugs still under patent. It is claimed that hundreds of millions of pounds are wasted this way each year.

The second claimed problem is that drug companies put a great deal of effort into competing for market share in respect of particular disease classes – chronic and non-fatal – rather than engage in truly innovative and adventurous research to address currently untreated, more serious, conditions.

Whether or not the UK, and other European countries, introduce Value Based Pricing, there is no doubt that the basic issue that motivates it – the ever increasing spend on patented pharmaceuticals – will niggle away at European health policy over the coming decades.

Professor Jonathan Wolff is Professor of Philosophy and Director of the UCL Centre for Philosophy, Justice and Health.
Moving to an Outcomes-Focused NHS: Maximising Benefit to Patients and Populations
by Dr James Mountford

“...focusing on minimum standards and on what is not working has not helped quality measurement gain broad traction with clinicians to harness their energies to improve.”

Current National Health Service reforms in England place a welcome new focus on outcomes as the means to measure and drive quality and performance. Outcomes – often delivered through excellent processes – must be the ‘currency’ by which the NHS is judged. But what should we mean by “outcomes”? And how to keep focus on outcomes as the NHS faces severe cost challenges?

Despite significant improvements in important quality dimensions over recent years, the NHS’s current approach to quality measurement and reporting has at least three important shortcomings:

1) Largely compliance- and defect-focused, with narrow scope across the spectrum of specialties: Quality measurement has tended to focus on a few easily measurable elements, and on what organisations are doing wrong rather than what they are doing right – the most prominent measures have included mortality rates, hospital acquired infection rates and “never events”. These are, of course, important, and much progress has been made in these areas. But focusing on minimum standards and on what is not working has not helped quality measurement gain broad traction with clinicians to harness their energies to improve.

2) More professionally-focused, than patient-focused: The NHS has played a leading role internationally in building a more patient-focused agenda – but “quality” today is still largely professionally-defined and controlled. If outcomes are to have most relevance to patients’ lives we need outcomes to encompass three things: clinically-relevant outcomes, patient reported outcome measures (PROMS) and patient-reported experience measures (PREMS). Ideally all are tailored to the condition or pathway in question. For example, in elective surgery (such as knee replacement), the improvement in patients’ ability to perform a range of work and social activities after versus before surgery is at the heart of “quality”. Important too is involving patients in informed decision-making about treatment options to ensure that treatments performed appropriately reflect patients’ individual preferences.

3) Episodic and fragmented, rather than reflecting the journeys of care that patients follow: A less well recognised shortcoming in our current approach is the “snapshot” nature of quality measurement, which is designed to assess the performance of individual organisations or departments within a fragmented health care system, not to assess overall system performance. The NHS has rightly put great emphasis on individual steps in overall care pathways – such as door-to-balloon time for angioplasty in acute heart attack or door-to-scan/thrombolysis time in acute stroke. These are key because they are clearly linked to reductions in mortality and morbidity, but they are far from complete in describing a health system’s performance on these conditions. How well the system works overall matters most to patients. The measurement system should join-up pathways of care reflecting the journeys that patients follow. The best stroke and heart attack care is effective prevention to obviate the need for expensive rescue care after acute
There are likely to be significant demographic and economic pressures on health care systems in Europe over the coming years. The elderly population is set to increase, both in numbers and in proportion to the working age population. For example, in the WHO European Region the population aged 65 and over is projected to rise from 129 million in 2010 to 224 million by 2050. This represents a doubling in the ratio of elderly people to those of current working ages. These changes will be particularly large at ages 85 and over. This will create substantial new costs—of health and social care and pension payments. At the same time, improved availability of treatments, particularly those that extend the lives of terminally ill patients, are pushing up health care costs per patient. To counterbalance these pressures there is a pressing need to act on the social determinants of health so as to improve health for all, but particularly among the most vulnerable. The healthcare system cannot deliver these improvements alone. Action is required across the whole of society. The cost of doing nothing is unsustainable.

Work is currently being coordinated by UCL to document the scale of the problem across Europe and propose context-specific policies and interventions. Their aim will be to improve health by acting on early years development, the development of skills and capabilities, work and employment, gender and ethnicity, and the built environment. This will ensure that while health improves for all, the greatest improvements are among the disadvantaged.

Tackling the Social Determinants of Health in Europe

by Professor Sir Michael Marmot

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The percentage of population over the age of 65 in Europe 2011

Source: xxx xxxxx
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