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Future of Healthcare in Europe – Meeting future challenges: Key issues in context

Summary

- An ageing population, health inequalities and the social determinants of health present significant challenges to healthcare systems that go beyond medical problems. Ensuring a multilevel and holistic response by governments will be important in tackling these challenges
- Consideration of quality in healthcare requires examination of the different dimensions of quality, the impact of rationing devices, professional organisation and new models of healthcare delivery
- Equity of access remains a central tenet of European healthcare systems but raises complex questions of equity, comprehensiveness, and financing, as well as placing the principle of social solidarity under increasing pressure
- Healthcare costs have steadily increased in recent years, although this is not necessarily driven by increased need. Cost-effectiveness, value for money considerations, pharmaceutical pricing, new technologies and diversity of provision are all important elements in exploring how to reduce health costs
- While states remain the main actors in healthcare policy in Europe, EU policies and law can influence healthcare delivery, particularly when considered in terms of the inter-relation between health and other sectors. While internal market rules ensuring the free movement of people and services can challenge domestic health sectors, there are also tangible benefits and opportunities of collaborating at EU level, not least the potential for coordinated policy

Four key conclusions emerge:

- Social values become increasingly important as pressures on healthcare systems intensify
- Political will – to reflect social values while delivering effective healthcare – is essential
- Any renegotiation of the health social contract needs to be consistent with the demands of political accountability in a democratic society
- There is unlikely to be a single solution to responding to challenges in delivering healthcare costs; an integrated approach that takes account of the broader context is essential.

INTRODUCTION

European governments face a growing number of major health challenges, which are putting unprecedented pressures on public health systems. As main actors responsible for the delivery and financing of healthcare, generally based on the principle of social solidarity, they need to identify policy solutions in this and relevant non-health sectors to best address these challenges. Despite its limited competences with regard to health, the European Union also has an impact, particularly by encouraging cooperation between member states, funding health programmes and reinforcing internal market rules.

This policy briefing draws together themes that emerged from the 2011 *Future of Healthcare in Europe* conference with the issues explored in the accompanying thought-pieces in order to discuss four key ideas.

1. Health is more than a medical problem
2. Maintaining high-quality healthcare
3. Maintaining access to healthcare
4. Managing the costs of healthcare

1. Healthcare is more than a medical problem

Ageing population

The population aged 65 and over in the WHO European Region is projected to rise to 224 million by 2050. While individual countries are still at different stages in this development, this figure represents a doubling in the ratio of elderly people to those of current working ages. Sustaining this ageing population requires an increasing focus on prolonging and achieving equity in good health and wellbeing throughout the life course. But elderly people also increasingly require a package of long-term care that is partly delivered by healthcare and partly by social services, presenting a particular challenge for health systems.

> DEMOGRAPHIC CHANGE: In the WHO European Region, the population aged 65 and over is projected to rise from 129 million in 2010 to 224 million by 2050; with the number of people 85 years and older expected to rise from 14 million to 40 million. Since the number of people of working age is in decline, this means a significant increase in the old-age dependency ratio.

Health inequalities in Europe

There are major health inequalities within and between countries in the region, which are persistently large and, in some cases, growing. Life expectancy varies by as much as 16 years between some countries, with differences in healthy life years reaching almost 20 years. Inequality in mortality is also correlated with the length of education of individuals; this is greatest in central and eastern European countries and least in Italy, Spain and Sweden. The global economic downturn is likely to worsen this inequity and increase pressures on healthcare systems across Europe. Action to tackle health inequalities is vital, not least because they have significant social and economic costs to both individuals and wider society. There is a strong correlation between the level of social welfare spending in selected EU countries and health outcomes (as measured by standardised mortality rates).

> SOCIAL DETERMINANTS OF HEALTH
> Inequalities in early years, levels of education, employment status, welfare and health systems, level of income, the places where men, women and children live, and the norms and values of society – including attitudes concerning gender and ethnicity – all contribute to inequities in health. They are known as the social determinants of health.

The social determinants of health

Within countries, the levels of both health and life expectancy relate to and are graded by social and economic position. Health outcomes have a clear gradient across the population according to such factors as income, education, social position and employment. Ill health is conditioned by a toxic combination of poor social policies and programmes, unfair economic arrangements and the unintended consequences of other policies. The causes of many chronic lifestyle diseases (such as smoking, diet, alcohol consumption, physical activity) also reside in the social environment. Reducing health inequities thus requires action to reduce inequities in the social determinants of health.

A multilevel approach

Local-level action, with its proximity to people's lives and experiences, is key to tackle health inequity and the social determinants of health. Yet such action is also frequently constrained by national and global economic influences, power relationships and resource distribution, which perpetuate health inequity in society. Therefore, a concerted, multilevel approach is required to develop new policies and to produce sufficient coherence, scale and intensity of actions capable of transforming the social gradient in health. European governments can play an important role in introducing policies and regulation, within their particular social and democratic frameworks, to improve health and promote healthy behaviour. The EU also adopts measures to promote and improve health, specifically by funding cooperative health activities among member states and research programmes.

A holistic approach

Good health underpins economic and social welfare; a comprehensive and cross-sectoral policy approach to health will therefore deliver multiple benefits, particularly where common action can be taken across Europe. It is vital that policymakers are motivated to tackle problems in a coordinated way that recognises the importance of political will in solving complex health challenges. For example, action on the social determinants of health can also contribute to other social benefits such as wellbeing, improved education, lower crime rates, balanced and sustainable development and improved social cohesion and integration. Investment for health equity can directly contribute to attaining other sectoral and government goals, challenging the notion that health drains public resources.

2. Maintaining the quality of healthcare

Dimensions of quality

Maintaining high-quality healthcare is dependent on a range of dimensions, including access to care; clinical effectiveness of individual patient treatment; ensuring appropriate care; and relevance to the need of a whole community. Achieving quality thus often involves trade-offs: for example, the concentration of healthcare services can provide effective savings and specialisation but risks compromise in access both geographically and in terms of time. There is also a distinction between high-quality care and high-quality treatment (which are not necessarily synonymous). In particular, scientific and technological advancement must be balanced with value judgements in extending life.

> HEALTHCARE MODELS
> There are two main types of healthcare systems in Europe. The tax-funded model (eg UK, Scandinavia) is a single-payer, predominantly public, system with salary or capitation reimbursements, where patients have a choice of providers and specialist access is regulated through General Practitioners. The social insurance model (eg Germany, Netherlands, France) has both multiple payers and owners of provider assets with fees being levied for services, where patients have a choice of insurers and direct access to specialists.

Rationing devices

A high-quality healthcare system must ensure that everyone within it has access to appropriate care and avoid a two-tier system in which some individuals can only access the minimum level of care. There are system-wide features, such as waiting times or price mechanisms, that act as rationing devices which impact upon the quality of care. While some rationing may be necessary to maintain quality, given financial constraints, it is important that rationing does not become an impediment to the delivery of high-quality healthcare, by unduly restricting access (eg if waiting times are too long) or available treatment.

Professional organisation

Professional accreditation standards, professional review and performance measures are all factors in maintaining high-quality care. The extent to which clinicians are obliged to follow organisational rules or nationally set clinical or budgetary guidelines will also affect their practice and, possibly, patient outcomes. Challenges also emerge where policymakers seek to encourage the substitution of the high-cost labour of doctors by the lower-cost labour of nurses and paramedics (although lower cost does not necessarily equal lower quality). Giving patients direct access to specialist care might also improve quality of care; however, the mediation of a general practitioner can bridge not only specialty and clinical, but also medical and social boundaries. EU directives on the mobility and mutual recognition of professional qualifications have important implications for national systems.

New models in healthcare delivery

As delivery moves from clinical settings to alternatives such as telemedicine or over-the-counter diagnostic kits, there are options for increasing the effectiveness of healthcare. While these improve the access dimension of high-quality care, their clinical effectiveness remains to be seen. Similarly, the increasing focus on personalised medicine means that there is an important role for patient information in improving the quality of care, both through the use of individual data in health research and in terms of dialogue with patients to better understand what they require from high-quality healthcare. These come with their own challenges, such as balancing the individual value of informational privacy with the collective value of the potential benefits of research.

3. Maintaining access to healthcare

Social solidarity

European healthcare systems rest on the principle of social solidarity in healthcare, ie sharing the financial risks associated with ill health. Maintaining access to healthcare that is also high-quality and sufficiently comprehensive is thus their core objective. However, this principle is under increasing strain from demographic changes, rising chronic diseases, increasing social inequalitites, and economic constraints. Governments must therefore make fundamental value choices about: the appropriate level of healthcare that society should fund; where the line of collective responsibility rests; and what the reasonable limits of social solidarity might be, including the appropriate balance between social values of autonomy and solidarity. These are further challenged by the increasing demands of cross-border trade and movement, particularly across the EU's internal market.

HEALTH INEQUALITY IN THE EUROPEAN REGION

There is significant inequality in health across the European Region, notably in life expectancy, which differs between countries by 20 years for men and 12 years for women. There is also considerable variation in inequality in mortality based on the length of education of individuals. In terms of healthy life years, the variation between countries is 19.4 years for males (from 51.5 years in Latvia, to 70.9 years in Iceland) and 19.6 years for females (from 52.3 years in Slovakia, to 71.9 years in Malta).

HEALTH EXPECTANCIES AND HEALTHY LIFE YEARS

Health Expectancies extend the concept of life expectancy to morbidity and disability in order to assess the quality of years lived – that is the health that individuals experience during their lifetimes, measured by how many years were spent in good health and how many were not. Healthy Life Years is a composite indicator of health that takes into account both mortality and ill-health, providing more information on burden of diseases in the population than life expectancy alone. Healthy Life Years at Birth is an EU Structural Indicator.

Equity of access and treatment

Equitable access is key to providing high-quality and comprehensive healthcare, with limitations to access proving to have a significant impact on health outcomes. However, a tension persists between providing access to and determining the effectiveness of treatment, and in determining the level of benefit at which a treatment is considered effective. Judgements of this kind are likely to be made within a set of complex of social and cultural values, and scientific, clinical and organisational factors. Furthermore, policies need to address whether allowing the private purchase of clinically excellent but not publicly funded care undermines equitable treatment, as not all patients are able to pay for additional care in this way.

Comprehensiveness

Limiting the comprehensiveness of care is a common way to deal with cost pressures, restricting available care by type of intervention, type of patient or level of costs. These are often dependent on questions of social and cultural value, which vary between countries. Most healthcare systems trade off comprehensiveness of care against quality or access to some degree: the challenge for policymakers is establishing the appropriate balance between them.

Financing access

It is likely that all health systems will have to continue or increase co-payments by patients to secure equitable, high-quality and comprehensive care in the context of increasing pressures. With individual income levels a substantial factor in access, one important consideration is the relation of costs to access. Ensuring the absence of financial barriers does not necessarily mean that all medical services must be free at the point of use, but rather that charges must not debar patients from getting the care they need. However, implementing such a system, which takes into account difference of wealth among different socio-economic groups and recognises that equal costs do not necessarily lead to equal access, is highly complex.

4. Managing the costs of healthcare

Increasing costs

The proportion of income spent on health in virtually all developed countries has progressively increased. For example in the UK, 4.1% of GDP was spent on the NHS in 1950/51; in 2008, this figure was 8%. As spending on healthcare systems has increased, there has been a parallel increase in concerns about value for money in healthcare, leading to new considerations of cost effectiveness and definitions of value, which are reflected across Europe.

The relation of healthcare need to spending

There is a clear relationship between GDP and spend on healthcare between countries. The largest rises in healthcare spending are in those countries that are the most wealthy, suggesting that healthcare growth is driven by the costs of newer drugs and medical technologies available in richer countries and the demand for the highest levels of treatment in these countries. It is not driven by an increased perception of need as GDP increases, since health needs are greatest among poorer individuals and countries.

Cost-effectiveness and value for money:

Value-for-money concerns are prevalent throughout healthcare systems. There is an increasing emphasis on determining the level of benefit at which interventions are effective enough to justify funding, as attention is increasingly focused on how to gain the most possible value from the healthcare purchasing budget. Yet cost-effective healthcare must also take account of the impact on the broader healthcare system and the potential consequences of funding an expensive treatment for one person that may mean the loss of services for a large number of other people. This determination, however, requires both clinical and social value judgements, provoking questions as to the extent to which social values should inform cost choices and judgements of cost effectiveness.

HEALTHCARE EXPENDITURE

Healthcare expenditure per capita varies across Europe. In 2006, it was highest in Luxembourg and EFTA countries – in excess of €4,000 per person per year – and below €1,000 in the most recent EU members. In every country, the largest proportion (30-45%) was spent on hospital provision, while public health expenditure varied between 0–3%. As a proportion of GDP, health expenditure has exceeded economic growth in almost all OECD countries in the past 15 years. The proportion in the UK – 8.0% of GDP on the National Health Service in 2008/9, 0.7% on private medicine – has doubled since 1950/1951.

Value-based pricing of pharmaceuticals

The assessment of medicine is particularly important to address value-for-money concerns. One response under discussion is to introduce value-based pricing – where the price of a drug would reflect its therapeutic value. The UK for instance is proposing to do so by 2014. While this in itself may help to cut costs by making some drugs cheaper, there are concerns that it will not achieve its broader ambitions of encouraging General Practitioners to prescribe generic rather than branded drugs. Nor will it encourage pharmaceutical companies to develop novel treatments rather than variations on existing drugs in order to incentivise research that is likely to have the greatest long-term benefit. There also remain major challenges in establishing the health value of a drug and measuring health value to translate into prices.

HEALTH TECHNOLOGY ASSESSMENT

Health Technology Assessments analyse the effectiveness, costs and broader impact of healthcare treatments for those who plan, provide or receive care, taking into account medical, social, economic and ethical issues. Its most important sub-branch is Pharmaco-Economic Assessment, the assessment of medicines.

Technology

Innovative health technologies can provide a real solution to growing healthcare costs by delivering greater cost-efficiency and economic productivity. Innovative use of simple technologies which are used outside of Europe may offer one way to increase cost-efficiency. e-Health also offers opportunities for personalised, tailored healthcare and the scalability of large public health interventions which could increase cost-efficiency. The EU's new legal basis for e-Health and the assessment of safe and effective health technologies certainly allows for further coordination among European governments in this field. However, technological advances can also increase cost pressures and it is important to resist the driving up of costs through ever-more complicated and expensive technological treatments.

Diversity of provision

One response to increasing costs is to move beyond public sector provision of healthcare. Europe has seen new Private Financing Initiatives and expanding diversity of private providers of healthcare working within the publicly funded system. These often report initial success in terms of reducing costs for specific treatments, although questions remain about whether this success would be replicated across all treatment areas, and the long-term role of private providers in a public healthcare system. The recent organisational changes proposed for the National Health Service in the UK will significantly increase diversity of healthcare provision and blur the line between public and private providers, with the intention of delivering choice and efficiency but with as yet unknown consequences. EU directives on free trade and movement can further challenge domestic healthcare systems, both as providers and employers.

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