

The implications for health of European Union enlargement

Challenges and opportunities lie ahead

The European Union has come a long way from its beginnings in 1957 when six countries signed the Treaty of Rome, committing themselves "to lay the foundations of an ever closer union among the peoples of Europe."¹ This aspiration has become reality. The original grouping has widened progressively, to include most of western Europe. It has also deepened, extending beyond coal and steel production to an entity with its own flag, foreign policy, currency, and laws that impinge on almost all areas of daily life. On 1 May 2004 the European Union will undergo the latest stage in its evolution over the years as 10 new countries join it. What impact will this enlargement have on health and health policy?

Although this is only the latest of a series of enlargements, this one is very different from those that have gone before. The most obvious difference is its scale. Earlier enlargements added between one and three countries; this one brings 10, increasing the European Union's surface area by 34% and its population by 28%. A second difference is the level of development between the existing member states and those acceding to the union, with the average level of national wealth in the acceding countries only half that in the current European Union. A third is the diversity among the acceding states. Earlier enlargements involved groups of broadly similar countries, such as Spain and Portugal in 1986. This enlargement includes three Baltic states that were part of the Soviet Union till 1991, four former Soviet satellites in central Europe, one country that emerged from the breakup of Yugoslavia, and two Mediterranean islands that are members of the Commonwealth.

Enlargement will almost certainly have implications for health and health policy.² However, prediction is an inexact science. Perhaps the only thing of which one can be certain is that the Europe of 25 countries will be very different from the Europe of 15. Beyond that lies a degree of uncertainty, with dominant political direction at any time reflecting the electoral cycles in different countries, as illustrated by the way the result of the recent Spanish election has shifted the balance of power, forcing Poland to abandon its opposition to proposed new voting procedures within the council of ministers.

Bearing this caveat in mind, the new member states, which will now have a voice in both the council of ministers and the European Parliament, may well take a different stance from existing member states on the role

of the European Union in policies that promote population health. Given the much lower life expectancy in acceding countries in central Europe, which on current trends would not be expected to converge with that of the current European Union before about 2030, we might expect that they will be more supportive of an active role for the European Union than are some existing member states. For example, several, such as Poland, have adopted policies against smoking that go well beyond those in most countries of western Europe.³

They will also have views on the current anomalous situation whereby health services are excluded from the treaties while almost every element of a health service—from drugs to health professionals—is subject to European Union law in the context of competition, free movement, or other policies.⁴ This situation will not be resolved by the current proposals for the new European convention⁵; however, the situation now seems more fluid, and forthcoming negotiations may have an impact on health competencies. As key decisions have been made in pursuit of various other European Union policies, unanticipated consequences for health can be frequent—as with policies on movement of professionals or limits on working time. Several new member states face the possibility of losing large numbers of their most skilled health professionals as well as the prospect of patients demanding expensive care abroad.⁶ They may wish to see future European Union decisions pay attention to the implications for health care of policies on freedom of movement—although this may be resisted by countries such as the United Kingdom that see enlargement as a partial answer to a shortage of staff.

The new external frontiers of the enlarged European Union bring it into direct contact with countries whose transition during the 1990s has been much more traumatic than those now joining. Bulgaria and Romania will be joining the European Union in 2007 but most of the others such as Ukraine, Moldova, and the countries of the Balkans seem destined to remain outside for the foreseeable future. These countries face major health problems.⁷ From self interest or altruism, a strong case exists for the enlarged European Union to take action to narrow the gap with these countries, supporting policies that will enhance their wealth and their health.⁸

Enlargement will have an impact on health policy in Europe, although not what has been suggested by

the more xenophobic elements of the British tabloid press, which have raised the prospect of the NHS being swamped by migrants from the acceding states while ignoring the probability that anyone moving to the United Kingdom is more likely to be providing rather than receiving health care. Any effects are likely to be gradual, but in the long term they could be substantial, albeit in ways that no one can now predict. Enlargement brings challenges, but also opportunities, and Europe's politicians and professional associations

must continue to discuss how the European ideal can work to promote effective health policies that benefit all their citizens.

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Prevention of respiratory syncytial virus infection in infants

Palivizumab is effective but too expensive, and vaccines are unavailable as yet

Bronchiolitis due to respiratory syncytial virus is predictable, occurring during the dark winter in temperate climates and the rainy season in tropical countries. In the United Kingdom around 20% of admissions for infections of the lower respiratory tract in children are due to respiratory syncytial virus. The annual incidence of hospital admissions related to respiratory syncytial virus is 28.3 per 1000 for infants, and 1.3 per 1000 for children aged 1-4 years.¹ Interestingly, the number of laboratory reports for respiratory syncytial virus shows a marked downward trend in England and Wales from 1990 to 2003 (figures 1 and 2). Although changes in clinical or laboratory practice may be an influence, data from primary care show a fall in acute respiratory infections over the same years.² This is fortunate, as treating respiratory syncytial virus bronchiolitis remains a good example of therapeutic nihilism—nothing works except oxygen. Adrenaline, bronchodilators, steroids, and ribavirin all confer no real benefit. So if cure does not work, how are we doing with prevention?

Passive immunisation with the monoclonal antibody palivizumab is an option for high risk infants. The impact respiratory syncytial virus study, a double blind, placebo controlled, randomised study, showed that palivizumab was safe and decreased admissions related to respiratory syncytial virus in infants at high risk.³ The American Academy of Pediatrics revised its guidelines for passive immunisation against respiratory syncytial virus in 2003.⁴ Current recommendations are that palivizumab should be considered for premature infants born at less than 32.5 weeks' gestation or infants younger than 2 years, with chronic lung disease. In the United States around 100 000 infants a year receive palivizumab.

The current NHS guidelines have been formulated by the joint committee on vaccination and immunisa-

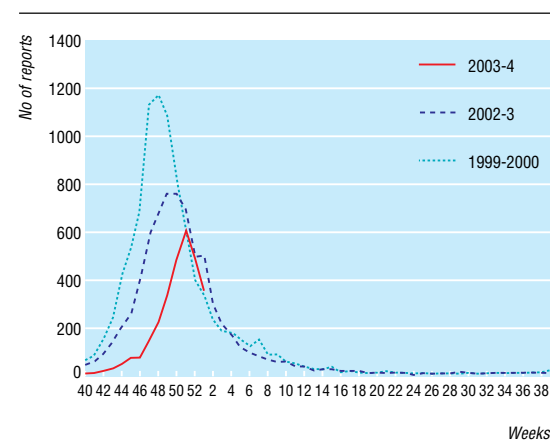


Fig 1 Laboratory reports of respiratory syncytial virus received by the Communicable Disease Surveillance Centre and microbiology laboratories of the Health Protection Agency, by date of specimen in 2003-4 and recent years. Data for 2003-4 are provisional, and caution should be exercised in interpreting a trend for the most recent weeks

tion of the Department of Health. They note that palivizumab seems safe, well tolerated, and effective in reducing admissions to hospital, but it remains very expensive, at a cost of around £2500 for five doses over the season for respiratory syncytial virus. In the United Kingdom, studies on readmission rates with respiratory syncytial virus bronchiolitis show that palivizumab is cost effective only in infants born prematurely with chronic lung disease receiving oxygen at home.⁵ The cost-benefit ratio will shift against palivizumab even more if it becomes clear that admissions for bronchiolitis due to respiratory syncytial virus are falling in parallel with laboratory reports. Recently, a further study of palivizumab in infants with cardiac