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EUROHEALTH

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Eurohealth Monitor

43 NEW PUBLICATIONS

44 NEWS



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Our final issue for 2014 throws the spotlight on migrant health and the importance of ensuring that everyone in Europe, irrespective of country of origin and legal status, has proper access to health services and treatment. In the *Observer* section, Williams and Noori explore the often higher infectious disease burden in migrant populations in Europe, including for HIV, TB and chronic hepatitis B.

Just as importantly, the authors highlight the real difficulties in monitoring and treatment, given the lack of reliable data on migrant-specific variables within current disease surveillance systems. Delving into more detail, Falla et al. identify the public health threat of viral hepatitis in Europe and emphasise the need for effective screening, particularly for vulnerable population groups such as migrants. The authors showcase the new HEPScreen Toolkit that has been developed specifically for the practical implementation of screening protocols.

Focusing on a particular sub-group of migrants, van Ginneken explores the disparate approaches taken by European Union countries on undocumented migrants' entitlement to health services and the practical barriers that may also impede access to services. The article highlights the many areas that still need to be addressed, including the lack of legal clarity to entitlements, ensuring confidentiality, removing financial and administrative barriers to access and addressing cultural and language barriers in service provision. Taking a health systems perspective, Keith et al detail two different approaches taken by Sweden and Spain in granting access to health services to undocumented migrants and the impacts this can have on health systems, including challenges for data collection, health monitoring and resource allocation.

De Raeye and colleagues address issues of planning and forecasting the future nursing workforce at EU level in the **Eurohealth International** section. They propose four categories for re-classifying nurses in accordance with the European Federation of Nurses Associations' nursing care continuum. In a second article, Connolly details the incremental growth of the European Commission's competence in health security. He discusses how the 2009 influenza pandemic in the United Kingdom led

to the establishment of the EU Health Security Committee and further legislative changes.

In the **Eurohealth Systems and Policies** section, Sobczak and Sagan present changes in the legal structure of Polish public hospitals and how this relates to financial losses and other challenges, such as access to necessary care. Affordability of care in the Dutch health care system is examined by Brabers and de Jong; they find that almost half of all service users believe that the rising costs of health care may prevent them from using care in the future. They also discuss the implications for access of shifting costs to individuals, through, for example, the introduction of out-of-pocket payments. Moving to the Mediterranean, Petrou first considers the weaknesses in Cyprus's health care sector prior to the financial crisis, then evaluates the bailout agreement measures implemented in terms of efficiency and expenditure. Finally, for England, where reducing avoidable mortality is a health policy priority, Karanikolos and colleagues identify areas where progress is needed and offer recommendations for improvements in prevention, care and outcomes.

Eurohealth Monitor features two new books: one on trends in health systems in twelve former Soviet countries and one on geographic variations in health care in thirteen countries. News covers national, European and international developments in the health sector. We hope you enjoy this issue and we wish you a happy holiday season and a prosperous new year!

Sherry Merkur, Editor

Anna Maresso, Editor

David McDaid, Editor

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INFECTIOUS DISEASE BURDEN IN MIGRANT POPULATIONS IN THE EU AND EEA

By: Gemma Williams and Teymur Noori

Summary: While migrants are often comparatively healthy, they can face specific health challenges. This article shows that certain migrant groups in the European Union (EU) and European Economic Area (EEA) have a higher burden of some infectious diseases including HIV, TB and chronic hepatitis B than the native population. However, reaching strong conclusions on the burden of infectious diseases in migrant groups is challenging as few surveillance systems capture reliable data on migrant-specific variables. Surveillance systems across Europe should be strengthened and harmonised to address this evidence gap in order to aid the provision of appropriate health services.

Keywords: Migrant Health, Infectious Disease, European Surveillance System (TESSy)

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Introduction

In 2011 there were an estimated 48.9 million foreign-born residents in the 27 countries of the EU, with 32.4 million born outside the region and 16.5 million born in a different EU country.¹ The increasing size and diversity of the migrant population in Europe is changing the epidemiology of infectious diseases and creating new challenges for the planning and delivery of health services, which need to adapt to accommodate disparate health needs.² Although migrants are often comparatively healthy overall, a phenomenon known as the ‘healthy migrant effect’,³ migrants are a heterogeneous group and some migrant populations seem to be at higher risk of contracting specific infectious diseases. The pathways through which some migrants may be at higher risk reflect a

complex set of factors, including migration patterns, the demographic profile of migrants, experiences during migration, high-risk behaviours and patterns of disease in migrants’ countries of origin.⁴ In addition, legal restrictions, lack of awareness of rights and entitlements, lack of familiarity with the health system, gaps in health literacy and discrimination can lead to poor access to health services, which is an important proximal risk factor for poorer health outcomes.⁵

Understanding and meeting the diverse health needs of migrants affected by infectious diseases in Europe is crucial in order to protect both individual and public health.⁶ However, accurate information on migrants is not available in many European countries and there are significant limitations in interpreting data

relating to migrant health. Comparisons of migrant health across Europe are challenging due to varied definitions of who constitutes a migrant, as definitions are determined by national legislative, administrative and policy factors and vary between EU/EEA Member States. Further complications arise as there is a lack of data on different types of migrants, particularly asylum seekers and irregular migrants, and health information systems and surveys in most Member States do not routinely collect or disaggregate data according to migrant status.

With the purpose of understanding the gaps in data on infectious diseases among migrant populations, the European Centre for Disease Prevention and Control (ECDC) recently published a report on key infectious diseases in migrant populations in the EU/EEA as part of their migrant health series.¹ Using data from multiple sources including The European Surveillance System (TESSy), a comprehensive literature review and survey of disease focal points in EU/EEA countries, this report aimed to assess the burden of infectious diseases among migrant populations in the EU/EEA in order to improve policy and public health responses. It additionally sought to assess the completeness, quality and usefulness of data reported to TESSy for disease-specific and migrant-specific variables. This article summarises the findings of the report for the human immunodeficiency virus (HIV), tuberculosis (TB), hepatitis B, gonorrhoea, syphilis, measles and malaria.

HIV

TESSy data suggest that migrants in the EU/EEA are disproportionately affected by HIV in comparison to the native population.² Between 2007 and 2012, 39.9% of HIV cases reported with information on geographical origin were in migrants (Table 1). Among migrant cases, the majority were from sub-Saharan Africa (54.3%), with significant proportions from Latin America (12.2%), Western Europe (9.5%) and central Europe (6%). The number of new HIV cases diagnosed in migrants rose slightly during the period, with increases among migrants from Latin America, Central and Eastern

Europe but decreases among migrants from sub-Saharan Africa. In 2011, the percentage of cases among migrants varied considerably among countries, ranging from less than 1% in Estonia to over 70% in Sweden.

Predominant modes of transmission differ between sub-groups of migrants depending on the region of origin. For example, a high proportion of HIV cases in migrants from Latin America have been reported in men who have sex with men (MSM) (59%), but the majority of cases (88%) in migrants from sub-Saharan Africa were due to heterosexual transmission. Overall, migrants represent a significant proportion of HIV cases for all modes of transmission.

Late diagnosis of HIV among migrants from Latin America, Africa, the Middle East, Asia and the Pacific is a key issue in some EU/EEA countries, and migrants with HIV infection often have poorer clinical and immunological indicators at diagnosis than native-born HIV cases. There is also growing evidence that migrant populations from countries with generalised HIV epidemics and migrant MSM are at higher risk of acquiring HIV infection after arrival in the EU/EEA.

In relation to HIV testing and access to care, EU/EEA countries would benefit from strategies and structures to ensure HIV testing can be easily accessed by migrants at risk for HIV in order to reduce the proportion of this population that is undiagnosed. It is crucial that HIV testing is linked to treatment and care, regardless of migrants' legal status, to ensure the effectiveness of proactive testing strategies and the benefits of timely treatment.

Tuberculosis

Although the majority of TB cases in the EU/EEA occur in native-born individuals, TB is a significant issue among migrant populations. Of 73,996 total cases reported in 2010, 25.1% were classified as 'foreign origin', 73.1% as 'native origin' and 1.7% as 'unknown'. The proportion of migrant cases varies considerably between countries, ranging from 0% in Bulgaria and Romania to over 80.0% in Cyprus, Norway and Sweden. Although

overall incidence is declining in the EU/EEA, the opposite trend is found among migrant populations.

The majority of migrant TB cases in the EU/EEA in 2010 occurred largely among those born in Asia (34.0%), followed by those born in Africa (22%) and Europe (13%). However, country or region of origin depends on migration patterns in individual Member States. For example, studies from the United Kingdom show that 57% of foreign-born TB cases reported in 2010 came from southern Asia and 27% from sub-Saharan Africa.³ In the Netherlands, the main countries of origin for TB cases are Somalia, Morocco and Turkey, which are the most common countries of origin among migrants.⁴

TESSy data show that the proportion of TB cases achieving successful treatment outcomes at twelve months is lower among migrants (50%) than among non-migrants (65%). This may reflect greater mobility than the native-born population, deportation before treatment is completed, or barriers to follow-up care and adherence to treatment among migrants. In order to meet the goal of TB elimination in the EU/EEA, it is essential that a comprehensive approach to TB prevention and control that addresses both TB disease and individuals with latent TB infection is adopted. Priority must be given to ensuring that all individuals, irrespective of country of origin, have the right to prompt, high-quality TB care.

Hepatitis B

Available data indicate that chronic hepatitis B is a health issue of concern for migrant populations in the EU/EEA. However, it should be noted that it is difficult to draw definitive conclusions or to make meaningful cross-country comparisons on hepatitis B in migrant populations due to differences in national surveillance systems and the incompleteness of data on migrant-specific variables.

In 2011, eighteen countries provided data on whether cases were 'imported' for 39.1% of all cases reported to ECDC; over half (52.6%) of these cases were recorded as 'imported'. In all, 6.3%

Table 1: Overview of infectious diseases in migrant population based on analysis of TESSy data

Disease	Data from	Migrant status variable used	Number of reporting countries	Total cases in EU/EEA	Cases reporting information on migrant or importation status	Cases in migrants (% of cases with information on migrant or importation status)	Primary regions of origin of migrant cases
HIV	2007 to 2012	Country of birth	29	151,890	125,255 (82.0%)	49,977 (39.9%)	Sub-Saharan Africa (54.3%)
TB	2011	Country of birth	29	73,996	–	18,601 (25.1%)	Asia (34%) and Africa (22%)
Hepatitis B	2011	Imported	28	17,025	6662 (39.1%)	3507 (52.6%)	–
Syphilis	2010	Country of birth	29	17,884	9991 (55.9%)	729 (7.3%)	Europe (55%) and Asia (13%)
Gonorrhoea	2010	Country of birth	28	31,983	8992 (28.1%)	1002 (11.1%)	Europe (46%) and South America (18%)
Measles	2013	Imported	30	10,271	10,271 (100%)	278 (2.7%)	–
Malaria	2011	Imported	26	5482	5482 (100%)	(99%)	–

Source: Reference ⁷

of these cases were acute infections and 81.5% were chronic infections. Among acute hepatitis B cases, the proportion of imported cases ranged from 0% in Austria, Czech Republic, Germany, Greece, Hungary and Poland to 69.2% in Finland. Among chronic cases the proportion of imported cases ranged from 0% in Estonia to 96.1% in Sweden.

Evidence from available literature suggests that hepatitis B prevalence is highest among migrants from countries with high and intermediate endemicity in Eastern Europe, Asia and sub-Saharan Africa.⁹ Most individuals with hepatitis B from countries of higher endemicity become infected at birth via vertical transmission from mother to child or during early childhood, when the risk for chronic hepatitis B infection is greatest. In contrast, the majority of hepatitis B cases in the native-born population occur in high-risk groups, such as injecting drug users and MSM.¹⁰

High rates of chronic hepatitis B among migrants in Europe reflect the large global burden of hepatitis B and migration to Europe of individuals from countries where prevalence is high. An EU-wide approach to screening of individuals born in high endemicity regions would be beneficial, as would greater efforts

to ensure that migrants have access to hepatitis B virus diagnosis and appropriate follow up.

Gonorrhoea and Syphilis

Data on gonorrhoea and syphilis disaggregated by migrant status are only available from a few EU/EEA countries. Although such cases were reported to TESSy by 28 and 29 countries respectively in 2010, only eleven countries reported on country of birth. These data show that in 2010, 11.1% of gonorrhoea cases and 7.3% of syphilis cases were in migrants. Approximately half of migrant gonorrhoea cases in 2010 came from another European country (46%); South American (18%), North American (13%), Asian (11%) and African (10%) countries accounted for the remaining cases where country of birth was reported. Of migrant syphilis cases in 2010, 55% were born in another European country, with the remainder mainly born in Asia (13%), Africa (11%), South America (11%) or North America (9%). Between 2000 and 2010, TESSy data indicate that migrants were more likely to acquire gonorrhoea and syphilis through heterosexual contact, while non-migrants were more likely to contract these sexually transmitted infections through MSM contact.

Overall, available data on syphilis and gonorrhoea are limited both by lack of evidence in the peer-reviewed literature as well as by poor quality data on migrants reported to TESSy. Results are therefore not representative of the situation in the EU/EEA and should be interpreted with caution. Understanding of gonorrhoea and syphilis infection in migrants can only be improved if countries invest in strengthening and harmonising surveillance systems to collect standardised case-based data with information on countries of origin.

Measles

Available data suggest that migrants have a low-burden of measles in comparison to the native population. In 2013, 10,271 measles cases were reported by 30 EU/EEA Member States, with 2.7% (748 cases) categorised as ‘imported’, 0.7% (34 cases) ‘import-related’, 88.9% (9132 cases) ‘indigenous’ and 8.1% (827 cases) as of ‘unknown’ origin. However, drawing conclusions on measles in migrants using TESSy data is difficult as the variable ‘importation status’ is a better marker of whether someone has been travelling abroad in the days previous to disease onset as opposed to whether someone is a migrant. This variable therefore does not make it possible to distinguish between cases in migrants and other travellers.

Evidence from the literature suggests that some migrant population groups may in fact be at elevated risk of measles due to low vaccination coverage of migrant children^{11, 12}. Unfortunately, data on immunisation rates in migrant populations is limited, as they are not routinely collected or monitored in EU countries. Surveillance data on measles infections and measles, mumps and rubella (MMR) vaccination rates should be strengthened to capture migrant relevant data, such as country of birth. These data can help to inform the provision of preventive services that may need to reach out to vulnerable migrant populations that may face barriers in accessing routine immunisation and health services.

Malaria

In 2011, 99% of 5,482 confirmed cases of malaria in the EU/EEA were classified as imported. However, indigenous cases were reported in Greece due to transmission by native *Anopheles* vector species. These indigenous cases are likely linked to the presence of efficient malaria vectors and favourable conditions for malaria transmission, combined with the arrival and high turnover of migrant seasonal workers from malaria-endemic countries. To limit the risk of transmission in Europe it is important that recently arrived immigrants have access to health care and that health professionals are aware of the possibility of asymptomatic infection.

For a variety of reasons, migrants visiting their home country appear to be at higher risk of acquiring malaria than other travellers.¹³ These migrants are more likely to visit rural areas, where there is a higher risk of malaria transmission, and to stay for longer periods. In addition, uptake of pre-travel advice and chemoprophylaxis is lower among migrants visiting their home country than among other travellers, partly due to the difficulties in accessing health services, the cost of seeking pre-travel advice and prophylaxis and misconceptions about life-long immunity.¹⁴ Collecting information on country of birth and residence, destination and purpose of travel, and use of chemoprophylaxis would improve understanding of risk groups for imported malaria in the EU/EEA and targeting of prevention measures.

Conclusion

Available evidence indicates that sub-groups of migrants in the EU/EEA have a higher burden of some infectious diseases, including HIV, TB, and chronic hepatitis B, than the native-born population, but are less affected by others such as measles. However, drawing overall conclusions on infectious diseases in migrant populations in the EU/EEA is challenging as patterns and trends vary considerably depending on the disease in question and are confounded by the diversity of migrants and the changing patterns of migration both to and within Europe.

Differences in national surveillance systems and gaps in migrant-related data also limit the extent to which strong conclusions can be drawn. Although efforts have been made to harmonise data collected by national surveillance systems, the type and quality of data collected still varies between EU/EEA countries and reporting on some migrant-specific variables is poor. Understanding of infectious diseases in migrants can only be improved if countries invest in strengthening and harmonising surveillance systems to collect standardised case-based data on variables, specifically country of birth and probable country of infection. Adding a variable on 'year of arrival' would additionally help strengthen monitoring of post-arrival acquisition of infectious diseases among migrants. European disease-specific networks should engage in discussions on what data is already collected at national level, and whether certain variables currently being analysed should be dropped or if additional variables would add value at EU and country levels.

Further strengthening of surveillance systems in the EU/EEA is essential to provide the basis for planning, implementation and evaluation of appropriate health services. Of equal importance in reducing the burden of infectious disease in migrant populations is ensuring equality in access to health services. It is therefore vital that all Member States guarantee that all individuals, irrespective of country of origin and legal status, have the right to

prompt testing and screening that is linked to high-quality and appropriate treatment and care.

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THE PUBLIC HEALTH CHALLENGE OF CHRONIC VIRAL HEPATITIS: AN URGENT NEED FOR SCREENING

By: **Abby Falla**, **Irene Veldhuijzen** and **Jan Hendrik Richardus** on behalf of the HEPscreen consortium

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Further information:
www.hepscreen.eu



Summary: Hepatitis B and C are stealthy viruses that, if left untreated, silently attack the liver and can cause serious liver disease, decades later. Most viral hepatitis in Europe remains undiagnosed, creating a ‘ticking time bomb’ of liver disease-related ill-health and death. Without screening and treatment, mortality from viral hepatitis associated liver disease in Europe is predicted to increase, peaking around 2030. The HEPscreen Toolkit has been developed through research including pilot studies and aims to motivate and enable others to respond to this public health challenge through the implementation of effective screening, particularly for vulnerable population groups such as migrants.

Keywords: *Hepatitis B, Hepatitis C, Cross-border Health Threats, Migrant Health, HEPscreen Toolkit*

Global policy context

The urgency and scale of action required on viral hepatitis is recognised in a number of high profile global policy documents, frameworks and guidelines. Spring 2014 was an especially important time as the first World Health Organization (WHO) guidelines dealing with hepatitis C screening and treatment were published in April.¹ In May, the World Health Assembly passed a resolution to improve the prevention, diagnosis and treatment of viral hepatitis as well as ensure equitable access among vulnerable groups including migrants.² These build on the WHO’s Framework for Global Action on Viral Hepatitis (2012), which outlined the need for a comprehensive approach to viral hepatitis on a global scale including, obtaining data for evidence-based policy,

raising awareness, creating partnerships, and prevention, diagnosis, care and treatment.

European policy interest

Action on screening for viral hepatitis at the European level contributes to two areas of the European Union (EU) policy agenda. The infectious nature of viral hepatitis and the role of migration in contributing to the burden of disease place the issue within the domain of cross-border health threats. In addition, the disproportionate impact on marginalised populations, and therefore on health inequalities, links to the principles of human rights, dignity and solidarity on which the EU was built.

The European Centre for Disease Prevention and Control (ECDC), an EU agency with an infectious disease surveillance and coordination mandate, established a viral hepatitis network to improve data quality, bring stakeholders together, share good practices and support Member States to tackle the issue in their populations.

A high level meeting in June 2014, under the auspices of the Greek EU Presidency and involving key stakeholders, including the ECDC, examined national approaches, debated new developments and identified public policies that facilitate and improve access to treatment for hepatitis B (HBV) and C (HCV), especially in countries where austerity programmes are in place. Concluding outcomes are for health care systems to develop urgent responses to this simmering public health crisis.

The HEPscreen project

HEPscreen comprised ten partners in six countries – Germany, Hungary, Italy, the Netherlands, Spain and United Kingdom. The central aim of the project was to assess, describe and communicate good practices in screening among migrant communities for hepatitis B and C. A key area of inquiry concerned the epidemiological evidence on the burden of HBV and HCV among migrants in Europe. Building on this, the project reviewed cost-effectiveness and whether the benefits of screening outweigh the harms. Another line of inquiry focused on recommended (i.e. guidelines) and current practices in screening, counselling, referral and treatment. Another key task was the collation and appraisal of translated information materials for people offered testing.

Finally, four pilot investigations using both innovative and well-known approaches to screening were conducted in Grampian (Scotland, UK), London, Central Hungary including Budapest and Barcelona. These research and practice questions were especially interesting given the three models of health system organisation found in our participant countries: tax-based National Health Services in the UK, Spain and Italy; social health insurance (SHI) systems in Germany and the

Netherlands; and a transitional ‘Semashko’ centralised SHI health care system in Hungary.

These six countries also differ with regard to their history and experience of migration. Italy and Spain experienced much more rapid and recent migration than the UK, Germany and the Netherlands, for which migration dating back to the 1950s has been common. Migration to Hungary is also a recent phenomenon and remains less common compared to northern European nations. In this article, we summarise the key findings, recommendations and practical tools developed during the three-year study (see Box 1).

Successful preventive measures

Public health primary prevention measures, including antenatal HBV screening, HBV vaccination, sterile medical/dental procedures, a safe blood supply and harm reduction activities among people who inject drugs (PWID) have successfully halted much of the transmission of HBV and HCV across Europe. However, variable speed of adoption over time has resulted in distinct geographical variations in prevalence across Europe; prevalence in the general population varies from 0.1% to 5.6% for chronic hepatitis B infection and from 0.4% to 5.2% for chronic hepatitis C. The burden of disease is generally low in the north western countries and higher in the south eastern region of Europe. However, as primary prevention measures do little for those who are already infected, there remains a large undiagnosed burden of chronic viral hepatitis.

The impact of migration

Over centuries an exporter of people, it is only in the last half century that Europe became a receiver of people. Migration has major impacts on the physical, mental and social dimensions of health, and presents new public health challenges for receiving societies. Indeed, most chronic viral hepatitis infections in Europe are among people born in HBV or HCV endemic countries. In an epidemiological analysis, we found that even though migrants make up a minority (4–15%) of the population in

Box 1: Key HEPscreen findings and recommendations

- Screening needs to be scaled up. The small-scale, time-limited examples identified are not sufficient to adequately address the public health challenge of chronic viral hepatitis. Guidelines and policy recommendations are urgently needed as a first step.
- There are pragmatic yet systematic responses that are relatively simple to implement – for example through routine (but voluntary) registration of country of birth in primary care, as part of a medical history. This can improve access to screening for viral hepatitis-related liver disease among people from endemic areas.
- Clear referral pathways need to be central to the design of screening interventions. Highly complex and at times ineffective patient pathways, along with the complex nature of viral hepatitis, compound other health service-related and patient-side barriers facing migrant groups. Effective linkage to specialist care, including antiviral treatment, is crucial to maximise the possible health impact of screening.

the six HEPscreen study countries, the top five most affected migrant communities (defined by country of origin) account for between 10–45% of the burden of chronic hepatitis B in these countries. In endemic countries, HBV is most commonly transmitted from mother to child during pregnancy or in early childhood. Unsterile medical, shaving or dental equipment are most common exposure risks in areas where hepatitis C is common. However, as a large proportion of HCV in Europe is also found among PWID, infection is often associated with illicit drug use. This has stigmatised infection and overshadowed the health needs of people from endemic countries.

Current action on screening for chronic viral hepatitis in Europe

Outside Europe, national guidelines from Canada, the US and Australia recognise the need for screening among people from endemic countries. The project investigated availability of guidelines within Europe via a literature search and an extensive survey among expert clinicians and public health professionals. We also investigated current practices for screening among risk populations, including migrants from endemic areas. In the six HEPscreen European countries, we identified one guideline, from the UK, about screening among people from endemic areas.²⁴ Our assessment of current practices mirror this: other than antenatal HBV and HBV/HCV blood donor screening, there is no other systematic HBV/HCV screening in the six study countries. We did identify some good practice examples of screening among people from endemic countries, mostly from the UK and the Netherlands, but these examples remain time-limited, small-scale and scarce.

Four main ways of screening

One objective of the project was to identify and synthesise the fragmented knowledge of effective ways of screening among migrant communities. As part of the HEPscreen Toolkit, we compiled a repository of the good practice examples identified. There are four main ways of screening (see Box 2). Each method has ethical, epidemiological, evaluative and economic implications. General practitioners (GPs), community nurses and sexual health clinics are often in a well-trusted position to raise awareness and offer testing opportunistically to their patients with country of origin-related risk factors. Combining with an existing infectious disease screening programme, such as tuberculosis (TB), builds on existing infrastructure, including appropriately trained staff. Each model varies in its scope and means to raise awareness in the community and to provide information to people offered testing. For example, public awareness information and education sessions and materials are a key part of community outreach screening models.

Restricted access to treatment among vulnerable groups

Legal and other barriers to health care, such as socio-economic vulnerability and insecure housing or employment conditions, are suggested as partial explanations for the lack of screening among migrants. Previous studies also found lower preventative health care usage²⁵ and poorer health outcomes from viral hepatitis among migrant groups.²⁶ The project was interested to find out whether there are formal treatment restrictions in place in the six countries for vulnerable risk groups, such as asylum seekers, undocumented migrants, people without health insurance and PWID.

Results from a survey of over 60 gastroenterology or infectious disease specialists involved in the direct clinical care of chronic viral hepatitis patients show a distinct lack of consensus among professionals in the same country about which patients are entitled to which sort of care. This discordance was especially surprising given that the health care system or policy context often defines access to treatment for these specific groups.

Our results suggest that health care entitlement guidance is unclear, unavailable or unknown to medical professionals most involved in treating patients. A lack of consensus may also either be an important explanation of, or in fact caused by, the limited existence of screening programmes that target these higher risk populations. Significant restrictions in treatment for undocumented migrants and people without health insurance were reported by the majority in the UK, Germany, the Netherlands, Hungary and Spain; only in Italy did the majority report there to be no or few restrictions. Our results suggest that risk groups such as undocumented migrants, people without health insurance coverage and asylum seekers are rarely screened for viral hepatitis and if found to be chronically infected, do not reliably reach secondary care.

Access to antiviral treatment

The centralised approval system for pharmaceutical innovations for

Box 2: The four main implementation models of screening

- **Outreach-based combining educational/awareness raising with testing either in the community or in a closed/ fixed setting** like a workplace or institution.
- Offering **opportunistic HBV/ HCV testing as part of other health care encounters in primary care** such as through GPs, public health services or sexual health clinics.
- **Extending existing screening initiatives already targeting migrants** such as TB screening to include viral hepatitis.
- **Invitation-based models using municipal population or patient registries** as a means to increase access to screening among individuals born in medium/high viral hepatitis endemic countries.

viral diseases in Europe, through the European Medicines Agency (EMA), appraises applications to grant approval for single marketing authorisation in all EU countries. Decisions on pricing and reimbursement are generally made at the national level however, and differences between Member States in availability, uptake and use of new medication, especially for HCV, have been suggested.²⁷ Using the same survey of clinical specialists described above, we found that first generation protease inhibitors for HCV, boceprevir and telaprevir, are either significantly or completely restricted for use in Italy, Spain and Hungary despite European-level approval. Epidemiological, health system, clinical and economic factors offer some explanations for this finding. Since our survey in 2012, three new HCV drugs have been approved for use in Europe, with future antiviral development expected. But with expected costs in excess of €60,000 per patient, differences in approval and subsequent use of these expensive options are likely to emerge across Europe.

Health information in a linguistically and culturally diverse Europe

Providing accurate, appropriate and understandable information to people from endemic countries is a means to raise awareness, improve the acceptability of screening, secure informed choice, normalise testing and alleviate feelings of stigma, shame and fear. To enable health professionals across Europe to provide this in a written format to people offered testing, HEPscreen has developed a tool to create multi-lingual leaflets. The culturally appropriate and simple to understand content is available in 40 languages, from which any combination of two can then be selected to generate a health information leaflet. It has been particularly written for people with limited health literacy or people from cultures where norms and values about unsafe sex and illicit drug use heighten stigma when viral hepatitis is explicitly associated with these routes of transmission.

The Toolkit – practical support for implementation

The HEPscreen Toolkit builds on the increasing recognition of the need for systematic action on viral hepatitis. Epidemiological HEPscreen tools can assist public health planners and other professionals to estimate the burden among people from endemic countries, as well as to understand which communities are most at risk of viral hepatitis-related liver disease. Focusing screening on higher risk groups increases the chance of finding positive cases and makes more effective use of scarce health care resources. Knowledge of which communities are most affected can add to local community expertise and be used to tailor approaches to specific cultural, linguistic, and social norms and values.

To complement this, culturally appropriate, understandable pre-test information leaflets are available in over 40 languages. A pre-test discussion checklist, compiled through a literature review and survey can aid health professionals offering testing to discuss viral hepatitis with culturally and linguistically diverse populations. Practical guides and case studies of the different ways of screening can help to design evidence-based

screening programmes. An indicator can help to monitor screening programmes after implementation. These are a few examples of how aspects of the HEPscreen Toolkit can raise awareness, improve knowledge and motivate action to tackle the simmering public health crisis of viral hepatitis in Europe (see Box 3).

Scientific consensus – time for action

The Global Burden of Disease study (2010) ranked viral hepatitis ninth in the list of causes of mortality, with a larger disease burden in Europe than HIV and TB.⁹ Studies also show that screening in populations with an expected prevalence of 2% or higher is likely to be cost-effective.¹⁰ Yet, viral hepatitis receives much less public health, policy or political attention in comparison to HIV. The complex epidemiology and natural history, insufficient advocacy in the field, the global economic crisis and the immense pressure on health care expenditure are important explanations.¹⁰ The current climate of economic austerity, rumbling xenophobia and an increasing demand for health care resources is not ideal to advocate for resource allocation to the secondary prevention of a condition mostly limited to some of the most marginalised and vulnerable members of society. But in the midst of this noisy, highly politicised debate it is our responsibility as public health professionals to articulate the case for evidence-based disease prevention and health promotion. As Da Vinci once said: “Knowing is not enough; we must apply. Being willing is not enough; we must do”.

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Box 3: Key aspects of the HEPscreen Toolkit

- Videos and animations about the public health challenge of chronic viral hepatitis
- Epidemiological tools to assess the burden of chronic viral hepatitis among migrants
- ‘How-to’ guides, case studies and videos about the different ways of screening
- A repository of good practice screening projects
- A tool to create multi-lingual leaflets for people offered hepatitis B/C screening – with over 40 languages available
- Tools to support primary care to offer testing to their patients from endemic areas, including a pre-test discussion checklist
- Good practice recommendations for post-test counselling and linkage to specialist care.

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HEALTH CARE **ACCESS FOR UNDOCUMENTED MIGRANTS** IN EUROPE LEAVES MUCH TO BE DESIRED

By: Ewout van Ginneken

Summary: While a few countries in theory provide full access to their health system, undocumented migrants mostly only have access to emergency care across Europe. There are substantial differences between official policies and the practical experiences of undocumented migrants, health workers, and public officials. Policies should create legal clarity of entitlements among undocumented migrants, doctors, and officials; ensure confidentiality for all parties involved, and take away the fear of being reported, losing a job, or facing prosecution; mitigate financial and administrative barriers for health care for undocumented migrants and providers; and address cultural and language barriers.

Keywords: *Undocumented Migrants, Health Care, Legal Entitlements to Care, Access Barriers*

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Introduction

Undocumented migrants include individuals who have entered a country without documentation, people whose residence status (e.g. visa, residence or work permit) has expired or become invalidated, those who have been unsuccessful in obtaining asylum, and those born to undocumented parents. Estimates of the number of undocumented migrants in European Union (EU) countries (Croatia not yet included) range from 1.9 to 3.8 million people.¹ Undocumented migrants may have particular health care needs.

Although no population-based health status data are available regarding undocumented migrants in Europe, a scoping review of European literature suggested that the most common health care needs relate to mental health problems, reproductive health issues, and injuries, with pregnant women, children and detainees being the most vulnerable groups.²

Access to health care for undocumented migrants is often problematic, involving the interaction of health and immigration policies. Policies are highly variable across countries, and there are differences between official policies and the practical

experiences of health workers and public officials as well as undocumented migrants. Moreover, with many European countries undergoing strict austerity programmes in recent years, policies regarding undocumented migrants have come under increased scrutiny, particularly it seems, in election years.

Access barriers

In broad terms, undocumented migrants face three sets of challenges in getting medical care. One set is associated with migrants' residence status and lack of legal entitlements. It is normally a matter of law and policy whether migrants are entitled to access public health insurance coverage or subsidised services, as well as what the obligations of hospitals or physicians may be. In countries where undocumented migrants are expected to pay the full costs for treatment, this creates an insurmountable economic barrier to access.

“ differences exist between official policies and practical experiences

A second set of challenges is around implementation and access to services in practice. Health care providers, as well as undocumented migrants, are often unaware of the rights and duties around undocumented migrants' access to health services. This leads to an underutilisation of available services and discriminatory refusals of care that migrants are entitled to access. Rules around entitlements and administrative procedures are sometimes complicated, exacerbating lack of awareness, discrimination, and the role of discretion on the part of the provider. Another major practical issue is risk and fear of being identified by authorities and

being deported as a result of accessing services, which deters people from seeking the care they need.⁵

The third set of challenges includes the language, cultural, and economic barriers to health care that face migrants. Examples include language and literacy problems that can lead to miscommunication and non-adherence to treatment; cultural differences that can affect use of certain services (e.g. women's reluctance to see a male doctor); differences in conceptions of health and disease; lack of familiarity with the health care system and how it works; problems associated with low income or high risk occupations; or even discriminatory attitudes among health professionals.

Policy background

A number of countries have tried to address the difficulties of undocumented migrants in getting access to health care. Policies regarding immigrants can become highly politicised, and changes may occur regularly. Several issues and concerns are commonly discussed in EU countries about making medical care available to undocumented migrants.⁶

Human rights

All EU Member States have ratified a number of international and regional human rights instruments that enshrine life and health as human rights that should be available to everyone within a state's jurisdiction without discrimination, with different implications for the provision of services. Among them, is the *International Covenant on Economic, Social, and Cultural Rights* (ICESCR), which has been ratified by most countries (although not, notably, in the United States) Furthermore, the World Medical Association made a *Declaration on the Rights of the Patient*, asking to give appropriate medical care to all people without discrimination and refusing all restrictive legal measures that alter medical ethics.

Humanitarian and ethical concerns

The humanitarian and ethical arguments focus on how a society should treat people who are poor or vulnerable for a variety

of reasons – for instance, age, gender, experiences of violence and exploitation, trauma or language barriers – particularly when the breadwinners in many migrant households contribute to their country of residence's economy and society, usually performing vital jobs under poor conditions. The other major ethical argument is around medical ethics. Health care professionals are obliged to provide care on the basis of need. Asking them to verify a patient's residence status and provide care accordingly goes directly against their professional role and ethics.

Public health issues

Public health concerns underlie policy decisions in some countries to provide undocumented migrants with access to services such as vaccination and prenatal care, as well as to provide treatment for communicable diseases. The argument here is that providing such access is in the interest of the native population.

The magnet concern

One objection to providing access to health care for uninsured immigrants is that this will attract more migrants; however, available evidence indicates that other factors are much more important in influencing people's decision to migrate and to where. For example, migrants among 27 cities in 10 countries cited health problems only in 2.3% of cases as a reason for migration, far behind economic survival (47.2%), political, religious, ethnic or sexual orientation (24.2%), to join or follow someone (14.6%) or to escape from war (6.9%).⁷

The free-rider concern

Another argument against providing care to uninsured immigrants – particularly if they lack means to pay – is that they should not benefit from a system for which others have paid. However, it is worth noting that in many cases, undocumented migrants have a job, are contributing to the economy through their employment and may be contributing to the health system through taxes, contributions or premiums. All undocumented migrants also contribute to the public purse through taxes on goods and services.

Health system concern

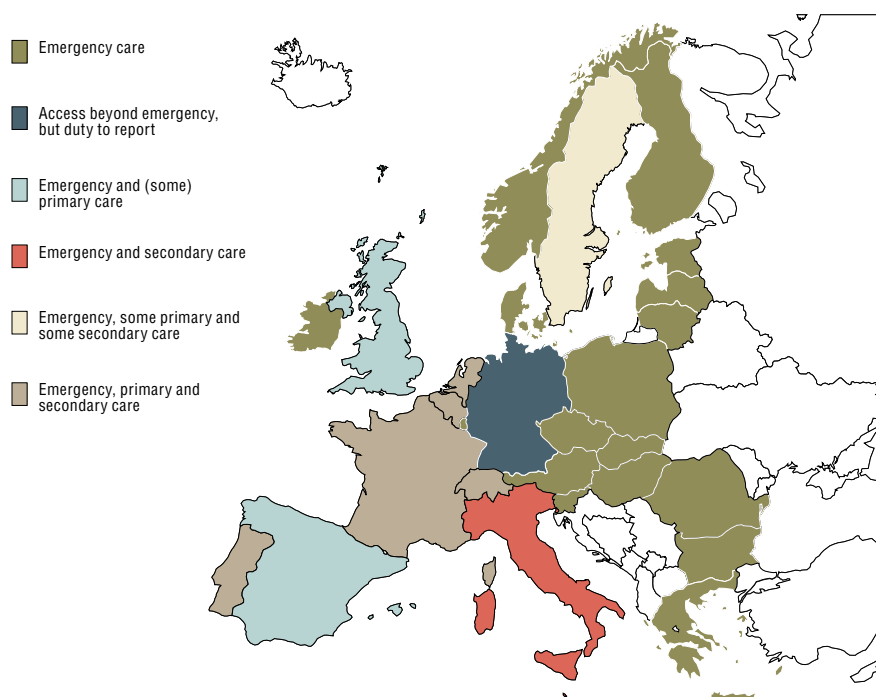
Opponents of providing access to care for undocumented migrants also commonly argue that this could reduce access for others. Additionally, all countries have concerns about health care costs, which, it is argued, would increase if services are provided to migrants. In contrast, proponents of providing access to care for undocumented migrants may argue that a lack of primary and preventive care services may lead to much higher costs elsewhere in the health system (e.g. use of costly emergency care).¹⁴ Unfortunately, little is known about the relative cost of different coverage policies, which roughly range from no access to full and ‘free’ access to the health system. This probably also relates to contextual factors in a given country, such as the numbers of undocumented migrants and health system characteristics.

Undocumented migrants’ eligibility for health care

Several organisations and research projects have aimed to map and/or group policies around health service provision to undocumented migrants in Europe. Most notably, this includes the Platform for International Cooperation on Undocumented Migrants (PICUM), the Health Care in Nowhereland project, and the European Observatory of Medecins du Monde – Doctors of the World International Network, as well as the EU Agency for Fundamental Rights (FRA).

The important work carried out in these projects highlights that beyond basic emergency care, which cannot legally be denied to anyone in need in Europe, there is great variation in entitlements to care for undocumented migrants across European countries. Five main categories of entitlement can be identified¹⁵ (see Fig 1). It should be noted however, that describing policies on undocumented migrants is like aiming at a moving target as policies are often complex, and changes occur continuously. Furthermore, as is illustrated below, even when an entitlement or system exists, it does not necessarily equate with access in practice.

Figure 1: Health care entitlements for undocumented migrants in Europe (EU27, Switzerland and Norway)



Source: modified from ¹⁵

In 18 out of the 29 countries featured in Fig. 1, undocumented migrants are only entitled to access emergency care services, and in 11 of these countries they are expected to pay for such services, despite their usually low incomes and the incredibly high costs associated with emergency services. These countries include Austria, Bulgaria, Czech Republic, Denmark, Finland, Greece, Hungary, Ireland, Latvia and Poland for emergency services at full cost; and Cyprus, Estonia, Lithuania, Luxembourg, Malta, Romania, Slovakia and Slovenia for emergency services free of charge.¹⁶ Sweden used to be in the former category, but legislative change in 2013 gave undocumented children access to all public health services, while adults also have access to some primary and secondary care services (acute care and care that ‘cannot be postponed’, which includes for example maternity care and dental care).

Norway also provides ‘necessary health care’ from municipal health care services, but undocumented migrants are obliged to pay the full costs of any such treatment except some preventive care, which is free of charge.¹⁷

Germany, the United Kingdom (UK), Italy, and Spain are special ‘in-between’ cases. In Germany, undocumented migrants have a right to health services beyond emergency care, but in practice, they only have access to emergency care as the procedure to reimburse the cost of non-emergency care involves public officials with a duty to report to immigration authorities, which prevents access in practice since it will lead to deportation.¹⁸ The UK provides access to primary health care free of charge (including General Practitioners (GPs) or local health centres).¹⁹ Spain used to provide undocumented migrants with full access to the health system, but since September 2012, this was restricted to emergency, maternity and paediatric care. In Italy, undocumented migrants have access to emergency services and may access secondary care, but are not allowed to register with a family doctor, which affects their access to specialists.²⁰

Five countries (Belgium, France, the Netherlands, Portugal, and Switzerland) allow access to the full range of services in the health system, at least in theory, as long as the undocumented migrants meet certain conditions. In Switzerland,

undocumented migrants are obliged to purchase insurance after three months, which in most cases will form an insurmountable financial barrier. In the Netherlands undocumented migrants have to pay the full cost of treatment unless they cannot pay, in which case there is compensation available. This, however, may create an administrative burden and in practice a great deal of legal ambiguity for undocumented migrants as well as providers. In Belgium, medical certification regarding the need for care is required, which poses a significant practical barrier. In Portugal and France, conditions such as proof of identity or length of residence also pose substantial access barriers for some.

Policy options

The reasons why countries differ in their policies toward undocumented migrants are elusive and the result of a combination of factors. Factors such as the history and magnitude of a country's experience with immigration play a role. Also, countries differ in their overall political climates and prevailing attitudes towards migrants and immigration.

In many European countries, health care access for undocumented migrants is a policy and political problem, although undocumented migrants have the right to health care under legal conventions adopted by the EU Member States. Only a few countries have put arrangements in place that at least in theory provide full access to their health system. Yet even in these countries barriers remain that relate to the vulnerable position of undocumented migrants as well as the economic and the national or local political context. This shows that there is still substantial room for improvement and that a right to health care does not equate to access to the wider health system. Furthermore, reliable data are generally lacking in many of the countries, and policy-making is often reliant on anecdotal and patchy evidence. Unless the problem is made more visible, policy-makers will not feel spurred to take action.¹²

The experience of several European countries shows that it is possible to substantially improve access to health care

for undocumented migrants. European policies highlight the difference among: (a) allowing undocumented migrants to purchase insurance coverage in the national system (e.g. Switzerland); (b) providing them with coverage in the national health service (e.g. Portugal); and (c) providing an additional source of funding that allows the adoption of policies to assure that physicians and hospitals receive compensation for providing services (e.g. the Netherlands).¹²

But even if such policies are put in place, they do not explicitly address many problems experienced by undocumented migrants and their doctors as well as public officials. Policies would ideally do several things. First, they should improve awareness and create legal clarity of entitlements among undocumented migrants, doctors and officials. Second, confidentiality should be ensured for all parties involved in seeking care to take away the fear of being reported to the authorities, losing a job, or facing prosecution. Third, immediate financial barriers for providing health care to migrants, which are present in many systems, could be mitigated both for undocumented migrants and from the perspective of the provider. Lastly, cultural and language barriers should be addressed.¹²

Conclusion

Facilitating access to care for undocumented migrants may require multiple policy changes. Until such changes occur, the interim solutions found by health professionals, voluntary and charity organisations, and in some cases local and regional authorities, will continue to meet some of the immediate health needs of their communities under difficult circumstances, while the negative impacts of formal exclusion on individual and public health continue.

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HEALTH SYSTEMS AND SERVICES FOR UNDOCUMENTED MIGRANTS: DEVELOPMENTS IN SPAIN AND SWEDEN

By: Lilana Keith, Michele LeVoy and Frank Vanbiervliet

Summary: Policy changes in Spain and Sweden provide insights on the impacts on health systems of restricting and broadening the level of health services provided to undocumented migrants. Legal restrictions have resulted in the diverse provision of services by health professionals and local and regional authorities, leading to inconsistency and uncertainty as well as challenges in data collection, monitoring and resource allocation. Evidence shows that providing non-discriminatory access to health services is beneficial for public health; reduces expenditure and administrative burdens; promotes the welfare of health professionals and social cohesion; and improves fulfilment of human rights obligations and safeguarding duties towards vulnerable and at risk populations.

Keywords: *Undocumented Migrants, Entitlement to Health Care, Access, Spain, Sweden*

Introduction

Legal entitlements for undocumented migrants to access health care vary across Europe, from emergency care only and subject to payment, to near equal access to health services for all residents, regardless of status.¹ (See also article by van Ginneken in this issue). The numerous barriers to accessing health services in practice further limit undocumented migrants' use of the services they are entitled to. Most notably, the lack of clear separation between immigration control and health service provision prevents

many people from receiving the care they need, even in emergency situations.

Recently, two countries, Spain and Sweden, have significantly changed their policies regarding which health services undocumented migrants are entitled to access – in opposite directions – thus providing a key opportunity for analysis. The developments and experiences in Spain and Sweden provide insights on the many impacts on health systems of providing and restricting health care entitlements to undocumented migrants.

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Spain

Legal reform: restricting access to emergency care only

Until 2012, undocumented migrants were entitled to near equal access to health services in Spain. All residents in Spain can register in the municipal register regardless of status, and at the time, this registration formed the basis for equal access to health services. Although the requirements for municipal registration, as well as other practical barriers, still limited access for some, the system in Spain was comparatively effective. Including undocumented migrants within the mainstream system for managing service provision meant the administrative burden on the system was minimal, data on most of the population and their health were available, and research found that migrants contributed more to social protection systems, including the health system, than they cost.²

“
patchwork of
service provision
across Spain

However, since September 2012, Royal-Decree Law 16/2012 on ‘urgent measures to ensure the sustainability of the national health system and to improve the quality and safety of its services’ excludes undocumented migrants from access to health care and ties health care coverage to employment status. The reform implies a significant breakdown of the universal health care model that had been implemented in Spain for over a decade, through the implementation of an insurance-based health care system. Although health care protection for undocumented pregnant women and children is explicitly retained, for many, access is nevertheless made impossible in practice by administrative barriers in some regions (autonomous communities, ACs),³ as well as by the failure to issue individual health cards. The increasingly widespread impression created by political discourse,

that all undocumented foreign nationals are excluded from the health care system, is a further barrier to access.

The only remaining point of entry for many undocumented migrants, including pregnant women and children, is through hospital accident and emergency services, meaning that many health conditions are not identified and given the necessary care and treatment. Identification and protection of vulnerable and at-risk groups, including victims of violence, is also limited.

Implementation challenges

While the justification initially provided for the health system reform was financial,⁴ little evidence has been provided publicly, and the legislation was rushed through parliament at a pace resulting in legal challenges by several ACs about the constitutionality of both its form and substance.⁵ Moreover, implementation by the ACs across Spain has been very varied. Only one out of Spain’s nineteen ACs, Castilla-La-Mancha, is fully implementing the restrictions contained in the national law. At the very least, other ACs are providing additional services for public health reasons, while the majority are implementing special programs to provide wider baskets of services. Two regions, Andalusia and Asturias, have maintained the previous level of provision, ensuring access to all services for all residents.⁶ The reform has been rejected by more than 2,000 health care professionals across the country (see derechoacurar.org), who have signalled their conscientious objection and intention to continue to provide health care to all patients on the basis of need, regardless of residence status, as per their professional ethics.

Considering this patchwork of service provision across Spain, itself a major complication for health system evaluation and monitoring at national level, it becomes clear that restricting undocumented migrants’ access to health services to emergency care only is not a favoured policy option. In economic terms, at a time of budget cuts, nearly all the regional governments in Spain chose to provide a wider level of services than that

provided at national level. Those that are providing the greatest levels of services include some of the poorest, and some of those with large undocumented migrant populations. Given the extremely high costs of emergency care services compared to preventative and primary care services, restricting provision to emergency care significantly increases public health expenditure.⁷ In terms of public health, it is counterproductive to exclude segments of the population from preventative and treatment services, especially for chronic, communicable and vaccine-preventable diseases. The intention not to restrict maternity services and health services for children has been undermined by negative political discourse, lack of awareness, and impractical changes in the administration and management of access.

Regional responses have mitigated some of the impacts of the reform, but not neutralised them. With potential for a change in political leadership, the national elections in Spain at the end of 2015 will represent a critical opportunity to evaluate the real impacts the reform has had on health systems across the country and to reconsider the national legislation.

Sweden

Legal reform: broadening from emergency care to a range of primary and secondary services

Until 2013, undocumented migrants and their children in Sweden only had access to emergency care services, and these services were subject to payment and billed after treatment. For example, a pregnant undocumented woman would have been expected to pay a fee of around €5,000 in order to give birth in a public hospital, without complications.

In July 2013, a new law came into force that allows all children to access public health care services free at the point of delivery. Adult undocumented migrants have obtained the same rights as asylum seekers: they can access acute care and health care ‘that cannot be postponed’, including maternity care, family planning, termination of pregnancy, dental care and associated medicines, provided that they pay the fee of around €5 per visit.

In addition, the new law stipulates that county councils may offer undocumented migrants wider health coverage, up to the level of citizens.

The reasoning behind the reform

The decision to significantly expand service provision was based on a multi-stakeholder and evidence-based process that contains lessons for others seeking to improve their health systems. Non-governmental organisations and networks of volunteer doctors, nurses and others have been providing essential care to undocumented migrants, asylum seekers and refugees for many years. Despite the restrictions on undocumented migrants' access to health care before July 2013, undocumented migrants continued to reside in Sweden and their exclusion from the health system forced health care professionals and local authorities to deal with the ethical, humanitarian and medical necessity of providing health care to all those in need. The informal solutions placed health professionals and undocumented migrants under enormous strain and resulted in a parallel system of health service provision in Sweden. Reacting to increasing consensus among wider civil society (The Right to Health Care Initiative, www.vardforpaperslosa.se), the international community¹⁴, and several local and regional actors¹⁵ that the policy of the time was contrary to human rights and impractical, the government launched an inquiry into reforming the law.

As a result of the evidence gathered by the government-led inquiry,¹⁶ the inquiry recommended that undocumented migrants be provided with the same access to health services as nationals. The main reasons cited were the need to comply with Sweden's human rights commitments; the need to meet standards of patient safety and information management in health care; the need to uphold administrative principles in the health system in view of the 'grey' provision of health services by voluntary clinics and local authorities (with reference to ensuring appropriate monitoring and allocation of resources, resolving uncertainty and lack of legal clarity due to diverse local guidelines, and maintaining the division of competences

between the state and local authorities); and the need to address the issues around professional ethics and the difficult working environment imposed on health professionals. The estimated increased costs for health services were not considered a barrier.¹⁷

“Inquiry recommended that undocumented migrants be provided with the same access

The inquiry anticipated that providing the same level of health services to all residents, regardless of status, would benefit everyone in Sweden, as the responsible authorities would be able to obtain a better picture of population health status, reach more people with preventive efforts, and prevent the spread of communicable diseases.¹⁸ The inquiry also found that the combined experience gained abroad and in Sweden in connection to previous legislative changes indicated that the availability of health services does not have any major impact on irregular migration.¹⁹ Likewise, there is no evidence of an increase in migration as a result of the recent health care reform.

On this basis, the government has widely increased the services that undocumented migrants are able to access. It is important to note that many health care professionals are still unaware of these changes and the law is not always correctly applied; undocumented migrants are sometimes asked to pay more than they should or are denied access to care. A major problem is that migrants often cannot know what will be considered as care 'that cannot be postponed', especially as each medical doctor may have their own interpretation of this criteria.²⁰ Health professionals have challenged this concept as medically and ethically inappropriate.²¹ Nevertheless, the

new law is a major step forward towards universal health coverage. Despite the prevailing barriers to access – and ongoing efforts to ensure equal access to services for all residents, as the evidence suggests – the provision of these additional services for undocumented migrants is functioning and improving.

Conclusion

While nearly all EU Member States restrict access to health services for undocumented migrants to different degrees in law, this is counterproductive for health systems. When a segment of the population is not able to access preventative and curative treatments or services, and is forced to rely on emergency services, it increases the burden on those emergency health services at much greater costs to public health systems. It also undermines progress towards general and local public health objectives, including reducing health inequalities, restricting the spread of infectious diseases, and reducing neonatal and infant morbidity and mortality rates. Data collected by Médecins du Monde clinics across Europe provides further illustrations (**see Box 1** overleaf).

Legal restrictions to access result in very diverse provision of services at local level, with varying degrees of formality, by health professionals and local and regional authorities, leading to inconsistency and uncertainty, and significant challenges for maintaining health system information, monitoring and supervision, as well as resource allocation. It can also place additional strain on health systems by creating a difficult working environment for health professionals, who are committed to providing care on the basis of need by their professional ethics.

In addition to the cases of Spain and Sweden, there are numerous examples of local, regional and national governments implementing measures to improve health system access by undocumented migrants in recent years^{22, 23}. Health care systems should be effective, efficient, resilient and financially sustainable. In order to achieve this, they have to cover the whole population, leaving no gaps; in particular, they should not exclude from the system

Box 1: Key results from the *Médecins du Monde* International Network Observatory on access to health care, 2013

16,881 patients received in *Médecins du Monde* health centres in 25 cities in 8 European countries

Among pregnant women:

- 65.9% had no access to antenatal care
- 42.8% had received care too late
- 70% required urgent or semi-urgent care according to doctors
- 50% of children (on average) had been vaccinated against tetanus. On average, 70% had not been vaccinated, or did not know whether they had been vaccinated against hepatitis B, measles or whooping cough.
- 60.7% of individuals without permission to reside said this restricted their movement or occupation due to fear of arrest.
- Two thirds of the patients in this sample had no health care coverage whatsoever when they first came to the programmes, meaning that most of them are invisible to national public health monitoring systems. As a result of being invisible, their health needs are not taken into account in the planning of health services or health care policy. Consequently, their health status or the outcome of the little care they receive is not being monitored, thereby completing the circle of permanent invisibility.

Source: Reference ⁹

people like undocumented migrants, who are confronted with multiple vulnerability factors. Providing non-discriminatory access to health services is beneficial for public health objectives, reduces expenditure and administrative burdens, promotes the welfare of health professionals and social cohesion, and improves fulfilment of legal human rights obligations and safeguarding duties for vulnerable and at-risk populations.

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THE POLITICS OF HEALTH WORKFORCE PLANNING AND FORECASTING

By: Paul De Raeve, Andreas Xyrichis, Silvia Gomez Recio and Alessia Clocchiatti

Summary: Planning the health workforce is key when modernising health care systems throughout the European Union (EU). As health policy-makers and researchers have long argued, current data collected at national level on the health workforce tend to be fragmented, incomplete, and not comparable. Therefore, a comprehensive picture on how to plan and forecast the nursing workforce at EU level can be obtained by deploying four categories: health care assistant, general care nurse, specialist nurse and advanced nurse practitioner.

Keywords: Health Workforce, Health System Reform, Comparable Data, Planning and Forecasting, Nurses

The EU Political Workforce Agenda

The European Federation of Nurses Associations (EFN) engaged in the EU Health Workforce Agenda in 2008 through the Green Paper on the EU Workforce for Health.¹ In 2010, EFN moved workforce up the political agenda of the European Parliament, launching a written declaration (n°40/2010) that was presented at a European Parliament roundtable. It was an occasion to present individual testimonies from nurses and doctors who had experienced professional mobility and administrative challenges associated with the recognition of their professional qualifications. These policy initiatives were the crowning moment for EFN to collect comparable data within its membership and explore which categories and methodologies were needed for forecasting the future nursing workforce. Planning the nursing workforce, the largest occupational group in the health sector,

necessitates innovative strategies and policies, as the current data collected and methods used are not fit for purpose.

The Council Conclusions² provided a pathway for the 2011 and 2012 EU Presidencies to create several policy initiatives on the EU workforce, among which are the Action Plan on EU Workforce for Health in 2012 and the Joint Action on EU Health Workforce in mid-2013.³ One of the objectives of this Joint Action is to analyse the gaps in quantitative data collected through the Joint Questionnaire of WHO-Eurostat-OECD. The categories for the nursing profession currently used in that Joint Questionnaire to collect data at national level are based on the ISCO-08 code, focusing on tasks and occupations instead of qualifications and cause concerns regarding compliance with EU legislation (Mutual Recognition of Professional

The European Federation of Nurses Associations (EFN) was established in 1971 to represent the nurse's voice and the profession's interests at European institutions. The EFN is the independent voice of the nursing profession. EU policy outcomes will impact on three million nurses all over Europe as EU legislation will need to be transposed into national legislation. www.efnweb.eu

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Qualifications Directive 2005/36/EC, amended by Directive 2013/55/EU,⁵ hereinafter called the PQD Directive). If the quantitative and qualitative data sets aim to plan and forecast the workforce in relation to future needs in health care systems, the policy-makers at Eurostat, WHO (World Health Organization), OECD (Organisation of Economic Co-operation and Development) and International Labour Organization (ILO) will need to take into account what the profession sees as accurate data and ‘fit for practice’ methodologies. Using the ISCO 08-code for nursing care leads to inaccurate data collection, inappropriate comparison of the nursing workforce and, finally, to unrealistic planning for the future.

To have a coherent approach to workforce planning and forecasting across the different EU-led initiatives, EFN is engaged in the ESCO project (European Skills/Competences, Qualifications and Occupations), led by the European Commission’s DG Employment, which seeks to identify and categorise qualifications, skills and competences using common terminology in all EU languages. It is within this policy context that the four categories of the EFN Nursing Care Continuum (health care assistant, general care nurse, specialist nurse and advanced nurse practitioner) were designed to: (i) define categories which make sense in relation to the minimum requirements of EU legislation; (ii) clarify the competencies of the four categories; (iii) assist policy-makers to advance the mind-set on how to collect comparable data for planning and forecasting, which is currently highly political; (iv) assist in curriculum design, negotiating skill mix and skill needs to respond to societal challenges; and finally (v) guide the formulation and revision of competencies at national jurisdiction level to guarantee compliance with the modernised PQD Directive. As one of the fundamental pillars to maintain sustainable health care systems and implement high quality and safe care is to have a highly educated, dedicated and skilled workforce, the collected data needs to be comparable within the EU and

methods used for planning and forecasting have to incorporate criteria and logarithms that are nursing sensitive.⁶

The EFN Nursing Care Continuum Qualification Categories

A clearer understanding of the different roles between the four categories in nursing care and comparable numbers of the entire nursing care continuum will lead to valid and reliable data upon which good nursing workforce policies can be developed at regional and national level.

Since the EFN members agreed on the EFN Nursing Care Continuum (October 2012),⁷ they have engaged in collecting data, country by country, on the entry-level education, qualification and competences for each category to have a more accurate understanding of the four categories in the 28 EU Member States. The analysis highlights some key findings discussed in turn below.

Health Care Assistant

*The health care assistant (HCA) is an auxiliary that assists directly in nursing care in institutional or community settings under the standards and the direct or indirect supervision of the general care nurse.*⁸

With regard to HCAs, there are differences in terms of regulation and education across Member States but they are all present in the nursing care continuum supporting nursing activities under the supervision of a general care nurse. Their education starts after 8 (Croatia), 10 (Netherlands) or 13 (Ireland) years of general education, it lasts from 9 months (Bulgaria) to 3 years (Denmark), and is situated at the upper secondary school level. The competencies differ slightly but are all related to providing basic nursing care (such as hygiene, mobilisation and feeding). Additionally, in some Member States the role of HCA is not formalised, resulting in different nominations of the title “nurse”, (i.e. practical nurse), a situation which creates confusion among patients. For instance in Finland, the title ‘nurse’ include professionals whose education has started before the minimum ten years of general education and consequently do not comply with the minimum requirements

established for a general care nurse as set out in the PQD Directive. Therefore, this role falls better into the category of HCA as the role and responsibilities undertaken correspond more closely. The same example holds for Italy where there is a group of health care workers who call themselves nurses, but do not comply with the minimum requirements of the PQD Directive relating to the entry level, duration, and balance between theory and practice.

“coherent approach to workforce planning and forecasting”

The EFN supported the DG SANCO study “Contec” whose objective was to map the current situation of HCAs in each participating Member State and to discuss the comparability of their qualifications, with particular emphasis on cross-border mobility. These designs cannot be created in isolation from the existing EU legislation. The Contec study results were therefore helpful to create a clearer and more detailed framework for the employment and duties of HCAs, next to the scope of the skills and competences required, benchmarked with that of the general care nurse.

General Care Nurse

*A general care nurse is a self-regulated health care professional who works autonomously and in collaboration with others and who has completed a nursing education programme and is qualified and authorised in his/her country to practise as a general care nurse (ref. Art 31, Directive 2013/55/EU).*⁹

This second category is legally set by EU law, the PQD Directive and Chapter 3 of the *Acquis Communautaire*. It applies to students fulfilling educational programmes totalling at least three years

of study, consisting of at least 4,600 hours, of which one third is theoretical and one half (2,300 hours) clinical training. The PQD Directive includes a list of measurable learning outcomes and competencies, highlighting the independence of the nursing profession.

Specialist Nurse

*A specialist nurse is a nurse prepared beyond the level of a general care nurse and authorised to practice as a specialist with specific expertise in a branch of the nursing field.*¹³

For this third category of the EFN nursing care continuum, there are different specialities and lengths of education across Member States but the common trend is that the specialist nursing education starts after achieving the qualification of a general care nurse, through postgraduate studies. In some cases, in addition to an existing qualification as a general care nurse, nurses are requested to prove professional experience of two years before entering specialisation studies. Most specialist nurses are disease-specific (oncology nurse, diabetes nurse, etc.), life cycle-specific (paediatric nurse, geriatric nurse, etc.) or sector-specific (community care nurse, operating room nurse, intensive care nurse, etc.).

Advanced Nurse Practitioner

*The advanced nurse practitioner (ANP) is a general care nurse who has an advanced knowledge base, complex decision-making skills and clinical competencies for expanded clinical practice; the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice.*¹⁴

The fourth category of the EFN nursing care continuum is a general care nurse in compliance with the PQD Directive who has acquired advanced knowledge and expertise on clinical judgment, skilled and self-initiated care, and research inquiry. Many EU countries already have regulations on ANP in place (Finland, Iceland, Ireland, the Netherlands, Norway and Slovenia), whereas others have officially started the legislative process (Denmark, Lithuania, Poland and Sweden). From the data analysis, it becomes clear that the ANP profile

has become prominent, especially in chronic disease management, where it has proven to be successful in delivering sustainable and cost-effective care.¹⁵ The EFN welcomed the study conducted by the OECD in 2010, providing an overview of advanced nursing practice.¹⁶ To further develop and implement the ANP in EU health care systems, the EFN started an EU thematic network (co-ordinated by DG Connect) with specific focus on the design of EU guidelines for the development of ANPs in clinical settings.

Qualification versus occupation

Health policy experts and researchers have long argued that current data tend to be fragmented, inconsistent, and not comparable nationally or internationally.^{17 18 19} Questionnaires for data collection, mainly designed from the ISCO-08 code, are mixing qualifications with occupations, leading to confusion and political discussions that do not benefit professional development in the EU and Europe. The questionnaires used by Eurostat, OECD, WHO and ILO lead to inappropriate comparison of the nursing workforce and, as such, to unrealistic planning for the future. With the data collected through the WHO-Eurostat-OECD Joint Questionnaire that is based on an occupational approach, it becomes challenging to build confidence within the profession as the numbers provide space for ambiguous interpretations.²⁰ Therefore, if we really want to look into gaps in the data analysis, we should focus on using the four categories of the EFN nursing care continuum, as these are clear in definition, non-biased in numbers, and simple to use. Even more important for the EU health workforce, these categories start from the legal basis of the PQD Directive which does not describe where a nurse needs to work – hospital or not – but explains who is a nurse and who is not.

Due to the clear structure from a lower to a higher qualification level, the four categories of the EFN nursing care continuum are more suitable for use by statisticians and health economists to collect data and conduct research that is trustworthy for the design of evidence-based policies.

Challenges

The main challenge in redesigning measurement scales and methods to plan and forecast the nursing workforce is the mind-set of European policy-makers and international institutions responsible for data collection. In the last few decades, systems have been developed without engaging the professions substantially, which explains the existence of titles falling in between categories of the nursing care continuum and creating disruption in the comparability of data. The leaders of the nursing profession therefore feel an urgent need for more dialogue with policy-makers and politicians to better understand, from a professional perspective, the rationale for change. Building trust systems and mechanisms for the collection of EU-wide data is key to making sense out of planning and forecasting. Claiming more nurses and health professionals for health systems implies a robust stakeholder engagement approach to deliver successful policy outcomes.²¹

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Going beyond definitions and glossaries is key to making change possible. Implementing new knowledge into practice goes beyond mapping exercises, literature reviews, and developing ‘cookbooks of best practices’. Nurses struggle daily to survive in a complex working environment, where they waste their time in collecting data that do not serve their needs, but that leads to recommendations which will never be implemented. We need to go beyond recommendations; we need to implement findings into practice. Although there is a tendency to make the analysis of policies and health processes very complex, the health and nursing workforce is not demanding this complexity. Instead,

data collection needs to be “simple” and “digital” in order for nurses to free up time for the benefit of direct patient care.

Finally, speaking with one voice is key for change. The nursing leaders from the professional associations, the regulatory bodies, the nursing unions and the governmental chief nurses should strengthen each other to build nursing further as a profession within the EU.¹³ The nursing community leaders need to jointly advocate datasets and methodologies for planning and forecasting which support the professional bodies, the regulators, the unions and the Chief Nursing Officers. Speaking with one voice for nurses and nursing is key to success.

Conclusions

Based on the statistical and economic shortfalls in using the ISCO-08 code in the WHO-Eurostat-OECD Joint Questionnaire, the EFN argues professionally and politically that politicians, policy-makers, researchers and nursing leaders should deploy the four categories of the EFN Nursing Care Continuum to collect comparable data and use it to plan and forecast the nursing workforce. The EFN is also of the opinion that the ISCO-08 code creates confusion on terminology and leads to unreliable

data collection. The EFN advocates for the replacement of the ISCO-08-based categories with the four categories of the EFN Nursing Care Continuum, in order to collect reliable data. Only by using a terminology that can be understood at EU level by health policy opinion formers and researchers, will it be possible to plan and forecast the future nursing workforce adequately and to deliver safe and high-quality health services in continuously reforming health systems.

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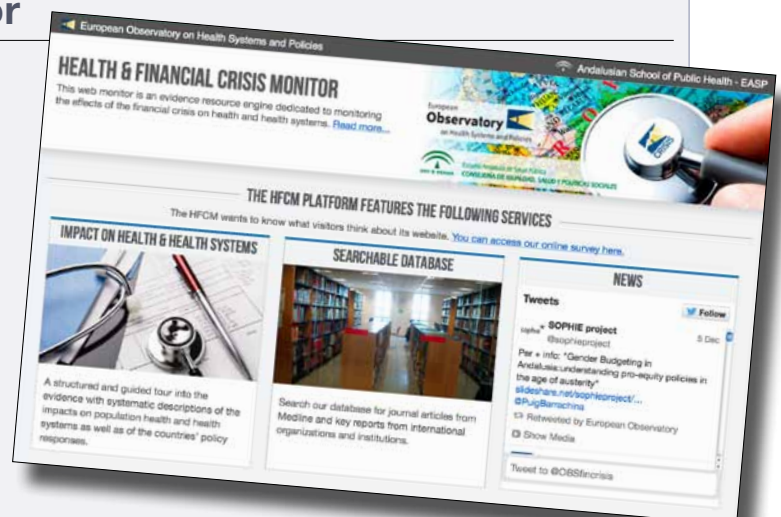
Health and Financial Crisis Monitor

The Health and Financial Crisis Monitor (HFCM) collates scientific evidence about the effects of the financial crisis on health and health systems across Europe, particularly in those countries most affected. The platform is intended to support and inform policy-makers and those who advise them by identifying and organising publications, data and analysis on this subject.

This web monitor is developed jointly by the European Observatory on Health Systems and Policies and the Andalusian School of Public Health. It is also linked with a dedicated Twitter channel that also provides information on grey literature (press articles, opinion pieces) as well as on relevant events and activities.

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PANDEMIC INFLUENZA IN THE UK AND **EU COMPETENCE** IN HEALTH SECURITY POLICY

By: John Connolly

Summary: The European Commission's competence in health security has grown incrementally and this article documents these developments. It highlights that the 2009 influenza pandemic in the UK can be described as a critical juncture in that it led to the establishment of a formal EU Health Security Committee and further legislative changes. Although cross-EU cooperation for health threats makes sense within a borderless territory, the increasing 'Europeanisation' of health security functions is not without its policy challenges, which largely stem from the risk of national policy-makers being protectionist around the sharing of information on data and preparedness planning for health security threats.

Keywords: *Pandemic Influenza, Health Security, Europeanisation, Contingencies, Public Health*

Introduction

Contingency planning and crisis management processes for health security present trans-boundary challenges for policy-makers which stem from the fact that diseases can penetrate integrated political and economic systems (such as the EU). This calls for a large number of policy officials and public health agencies to be engaged in contingencies and crisis management processes across multiple levels of governance (particularly those which cross-cut Member State and EU levels of public policy). In fact, the former Chair (up until early June 2014) of the Health Select Committee of the UK Parliament, Stephen Dorrell MP, argued in an interview that it is 'just good common sense' to cooperate across territories in the area of health security.

This might be the case; however, this does not negate the need for closer examination of the processes and developments of public policy around contingencies management in order to understand the contours of EU policy-making in this area. Evidence of such contours are often unaddressed and hardly ever mentioned in official governmental documents (such as strategies and contingency planning documents) which read as if crisis management processes are in some way 'non-political' in that such documents tend to focus on a range of procedural logic-based, technical and sequential steps that authorities need to take as a 'crisis manager'. This article seeks to shed some light on the developments surrounding European health security policy which has led to a strengthened EU Health Security

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Committee in the European Commission following the 2009 pandemic influenza outbreak in the UK.

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collaboration
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Pandemic influenza in the UK

The implications of disease threats on the population – such as pandemic influenza (which remains *the* biggest risk to UK population health²) – are feared by politicians, health practitioners and security experts.³ Policy-makers are aware that in the last century alone the 1918, 1957 and 1968 influenza pandemics have contributed to millions of fatalities as well as vast economic and social disruption. Concern over the threat of a widespread pandemic occurring has not been so heightened since the re-emergence of the avian flu virus from Asian countries (H5N1 virus) in 2003 and 2004.

More recently, fear over human to human transmission of influenza was particularly acute as a result of the 2009 H1N1 ‘swine flu’ virus. The threat emerged when the World Health Organization (WHO) declared that there was an outbreak of swine flu following the confirmation of human cases in the US and Mexico in April 2009.⁴ Two confirmed cases of pandemic influenza subsequently emerged which involved a couple who had returned to Scotland from Mexico. This led the UK government to increase their stockpile of antivirals (Tamiflu) to 50 million (from 35 million). When the WHO declared the outbreak had moved to pandemic levels this triggered the UK Government to procure vaccines to cover 100% of the population.

In late November 2009, modellers concluded that the pandemic had peaked

and a gradual reduction in cases followed. The pandemic led to 457 deaths in the UK.⁵ Following the 2009 pandemic, the UK Department of Health produced a *UK Influenza Pandemic Preparedness Strategy*⁶ which sets out in some detail the key planning assumptions and presumptions for planning for a pandemic – including a summary of the key roles of government departments and agencies, as well as the control strategies to mitigate the impact of a pandemic influenza crisis. An important point, yet made rather passively in the strategy, is that preparedness and response to the threat is coordinated at international levels.⁷ At the EU level, the dominant narrative to emerge from the European Commission was that the main lesson to be learned from this event should be that the EU institutions have increased policy competence over Member State health security policy.⁸

The European Commission and health security policy

Public health disease management within the EU is led by DG SANCO of the European Commission. The Commission saw the 2009 H5N1 pandemic as an opportunity for further Europeanisation in that there was a desire by the European Commission to ‘reinforce the collaboration at EU level on serious cross border health threats’ by putting in place, where necessary, additional structures, risk communication and coordination mechanisms.⁹ In other words, the competence of the EU in coordinating contingencies and crisis management for public health threats has increased since 2009. There is now a system in place for community-level surveillance in that Member States are obliged to statistically report on cases of communicable diseases on an annual basis and are obliged to inform each other, using an electronic system of outbreaks, if communicable diseases could have implications for other Member States.

Predating the influenza pandemic was the 9/11 US terrorist attacks which widened the scope of the EU’s role to biosecurity issues which prompted the Council of Ministers to establish the Health Security Committee (HSC). The

committee is made up of senior public health representatives of the Member States. For the UK, representation to the committee is made by officials from the UK Department of Health. Originally, the committee was an informal forum in order to coordinate Member State biosecurity planning and response in order to avoid the deliberate release of biological agents or natural events which might be of a similar nature. In 2013, the Commission pulled together the system that has been in place since 1998 for surveillance and control of communicable diseases with measures on biosecurity (through Commission Decision 1082/2013/E, October 2013). There is now a system comprised of the following parts: a) a surveillance system for communicable diseases; b) the Early Warning and Response System, which has now been extended to include not only communicable diseases but other serious cross-border threats to health (for example, environmental events, biosecurity and chemical events); and c) joint risk assessment with Member States by the European Centre for Disease Control (ECDC) in Stockholm.

The politics of a strengthened Health Security Committee

There has been a creeping increase in the legal obligations placed on Member States since pandemic influenza in the UK. John Ryan – the Director of the Health Threats Unit of the European Commission and Chair of the HSC – noted that ‘the 2009 influenza pandemic and the lessons that emerged from it meant that Member States realised that continuing in a more informal, limited way, in terms of just coordinating in terms of communicating diseases as we did before, was inadequate because many of the aspects relating to communicable diseases are large scale events and cross-sectorial’.¹⁰

Up until now, the politics of the increasing role of the European Commission in the management of public health disease threats, and quite contrary to the dominant and general political narrative in British politics at the moment, has not been seen by UK officials as being ‘top-down’ in its approach to policy-making for contingencies management. This stems from the fact that the larger Member States

Table 1: Developments in EU health security policy

Year	Development in EU health security policy	Implications
1998	Decision 2119/98/EC of the European Parliament and of the Council	The legislation set up a network for epidemiological surveillance and the control of communicable diseases. It focuses on the surveillance of communicable diseases and early warning and response coordination.
2001	EU HSC set up (an informal committee)	EU health ministers decided to establish the HSC as an informal structure to ensure enhanced coordination of public health risk assessment mechanisms and the management of other serious cross-border health threats in the EU (initially focused on bioterrorism). The remit of the HSC subsequently has been extended to cover all types of public health-related threats.
2005	The European Centre for Disease Control (ECDC) was established	The body identifies and assesses the risk of current and emerging threats to human health posed by infectious diseases.
2007	International Health Regulations (IHR)	The IHRs established a new framework for the coordination of the management of events that may constitute a public health emergency of international concern. This covers all hazards including communicable diseases and other health threats. IHRs impose an obligation on each Member State to individually build core capacities for surveillance and response.
2009	Lisbon Treaty – Article 168	The Treaty stipulates that the EU must complement and support national policies and encourage cooperation between Member States, without superseding their competence in that field.
2011	Commission's legal proposal	Proposal on serious cross-border threats to health.
2013	Decision 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross border threats to health. EU HSC becomes a formal legislative body.	The legislation extends the protection provided to European citizens to all serious cross-border threats to health caused not only by communicable diseases but by other biological, chemical and environmental threats.
2013 onwards	Implementation of the legal proposal: EU assessment and management of serious cross-border threats to health.	The EU HSC becomes a formalised system and accountability forum which monitors and evaluates Member State preparedness for health security threats.

Note: The author is grateful to Mr John Ryan, Director of the Health Threats Unit of the European Commission, for providing information which formed the basis of the content of this table.

(such as the UK, Germany and France) are competent in contingencies management as compared to small Member States – warranting the larger Member States to take the lead in influencing EU public policy. Therefore, policy is regarded by the larger Member States as being driven by them. However, there remain policy challenges in terms of working on the basis of closer EU-wide cooperation. A senior official in Public Health England² (the UK government's national public health agency) outlined this point and noted that the added work on cross-EU cooperation can be a 'distraction' given that larger Member States have their own tried and tested crisis management systems in place. There can be tensions when it comes to supporting Member States with less developed systems, but this presents a 'catch 22' situation in that the swift and effective implementation of countermeasures to minimise cross-

border risks requires leadership from Member States such as the UK, France and Germany.

A further development in terms of Commission Decision 1082/2013/E, in relation to the management of cross-border threats, has been the development of joint procurement for vaccines which was a response to pandemic influenza. The policy of joint procurement emerged as a result of the fact that several Member States had difficulty in procuring the supplies of vaccines given that several other Member States had bought up supplies in advance or had put in place advance purchase orders. In political terms, John Ryan (the Director of the Health Threats Unit in the Commission) outlined that reaching agreements on joint procurement 'has been a very difficult process... for the security aspect Member States don't want their neighbours to know what they are planning and what their

provisions are in respect of pandemics because it is considered sensitive information'.²

The details of pandemic planning in Member States could have considerable implications for fellow Member States given that some Member States plan to vaccinate 2% of their population in the event of a pandemic; whereas other countries that are providing coverage for 100% of the population. The details of the countries and their vaccination strategies are deemed to be confidential by the European Commission (i.e. the 98% of the citizens of the country that has a vaccination plan to cover 2% of the population who will not receive the vaccine might have some questions to ask of their politicians).

At the UK level, there has been a reluctance to accommodate the provisions of Commission Decision 1082/2013/E.

This is in relation to the idea that the European Commission should be able to collect information on planning at the Member State level on the basis of a template which would be analysed by the Commission and evaluated in the HSC. This could appear to be a rather straightforward development; however, this turned out to be the most difficult aspect of the legislation to negotiate. According to the European Commission, this emerged from the demanding nature of UK representations on this particular decision given that the UK regard most of the information that concerns national preparedness planning to be sensitive in nature and that it has implications for national security.²

“challenges of an ever closer union in relation to health security”

Up until October 2013, Member States were communicating data confidentially to the WHO in Geneva and they did not know each other's level of preparedness. From the perspective of the Commission, this is the 'value added' of the new legislation because for 'the first time Member States, such as the UK, will communicate all of this information to the Commission and the Commission will look at this and analyse all of the gaps and will then report to the HSC'.³ The future role of the HSC will be to evaluate whether there are deficiencies in preparedness planning for health security at Member State level and assess how these can be developed. Unlike the WHO, which has no legal powers to act on the information they have from Member States, the Commission can now produce monitoring and evaluation reports in order to hold Member States to account in relation to preparedness planning.

Conclusions

In summary, the 2009 pandemic and the lessons to emerge from it has solidified the role of the European institutions in contingencies and crisis management for health security and ensured that this area of national public policy has taken a significant step in the Europeanisation process. **Table 1** provides a summary of the developments in EU health security policy since 1998. Despite much of the rhetoric in official contingency planning documents, the insights of those involved in the formation of EU public policy in this area highlight the challenges of an ever closer union in relation to health security.

There are opportunities from this point to consider the implications of the new role of the HSC given its stronger competence in monitoring and evaluation when it comes to the contingency and preparedness planning arrangements of Member States. What does this mean in terms of intergovernmental relations between Member States in the EU context? How much cross-state cooperation is sufficient? In addition, there are further questions here from a comparative public policy perspective in terms of mapping the extent of patterns and paradoxes in health security policy-making across a range of specific areas within the policy sector (e.g. bioterrorism, disease outbreaks) and across policy sectors (e.g. between health security and other matters relation to other areas which concern contingencies and crisis management for security in the EU, such as animal health and energy policy).

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THE COMMERCIALISATION OF PUBLIC HOSPITALS IN POLAND

By: Alicja Sobczak and Anna Sagan

Summary: Indebtedness of Polish public hospitals has been a long-standing problem and was often attributed to the shortcomings of their legal form. In the late 2000s, a further change of the legal form, conducted on a large scale, was seen as the most effective single solution to this problem. So far, the pace of voluntary transformations into Commercial Code companies has been slower than expected and some of the transformed hospitals continue to accumulate losses. “Forced” transformations or liquidations of indebted hospitals should have started from mid-2014 but implementation has been delayed pending local government elections. Big changes may bring new problems, such as with assuring access to necessary care.

Keywords: Health Care Reform, Hospitals, Debt, Commercialisation, Poland

Introduction

Poland spends around 6.7% of its GDP on health. This share is roughly the same as the average for the EU12 countries, but much lower than the EU15 average of 10.4%. The same can be said about the share of publicly funded health care expenditure as a proportion of total health expenditure (THE) – in Poland and other EU12 countries this share is around 70%, while in EU15 countries approximately 77% of THE comes from public sources.¹ The vast majority (over 80%) of public expenditure on health in Poland can be attributed to universal health insurance administered by a single health insurance fund (NHF). About 50% of NHF expenditure is spent on hospital care.²

Indebtedness of public hospitals had been a longstanding problem in the Polish health care system and was often attributed to the legal form in which

the majority of the providers operated: budgetary entities (until 1999) and autonomous public health care units, known as SPZOZs (since 1999). The budgetary entities that dominated until the introduction of universal health insurance in 1999 were not legal entities and were entirely dependent on the budgetary means with which they were endowed. They were also governed by ineffective budgetary rules; for example, they had to follow rigid categories of expenditures, with no possibility of shifting resources between categories. During the 1990s, many of them accumulated debts and these were cleared by the state a number of times.³

It was hoped that a systemic change, i.e. the replacement of the Semashko-style system of general tax financing based on budgetary rules by financing from health insurance contributions, would improve both the level of financing as well as the efficiency of health care provision.

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Table 1: Selected differences between SPZOZs and Commercial Code companies

	SPZOZ	Commercial Code Company
Can it generate profits?	No (an SPZOZ operates on a not-for-profit basis)	Yes (a Commercial Code company operates on a for-profit basis)
Can it raise additional funds outside contracts with the NHF (including directly from patients)?	Limited (an SPZOZ must sign contracts with the NHF for all types of services it provides and that are required by the NHF; no additional payments can be levied on the contracted services and no contracts with other payers (e.g. private insurance companies) can be signed for the services covered by the NHF contracts)	Yes (a Commercial Code company can refuse to sign contracts with the NHF for the provision of unprofitable services; it can sign contracts for the provision of all types of services it provides with other payers (besides the NHF))
Can it go bankrupt?	No (an SPZOZ can be liquidated by its public owner but only after the latter covers its financial obligations)	Yes
Are the owners fully responsible for its financial obligations?	Yes (fully)	No (only up to the amount of invested capital)
Is it liable to pay corporate income tax?	No	Yes
What are its key governance and management bodies?	Director, social council, the founding body (i.e. public owner)	Meeting of shareholders, board of directors, audit committee (there is more emphasis on profitability and professional management in these bodies compared to the bodies governing an SPZOZ)

Source: Based on ¹

The 1999 reform introduced a split between the public payer(s)* and providers (public and non-public) creating a ‘quasi-market’ for the provision of health care services. In order to participate in this quasi-market, before the reform took effect (mainly in 1996–1998) the budgetary entities were transformed into SPZOZs, modelled on the English National Health Service (NHS) trusts.

The SPZOZs have to cover the full cost of their activities from their revenues. They enjoy significant economic and managerial autonomy, e.g. over the number of staff and their remuneration, the number and structure of beds, medical equipment, outsourcing, etc. However, this legal form again allowed the accumulation of debts and led to poor financial management. The main reason for this is that the public founding bodies/owners of the SPZOZs (i.e. mainly local (municipal) governments) were made ultimately responsible for their debts. A large number of other factors also were to blame for the poor financial performance of hospitals, including:

- poor managerial competencies (hospital managers were usually medical professionals with no managerial experience);
- existence of several types of public owners (mainly various levels of local self-government, with each level ‘protecting’ the hospitals they own and poor cooperation between them);
- insufficient control of the public owners over the management of the SPZOZs;
- the monopsony position of the NHF (with providers having no control over the volumes and values of contracts and the contracting process);
- lack of payment or delayed payment for “overprovision” of services; and
- uncoordinated development of hospital infrastructure which led to overcapacity in certain regions/specialties.

Commercialisation of public hospitals

Since the mid-2000s, and especially after the liberal-conservative Civic Platform came to power in 2007, commercialisation of public hospitals (and other public health care providers operating as SPZOZ) has been seen as a means for improving health system efficiency and as a remedy for unsound financial

management.² Commercialisation involved the transformation of SPZOZs into companies governed by the Commercial Companies Code, i.e. making them limited liability or joint stock companies.

“ low rate
of voluntary
transformations

The key differences between the SPZOZs and Commercial Code companies are summarised in **Table 1**. Unlike an SPZOZ, a Commercial Code company may go bankrupt if it does not manage to cover its debts. In this way, the change of legal form could indirectly stop the accumulation of debts by hospitals. The rationale is that the threat of bankruptcy may motivate the hospitals’ management to increase operational efficiency (e.g. by cutting the number of staff, increasing the use of beds), but also to concentrate on the most profitable services and limit or even eliminate provision of the least profitable ones. However, other factors that also have a negative impact on the financial situation of hospitals (see above) have remained.

* Initially, there were 17 sickness funds, and since 2003 a single payer – the NHF.

Many public providers functioning as SPZOZs (especially ambulatory outpatient clinics) were transformed between 2000 and 2010, among them over 100 hospitals and over 50 hospital wards, i.e. about 13% of the total number of hospitals at the end of 2010.[‡] Both well-performing hospitals and hospitals in poor financial condition were transformed. Transformations have been successful in hospitals that took steps to reduce costs (e.g. by decreasing the number of beds and/or staff) and increase revenues (e.g. through efforts to generate additional revenues from the provision of health care services outside the contracts with the NHF). However, not all transformed hospitals implemented such measures and some of them continued to incur losses. According to an audit conducted by the Polish Audit Office, among the fifteen SPZOZs that were analysed, ten were still indebted after their transformation.[‡]

Although there was no clear evidence that the transformed hospitals performed better than those that remained public, several attempts were made in late 2000s to achieve a large-scale transformation of SPZOZs into non-public entities. They included a failed attempt to introduce compulsory commercialisations (vetoed by the President in 2008) and the introduction of the so-called Plan B for hospital commercialisation, offering state assistance to territorial self-governments that decided to transform the hospitals they owned into commercial companies in 2009–2010. Since the transformed SPZOZs become autonomous companies, these measures did not include any proposals that would aim to increase their financial accountability or strengthen control over their financial performance (or in any other way interfere in their operations). Consequently, few self-governments applied for state assistance and Plan B had limited success.

A second attempt

Another attempt to introduce large-scale hospital transformation came with the introduction of a new legal framework governing health care provision – the Therapeutic Activity Act. The proposed draft of this Act was controversial, as it could lead, in some cases, to “forced”

commercialisations or liquidations of a significant number of indebted public hospitals. However, since it was submitted by MPs and not by the government, it did not have to be subjected to public consultation. Despite the opposition, the coalition government succeeded in passing the Act through Parliament in April 2011.

One of the main objectives of the Act was to limit the role of SPZOZs in the health care system. This was to be achieved in two ways. Firstly, new ‘therapeutic entities’ (i.e. health care units) could no longer be established as SPZOZs (except for mergers of two or more existing SPZOZs). Secondly, owners of SPZOZs that had unpaid debts, had to cover them within three months of having approved the SPZOZs’ financial statements, or else transform them, within twelve months, into one of the legal forms foreseen in the Act (i.e. a Commercial Code company[†] or a budgetary unit) or liquidate them.[‡] Financial support was offered to SPZOZs that started transformation procedures before the end of 2013.

“no clear evidence that transformed hospitals performed better”

According to the explanatory note to the Therapeutic Activity Act (15 October 2010), it was expected that about 40% of the SPZOZs (mainly hospitals) would be transformed or liquidated between 2011 and 2014. However, the rate of voluntary transformations has been much lower than expected: between 1 July 2011 and 31 October 2013, only 48 SPZOZs, including 34 hospitals, were transformed.

[†] A Commercial Code company established as the legal successor of a transformed SPZOZ has to take over its assets and obligations.

In addition, most of the transformed SPZOZs were, in fact, in good financial condition before the transformation.[‡]

The self-governments prefer to transform hospitals that are in good financial condition and can thus ‘survive’ after the transformation. On the other hand, they prefer to cover the losses of hospitals that perform poorly, rather than transform them, since transformation would mean a loss of control, while at the same time they remain accountable to their constituencies and have the constitutional duty to provide health services to their populations. The key reasons why hospital managers fear transformations are the risk of bankruptcy and the lack of well-trained managers who are prepared to take responsibility for the transformation process and assure the long-term ‘survival’ of the commercialised hospital.[‡]

According to financial statements from the end of 2012, around 205 SPZOZs (mainly hospitals) recorded a negative financial result.[‡] The public owners of the indebted hospitals are faced with a dilemma – whether to transform them into Commercial Code companies, repay their debts or liquidate them (transformation into budgetary entities is also an option, but this option is not widely considered). Given that local elections took place in November 2014, it will be the newly elected authorities who will decide which option to follow.

Conclusions

Given the low rate of voluntary transformations and the continued accumulation of losses in the sector, transformations or liquidations of indebted hospitals were anticipated from mid-2014. However, the self-governments and other public owners have tended to avoid the process and have kept hospitals operating as SPZOZs (by covering their debts, instigating financial improvement programmes, subsidies and credit warranties for restructuring, and/or delaying the approval of financial statements). Sharp changes to hospital structures may threaten access to health care services for the population and may also constitute a breach of the Constitution which guarantees all citizens the right to

equal access to health services financed from public sources. Thus, limiting or stopping the provision of services may be unconstitutional. If transformed SPZOZs decide not to provide unprofitable services, or if they continue to incur losses, they may go bankrupt and stop provision completely (although it is not clear if the state would allow this).

Experts are therefore calling for a set of systemic changes that would improve the hospital system as a whole and solve some of the other problems mentioned above, including: improving regional planning and coordination, improving contracting by the NHF, and improving financial and operational management of health care providers in order to achieve a better use of resources.

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New HiT on Italy

By: F Ferré, AG de Belvis, L Valerio, S Longhi, A Lazzari, G Fattore, W Ricciardi, A Maresso.

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Budget cuts and regional disparities increase the pressure on the Italian health system

Coinciding with the Italian Presidency of the European Union's Council of Ministers, the new health system review (HiT) on Italy has just been published.

Faced with rising regional deficits and austerity budgets focused on reduced public spending, the Italian National Health Service has been grappling with a dual challenge: containing or even reducing health expenditure while at the same time dealing with greater demand for its services. To date, these efforts have managed to be successful – regional deficits are now largely under control and the benefit package continues to be delivered effectively, albeit with



much more tightly stretched resources and increased cost-sharing for some services. Italy's belt-tightening responses to its fiscal crisis have also exacerbated the existing inequity across regions, where gaps in service provision and health system performance persist.

Government policies have focused on setting caps on pharmaceutical spending, reducing the number of hospital beds and shifting care away from acute stays, increasing co-payments and instituting new purchasing contracts for medical goods. A major policy tool has been the adoption of 'financial recovery plans' by high-deficit regional health systems, targeting the structural determinants of costs, as well as national 'health pacts' binding regions to budgetary discipline. However, the overt focus on financial retrenchment should not overshadow the need for longer term strategies for better health system performance, such as efforts to promote greater group practice among health professionals working in primary care, bolstering the quality of professionals managing public facilities, and ensuring that the concentration of organisational control by regions of health care providers does not stifle innovation.

The HiT report on Italy was formally launched, in conjunction with the new OASI (Observatory on Italian Healthcare Management) report on the Italian National Health Service, at a conference, called "The National Health Service that we would like to have", which took place at Bocconi University (Milan) on 24 November 2014.

PERCEPTIONS ABOUT AFFORDABILITY OF CARE IN THE NETHERLANDS

By: Anne E.M. Brabers and Judith D. de Jong

Summary: The search to maintain a sustainable health care system often results in health care users facing increased costs. The burden of collective expenditure is shifted onto individuals, which could have an impact upon the affordability of care. One third of Dutch health care users find health care currently not affordable for themselves. Almost half believe that the rising costs of health care may prevent them from using care in the future. Monitoring whether health care users experience problems can provide an insight into unintended effects, such as inequalities in access and affordability, which are not in accordance with goals of the health system.

Keywords: Health Expenditures, Health Care Reform, Health Care Disparities, Affordability; the Netherlands

The challenge of financial sustainability

A question raised frequently in the health policy debate is whether health systems will be financially sustainable in the future.¹ Over recent decades, health care expenditures have risen in most OECD countries and are projected to increase significantly in the future: the combined public health and long-term care expenditures for OECD countries are projected to reach 9.5% of gross domestic product (GDP) by 2060, even under the assumption that policy action is undertaken to rein in costs.² Factors identified as contributing to growth in expenditure include the ageing of the population and growth in personal income, as well as advances in medical technology.^{3, 4} Since resources are limited, finding a balance between rising cost pressures and resources is a concern

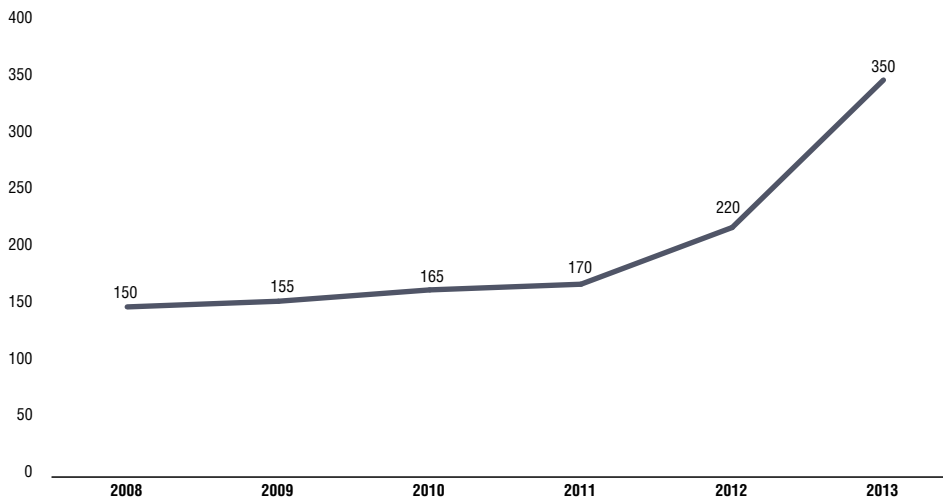
across many countries.⁵ This is even more relevant in the context of the current financial crisis that started in 2007,⁶ which is having a significant impact on health systems.⁷ In Europe, countries have implemented a wide range of policies in response, including strategic purchasing, price reductions for pharmaceuticals, reducing the scope of essential services covered, and introducing user charges for essential services.⁸

A case study: the Netherlands

Like governments in other countries, the Netherlands faces the challenge of keeping the health system financially sustainable. Compared to other countries, the Netherlands spends much on health care, both as a percentage of GDP and per citizen.⁹ In 2010, more than 13% of Dutch GDP was spent on health care.¹⁰ Estimates

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Figure 1: Compulsory deductible, 2008–2013

Source: ¹⁰

for the future show an increase in expenditures of between 19% and 31% of GDP by 2040.¹⁰ In addition, an increasing part of Dutch household incomes is spent on health care. If health expenditure continues to increase as in the last decade, then it is estimated that by 2040 an average Dutch family will spend almost half of its income (47%) on health care.¹¹

“46% of health care users think that rising costs will pose a barrier”

The Dutch health care system aims for affordable and accessible health care.¹² In 2006, a system of managed competition in the health insurance system was introduced in the Netherlands (see Box 1 for more information about this system). Within this system there is a large degree of solidarity with regard to both the accessibility of care, in that everyone is entitled to the same basic services, and the funding of care.¹³ However, solutions have to be found in order to keep health care sustainable. One of the possibilities is to finance health care by shifting the allocations within collective expenditure.¹⁴ However, since 25% of

all Dutch collective expenditures are already spent on health care¹⁵ shifting more resources to health would mean large budget cuts in other collective expenditures.¹⁶ Another possibility is to reduce the pressure on collective expenditures by, for example, reimbursing less care out of the basic insurance package, offering less compensation for people on low incomes and increasing out-of-pocket (OOP) payments for some health services.¹⁷ Currently, the Netherlands covers a relatively low percentage of health care spending through OOP payments compared with other countries.¹⁸ Nevertheless, an example of increased OOP payments is that the compulsory deductible, i.e. the amount that must be paid out-of-pocket before a health insurer will pay any expenses, more than doubled from €150 in 2008 to €350 in 2013 (see Figure 1).

The Netherlands continues to discuss the possible introduction of several other OOP payments. For example, in 2012, a charge for secondary mental health care was applied, but it was abolished a year later. There were also suggestions that OOP payments for visits to a general practitioner (GP), and for self-referrals to emergency departments should be introduced but as yet, these policies have not been adopted. Such measures would shift collective expenditure onto individuals, presenting them with additional costs, which may reduce health care use.

Do users find their health care affordable?

Health care users are faced with additional costs in order to keep overall health expenditure under control. Therefore, we need to gain some insight into the current experience of users and into future unintended consequences, such as avoiding necessary health care due to cost barriers. In October 2012, a mixed-mode questionnaire was sent to 1,500 members of the Dutch Health Care Consumer Panel, run by the Netherlands Institute for Health Services Research (NIVEL) (www.nivel.nl/consumentenpanel-gezondheidszorg). This sample was representative of the Dutch population aged eighteen years and older regarding age and gender. In total, 845 respondents (56%) returned the questionnaire.

Firstly, we asked health care users if they currently find health care to be affordable. About three out of ten (31%) replied that health care is not, now, affordable. In addition, we asked how confident they were about the future. More than half (52%) of respondents indicated that they had little, or very little, trust that health care would be affordable for themselves in the following year (2013). Furthermore, approximately seven out of ten (69%) health care users have little, or very little, trust that health care will be affordable in the longer term.

An indication of whether there is inequality in access to health care is whether there are groups of health care users who are especially facing financial difficulties and expecting more challenges in future. As shown in Table 1, there are considerable differences in the affordability currently experienced, as well as the expected future affordability, between groups of health care users. For example, there is an association between income and affordability: health care users on a low income experience more problems with the affordability of health care than health care users with middle and high incomes. Furthermore, there is an association between affordability and health status: health care users with a poor or fair perception of their own general health find more often that health care is now not affordable for them. They also have less trust in its future affordability

Table 1: Multivariate logistic regression models for the current affordability experienced, and the trust in affordability in the next year and in the future

	Health Care affordable now? (0 = yes; 1 = no)*		Trust in the affordability of health care next year (0 = (very) much trust; 1 = (very) little trust)*		Trust in the affordability of health care in the future (0 = (very) much trust; 1 = (very) little trust)*	
	N = 733		N = 756		N = 743	
	coef.	p-value**	coef.	p-value**	coef.	p-value**
Gender (0 = man; 1 = women)	0.369	0.037	0.188	0.251	0.253	0.153
Age	-0.025	0.000	-0.026	0.000	-0.033	0.000
Monthly net income						
- <1750 euro	reference category		reference category		reference category	
- 1750–2700 euro	-0.808	0.000	-0.576	0.003	-0.552	0.012
- >2700 euro	-1.764	0.000	-1.664	0.000	-1.015	0.000
General health						
- Very good/excellent	reference category		reference category		reference category	
- Good	0.514	0.014	0.785	0.000	0.848	0.000
- Poor/fair	1.274	0.000	1.389	0.000	1.063	0.000
Constant	0.738	0.084	1.556	0.000	2.575	0.000

Notes: * In all regression analyses "no opinion" is recoded as missing. ** Bold p-values indicate $p < 0.05$

compared to health care users with very good or excellent health. Therefore, there are differences between groups of health care users with regard to their experienced affordability and there are particular concerns among vulnerable groups.

Do rising costs pose an impediment to future health care use?

An important unintended consequence of facing up to problems of health system sustainability is that, due to OOP costs, health care users may not have access to care that is necessary for them. This does not seem to be the case yet. Only a small proportion (7%) of health care users reported that they did not visit a doctor in 2012 due to costs. A similar proportion (8%) reported not to have had a medical examination or treatment in 2012 due to costs. However, this may change. Almost half (46%) of the health care users surveyed think that rising costs will pose a barrier against them making use of health care in the future. Furthermore, health care users facing problems with affordability, more often, did not visit a doctor, or did not have a medical examination or treatment in 2012. Moreover, both these users and health care

users who do not have much trust in the future, more often think that rising costs will pose a barrier to their making use of health care in the future.

“shifting
collective costs
to individuals
does have
implications for
access

The importance of further monitoring

European countries have implemented a wide range of policies in an attempt to keep health care affordable.¹⁴ Health system aims, such as equality of access, should be kept in mind when implementing such measures. While some policies promote these aims, others, such as user charges, risk undermining them.¹⁵ International evidence suggests that such charges disproportionately affect

low income groups and regular users of care.¹⁶ Furthermore, they are unlikely to reduce total health care expenditure as a result of reduced use of necessary care.¹⁷ The results of our study among Dutch health care users are in line with these findings. Meanwhile, a considerably larger proportion of surveyed users fear that health care may not be affordable for them in the future. Even more importantly, we observed that vulnerable groups in particular, such as people on lower incomes or in poorer health, more often experience or expect problems.

These results suggest that the aim of equal access to health care could be challenged. For example, an unintended consequence of introducing measures such as user charges is that individuals are avoiding or delaying care due to the costs. This is confirmed by results from the Commonwealth Fund's international survey, which found that 22% of the Dutch population experienced problems accessing care which were related to cost.¹⁸ This percentage is high compared to the other countries in the study, except for the US at 37%.¹⁹ Furthermore, this percentage increased in the Netherlands between 2010 and 2013, while a less clear pattern was

Box 1: The Dutch health insurance system

- Every citizen at age eighteen is obliged to take out health insurance (i.e. a basic package).
- Health insurance companies are obliged to accept every citizen for the basic package without premium differentiation, risk selection or risk adjustment.
- The basic package is identical for everyone and includes all necessary care. The idea is that companies compete on both price and quality.
- Complementary insurance is also available, but is not obligatory and does not necessarily have to be purchased through the same insurer as the basic package.
- Citizens are free to choose between different insurance companies. Switching is possible once a year.
- A nominal level of premium, approximately €1,250 (in 2012) plus an income-related contribution initially paid by employees and then subsequently reimbursed by employers. Half of the total costs of premiums will be from nominal premiums and the remainder from income-related contributions.
- There is compensation for citizens on low incomes.
- There is a compulsory deductible which increased from €150 in 2008 to €350 in 2013 (see Figure 1); and choice of a further voluntary deductible, additional to the compulsory deductible (minimum €100, maximum €500).

observed in other countries. This could possibly be explained by policy measures taken in the Netherlands in these years, like implementing a higher compulsory deductible (see Figure 1).

Another study found that 9% of Dutch health care users stated that they made less use of medical care in 2012 because part of the costs had to be paid out of pocket as a result of the compulsory deductible. The compulsory deductible did not include GP visits, but even so, a majority of these health care users indicated that they visited their GP less often.¹⁰

Conclusion

The results of various studies suggest that shifting collective costs to individuals does have implications for access to health care. Therefore, it is important to keep monitoring whether health care users in the Netherlands, or particular sub-groups, do indeed, as they expect, experience an increase in problems in accessing care related to costs. This would not be in accordance with the aims of the health

system, which state that necessary care should be accessible and affordable for everyone.

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FINANCIAL CRISIS AS A **REFORM** **MEDIATOR** IN CYPRUS'S HEALTH SERVICES

By: Panagiotis Petrou

Summary: Cyprus entered a prolonged financial recession in 2011 and in 2013 it applied for a bailout agreement with international lenders. This has stipulated massive structural reforms in the health care sector aiming to reduce public health expenditure and enhance efficiency. Several cost containment along with performance enhancement measures have been implemented. This article aims to examine the weaknesses of Cyprus's health care sector before the financial crisis, present and assess the measures implemented in the context of the bailout agreement, and propose new policies that can further enhance efficiency and curtail expenditure without compromising health outcomes.

Keywords: Health Policy, Financial Crisis, Reforms, Bailout, Cyprus

Introduction

In 2013, Cyprus reached the verge of bankruptcy and had to resort to a bailout agreement with international lenders consisting of the International Monetary Fund (IMF), European Commission and European Investment Bank, commonly known as the Troika. Cyprus constitutes an inimitable case among European recession countries. In contrast to other countries which have been struggling for many years with financial deficits, Cyprus experienced a fast and abrupt fiscal deterioration. The “economic miracle” (a term used to describe Cyprus's financial growth in the 2000s) in less than two years turned rapidly into a fiscal nightmare and a monumental, unavoidable public deficit forced the government to resort to the international loan agreement. In line with practices implemented in other

bailout countries,¹ the disbursement of financial instalments is conditional upon several reform prerequisites outlined in the country's Memorandum of Understanding (MOU) which the government must fulfil in advance.

A fragmented health system

The health sector ranked high on the reform list. Weaknesses and deficiencies of the health system were apparent, even prior to the economic crisis and many of them are interrelated. As the only European Union (EU) country without a universal health system, the current health care sector is highly fragmented between private and public segments. The public health sector is highly centralised and is funded by the Ministry of Health (MoH). A legacy from the English colonial era,

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the public health care sector provides free care to its beneficiaries who constitute up to 85 % of the total population, based on socioeconomic criteria and employment status. Eligibility criteria are rather biased, favouring some cohorts of the population, such as public servants, thus resulting in grossly uneven access to public health care.²

Despite 85% of the population being beneficiaries of the free public health care sector, in practice data are far less impressive. This feature is mediated by the fact that out-of-pocket payment is the primary source of health care funding in Cyprus² verifying previous findings indicating that Cypriots disparage the public health care sector,² particularly due to perceived issues of quality and long waiting times.² Inadequacies include minimum adoption of information technology (IT), which leads to lack of coordination, and interruption of continuity of care between primary and secondary care, resulting in duplication of diagnostic activities. The lack of clinical guidelines has hampered benchmarking and the setting of performance targets, while leading to significant variability of health outcomes among health centres. As a snow-ball effect, the nonexistence of monitoring and clinical guidelines has led to over-utilisation of laboratory and imaging exams, coupled with polypharmacy. Indicatively, 39% of all prescriptions in the public sector carry more than five products, while consumption of antibiotics is the second highest among EU countries. These features have also impeded monitoring and medical auditing.

The cumulative impact was magnified by a bureaucratic structure with significant lack of transparency on operational matters and ministerial decisions, such as on the reimbursement of patients for treatments not provided in public hospitals, and a lack of financial control. Moreover, Cyprus's health sector lacks an independent authority that can adequately manage the health setting and cope with problems such as corruption, inequity and inadequate planning of human resources, as attested by the shortage of family doctors. Therefore, the public health sector

evolved into a confusing hodgepodge, lagging behind international advances in health services.

From a financial point of view, the public health care sector was depicted as “generous” since no annual fees and no demand side measures, such as co-payment, were introduced. This resulted in overuse, misuse and abuse of the system.² Notably there is no continuity of care between the public and private sector, which is unregulated and financed out-of-pocket. Fragmentation of the private and public sector led to duplication of health infrastructures, especially high-cost technologies such as CT scanners, for which Cyprus has the highest number per capita in Europe. This leads to high running costs which are ultimately shifted to private patients.

Several ministers introduced ambitious reform plans; nevertheless, their implementation was stalled for various reasons, the most important of which was the much anticipated introduction of a new National Health System (NHS), which was perceived to be a “*Deus ex machina*”, capable of solving complex health problems. The General Health Care Scheme law (89 I/2001) sets out the framework of the health system in Cyprus and high hopes have been placed upon it, in terms of efficiency enhancement. Nevertheless, procrastination, intertwined with the anticipated introduction of the NHS, has led to stagnation, particularly in the introduction of efficiency improvement measures. However, the NHS has not yet been implemented due to concerns over its viability.

It is also worth emphasising that despite the current system's flaws, Cypriots score high on health indicators and enjoy high levels of health, above the EU average.

Policy Changes outlined as prerequisites by the Troika

Financial reforms

The first measure dealt with regulation of demand, through the introduction of demand-side measures. Co-payments were applied to out-patient visits, medicines, laboratory exams and emergency room

(ER) visits, in the form of fixed and capped fees for medicines and laboratory exams (both €0.5 per item, capped at €10 per visit) while a fixed €10 fee was applied for ER visits. User charges at the point of care were also introduced in the form of €3 for family doctors and €6 for specialists. This was coupled with the introduction of a 1.5 % annual fee to all beneficiaries (certain exceptions apply for vulnerable groups). Moreover, as a way to reduce tax evasion, two conditions for public health care eligibility were introduced: the primary prerequisite is that no tax should be owing while people who have not contributed to the Social Insurance Fund for three years are not entitled to public health care coverage. Eligibility criteria were further refined in order to restore equity to health access. Moreover, Category B, whose beneficiaries had been entitled to 50% reimbursement, was abolished.

As a result, the total health budget for 2014 was reduced by approximately 20%. In 2013, total public health expenditure was €598 million, while the budget for 2014 was set at €542 million, under the assumption that the aforementioned measures would regulate unnecessary health care provision and costs. Another important aspect is that the public sector's charges for non-beneficiaries were just indicative and definitely do not reflect the actual costs incurred. Consequently, a prerequisite of the MOU was the revision and increase of medical services fees for non-beneficiaries by 30%, in order to capture actual costs incurred by the system.

Performance and quality management measures

The current health system has been considered to be a transitional one, given the long awaited introduction of the NHS. Moreover, the fragmentation between the private and public sector implied that dissemination and implementation of guidelines and efficiency performance measures would be complicated. On the other hand, the lack of guidelines, performance standards and training is a well-known cause of medical errors, while doctors try to counterbalance this deficit by resorting to excessive medicine

prescribing, along with laboratory and imaging referral. These practices drain resources, hinder efficiency, lead to highly varying outcomes, and increase the discomfort and dissatisfaction of patients. Therefore, in line with the MoU, the MoH introduced a series of clinical pathways in twenty health conditions in primary, secondary and tertiary care aiming to:

- improve the consistency of care;
- minimise irrational approaches and inappropriate variations in the use in health care;
- restrain the use of ineffective treatment; and
- provide summarised guidance to physicians.

In addition to this, the MoH, along with the health insurance organisation, is developing a medical audit approach which will assess the impact of clinical pathways on health indicators. Within the scope of monitoring and auditing, the Troika also included in the prerequisites the implementation of a full-scale IT system in Cyprus's health care sector. Moreover, it also required the coding of inpatient cases through Diagnosis Related Groups (DRGs), aiming to replace the current obsolete hospital payment system. Health technology assessment (HTA) was also introduced selectively for four costly pharmaceutical products and for medical equipment. This signals the introduction of HTA in Cyprus, an area largely overlooked in previous years, despite its rapid adoption all over Europe.

The MoU also recommends a restructuring plan for public hospital, aiming to ameliorate quality and optimise cost control.⁶

Future Reforms

One of the most important reforms is the obligatory introduction of the NHS by 2015. Although this will occur in several phases, starting from primary care in mid 2015, it constitutes an important step in unifying the health sector in Cyprus. This will ensure health coverage for all citizens, based on equity and solidarity principles. It will also help cost containment through:

- reduction of current duplicative health structures;

- continuity of care between the public and private sector;
- large risk pooling; and
- a centralised negotiating process, which provides the purchaser of health services with increased bargaining power

A unified NHS is anticipated to offer further benefits, such as the establishment of family doctors as gate keepers, a measure which will regulate patients' access to specialists and contain ambulatory care expenditure. Moreover, a unified health sector will be easier to regulate, control and monitor.

Positive impacts of reforms

The impact of reforms can be assessed both as positive and challenging, while in some cases we have identified some collateral undesirable effects.

The gap in evidence-based medicine has been bridged through the introduction of clinical pathways and it has been assessed as a positive measure by 89% of physicians; in this respect we must underline that the inclusion of physicians in the process has been a critical factor in its success.⁷ In addition, user charges are in line with Cypriot citizens' buying power, neither too low to be ignored, nor too high to impede access, and are capped, therefore not punishing people in need. We have evidence from the introduction of co-payments for ER visits, which show a statistically significant reduction in potentially avoidable visits, but not in emergency non avoidable visits.⁸

Down-side to reforms

While much attention has been paid to the public health sector, the private sector has been overlooked – a similar pattern observed in other recession countries.⁹ Although we can speculate that the Troika, as a lender, is in principal interested in public expenditure, in the Cypriot context we cannot overlook the importance of the private health care sector since a significant proportion of the population is not eligible for public health care. This percentage has increased significantly after recent reforms. In particular, the prerequisite that three years of contributions to the Social Insurance

Fund are required for eligibility has unavoidably led to the non-inclusion of newly-recruited personnel, which are considered to be collateral victims of this measure. Moreover, the public health care sector is experiencing a leakage of doctors due to constant salary reductions, rumours about the possible introduction of significant taxation of retirement benefits, and uncertainty regarding doctors' employment status as tenured public servants. This has been aggravated by the government's commitment to freeze recruitment until 2016. Therefore, waiting lists are getting longer, spanning up to thirteen months for some orthopaedic operations, patients' dissatisfaction is growing and people have to resort to the private sector, which constitutes the only timely option for some treatments.

Prices of pharmaceuticals in the private sector are relatively high¹⁰ and several stakeholders are urging the introduction of price reductions. Since pharmaceutical pricing is a multifactorial process, all mark-ups must be scrutinised, beginning with the wholesale price, the pharmacy mark-up profit, which is the second highest in Europe, and Value Added Tax. Nevertheless, this must be performed with caution since the public sector already procures medicines at significantly low prices, and an inordinate price reduction in the private sector would probably lead to the industry's exit from Cyprus's unattractive pharmaceutical market.

Cyprus has not experienced adversities to population health status of the same magnitude as other countries, although the impact of austerity measures has not fully unfolded. Nevertheless, we can verify that several manifestations of the financial crisis have occurred, such as the sudden significant drops in household income, which led to the impoverishment of a significant part of the population (27.1% of the population are at risk of poverty or social exclusion).¹¹ This has led to a shift of patients to public hospitals, a trend confirmed by the 30% increase in public hospital admissions.¹²

Moreover, the formation of several multidisciplinary teams, required to implement HTA and recommended clinical pathways is a resource-demanding

process, which a small country such as Cyprus will probably find hard to sustain in the long term.

Recommendations for further policy changes

We expect that reforms will continue with the same intensity. We anticipate that the government will diverge from path-dependency and will propose innovative solutions, helping to secure additional health funds – either transferring resources from other ministries or through savings – which will be redistributed to health. This crisis emerges as an opportunity to address the deficits of the current system, especially with regard to its scope, mission and functional framework. The current health sector needs to accommodate an older population and address their chronic conditions effectively. The traditional pattern of health delivery, focusing on acute conditions is obsolete and inefficient. Therefore, new measures should extend beyond cost containment approaches and incorporate structural changes to the system. We suggest consolidating and merging smaller primary care regional centres into bigger and better staffed ones. This will enable infrastructure upgrades and the implementation of multidisciplinary teams, which have proven to be valuable in the management of chronic diseases such as diabetes and rheumatoid arthritis.

Specialised health services, such as breast cancer treatment centres and heart surgery, should be made available only in specific centres in order to create centres of excellence. Moreover, developing standardised and evidence-based care, and by capitalising on high-volume will enhance quality of services and provide comprehensive, effective, and patient centred health care. Additionally, standardisation of processes and quality improvement will possibly lead to cost reduction. These recommended measures should be accompanied by an increase in the spectrum of services provided by primary care teams and an upgrade of GP's functions in the system.

Alternative and cost-effective skill-mix pathways, such as the greater use of community nurses to oversee treatment

of appropriate conditions, has been neglected but could be utilised in order to decongest tertiary health care centres. A shift to electronic governance and the introduction of electronic patient records is also warranted.

From an organisational perspective, transparency, accountability and improved governance should be enhanced and disseminated to all health professionals and their institutions.

The scope, breadth and depth of publically provided services should be reassessed. Obsolete procedures should be abolished and savings should be reinvested in adopting innovation, based on principles of evidence based medicine. Overall, the health system must primarily try to meet the needs, rather than the demands, of patients.

Conclusion

The Cypriot health care sector is navigating through uncharted territories while the ramifications of the crisis are emerging. Unprecedented unemployment rates and the sudden significant drops in household income, which led to the impoverishment of a significant part of the population, boosted demand for public health care sector services, whose human resources have been depleted. We must keep in mind that from a financial perspective, Cyprus is doing unexpectedly well, which gives rise to hopes that the austerity measures will soften and more resources will be invested in health. Nevertheless, the MoH should not be complacent and monitoring of health indicators should be performed regularly, in order to identify early deviations. The health system should also seek to mitigate the impact of reform measures on vulnerable groups.

Moreover, the government's commitment to proceed with the introduction of a universal health system partially alleviates concerns, although we must underline that change, by default, is difficult and carries an inherent counterforce of denial and resistance by entrenched interests. Therefore, the externally propelled changes to the flawed and asymmetric health system can be considered to be

a restructuring force which, in a short period of time, has addressed many of its inertias. Above all, it can be attested that health professionals in Cyprus have ticked more boxes than requested and currently are committed to restoring citizen's trust in their problematic but reforming health system.

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REDUCING **AVOIDABLE** **MORTALITY** IN ENGLAND: WHAT CAN BE DONE?

By: Marina Karanikolos, Ellen Nolte, Dimitri Varsamis, Celia Ingham Clark, Jazz Bhogal and Martin McKee

Summary: Reducing avoidable mortality has been designated as a priority for health policy in England. An initial scoping exercise identified four areas where substantial or more urgent progress was needed: child health, older women, COPD and liver disease. Based on a series of evidence reviews and policy dialogues, we offer cross-cutting recommendations to improve prevention, care, and intermediate health outcomes and, ultimately, to reduce deaths considered avoidable through appropriate action. These include ensuring access to timely diagnosis and appropriate care, establishing strong leadership and clear lines of accountability, and promoting the collection of and access to comparable high quality data.

Keywords: *Avoidable Mortality, National Health Service, International Comparison, England*

Introduction

Reducing mortality that can be avoided by policies in the health sector, alone or in cooperation with other sectors, has been identified as a priority in England. The Secretary of State for Health has set out a challenging ambition for the nation to be among the best in Europe at reducing deaths from the five biggest killers – cancer, heart disease, stroke, respiratory disease and liver disease. England’s performance in these areas has been uneven, with variations according to age and gender.

An initial scoping exercise undertaken by the authors identified four distinct areas, where England lags behind comparable European countries. These were children and older women (considering all causes,

reflecting the extent of multi-morbidity, but recognising the importance of cardio-vascular and cancer deaths in this population), as well as chronic obstructive lung disease (COPD) and liver disease. These were the subject of two policy dialogues that examined how service delivery may be improved to reduce avoidable mortality in England.* The purpose of the policy dialogues was: 1) to describe trends and patterns of mortality and summarise what is known about processes of care, thereby identifying specific issues that may have an adverse

* The policy dialogues on reducing avoidable mortality in England (February and May 2014) were organised by the European Observatory on Health Systems and Policies, the English Department of Health and NHS England, with participation from clinical and public health experts from the UK, Finland, France and Sweden, national clinical directors in England, policy-makers, academics and health professionals.

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impact on mortality; and 2) to explore how England differs from other comparable countries in policy and practice, thereby suggesting potential opportunities for improvement.

This article summarises the discussions and outcomes of the policy dialogues and draws lessons from the published evidence as well as from international experiences of improving health outcomes of the selected conditions or specific population groups. It also identifies a series of cross-cutting themes and proposes synergies and priority areas for action in the short- and medium-term that, based on the best available evidence and other countries' experiences, can help reduce premature mortality in England.

Identifying scope for improvement

Children

A recent analysis within the Global Burden of Disease study found that in 2013 the UK had the second highest mortality rate for children under 5 among 22 western European countries, with 4.9 deaths per 1,000 live births compared to an international average of 3.9.² Wolfe et al.³ recently demonstrated how reducing child mortality rates in the UK to those seen in Sweden could prevent almost 2,000 child deaths per year.

Key areas that were identified to have the potential to improve child health outcomes in England include:

- **Reducing neonatal and post-neonatal mortality** – While there are definitional and reporting issues that complicate international comparisons of perinatal and neonatal deaths, policy dialogue participants proposed several specific measures that would likely reduce pre-term births and improve maternal care, such as reducing smoking rates in pregnancy and considering use of third trimester ultrasound scans to identify developmental problems earlier.
- **Accurately identifying a sick child (acute illness)** – This requires improvement in several areas, including early diagnosis – ensuring rapid access to those with appropriate expertise at the first point of contact; strengthening collaboration between

primary and secondary care providers; and ensuring timely referrals to appropriate specialists.

- **Better management of chronic disease in childhood** (asthma, epilepsy, diabetes, mental illness) by enhancing skills and strengthening networks, with a particular focus on the transition to adult care.

Older Women

Over the past 20 years, mortality among women aged 60–74 years in the UK has consistently been among the highest in the EU-15, reaching 853 per 100,000 population in 2010/11, and exceeded only by Denmark (1,046 per 100,000), reflecting the high burden of smoking-related disease among Danish women. There is a range of causes driving the relatively high levels of mortality in older women in the UK, with ischaemic heart disease (IHD) and lung cancer among the most important.⁴

Policy dialogue participants recognised the multi-faceted nature of premature mortality among older women, highlighting the need to simultaneously tackle a series of issues across the spectrum of care in order to improve health outcomes for this group in England:

- **Reducing the prevalence of risk factors** such as smoking, obesity, and alcohol consumption; increasing physical activity; and reducing preventable injuries from falls in elderly and frail people.
- **Reducing misdiagnosis or delayed diagnosis**, addressing failures to take account of differences in presentation by women of common conditions such as angina. Greater use of advances that provide objective assessments that may overcome gender-specific differences in presentation (e.g. brain natriuretic peptide measurement to diagnose heart failure, troponin to diagnose myocardial infarction).
- **Taking account of individual needs and expectations** of women during the care process, as well as addressing comorbidities.
- **Providing greater social support.** Women live longer and spend more

years in ill-health, thus requiring measures that reduce social isolation and loneliness.

COPD

Mortality from COPD in the UK has long been among the highest among EU-15 Member States, alongside Denmark and Ireland. In 2010, the associated mortality rate was 28 per 100,000 population, compared with 7.6 per 100,000 in France, 14 per 100,000 in Finland and an EU-15 average of 18 per 100,000.⁵ A study of differences in outcomes achieved by health systems in France, Finland, Germany and the UK, drawing on the Global Initiative for Chronic Obstructive Lung Disease (GOLD) report, reiterated the longstanding concern that premature mortality in the UK was almost twice as high as in the rest of Europe.⁶ However, observed differences have to be interpreted with caution because of known variations in coding of respiratory disease, both between countries and over time.

“timely diagnosis and appropriate treatment are key

Experiences of other countries point to a number of factors that contribute to poorer COPD outcomes in England compared with other countries, and potential ways to address this challenge:

- **Understanding the impact of timely diagnosis.** In England, individuals with COPD are diagnosed very late, with 85% having missed previous chances to be diagnosed. This is believed to have adverse consequences for survival and highlights the need for improved case finding. In addition, there is a perception that general practitioners are referring too few patients with COPD to a specialist for assessment but it was recognised that the association between late diagnosis and late referral is still unclear.
- **Enhancing approaches to assessing breathlessness in midlife** including

spirometry testing to identify early disease as well as promoting fitness that can slow progression to more severe disease subsequently and associated comorbidities.

- **Promoting smoking cessation** as a core approach to treating COPD.
- **Improving the availability of and access to pulmonary rehabilitation services.** Evidence from other countries provides limited insights into which health service intervention along the care pathway would provide the greatest potential for reducing premature mortality from COPD in England. However, it is conceivable that improvement in the availability of and access to pulmonary rehabilitation services can contribute to better outcomes for people with COPD. Together with smoking cessation, pulmonary rehabilitation is the most important intervention to achieve further reductions in mortality from COPD.

Liver disease

In 2010, the UK had the second highest rate of premature mortality from liver disease among the EU-15 Member States, at 9.5 per 100,000 population compared to an EU-15 average of 7 per 100,000, surpassed only by Finland (15.4 per 100,000).²⁴ It is also one of three countries (with Finland and Ireland), which experienced marked increases in liver disease mortality between 1990 and 2010.²⁵ Much of the rise in the burden of liver disease in the UK has been attributed to alcohol use, and hospital admissions for alcohol-related diseases in the UK are projected to reach two million per year by 2020.²⁶ While harmful alcohol consumption is an important determinant of liver disease, other leading causes of liver disease in England include viral hepatitis B and C and metabolic syndromes related to obesity.

A series of issues spanning from prevention to clinical management have been identified as offering scope to reduce the burden of mortality from liver disease in England:

- **Addressing the underlying risk factors for liver disease** by means of

alcohol pricing policies and systematic use of screening or risk assessment tools, which would identify people with problematic alcohol use at an early stage.

- **Enhancing early detection, diagnosis and treatment of viral hepatitis.**

There are opportunities to learn from other countries that have implemented systematic approaches to early detection and case finding and the rolling out of newer (expensive) treatments (especially for hepatitis C).

- **Communicating clearly with the public that obesity is a significant cause of liver disease.**
- **Improving the provision of appropriate services for patients with established liver disease** was seen to be key to enhancing outcomes and it was recognised that there is a need to better understand how other countries have organised care along the pathway and the professional roles involved in service delivery from primary care and admission to hospital (who are they seen by, are there alcohol care teams) to treatment in specialist centres (e.g. liver centres).
- **Designating liver disease as a priority area.** There was recognition that the burden of premature mortality from liver disease can only be tackled if it is designated as a priority area. There was also a need to better understand mechanisms by which liver disease can be placed higher on the policy agenda and public awareness of liver disease and associated risk factors be raised.

Common themes

Several cross-cutting themes emerged across the four areas, each offering potential to improve prevention, care and health outcomes and, ultimately, reduce deaths considered avoidable by appropriate action.

Values and priorities

There was concern about a perceived ‘fatalism’, coupled with low expectations, among both patients and health professionals in England, leading to a belief that, sometimes, little could be done. Thus, patients who might benefit from specialist assessment or treatment may not

always receive it, even when it is available. Empirical evidence suggests that fatalism among those of low socio-economic status in the UK is associated with delayed diagnosis and exacerbates inequalities in outcomes.²⁷

Prevention and risk factors

There is considerable scope to reduce the burden of disease requiring treatment through actions outside the health system and through multi-sectoral efforts to reduce risk factors, including smoking, obesity, physical inactivity and excess alcohol consumption, and expanding health promotion and disease prevention strategies. A recent study has shown that the United Kingdom ranked 12th among European countries in performance on a range of public health measures, behind the Nordic countries, France and the Netherlands, among others.²⁸ The Commonwealth Fund reported that the UK ranked first on health system performance, leading in domains such as quality of care and efficiency, but lagged behind other comparable countries on healthy lives indicators.²⁹

The role of primary care

Timely diagnosis and appropriate treatment are key to reducing premature mortality. The UK has been identified to be among the countries with strong primary care systems, and strength of primary care has been associated with better health outcomes in a range of conditions.³⁰ At the same time there are concerns that strict primary care gatekeeping, potentially encouraged by incentives to reduce the number of inappropriate referrals to specialist care, may play a role in untimely diagnosis and access to appropriate care. Primary care professionals may lack easy and rapid access to diagnostic tests, and in areas such as child health, COPD and liver disease a referral to a specialist frequently be seen as a last resort.

Leadership and accountability

Lines of responsibility and accountability can be unclear within the recently reconfigured English National Health Service. Clinical Commissioning Groups are responsible for commissioning the majority of services in secondary care, while NHS England commissions primary

care and specialised services. In order to influence changes along a care pathway that spans primary and secondary care, it is necessary for commissioners at different levels to work together on a shared ambition for improvement.

“work together on a shared ambition for improvement”

Collection and use of data

The availability of high quality, comparable data can drive improvement in the quality of care. England has invested in a number of national audits for selected conditions, generating high quality data, but their impact on outcomes may not have been immediately clear.

Broader health system factors

The health system in England operates within considerable constraints compared to similar countries in Europe, with the proportion of GDP spent on health care being lower than the EU-15 average (at 9.3% compared with 9.9% in 2012).¹¹ Some commentators believe that recent policy developments that may increase the role of the private and voluntary sector in delivering services risk leading to fragmentation, creating perverse incentives and reducing clarity about who benefits from the incentives.¹² There is also a perception that such changes might generate higher costs through the administration of an increasingly diverse system and the complexity of monitoring the quality of new providers.¹³

Health inequalities

Health indicators are influenced by demographic and socio-economic circumstances, with most evidence linking lower socio-economic status (education, income, etc.) to worse health outcomes. The Strategic Review of Health Inequalities in England post-2010¹⁴ has estimated that premature deaths as a result of health inequalities account for between 1.3 and 2.5 million of years of life lost annually. Reducing

variation in health outcomes resulting from inequalities requires action across multiple policy areas, including providing children and young people with an optimal start, creating fair employment opportunities, ensuring a healthy standard of living for all, creating and developing healthy and sustainable communities and strengthening disease prevention.

Conclusions

The policy dialogues explored how England could perform better in improving avoidable deaths in childhood and among older women, and from COPD and chronic liver disease. Areas for action were apparent at both health system and broader policy level to effectively address each of these areas. A number of cross-cutting themes emerged, including the effect of the gatekeeping role and financial incentives in primary care; leadership and accountability among bodies responsible for health service commissioning; and the importance of accurate and comparative data, as well as its use.

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NEW PUBLICATIONS

Trends in health systems in the former Soviet countries

Edited by: B Rechel, E Richardson and M McKee

Copenhagen: World Health Organization 2014, Observatory Studies Series No. 35

Number of pages: xviii + 217 pages; **ISBN:** 978 92 890 5028 9

Freely available for download at: http://www.euro.who.int/__data/assets/pdf_file/0019/261271/Trends-in-health-systems-in-the-former-Soviet-countries.pdf?ua=1

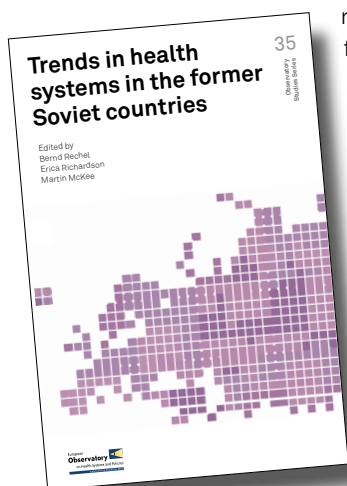
After the break-up of the Soviet Union in 1991, the countries that emerged from it faced myriad challenges, including the need to

reorganise the organisation, financing and provision of health services. Over two decades later, this book analyses the progress that twelve of these countries (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan) have made in reforming their health systems.

Building on the health system reviews of the European

Observatory on Health Systems and Policies (the HiT series), it illustrates the benefits of international comparisons of health systems, describing the often markedly different paths taken and evaluating the consequences of these choices. This book will be an important resource for those with an interest in health systems and policies in the post-Soviet countries, but also for those interested in health systems in general. It will be of particular use to governments in central and eastern Europe and the former Soviet countries (and those advising them), to international and non-governmental organisations active in the region, and to researchers of health systems and policies.

Contents: Introduction; Health trends; Organisation and governance; Health financing; Health workforce; Public health; Primary health care; Specialised and inpatient services; Pharmaceutical care; Mental health care; Health system performance; Conclusions.



Geographic Variations in Health Care: What Do We Know and What Can Be Done to Improve Health System Performance?

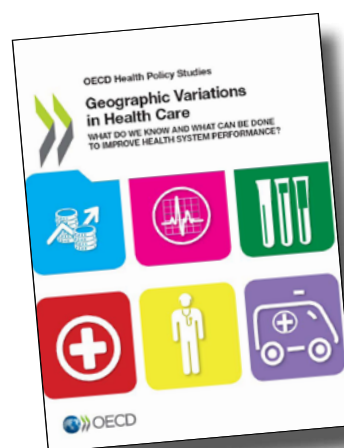
Edited by: D Srivastava, G Lafortune, V Paris and A Belloni

Paris: OECD 2014, Health Policy Studies

Number of pages: 420; **ISBN:** 978 92 642 1659 4

Info available at: <http://www.oecd.org/els/health-systems/medical-practice-variations.htm>

Variations in health care use within a country are complicated. In some cases they may reflect differences in health needs, in patient preferences or in the diffusion of a therapeutic innovation;



in others they may not. There is evidence that some of the observed variations are unwarranted, signalling under- or over-provision of health services, or both.

This study documents geographic variations for high-cost and high-volume procedures in select OECD countries. It finds that there are wide variations not only across countries, but within them as well. A mix of patient preferences and physician

practice styles likely play an important part in this, but what part of the observed variations reflects over-provision, or whether there are unmet needs, remain largely unexplained. This report helps policy makers better understand the issues and challenges around geographic variations in health care provision and considers the policy options.

Contents: Executive summary; Geographic variations in health care use in 13 countries: A synthesis of findings; Australia; Belgium; Canada; Finland; France; Germany; Israel; Italy; Portugal; Spain; Switzerland; United Kingdom (England).

NEWS

International

EU boosts anti-Ebola aid after Commissioners' mission to worst-hit countries

The European Union has continued to scale up its response to the Ebola epidemic following the return of its Coordinator for the emergency, Commissioner for Humanitarian Aid and Crisis Response, Christos Stylianides, together with Vytenis Andriukaitis, Commissioner for Health from a four-day mission to Sierra Leone, Liberia and Guinea in November.

Additional funds have been made available for transporting vital aid supplies and equipment to the affected countries, evacuation of infected international aid workers to hospitals in Europe and training and deploying health workers. Money will also reinforce local health facilities. Extra funds have also been allocated in assistance to neighbouring countries, to help them prepare for the risk of an Ebola outbreak through early detection and public awareness measures. The new funding brings the European Commission's assistance for this emergency to €373 million. The European Union's total contribution is close to €1.1 billion. This financial aid is in addition to essential equipment, medical personnel from Member States and coordinated delivery of support.

Speaking after the mission Commissioner Andriukaitis said that he "saw great suffering and enormous needs during this trip: there are not enough doctors and nurses and I am appealing to all Health Ministers to send more medical staff to West Africa. I witnessed great need for equipment, medicines, transport means, water and sanitation. Europe is here to help put an end to Ebola now and to help the long-term recovery required to address these needs".

Important measures taken in recent weeks include (1) a joint mission of the Commission and the European Centre for Disease Prevention and Control (ECDC) in the affected countries which found

that exit screening was been performed in line with the rules and that the risk of an infected person travelling outside the countries concerned was therefore very low; (2) the launch of an EU network of clinicians on 11 November, aimed at sharing good practices on treatment of Ebola patients; (3) a record of the fact that the EU coordination mechanism for Ebola patients' evacuation is now fully operative; and (4) a survey conducted by ECDC showing that there is a sufficient high level of preparedness for management of viral haemorrhagic fevers patients including those suffering from Ebola in the EU member states.

More information at: http://ec.europa.eu/health/ebola/index_en.htm

EU innovation for the benefit of patients

At the Employment, Social Policy, Health and Consumer Affairs Council meeting in Brussels on 1st December Ministers adopted conclusions on innovation for the benefit of patients. They followed on from debate at the informal meeting of health ministers in Milan on 22–23 September, at which it was agreed that patients should benefit from new therapies at affordable prices and that innovation in the pharmaceutical sector needed to be supported.

Member States are now invited to explore further opportunities for cooperation on exchange of information between competent bodies in relation to a 'life cycle approach' for innovative medicinal products, including, where appropriate early dialogue and scientific advice; pricing and reimbursement models; registries for monitoring the effectiveness of therapies and technologies; appropriate re-assessments; and post-authorisation studies. There are also opportunities for more effective sharing of information on prices of and expenditure on medicinal products, including innovative medicinal products.

The Council also invited an exchange of views between Member States and the

Commission on how to make effective use of the existing EU regulatory tools of accelerated assessment, conditional marketing authorisation and authorisation in exceptional circumstances, and on the effectiveness and impact of these tools while ensuring the high level of patient safety. The Council also invited the Commission to consider possible changes to current regulations with a view to analysing, and if necessary reducing, regulatory burdens to increase incentives for small and medium sized enterprises and academia, while maintaining the principle of marketing authorisation based on quality, efficacy and safety. The Commission was also asked to continue to support research and information tools that aim to provide a better understanding of how pharmaceutical pricing may be applied to maximise benefits for patients and Member States' health systems and, where relevant, to minimise possible unintended negative effects on patient access and health budgets.

Further information at: http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/145978.pdf

Investment in health and Europe 2020 midterm review

On 1st December at the Employment, Social Policy, Health and Consumer Affairs Council meeting in Brussels views were exchanged on the contribution that investment in health systems makes to the objectives of Europe 2020, the EU's growth strategy. While Member States recognised that health is an important factor for social well-being, economic growth and employment, a number of delegations called for deeper reflection on the role played by the healthy population in achieving the objectives of the EU 2020 strategy and some of its headline targets (such as employment, research and education). The addition of a specific headline target related to health was not supported. The meeting noted that the best way forward is to exchange information and best practices on improving sustainability

and efficiency of health systems. It also noted that cooperation between the Council working party on public health at senior level and the Social Protection Committee in assessing health-related country-specific recommendations under the European Semester process needs to continue and to be further strengthened.

The review of the EU 2020 strategy is being addressed in all relevant Council configurations, with each focusing on aspects within its competence. A summary report on the outcome of discussions in all the various Council configurations will be presented to the European Council on 18–19 December. This summary will provide input to the Commission which is expected to present proposals in time for a discussion in the March 2015 European Council. The review of the strategy is due to be endorsed by the European Council in 2015.

High cancer burden due to overweight and obesity in most European countries

A new study from the International Agency for Research on Cancer (IARC), the World Health Organization's (WHO) specialised cancer agency, shows that overweight and obesity are major risk factors for cancer. The study, published in *The Lancet Oncology*, highlights that overweight and obesity have become major risk factors responsible for an estimated 3.6% (481,000) of all new cancer cases in 2012. In most countries in the WHO European Region, the percentage of new cases that can be attributed to overweight and obesity is higher than this global rate. In almost all countries in the European Region, the percentage of cancer cases among women attributable to excess body fat is higher than the global average (5.3%). In the Czech Republic, Malta and the Russian Federation, the proportions are more than double the global figure.

Although the proportion of cancer due to overweight and obesity is lower among men, it is higher than the global average in most countries in the WHO European Region. The proportion is at least double the global figure in 10 countries: the Czech Republic, Germany, Hungary, Ireland, Luxembourg, Malta, the Netherlands, Slovakia, Spain and the United Kingdom.

Some of this excess risk is avoidable. A high body mass index (BMI) (25 kg/m² or more) is a known risk factor for cancer of the oesophagus, colon, rectum, kidney, pancreas, gallbladder, postmenopausal breast, ovary and endometrium, as well as for other non-communicable diseases, notably cardiovascular diseases and diabetes. Reducing overweight and obesity at the population level could have significant health benefits, including reducing the burden of cancer. The IARC study shows that a quarter of all cancer cases attributable to overweight and obesity worldwide (118 000 cases) could have been prevented if populations had maintained their average body mass index (BMI) of 30 years previously.

More information at: [http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(14\)71123-4/abstract](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(14)71123-4/abstract)

Country News

Northern Ireland and Wales confirm support for minimum alcohol pricing plans

On 3rd December Jim Wells, Minister of Health, Social Services and Public Safety in Northern Ireland, confirmed his support for the introduction of minimum unit pricing (MUP) for alcohol. MUP sets a baseline below which alcohol cannot be sold. It increases the price of drinks, such as own-brand spirits, high strength beers and white cider, which have high alcohol content but are usually very cheap. The more units a drink contains, the stronger it is and therefore the more expensive it will be.

The Minister's support follows publication of a report commissioned from the University of Sheffield that demonstrates that MUP will help reduce alcohol consumption and, as a result, lead to a decrease in alcohol-related deaths, alcohol-related hospital admissions, crime and absenteeism. MUP will only have a modest impact on moderate drinkers but a much greater impact on hazardous and harmful drinkers who make up around 20% of the population but drink almost 70% of all the alcohol consumed in Northern Ireland.

A policy paper will now be drafted and put out to consultation and brought to the Northern Ireland Executive for agreement.

This consultation will shape and inform future decisions on any legislation needed to bring MUP into law.

Similar work commissioned by the Welsh Assembly Government from the University of Sheffield team was published on 8th December. The Welsh work estimates that a 50 pence MUP would reduce overall consumption by 4%, saving the government £882 million over 20 years from health, crime and workplace harms alone. Welsh health minister Mark Drakeford said that "this latest Wales-specific research is further evidence that introducing a minimum price for alcohol of 50p a unit will have significant benefits on the health of the nation, reducing alcohol misuse and drink-related harm". He added that "we will consider these findings and continue to develop our proposals with a view to introducing legislation".

The report on the impact of MUP in Northern Ireland, prepared by a team from the

University of Sheffield is available at: http://www.dhsspsni.gov.uk/mup_ni_report_from_university_of_sheffield.pdf

France: Minister Touraine handed first National Suicide Observatory report

On 2nd December, Minister of Social Affairs, Health and Women's Rights, Marisol Touraine, received the first annual report of the newly established National Suicide Observatory. The report states that over 11,000 people die each year in France by suicide and almost 200,000 people require hospital care after a suicidal event. At the launch Minister Touraine called for the development of a new national suicide prevention programme, including measures to reduce suicidal risks in older people. A call for research on suicide will be launched in early 2015 based on the priorities identified in by the Observatory.

The report is available (French only) at: http://www.sante.gouv.fr/IMG/pdf/rapport_ONS_2014.pdf

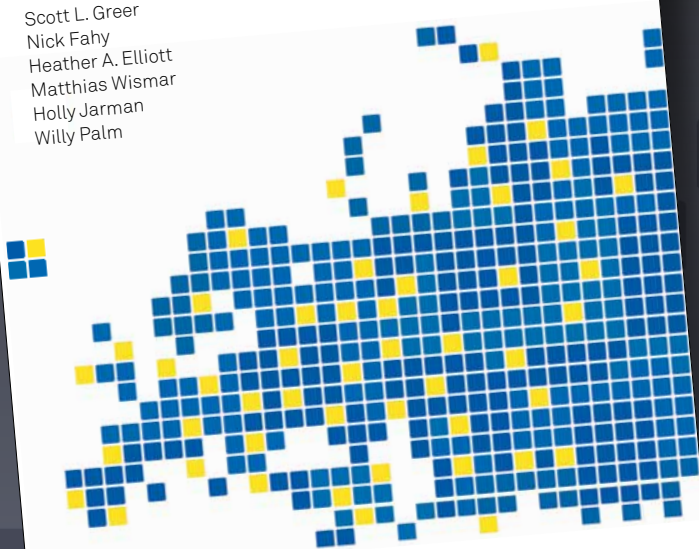
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Everything you always wanted to know about European Union health policies but were afraid to ask

Scott L. Greer
Nick Fahy
Heather A. Elliott
Matthias Wismar
Holly Jarman
Willy Palm

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Observatory
Studies Series



European
Observatory
on Health Systems and Policies
EUROPEAN COMMISSION

What does the European Union mean for health and health systems? More than one would think. The EU's health mandate allows for a comprehensive set of public health actions. And there are other EU policies, though not health related, which have important consequences for governing, financing, staffing and delivering health services. In other words: EU actions affect the health of Europe's population and the performance of health systems.

Given how important health systems are, we need an informed debate on the role of the EU and its contribution. But this is not easy because EU health policy is difficult to comprehend. There is no single strategy with a neat body of legislation implementing it; rather, there are many different objectives and instruments, some of which appear in unlikely places.

Understanding the EU role in health is especially important now, when health systems have to deal with a plethora of challenges, the European social model is confronted by the threat posed by the financial crisis, and the EU is facing increasing euro-scepticism in politics.

This short book makes EU health policy in its entirety (and complexity) accessible to political and technical debate. To this end the volume focuses on four aspects of EU health policy:

- the EU institutions, processes and powers related to health;
- the EU action taken on the basis of this health mandate;
- the non-health action affecting health and health systems;
- and, because of its growing importance, financial governance and what it means for European health systems.



available on: www.healthobservatory.eu