



Health *Research Digest*

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Director's Introduction

It is a pleasure to introduce the second LSE Health Research Digest, with an update on the Centre's various activities and accomplishments during 2008. It has been an exciting and successful year for LSE Health. This was firstly demonstrated by the results of the 2008 Research Assessment Exercise (RAE), for which the Department of Social Policy ranked first amongst all comparable departments in the UK. LSE Health academics were an important part of this submission, as well as for the RAE in business and management studies, which were also highly ranked. Since 2005, LSE Health staff have published more than 380 papers in leading peer reviewed journals, in addition to 190 books, book chapters and monographs. This digest highlights some of the most recent publications from the last year.

We have experienced significant internal expansion during the last year with consolidated activities across the Departments of Social Policy, Management and the Accounting Group. LSE Health has also welcomed several exciting new research collaborations and groups, including the LSE Health Risk Research Programme, the Centre for the Study of Incentives in Health (in collaboration with King's College and Queen Mary College), LSE Health-TISS Programme on health policy in India, and the Health Information Systems Group. The Centre also celebrated the tenth anniversary of the European Observatory on Health Systems and Policies. All of these initiatives and collaborations have further strengthened the breadth and depth of LSE Health's expertise and its contributions as a leading centre in health economics and policy.

Working to inform policy is central to LSE Health's aims. Staff serve as advisors to Ministries of Health and Social affairs in now more than 15 countries and over 20 members of staff hold appointments with national and international policy-making bodies. This work has had a notable policy impact both in the UK and abroad. For example, our staff have undertaken several policy reviews in 2008, including research on economic incentives for preventive care for Health England and a review of health systems performance across different European countries for the Commonwealth Fund in the US. The latter work was presented at a high-level symposium in Washington DC in November. Other policy reviews focused on the Finnish pharmaceutical regulatory system, incentives to stimulate research and development for infectious diseases and health technology assessment systems in Europe.

Dissemination of new research and ideas to academic and policy communities continues to be an important aspect of the Centre's activities. A new programme for knowledge transfer has also been launched in partnership with the NHS Confederation, which aims to improve the transfer of practical, relevant health policy experience and lessons in Europe to the NHS in England. *Eurohealth* and *Euro Observer* continue to offer a forum for health policymakers, practitioners and academics to exchange ideas and debate on a range of health policy issues. The peer-reviewed journals, *Health Economics, Policy and Law (HEPL)* and *Globalization and Health*, edited by several LSE Health staff, published a number of engaging and highly-

accessed articles throughout the year, with HEPL now indexed in Medline.

In addition to the extensive research and policy activities, LSE Health continues to offer high quality teaching programmes. In late 2008, we launched a new executive-style MSc in Health Economics, Policy and Management. Investment in the doctoral programme continues, with students working in key areas of national and international health policy that impact both developed and developing countries.

LSE Health was pleased to welcome several new members of staff in 2008 and looks forward to a period of continued growth in 2009. Yet, as new faces were welcomed, we had to say goodbye to Sara Allin, Cristina Masseria and Charitini Stavropoulou, although we look forward to maintaining contact as part of the LSE Health affiliates located throughout the world.

We hope that this Research Digest highlights the work undertaken in 2008, demonstrating LSE Health's important contributions to research, policy development, dissemination and teaching.

Elias Mossialos
Director, LSE Health

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LSE Health

LSE Health is a research centre located within the London School of Economics and Political Science. It is affiliated with the Departments of Social Policy, Management and Accounting. The Centre's fundamental mission is the production and dissemination of high quality research in health care. The Centre's unique research base contributes to LSE's established world presence and reputation in health policy, health economics and demography. Bringing together a core team of researchers and academics, LSE Health promotes and draws upon the multidisciplinary expertise of 38 staff members, 20 associated academics and a number of PhD students. The Centre's health policy research focus includes comparative health policy; health care financing and equity; risk analysis; HIV/AIDS; and pharmaceutical policy. In health economics, current areas of interest include: economic evaluation; pharmaceutical economics; health care technology diffusion; the hospital sector; health in developing countries and workforce concerns. Demographic research currently includes mortality forecasting, reproductive health and the effects of childhood experiences on later outcomes.



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This Research Digest was compiled and edited by Elias Mossialos, Emma Pitchforth and Corinna Sorenson.

Research

LSE Health maintains a high rate of peer reviewed publications in leading international journals. Examples from 2008 are presented here and include papers in several broad areas: *health policy, health economics, behavioural economics and risk, health in developing countries, and demography and population*. Contact details for the authors are provided for those interested in further information about the papers.

Health policy

Public sector health care reforms that work? A case study of the United States' Veterans Health Administration

The United States (US) is not a health care 'system', in the sense of their being a well defined set of organisations providing health care to the whole of the population. Rather, it is a collection of systems, still dominated by employer-based health care insurance, leaving a significant proportion of the population (specifically, about 46 million people) uninsured.

Nonetheless, approximately half of US health care spending is financed from public sources. Principal among these are Medicare, the publicly-financed health care programme for the elderly, and Medicaid, the publicly-financed health care programme for the very poor. The Veterans Health Administration (VHA) is an important component of public sector health care in the US: it is a publicly-financed and provided health care system for veterans of the US armed forces that is structured very similarly to the UK National Health Service.

Between the 1970s and 1990s, the VHA had a terrible reputation for providing poor quality health care, but following a series of health care reforms introduced in the mid-1990s, the VHA has experienced substantial improvements in quality over the past decade. Indeed, the system is now arguably the best performing sector of US health care, as indicated in Figure 1, which compares the VHA, the commercial sector, Medicare and Medicaid across several commonly collected performance criteria.

The improvements in the VHA have been driven by not one factor, but rather by a number of factors acting in combination. These include strong leadership; the development of the VHA from a hospital-based into a broader health care system that significantly extended the use of primary care; the establishment of regional health care planning bodies similarly in nature to health authorities; the introduction and extensive use of financial and non-financial performance management; the development of an electronic health record; and, long-term investment in health services research. There is, however, some concern that the development of primary care and the downsizing of hospital care have compromised access to the latter, particularly in light of new demands from veterans of the wars in Afghanistan and Iraq.

Nonetheless, given that the VHA integrates a single payer of health care with providers and therefore resembles a sort of mini NHS, it may offer policymakers not just within the US, but also in overseas health care systems, some interesting insights on how to achieve similar improvements in process quality.

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Oliver, A (2008) Public sector health care reforms that work? A case study of the United States' Veterans Health Administration. *Lancet*, 371: 1211-1213.

Sources: The VHA data is reported in: VA Office of Quality and Performance. The data for the commercial, Medicare and Medicaid sectors is Health Employer Data Information Set (HEDIS) data reported in: National Committee for Quality Assurance.

Figure 1: Summary of VHA versus non-VHA performance in 2004-05

Type of care indicator	Percentage of eligible patients who experienced the quality			
	VHA (2005)	Commercial (2004)	Medicare (2004)	Medicaid (2004)
<i>Preventive care</i>				
Mammography	86	73	74	54
Cervical cancer screening	92	81	Not reported	65
Colorectal cancer screening	76	49	53	Not reported
Influenza vaccination	75	Not reported	75	68
Pneumococcal vaccination	89	Not reported	Not reported	65
<i>Outpatient care</i>				
For diabetes:				
Annual measurement of glycosylated hemoglobin	96	87	89	76
Poor control: glycosylated hemoglobin > 9% (lower is better)	17	31	23	49
Semiannual lipid screening	95	91	94	80
Cholesterol < 100	60	40	40	48
Cholesterol < 130	82	65	71	51
Annual eye examination	79	51	67	45
Annual renal exam	66	52	59	47
For hypertension: BP < 40/90	77	67	65	61
For mental illness: 30 day follow-up after hospitalization	70	76	61	55
<i>Inpatient care</i>				
For acute myocardial infarction:				
Beta-blocker at discharge	98	96	94	85

Women's preferences and choice of place of birth in remote and rural Scotland

Recent policy documents and guidelines in the UK have emphasised that women should have choice of place of birth. As part of national 'choice guarantees', all women in England will be guaranteed choice of place of birth by the end of 2009. In Scotland, policy recommendations generally support local community-based services that may be more clinically appropriate for low-risk women. At the same time, sector-wide changes have shaped current configuration of services. NHS-wide workforce issues mean that sustaining acute medical service provision in more rural areas is difficult and there has been increasing pressure for centralisation of services. Limited working hours for junior doctors and consultants and recommendations for 24-hour coverage in labour wards all contribute to rising workforce costs. Further challenges are faced in remote and rural settings, including difficulties in recruiting and retaining medical staff, increasing requirements to train to subspecialty level, new recommendations on staffing and skills required to deal with obstetric emergencies, and professional requirements to demonstrate competency by completing a set number of procedures annually.

While greater choice is being promoted, there is a general lack of evidence as to safety, costs, clinical appropriateness and women's preferences associated with different places of birth and models of care. Using discrete choice experiments, Emma Pitchforth with colleagues from the University of Aberdeen sought to understand how women trade off between different models of care (varying by different staff involvement and availability of pain relief) and time travelled from home to delivery unit. Box 1 shows an example of a question that women were asked to complete as part of a questionnaire after giving birth. We also used focus groups to explore in more detail women's decision making and experience of choice. The study was based in the North of Scotland NHS region, which covers approximately half the land mass of Scotland (including islands to north and west) and is home to one fifth of the population.

Box 1: Example choice question

CHOICE 1

In which place would you prefer to give birth (*Please tick **one** box*)?

A

- Consultant-led care
- All methods of pain relief
- 90 minutes from home

☐

B

- Midwife-managed care
- No epidural available
- 60 minutes from home

☐

C

- Midwife-managed care
- No epidural available
- Home birth – Zero travel time

☐

The findings showed that in contrast to service redesign offering local midwife-managed intrapartum care, most rural women in our study expressed a preference to give birth in the hospital and have consultant-led care because they felt safer. Within limits, women showed a willingness to travel further in order to receive consultant led care. The study also showed that women's preferences were influenced by their home and family context, beliefs and previous pregnancy experiences. Furthermore, the qualitative analysis of women's experience of choice showed that women engaged differently in the choice process, ranging from 'acceptors' to 'active choosers'. The presentation of choice by health professionals, pregnancy complications, geographical accessibility and the implications of alternative places of delivery in terms of demands on social networks were also influential on women's ability to engage with choice.

The results highlight different challenges. For service redesign in remote and rural areas, there are challenges in providing comprehensive obstetric services within acceptable travel time, while still responding to the heterogeneity of women's preferences. As choice

around place of birth continues to be promoted, it is important to note that provision of different models of maternity services may not be enough to convince women that they have 'choice'. The research raises fundamental questions about the meaning of 'choice' within current policy developments and calls for a more critical approach to the use of choice as a service development and analytical concept.

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Pitchforth, E, Watson, V, Tucker, J, et al (2008) Models of intrapartum care and women's trade-offs in remote and rural Scotland: A mixed-methods study. *BJOG*, 115(5): 560-569.

Pitchforth, E, van Teijlingen, E, Watson, V, et al (2009) 'Choice' and place of delivery: A qualitative study of women in remote and rural Scotland. *Quality and Safety in Health Care*, 18(1): 42-48.



The giants of excess: A challenge to the nation's health

In 1942, Sir William Beveridge noted five major problems facing the welfare state, collectively known as the 'five giants of too little' – of want, squalor, idleness, ignorance and disease. Typically, those in the UK experienced low wages, high unemployment, poor standards of education and living conditions, and suffered from intolerable diseases and shortages in healthcare.

Sixty-six years on, there has been a complete turn around and we live in a society full of excessive behaviours, termed 'the giants of excess'. Arguably, this is reflected in a lifestyle surrounded by 'luxuries' and excess consumption of various goods – a not so atypical caricature would depict an overweight person slumped in a smoke-filled room in front of a computer screen eating junk food, drinking beer and failing to exercise adequately. The state of the nation's health has deteriorated in many aspects, with significant increases in morbidity and mortality from non-communicable diseases, such as cancer, heart disease and stroke, all of which are juxtaposed by the remarkable gains in life expectancy and fights against infectious diseases (Box 1).

The resulting challenge to policymakers is equally significant, because such behaviours arise from individual choice and there is an inter-temporal mismatch, whereby the costs of *unhealthy activities* impact in the future, whereas the benefits accrue in the present. Similarly, the costs to any solutions accrue now, but benefits may take time to have any significance. Therefore, for any rational individual there will be a tendency to discount the future, because of uncertainty and myopia.

Box 1: UK health statistics

The good news since 1942:

- Nearly 50% of students go on to universities in England and Scotland.
- UK life expectancy has risen from 62 (males) and 67 (females) in 1942 to 77 (males) and 81 (females) in 2004-06.
- 92% of households in Great Britain have central heating.
- Unemployment is relatively low.

The bad news since 1942:

- 85,000 deaths per year from smoking-related causes in England (18% of all deaths), costing £1.7 billion to the NHS in 1998.
- Deaths attributable to obesity: 30,000 in England in 2001, costing anywhere between £2.5 and £45 billion.
- Number of deaths due to over-use of heroin and cocaine in England and Wales increased five fold between 1993 and 2006.

Policy must therefore aim to change the incentive structure faced by individuals and to reverse the pattern above. Crucially, it must be acknowledged that not all would favour state intervention, which would seemingly dictate individual choice and therefore curtail freedom. This notion is challenged with the recognition that not all individuals have willpower, information or ability

to behave rationally or objectively ('reasoning failure') and therefore a paternalistic institution could step in to correct for this. To consolidate these two ideas, a philosophical strand of thinking, called 'libertarian paternalism', has been introduced.

Libertarian paternalism seeks to change the default mechanism of any policy made. That is to say, people would choose to opt out of, rather than into, schemes. Examples include people opting out of pension schemes, from donating their organs, or from the opposite perspective, making people carry permits to buy cigarettes (thus opting in to be a registered smoker). Evidence has shown that if people are automatically enrolled into such schemes, they will tend to stay in, but if they had to join, they would stay out. Similarly, policymakers might choose to realign incentives by rewarding those who undertake healthy activities, or give up unhealthy ones. Both ideas would maintain individual autonomy, whilst providing better health outcomes, although there would be difficulties in monitoring and perhaps instigating moral hazard.

Both developing and developed countries face enormous challenges to maintain the increase in standards of living achieved in the past 60 years. This article offers new ideas and innovative thinking to meet this aim without impinging on personal freedom.

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Le Grand, J (2008) The giants of excess: A challenge to the nation's health. *Journal of the Royal Statistical Society*, 171(4): 843-856.

Product development partnerships (PDPs) for neglected diseases: Considerations on governance

Neglected diseases (NDs), such as malaria, tuberculosis, cholera, schistosomiasis, and Chagas disease, result in considerable mortality and disease and social burden. Despite their social and economic impact, minimal investment has been made to research and develop (R&D) treatments (eg, vaccines) for NDs, principally because they are not considered a lucrative commercial 'market'. While various 'push' and 'pull' mechanisms (eg, tax credits) have been put forth to spur the development of new technologies and better align the social and financial incentives required to meet this aim, they have been somewhat ineffective, underused, or not sufficiently pursued. However, one such mechanism, product development partnerships (PDPs), has received considerable traction and support over the last ten years. PDPs serve to join-up the public and private sectors in both developed and developing countries, in attempts to pool the resources, expertise, and capacity required to facilitate and support ND R&D.

Despite the growth in PDPs and the resources invested in their establishment, there has been minimal investigation of the actual governance of these partnerships.

This article aims to address this gap by providing some initial conceptualisation on their governance based upon a wide body of literature, including neo-institutionalism, governmentality, and constructivism. In particular, it explicates how governance transpires in PDPs and what factors internal and external to the partnership shape this process. Such factors include the actor-structural arrangement of the PDP, which defines the roles that actors play within the partnership as well as prescribing the issues discussed and how they are dealt with; the different 'logics' or norms that constitute actor behaviour and, ultimately, partnership governance; the different power resources and interests of relevant actors; and, the more symbolic or normative constructions held and promulgated by partnership members. For example, in terms of power resources, PDPs have facilitated a shift in the locus of power from the public to the private realm, especially as investment in these partnerships is heavily skewed toward private entities. Consequently, the logics of private members assert a certain level of influence over the governance of the PDP, with regards to setting ND policies and research agendas, or establishing the norms and procedures of governance.

While the PDP governance model offers significant benefits, there are also potential pitfalls associated with its structure, organisation, and operationalisation that should be taken into account and further examined. While 'public-private partnership' carries a positive, collaborative connotation, these are complex structures that do not operate sans power, politics, and divergent agendas. In relation, the term does not necessarily accurately reflect who is represented and to what extent. This article concludes by maintaining that a theoretical and empirical approach is needed that views PDP structures, actors, and broader contextual factors in interaction, in order to fully elucidate their governance.

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Sorenson, C (2009) Product development partnerships (PDPs) for neglected diseases: Considerations on governance. *Health Policy, Economics and Law*, 4(1): 1-10.

The dynamics of commissioning across organisational and clinical boundaries

This paper investigates inter- and intra-organisational relationships in commissioning services within the NHS in England, through application of the principal agent theory. Commissioning is a process whereby primary care trusts (PCTs) evaluate the needs of their population groups and then try to access resources. Various assumptions are made, including a hierarchical chain where PCTs are positioned above NHS Trusts, and further, NHS Trust managers are placed above consultants.

There are two important sets of relations to evaluate within both these hierarchical chains: Tier 1, which describes the level at which commissioning negotiations take place and Tier 2, that of delivery. In the former, governance arrangements are contractual, whereas in the latter managerial concerns are dominant (Figure 1).

Three case studies provided material for observation, interviews, and documentary evidence to analyse the dynamics of commissioning. Empirics suggest that weak control may encourage non-compliance (demoralisation) by immediate agents, whilst strong control tempts agents down the hierarchical chain to introduce services without prior agreement ('creeping commissioning'). Thus, a healthy balance between control and trust must be struck, such as the maintenance of clinical freedom in the face of strict management rules. A suggested solution would be to strengthen local incentives and ownership in order

Principal agent theory

- An 'agent' is hired by the 'principal' to carry out services or produce goods in return for a reward.
- Incentives may not be aligned where objectives of agent and principal differ.
- Contracts are therefore used to correct this mismatch.

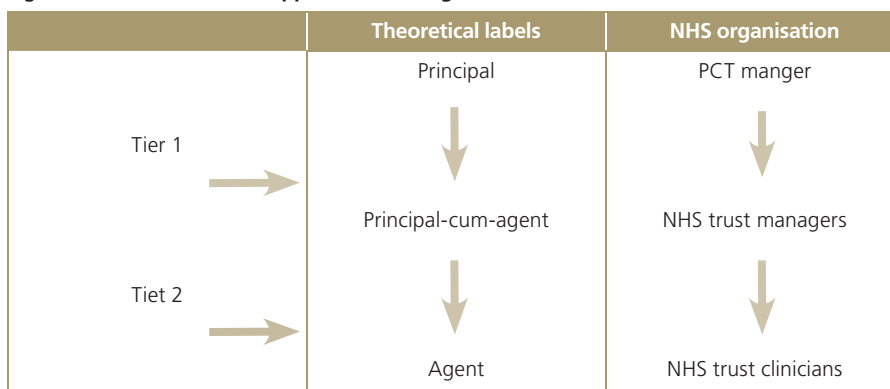
to reach national targets, as well as systems to ensure compliance with made agreements.

Further studies are suggested for the rest of the UK. Within England, commissioning relations of different specialities will allow for more in depth analysis at each level. Overall, incentives within organisations are as important – if not more so – as those between organisations.

For further information contact Julian Le Grand, j.legrand@lse.ac.uk

Le Grand, J, Baxter, K, Weiss, M (2008) The dynamics of commissioning across organisational and clinical boundaries. *Journal of Health Organisation and Management*, 22(1): 111-128.

Figure 1: Theoretical labels applied to NHS organisations



Risks of regulating healthcare by numbers

In a paper published in *Health, Risk and Society*, Peter Miller and Liisa Kurunmäki explore the implications of regulating health care by accounting numbers. The rise in regulatory agencies has changed the regulatory landscape within which hospitals function, and have altered the risks of providing healthcare. For example, total hospital revenue now depends on the volume, type and mix of activity undertaken, while their financial success, and ultimately survival, depends on the efficiency with which the chosen set of services is delivered.

The authors outline three main groups of regulatory agencies, as follows:

Costing – represented by accounting numbers, and by Monitor (oversees NHS foundation trusts and their financial management) as the relevant regulatory body. Costing bodies can produce incentives to hospitals to alter the volume and mix of activities, and even to cut certain treatments or even entire departments within individual hospitals.

Quantifying – represented by health economists, and by the National Institute for Health and Clinical Excellence (NICE) as the relevant regulatory body. Quantifying bodies make visible the costs and benefits of particular drug regimes or treatments.

Curing aspiration – represented by medics and their associated professional associations. Curing bodies make it appear that we live in a world of unconstrained resources in which all that matters is treating patients according to their needs and wishes, regardless of cost.

Potential conflicts can exist between these regulatory actors and expertises, as illustrated in the example of renal failure and the choice between hospital and home based dialysis care. The curing aspirations of medics, and the advice provided by the professional association of physicians, holds the views of patients as paramount, where, in most cases, the choice of initial dialysis modality would be based on patient choice. NICE and the quantifying models of health economists that it deploys still views patients as central, but concerns for cost-effectiveness calls for an account of the efficient use of NHS resources. In this particular instance, the advice regarding renal failure is largely consistent with that of the professional medical associations, even if that is not always the case. Finally, the costing domain, under the banner of 'service line reporting' and Monitor, focuses on the hospital as the accounting entity, and the comparison of costs of treatment relative to national tariffs (or indicative national tariff in the case of renal dialysis). If, for example, the cost of treatment exceeded the tariff, there would not necessarily be implications for continued dialysis care – rather, what is counted counts.

Thus, in so far as the hospital is taken as the accounting entity and obliged to operate, Monitor's risk-based focus on accounting numbers can come to dominate the various actors and expertises in the regulatory domain. For instance, a monthly reporting of income and earnings by 'service line' is required for trusts with the poorest risk ratings. Such intense and fine-grained monitoring is not limited to such entities, however. Any well-governed trust, according to Monitor, should have a good understanding of its service-line incomes and costs.

The authors maintain that a real risk of regulation by accounting numbers is that patient choice may end up taking second place to financial assessments of the 'profitability' of particular service lines or treatments. Another risk is that the financial management of the hospital may override the guidance of medics and the potential societal benefits of particular modes of treatment. Of course, in practice, these matters are much more complex.

For further information contact Peter Miller, p.b.miller@lse.ac.uk or Liisa Kurunmäki, l.kurunmaki@lse.ac.uk

Kurunmäki, L, Miller, P (2008) Counting the costs: The risks of regulating and accounting for health care provision. *Health, Risk and Society*, 10(1): 9-21.

Political analysis of different options in European Union health services policy

European Union health policy exists. But what is it, and what will it be? Health services policy in the European Union (EU) is at a critical juncture: a moment in which decisions are highly contingent but, once taken, will shape politics and policy for the future. There is no established EU health services policy community or trajectory, because EU health services politics have been a reaction to decisions by the Court of Justice. Instead, there are a range of different models of health policy, each with different logics, lineages, policy tools and bureaucratic sponsors. They range from treating health as a simple tradable service through to specific regulatory frameworks, and from 'new governance' approaches through to tough applications of competition and internal market law.

EU health politics may be fluid, but the decisions taken now will shape future policy, because of the importance and 'stickiness' of the EU – once the European Court of Justice has taken a decision, or legislation has passed, it is difficult to undo it. As a result, EU health policy is in a time of rare and important flux, when decisions taken by a few

people with little oversight or accountability shape the future options. By the time more lobbies, health systems, and experts are engaged, the basic policy framework will be in large part set. Already, the range of options has narrowed.

This article explains the challenges that created an EU policy arena where none had been; the reasons that decisions taken now will be subject to the logic of path dependency; and the different models that are being put forward for the EU. It works through the options, which each reflect their origins in different policies outside health. One approach is to incorporate health care into the internal market, treating it as a service like any other. This was the initial logic of EU health policy, but it is also the one that has been put to a democratic vote in the European Parliament, and lost; it will not be the future unless legislation with more respect for the complexity of health and its important role in social solidarity fails. However, looking at the alternatives means that the internal market option might still win out. One alternative, more popular in academic literature than Brussels politics, is treating health as a 'service of general interest', with special regulation to

support solidarity and social citizenship. Another is specific health legislation, which is currently being amended and debated in the EU institutions. Yet, another is incorporating health care into a broader vision of a 'European social model', using novel techniques of 'new governance', such as peer review and shared standards, to promote learning in health services and convergence on shared (vague) values of solidarity, financial sustainability, and quality.

The choice, mixture, and timing of the decisions will influence the kind and extent of future EU health policy. As a result, influencing EU health policy now, when the whole approach is being determined, will be far more effective than engagement later, when the issues might be clearer and less vague, but the basic framework is already set.

For further information contact
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Greer, SL (2008) Choosing paths in European Union health services policy: A political analysis of a critical juncture. *Journal of European Social Policy*, 18(3): 219-31.

Qualitative evaluation of an electronic prescribing and administration system

Tony Cornford and colleagues conducted a formative qualitative evaluation of a pilot implementation of an integrated electronic prescribing, automated dispensing, barcode patient identification and electronic medication administration record (EMAR) system on one ward in a London teaching hospital. This research was complemented by a companion quantitative study examining the impact of EMAR on prescribing and administration errors and staff time.

Data was collected by means of attending project meetings and conducting interviews and observations with doctors, nursing staff, pharmacists, hospital managers, and a number of adult patients who discussed their experiences with and attitudes towards the system. A focus group session with health professionals and hospital managers was also held nine months after the system went live. The study's approach was informed by the socio-technical perspective, which considers information systems as having social and technical elements, and technology's characteristics and capabilities as being revealed through use. This approach is reflected in the evaluation framework applied in the study (Table 1), which addresses technical performance, changes to delivery of care and work practices, as well as the longer-term prospects of a system and its sustainability within an organisational context.

The system was successfully implemented on the ward, and remained in operation for over two years. Many of the technical components of the system initially showed problems, but the system evolved with increased functionality and improved performance. Attitudes to the system in the early stages were at best mixed. Over time, however, staff attitudes changed to become more balanced and the potential benefits of

Table 1: Evaluation framework

	System functions organisational context	Human perspectives	
Structure	Technical detail	Work conditions and implied requirements	Sustainability, opportunity costs, management capacity
Process	Information processing; correct and valid	Human participation in tasks; social interaction	Altered delivery of healthcare
Outcome	Relevant, applicable, reliable	Quality of service, and outcomes	Effect in the world

the system became clearer. The system re-structured the work of ward staff, notably nurses, sometimes unexpectedly. For example, aspects of medicines use that were not readily structured became new sources of errors, or structuring led to wider rigidity, making it harder to introduce other innovations, such as one-stop medicines dispensing. Such problems were apparent in this single ward study, but across a hospital or range of hospitals, the effect would be greatly magnified.

Based on the study, a number of wider conclusions can be drawn:

- Much of the real work of designing and shaping these systems is undertaken in the local context and often after initial use. Hence, policymakers and implementers need to acknowledge that acquiring and implementing a technology is the start of the process, not the end.
- The effectiveness of any information computer technology-based system changes and develops over

time, and may have quite different effects in different settings at different points of time.

- Reshaped work tasks bring wider changes in how care is delivered and how professionals work together. These changes might be subtle, unexpected and not immediately apparent. Such change must be assessed and managed throughout the period of a systems' use.
- Overall, electronic prescribing systems need to be seen as occasions for change and learning, rather than black-boxed technical 'solutions' to prior identified 'problems'.

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Barber, N, Cornford, T, Klecun, E (2007) Qualitative evaluation of an electronic prescribing and administration system. *Quality & Safety in Health Care*, 16(4): 271-278.

Nasty or NICE? A perspective on the use of health technology assessment in the United Kingdom

Health technology assessment (HTA) has a long history in the United Kingdom (UK). It expanded rapidly in the 1990s, with the establishment of several key HTA bodies, such as the National Coordinating Centre for Health Technology Assessment (NCCHTA), and the National Institute for Health and Clinical Excellence (NICE). The latter had a particular significant influence on raising the international profile of HTA in the UK, as the work of NICE would be used in developing guidance for the NHS on the use of health technologies.

NICE has been widely debated and often criticised since its inception. However, it can claim several major achievements and still represents one of the more sophisticated attempts to integrate HTA into the decision-making process. The Institute's successes include the methodological rigor to which it applies to assessments; the level of transparency related to its processes; and, the engagement of a broad range of stakeholders in all areas of its work. However, as might be expected, the advent of NICE has led to considerable discussion and debate in the UK around its operations and, more broadly, on issues related to the allocation of healthcare resources. Of course, many of these issues existed previously, but the establishment of NICE made

them more explicit. In this article, we analyse and discuss a number of these major outstanding issues, with a particular focus on: 1) the independence of HTA, 2) topic selection and priority-setting, 3) timeliness, 4) the use of quality-adjusted life years (QALYs) and social values, 5) the cost-effectiveness threshold, and 6) the implementation of guidance.

Considering the strengths and weaknesses of NICE and its increasing position as an international model for HTA, we explore whether there are any lessons for other jurisdictions using, or contemplating using, HTA. In contrast to its assessment procedures, where there are certainly transferable lessons with regards to methods and stakeholder involvement, it is more difficult to draw many general learnings from NICE's activities in decision making. For example, whereas general recommendations based on a single incremental cost-effectiveness ratio and cost-effectiveness threshold may make sense in an integrated, single-payer system like the UK National Health Service, they may not be appropriate in more decentralised systems. Therefore, one would need to think carefully about the role of a central HTA entity in a country where the responsibility for providing healthcare is regionalised, or where there

is a wide range of public and private payers. In such jurisdictions, perhaps the role of any central HTA entity should be restricted to the production of high quality assessments that can be subsequently used by different decision makers. Local decisions may then differ, depending on the resources available. If technology assessments are to be used in this way, they need to be adaptable to local needs. Moreover, in countries like the US, where there are many private insurers, often in competition with one another, careful thought needs to be given to how transparency in decision making can be maintained.

While there are indeed lessons that can be learned from the experience and processes of NICE, in general, caution must be taken about making such inferences, as all HTA entities are creations of the healthcare systems in which they are based.

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Drummond, MF, Sorenson, C (forthcoming)
Nasty or NICE? A perspective on the use of health technology assessment in the United Kingdom. *Value in Health*.

What impact do prescription drug charges have on efficiency and equity?

As pharmaceutical expenditure continues to rise, third-party payers in most high-income countries have increasingly shifted the burden of payment for prescription drugs to patients. Despite research suggesting that user charges are unlikely to contribute to health policy goals, such as efficiency and equity, all OECD countries charge patients for some health services, most commonly for prescription drugs.

A large body of literature has examined the relationship between prescription charges and outcomes such as expenditure, use, and health, but few reviews explicitly link cost sharing for prescription drugs to efficiency and equity. In a recent paper, Marin Gemmill-Toyama, Sarah Thomson, and Elias Mossialos reviewed the literature on cost sharing for prescription drugs to discuss the extent to which prescription charges contain health care costs and enhance efficiency without lowering equity of access to care.

The authors find that user charges enhance allocative efficiency, but the unrealistic assumptions that accompany a traditional economic understanding of allocative efficiency limit its policy relevance. Thus, the authors employ an interpretation of efficiency more commonly used to evaluate policy: one that focuses on improving health through the provision of effective health care. From this perspective, the cost, health, and distributional consequences of prescription drug charges decrease efficiency.

Almost all the studies reviewed conclude that prescription charges reduce the use of prescription drugs; however, most patients are not particularly sensitive to changes in user fees. The implication is that these charges fail to achieve large or long-term reductions in total prescription drug expenditure, while simultaneously increasing patients' out-of-pocket spending on prescription drugs.

Few studies examined the impact of prescription drug charges on health, but those that directly considered health effects generally concluded that prescription drug charges increased the likelihood of needing more intensive care and, ultimately, of dying. A larger number of studies examined health effects indirectly and found that user charges lowered adherence to treatment and reduced the use of essential and non-essential drugs, strongly suggesting a negative impact on health.

Prescription charges are also likely to lower equity in the use of health care. Although the review did not find that low-income groups were more sensitive to price, poorer people reduced their use of prescription drugs even when co-payment levels were very low. Correlations between income, age, and health, combined with evidence that poorer people are sensitive to price and that the health effects of user charges are more pronounced among low-income groups, suggest that policymakers should focus on protecting poorer and older groups and heavy users of prescription drugs from the financial burden of user charges.

The evidence from the paper suggests two main options for policymakers wanting to use prescription drug charges to improve efficiency without lowering equity. First, enable patients to opt for cheaper alternatives, such as generic vs. brand-name drugs, or drugs that are cost-effective. While the cost savings may be limited, these policies have the advantage of contributing to efficiency in health care delivery. Second, introduce mechanisms to protect poorer people and heavy users of prescription drugs.

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Gemmill, M, Thomson, S, Mossialos, E (2008).
What impact do prescription drug charges have on efficiency and equity? *International Journal of Equity in Health*, 7: 12.

The determinants of willingness to donate organs in the European Union

Although progress in medical science and technology has vastly improved success rates for organ transplantations, severe organ shortages continue, preventing these medical advances from being realised for all potential patients. Efforts to expand the available organ supply have become more crucial for meeting transplant demand. However, available organ transplants often depend on institutional frameworks rather than on individual demand, namely the specific regulations in each country and individuals' awareness of this legislation.

Recent research by Elias Mossialos, Joan Costa-Font and Caroline Rudisill examined factors driving organ donation rates in the European Union. Specifically, they looked at how country regulation, individuals' awareness of regulatory settings, social interactions and socio-demographic determinants influence individuals' willingness to donate their own organs or those of a relative. The study uses Eurobarometer survey data from 15 European Union countries (Austria, Belgium, Denmark, Finland, France, Greece, Ireland, Italy,

Luxembourg, Netherlands, Portugal, Spain, Sweden, Germany, United Kingdom). The Eurobarometer survey series undertaken by the European Commission is designed to regularly monitor social and political attitudes of the EU public.

This study classifies European countries according to two types of institutional settings for confronting organ transplant needs: informed consent (opt-in) or presumed consent (opt-out). In countries with informed consent or 'opt-in' legislation, such as the UK, Germany, and Sweden, an individual or his/her family must give explicit permission for organ removal. Presumed consent countries, such as Spain, Portugal, and Austria, assume universal consent without explicit registration otherwise. The latter is more prominent in the EU, although countries with presumed consent legislation can differ in enforcement levels. Enforced presumed consent policy means that individuals who have not opted out of organ donation will automatically donate their organs upon time of death if organs are in a suitable clinical condition.

Findings indicate that individuals are more likely to donate their organs than to consent to the donation of a relative's organs. Both decisions are affected by type of organ donation regulation (presumed consent), awareness of regulation, and social interactions, such as the ability to count on others in case of a serious problem (reciprocity). The authors found that presumed consent organ donation policy positively affects the willingness of individuals to donate their own organs and those of a relative. This study highlights the importance not only of regulation type, but also awareness of this regulation and an individual's level of social interactions in making choices about donation.

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Changing paradigms of governance and regulation of quality of healthcare in England

In the late 1990s, a crisis of quality was perceived to engulf the English National Health Service (NHS). The Government's first policy response, in 1998, was to focus on the implementation of clinical governance in the NHS, together with establishing the Commission for Health Improvement (CHI), with responsibility, from 2000, for a rolling programme of visits to each NHS organisation to inspect the progress of implementation of clinical governance. Following this, there were Public Reports of Inquiries into three scandals that were symptomatic of the crisis of quality in the NHS: the Ritchie Report of the Inquiry into the arrogant incompetent gynaecologist, Rodney Ledward; the Kennedy Report of the Inquiry into excess mortality following heart surgery on children at the Bristol Royal Infirmary; and, the Smith Reports of the Inquiry into the General Practitioner (GP) Harold Shipman, Britain's worst serial killer. Each report highlighted alarming failures of governance and professional self-regulation of the quality of health care in England in the late 1990s; was strong in the forensic purposes of establishing the facts and examining accountability; but had limited influence on policy development, in part because the reports were produced when the new

systems designed to prevent failures of governance were still under development.

From 2002, Government policies sought to develop a common approach to inspect the quality of healthcare in the NHS and private sectors against national standards. These policies were seen to justify replacing inspection of organisations based on visits, to surveillance using routinely-available data and self-assessment. CHI's experience showed that large NHS acute hospitals and primary care trusts were so complex that none was without problems which were identified in an iterative approach to the collection of data organised around visits to organisations. The cases of Ledward, Bristol and Shipman showed how statistical monitoring of mortality data identified problems *when this was undertaken with hindsight*. Trying to do such monitoring prospectively is problematic because of problems of potential false positives and negatives. CHI's experience, and the three reports, challenge the notion that effective regulation of a sector as complex as health care can be based on surveillance. There is no good rationale for having abandoned regulation based on inspections of NHS providers through visits.

A further weakness in the regulation of the quality of health care in England is the government's extraordinary belief in the benefits of continual change and reorganisation. In April 2004, the Healthcare Commission was established, taking over responsibilities for regulating quality in the NHS (from CHI) and the private sector (from the National Care Standards Commission, established in 2002). In 2005, the Government proposed the creation of a new single regulator of health and social care to replace the Healthcare Commission and the Commission for Social Care Inspection (established in 2004). It has, however, taken four years for this to happen: from April 2009, the Quality Care Commission takes over responsibilities of the Healthcare Commission and also those of the Mental Health Act Commission.

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Bevan, G (2008) Changing paradigms of governance and regulation of quality of healthcare in England. *Health Risk and Society*; 10(1): 1-17.



Health Economics

The cost of stroke in the UK and cost-effective strategies for care provision

With colleagues from King’s College London, Alistair McGuire has been involved in a body of work seeking to quantify the annual cost of illness of stroke to the UK economy and to assess the cost-effectiveness of care strategies. Stroke is the second most common cause of death and the leading cause of disability in Europe. In addition to mortality, long-term morbidity from stroke is also a significant problem, associated with moderate or severe disabilities, leaving sufferers dependent on others to carry out daily activities. Assessing the societal costs of stroke, in addition to direct care costs, is therefore important.

The research estimated the cost of direct formal care costs, direct informal care costs and indirect costs, using data from the South London Stroke Register and other national sources. Direct formal costs were calculated in terms of inpatient stays, inpatient administration of thrombolysis, outpatient visits, drug costs and cost of stay for various chronic care institutions. For direct informal care costs time spent by the carers of disabled stroke patients was calculated. Indirect costs involved loss of earnings attributable to premature mortality, factoring in the rate of economic productivity, the current unemployment figures and the friction period. Loss of income from stroke morbidity and direct income payments relating to stroke morbidity were also included. Deterministic sensitivity analysis was carried out to test the robustness of the model and to identify important areas of uncertainty around assumptions.

The study estimated the cost of stroke care to be around £9 billion a year (Table 1). Total annual direct care cost was estimated to be approximately 49% of this total, informal care around 27%, and the indirect costs around 24%.

The total annual direct costs of stroke, shown to be around £4 billion, accounts for approximately 5.5 per cent of the total UK expenditure on health care. By differentiating between acute and chronic treatment phases, this study was able to highlight the burden of costs of informal care and lost productivity, which brought total annual costs to £9 billion. This highlights the importance of the chronic treatment phase and the need to develop better understanding of long-term care in terms of its effectiveness and cost-effectiveness.

A separate study assessed the cost-effectiveness of stroke unit (SU) care followed by early supported discharge. Treatment of stroke patients in SUs is becoming a standard treatment approach. This means that patients should be admitted under the care of a specialist team for their acute care and rehabilitation. Despite the growth and standardisation of this approach, there has been little health economics research on its cost and cost-effectiveness. Evidence exists as to the benefits of SUs in the acute treatment phase of stroke, but is less conclusive regarding the effective management of discharge and follow-up after acute care. Early supported discharge (ESD) offers an effective care pathway, where less disabled patients can be discharged early to undergo further rehabilitation at home. Existing evidence suggests that appropriately resourced ESD services could reduce long-term dependency and admission to institutional care, as well as reduce the length of hospital stay without causing any adverse effects on the mood or subjective health status of patients or caregivers.

This study aimed to evaluate the long-term (ten-year) cost-effectiveness of SU care followed by ESD compared with SU care and treatment in a general medical ward with no ESD. Data for the study were

obtained from the South London Stroke Register in England and from a randomized controlled trial of an ESD scheme for patients with stroke. Incremental costs-effectiveness ratios (ICERs) were calculated, as cost per QALY, to assess the cost-effectiveness of different strategies. The analysis showed that when SU options were compared with the general medical ward option, they were more cost-effective and when the two SU options were compared, SU with ESD was most effective. The ICER value for SU unit with early supported discharge was £17,721, which falls below the National Institute for Health and Clinical Excellence’s cost-effectiveness threshold level of £30,000 per QALY gained. The findings suggest that integrated provision of SU care followed by early supported discharge is likely to lead to improvements in treatment outcomes in a cost-effective manner.

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Saka, Ö, McGuire, A, Wolfe, C (2009) Cost of stroke in the United Kingdom. *Age and Ageing*, 38: 27-32.

Saka, Ö, Serra, V, Samyshkin, Y, McGuire, A, Wolfe, C (2009) Cost-effectiveness of stroke unit care followed by early supported discharge. *Stroke*, 40(1): 24-29.

Table 1: Estimated cost of stroke care

Cost item	Cost in £ (m)	Percentage
Diagnosis costs	45.604	0.51
Inpatient care costs	865.872	9.64
Outpatient costs	109.679	1.22
Outpatient drug costs	505.588	5.63
Community care costs	2,857.113	31.82
Annual care cost total	4,383.858	48.82
Informal care costs total	2,420.921	26.96
Income lost due to mortality	592.733	6.6
Income lost due to morbidity	740.158	8.24
Productivity loss total	1,332.892	14.85
Benefit payments	841.254	9.37
Total	8,978.926	



Equitable health care?

Publicly financed health systems aim to distribute scarce health care resources in a manner that is both fair, or equitable, and efficient. One approach to measure equity is by measuring differences in health care use across income groups based on the concept of the Lorenze curve. Two recent studies applied this approach to understand the roots of inequity in the Canadian health system, and to compare estimates of inequity across 11 European countries and the US.

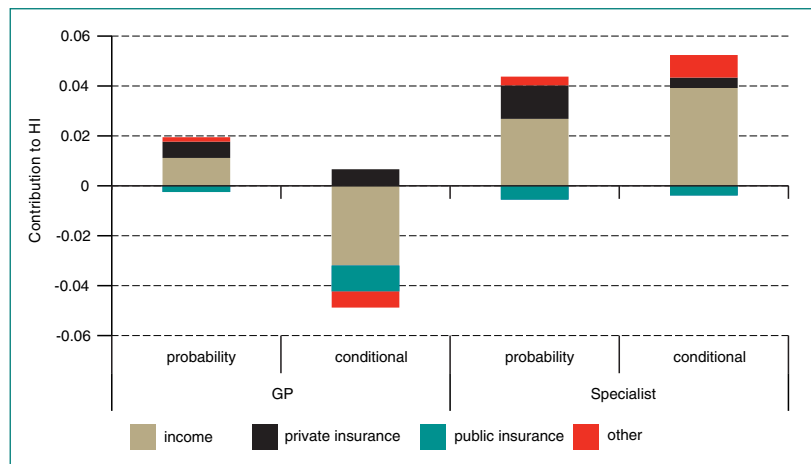
Physician and hospital services are fully publicly financed in Canada, while prescription drugs are financed through a mix of private complementary insurance, out-of-pocket-payment and public insurance. The first study sought to answer whether this mixed model of financing for prescription drugs contributes to inequity in the use of physician services, given that patients require a prescription from a physician to access medicines. Previous research has demonstrated two things: 1) that patients are sensitive to the price of medicines, and 2) that patients may be deterred from visiting a physician if they are not insured for the cost of prescription drugs that so often accompany a physician consultation.

This study analyses a population-level health survey from Ontario, Canada and confirms that patients are more likely to visit a physician when they have either private or public insurance than when they do not have any insurance. Since private complementary insurance is held disproportionately by higher income groups, and insurance increases the use of physician services, private prescription drug insurance contributes to inequity in physician services. Figure 1 shows the components of inequity in the probability of visiting a GP, the number of visits to a GP conditional on having had one visit, the probability of visiting a specialist, and the conditional number of specialist visits. The interaction between public and private sectors in health care therefore presents challenges to policymakers who seek to achieve equity in the public system.

European health policy makers are motivated to achieve an equitable allocation of health resources, and even in the US, where this equity objective is given less weight, public programmes are in place to protect vulnerable populations. The Health and Retirement Survey from the US and the Survey of Health, Ageing and Retirement in Europe provide relatively comparable information on health, health care use, and socioeconomic status in nationally representative samples of adults aged 50 and over in 11 European countries and the US.

In the second study, we compare socioeconomic differences in health care utilisation across these countries, and examine the sensitivity of the estimates of inequity when using income versus wealth as the indicator of socioeconomic status. In the US, survey respondents were asked whether they had visited a physician in the past two years (since the last survey), and in Europe they were asked whether they visited a physician or dentist in the past year. Even though the time period was twice as long in the US than in Europe, the level of inequity was higher in the US than in all other countries (Figure 2). Inequity tends to be

Figure 1: Contributors to inequity in GP and specialist service use in Ontario, Canada



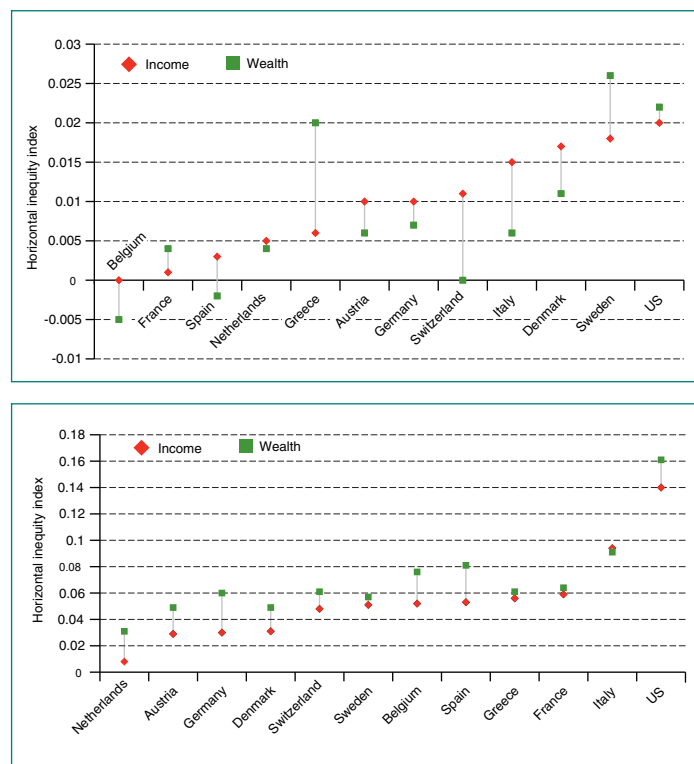
lower when it is measured by income than by wealth, especially in the case of dental care. As demonstrated in previous studies of the general population (and not just those aged 50 and over), the level of inequity in the likelihood of a dentist visit is much higher than in physician care in all countries. For the older adult population, many of whom are retired and over the age of 65, the level of wealth they have accumulated over their lifetime may be a more sensitive indicator of socioeconomic status than their income from employment or pensions.

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Allin, S, Masseria, C, Mossialos, E (2009) Measuring Socioeconomic differences in use of health care services by wealth versus by income. *American Journal of Public Health*; (forthcoming).

Allin, S, Hurley, J (2008) Inequity in publicly funded physician care: what is the role of private prescription drug insurance? *Health Economics*, Published online, DOI: 10.1002/hec.1428.

Figure 2: Estimates of income-related inequity and wealth-related inequity in physician and dental care in 12 countries



Wealth overruns income in explaining health inequalities among old aged

Using a representative cross-sectional database on the Spanish population aged 55 or over, this study examines the influence of housing assets in determining health and disability in old age. The rationale of the study lies in that some studies question the existence of income related socio-economic factors of health in old age. In the light of the evidence that older persons are typically low-income and relatively wealthy, this study employs survey data to explain the influence of both housing equity and income, along with other health-producing conditions, on health and disability. This is a policy-relevant issue as it affects prevention policies designed to overcome socio-economic health differences in old age. The data employed by the study is unique – despite being cross-sectional – in that it contains information that makes it possible to examine house prices and also contains income data, so that the influence of such variables can be tested together, along with a continuous measure of health.

Our results indicate that income does not exert appreciable effects on health and disability in old

age. This results are robust to the inclusion of several other covariates that are argued to be inputs (or controls) influencing health production. However, housing equity did (as hypothesised) exert a significant influence both on health and on disability in old age. Indeed, we find that doubling housing equity resulted in an increase of about three per cent in self-perceived health and a significant reduction in disability. While older persons rely on pension income, the wealth they have accumulated over their lifetime, primarily in the form of housing equity, overrides the effect of income as a determinant of health and (absence of) disability in old age. Furthermore, housing assets account for more than 90 per cent of socio-economic inequalities and 54 per cent of inequalities in disability.

In the light of the results, socio-economic inequalities in health among the elderly can be attributed to differences in housing equity rather than in differences in sources of income, most likely pension. An interpretation of these results is that at old age, retired individuals' capacity to enhance health is largely determined by the extent to which individuals have

either saved or benefited from the transfer of other people's wealth. Therefore, policies tackling health at old age, rather than focusing exclusively on the existence of income related inequalities in health would tackle wealth instead. Indeed, wealth related inequalities might be even more important at old age. However, policies designed to tackle health inequalities due to wealth should take into account that other inequalities could be generated by the policies themselves. Indeed, public policy should distinguish between transferred wealth and wealth generated by individuals themselves by forgoing income and savings for the future.

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Costa-Font, J (2008) Housing assets and the socio-economic determinants of health and disability in old age. *Health & Place*, 14(3): 478-491.

Assessing the influence of gestalt-type characteristics on preferences over lifetime health profiles

In contrast to the basic tenets of economic theory, there is substantial evidence that people's remembered utility of past episodes, and their predicted utility over future episodes, systematically differs from the utility that they actually experience. For example, people may well prefer to undergo a longer painful medical procedure, so long as the last moment of the procedure is not as painful as that for the shorter medical procedure. These systematic differences are often caused by the 'gestalt characteristics' of extended episodes that tend to influence people when they undertake assessments of past and future events. That is to say, the whole is very often greater than the sum of the parts. Such characteristics include the peak and final moments of an episode, the trend of the episode (ie, whether it gets better or worse), and the rate of change (ie, the 'slope') of the trend. This study tested whether people wish to maximise 'quality-adjusted life years' (QALYs), as is assumed implicitly in 'cost-utility analysis' (which is generally the most respected form of evaluation in the health economics community, and is recommended by health technology agencies internationally, including the National Institute for Health and Clinical Excellence), or whether QALY maximisation is compromised by them being influenced by factors that resemble the gestalt characteristics when choosing between lifetime health profiles.

The results indicated that people do not always, or indeed often, choose to maximise QALYs. For example, there are periods in the life course to which many

people attach a 'premium' on having good health, and, moreover, there are 'patterns' in lifetime health that many people would prefer to avoid, such as a relatively poor ending and particularly steep changes in health states. It seems quite reasonable, for instance, for people to trade off some total lifetime health in order to avoid one or more particularly poor health experiences.

Should these population preferences be important considerations for policy making decisions? The answer to this question depends upon how paternalistic one thinks policymakers ought to be, and how much faith one has in health maximisation as a priority setting decision rule. If one believes that the preferences of the general public are of some import in the policy-making process, then since people usually express good reasons for being influenced in systematic ways by the gestalt-type characteristics, decision makers perhaps ought to incorporate their possible influence in their deliberations on the appropriate allocation of health care resources.

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Oliver, A (2008) Assessing the influence of gestalt-type characteristics on preferences over lifetime health profiles. *Medical Decision Making*, 28: 723-731.

The impact of decentralisation and inter-territorial interactions on Spanish health expenditure

The importance of decentralisation in affecting public sector performance and outputs has been increasingly recognised. This is particularly relevant for those expenditure sources that have a sizeable impact on human welfare and that are publicly-financed, as is the case for health care. In a recent article, Joan Costa-Font and Francesco Moscone examine the determinants of regional public health expenditure in Spain, a country that has experienced decentralisation in the last decades. Unlike previous studies, they take into account possible policy and political interactions among regional authorities, as well as unobserved heterogeneity. Methodologically they employ a spatial panel specification using a dataset of all Spanish region states on aggregated and disaggregated health expenditures (pharmaceuticals, inpatient and primary care). Results suggest some degree of interdependence between neighbouring regions in spending decisions. Empirical evidence of long-term efficiency effects of health care decentralisation suggests that a specific spatial-institutional design might improve the health system efficiency as well as regional cohesion. Political and scale effects appeared consistent with theoretical predictions.

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Costa-Font, J, Moscone, F (2008) The impact of decentralization and inter-territorial interactions on Spanish health expenditure. *Empirical Economics*, 34 (1): 167-184.

Persistence in health limitations: A European comparative analysis

Persistent differences in health by socioeconomic status are one of the key policy issues facing many European countries, where concern exists over the level of inequalities in health and health care use, particularly as a result of the expansion of the European Union and the ageing of its populations. This paper presents an empirical analysis of health dynamics, to address why some individuals experience persistently good health and others experience persistently poor health. This may reflect the nature of health problems, as some illnesses are inherently chronic and long-lasting. These are known as pure dynamic effects or state dependence. However, health problems may be persistent for other reasons: an individual may have individual or socioeconomic characteristics that predispose them to poorer health and that linger over time, such as education, material deprivation, childhood nutrition and environment. Some of these factors may be observable, but others – such as ability, time preference and risk aversion – may be hard to control for (known as unobserved heterogeneity). The importance of regarding health as a dynamic concept has implications for policy development. If there is evidence of significant state dependence, then policy interventions designed to improve health should have long-term lasting effects.

We use the full eight waves of comparable micro-data available in the European Community Household Panel Users Database to explore the relative contributions of state dependence; unobserved heterogeneity; socioeconomic characteristics, in particular, income, education and activity status; and, how these vary across countries. We focus on two binary measures of health limitations, constructed from the answers to the question: 'Are you hampered in your daily activities by any physical or mental health problem, illness or disability?', indicating either any limitation or severe limitation. Dynamic non-linear panel data models are specified and estimated using pooled and random effects probit and logit models together with complementary log-log models.

The obtained partial effects show that state dependence is large and statistically significant in all the countries considered, which remains after controlling for measures of socioeconomic status. For both indicators of health limitations, the largest state dependence estimates are observed for Portugal and Greece, while the smallest estimates correspond to Spain and Italy. Cross-country comparison of results show that relatively high levels of state dependence are generally associated with relatively low levels of unobserved heterogeneity and vice versa. This may

indicate cultural differences in the reporting of health, which may differ systematically across countries.

The results obtained in our analysis highlights the role of educational achievement and job status as the main socioeconomic characteristics that influence the reporting of some kind of limitations. The largest positive effects of education achievement correspond to Portugal, Greece and Spain, while the largest negative effects of economic inactivity correspond to Ireland, Greece and Belgium. This emphasises the need for coordination of inter-sectoral policies aimed at improving health and reducing health inequalities, which has been recognised by most European countries. However, the existence of heterogeneity across countries in the impact of socioeconomic and activity status variables on health indicators suggests that further coordination across sectors and levels of government is required if harmonisation of outcomes is to be achieved.

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Hernández-Quevedo, C, Jones, AM, Rice, N (2008) Persistence in health limitations: A European comparative analysis. *Journal of Health Economics*, 27(6): 1472-1488.

Socio-economic inequalities in obesity are explained by differences in education

The expansion of obesity stands as a major food-related health concern arguably driven by socio-economic factors. However, alongside its prevalence, there is scant evidence on the underlying factors that explain the emergence of socio-economic inequalities in obesity. This paper makes use of evidence from Spain to empirically address the hypothesis of the existence of income-related inequalities in the probability of suffering obesity in Spain using data from 2003.

Findings suggest evidence of income-related inequalities in obesity regardless of the methodological approach employed (Figure 1). Roughly 70 per cent of inequalities in obesity are explained by differences in education, thus, capturing a large share of the income-related inequality. Explanations for this are contentious and could well be attributable to environmental factors. For example, people who finish college spend at least eight more years in the educational system and are therefore more likely to work an environment with people like themselves. Other competing explanations point towards the role of unobserved variables, such as knowledge, knowledge acquisition skills and time preferences. In all cases, government actions to reduce an income gradient in obesity should coordinate several policy areas, including food- and health-related risk communication. Our findings suggest that these policies would be more efficient that income transfers attempting to address inequalities. Hence, rather than the so-called pure 'income effect', we conclude that

socio-economic inequalities in obesity result from the additional influence of other confounding effects, namely education levels.

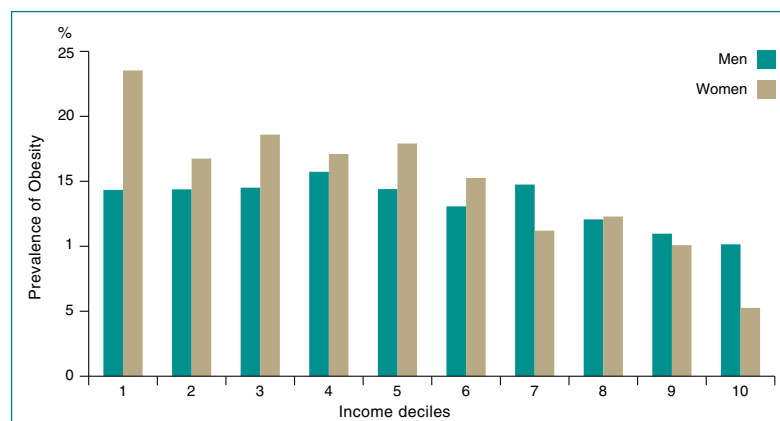
The results also connect to food-related fiscal policy, with regards to the introduction of incentives for healthy diets through market and regulatory mechanisms. Although some research indicates that body mass is negatively associated with the real price of groceries, other evidence questions possible effects of new taxes on the quantity of fat in food products.

However, promoting knowledge on or subsidising healthy lifestyles (eg, physical activity, healthy eating), especially to low income individuals, may well change behaviour toward the consumption of junk food.

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Costa-Font, J, Gil, J (2008) What lies behind socio-economic inequalities in obesity in Spain: A decomposition approach. *Food Policy*, 33(1): 61-73.

Figure 1: Income distribution of obesity by gender



Source: Spanish National Health Survey, 2003.

Competition in off-patent drug markets: Issues, regulation and evidence

In recent years, health insurers have placed a great deal of emphasis on generic medicines, because of their potential to deliver significant savings to overstretched health care budgets due to their lower cost and potential for a more efficient resource allocation.

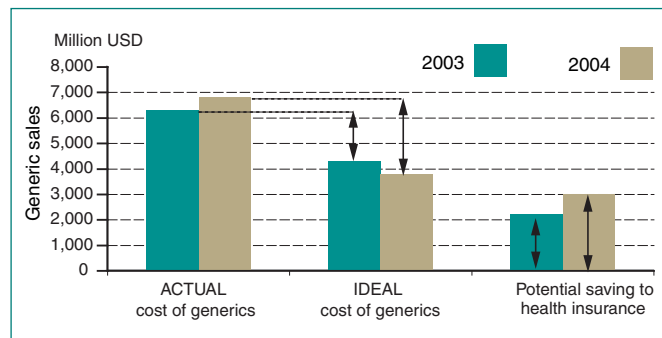
In this paper we use proprietary data across seven countries (UK, USA, Germany, France, Italy, Spain, Canada), and twelve molecules, selected across a wide range of therapeutic categories, over the 2000–2005 period. We endeavour to understand market developments after patent expiry. In particular, we study the overall determinants of generic (price) competition post patent expiry, along with the determinants of generic diffusion, and the impact that pricing and reimbursement regulation and product differentiation have on market structure, diffusion and prices. The data is unique in that it ensures comparability across countries and allows these questions to be explored at the molecule – as well as company-level. The former allows inferences to be made about the brand vs. generic relationship, while the latter takes into account generic market dynamics at individual company level and, therefore, allows inferences to be made about the effect that regulation has within the generic segment. Finally, the paper investigates whether health insurance captures the financial benefits from cheaper generics.

While all study countries seemingly pursue strong generic policies, we find that the level of generic penetration remains low in some (UK, USA, Germany) compared with others (Italy, France and Spain). We also find that, despite the proliferation of generic policies in many countries, prices in the off-patent sector do

not decline as fast as originally thought; that price competition among generics is very poor, and may be attributable to the effect of price regulation; and, that generic penetration can be improved significantly in several countries. The combined result of lower generic prices and higher generic penetration should bring greater savings to health insurance, which currently are not realised (Figure 1). We find that entry into the generic market is positively influenced by regulation – through reference pricing – and opportunities for product differentiation. Although reference pricing encourages entry into the generic market and contributes to price declines, the effect of these price declines is smaller than when the off-patent market is left to operate without market intervention. Finally, elements of product differentiation within generics promote their diffusion, but do not reduce prices.

There are significant implications for health and pharmaceutical policy. First, generic policies need to be pursued with greater rigour and ensure their timely enforcement and continuous evaluation. Second, policymakers may need to review their stance towards reimbursement (price) regulation, particularly reference pricing and evaluate its contribution to

Figure 1: Total effect of efficient generic purchasing in EU-G5, Canada and the USA



creating cost savings over the longer term. Third, in order for financial benefits from genericisation to be maximised, it is important that a switch to lower priced generics occurs early on and that the price gap between branded and generic is maximised as fast as possible. Finally, policymakers need to take into account that product differentiation may occur in the off-patent sector and have a positive effect on generic prices rather than negative.

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Kanavos, P, Costa-Font, J, Seeley, E (2008) Competition in off-patent drug markets: Issues, regulation and evidence. *Economic Policy*; 23(55): 499-544.



Behavioural Economics and Risk

People's attitudes and perception towards nuclear power are anchored in political ideology

The UK government's acknowledgement of nuclear energy's importance as part of a diverse energy policy has been met with the expected public outcry. Criticisms range from concerns about radioactive waste management to nuclear power plant sitting to the vulnerability of nuclear facilities to terrorist attacks. Even in the face of facts stating the relative safety of nuclear energy generation versus other forms of energy generation (eg, coal mining) and against other risk-related contexts, individuals maintain serious concerns about nuclear generation risks relative to other risks (Figure 1).

This study examined the influence of knowledge, self-perceived levels of knowledge ('certainty effect') and political anchoring on determining attitudes towards nuclear power generation and risks perceptions of radioactive waste. Data from a 2005 Eurobarometer survey of UK citizens allowed investigation of whether there is evidence of knowledge, certainty effects and political anchoring playing a determinative role in attitudes and risks perceptions.

We have found that knowledge plays an important effect, although its influence is far from straightforward. While knowledge decreases support for nuclear generation, it increases risk perceptions about waste storage, but not transport. Knowledge only becomes important in determining risk perceptions about waste transport when beliefs are excluded from the model. This finding negates previous literature promoting the importance of information uptake to reduce perceptions of risks and aid individuals in overcoming fears of risks about which they feel uncertain. We posit that the over-reliance of political beliefs to form attitudes about nuclear power and risk perceptions radioactive waste supersedes the traditional role of knowledge in adjusting attitudes.

Perceived knowledge also plays a significant role in nuclear power attitudes as those viewing themselves

as lacking sufficient knowledge seem to be more likely to support nuclear power. While those who feel that they are not informed about nuclear power generation are more likely to support nuclear energy, they are more likely to perceive waste storage and transport as risky.

Similarly to other studies we found that while individuals may have emotional reactions to technologies, attitudes and perceptions about nuclear power and related consequences are largely found to be 'ideological' grounded or 'value-laden.' Finding evidence of political anchoring explains political opposition to nuclear power as influencing an amplification of public risk perceptions about the subject. Coupling this finding with prospect reference theory, one might argue that political figures act to overweigh the risks of new technologies, thus explaining the distance between opinions of nuclear energy experts and lay individuals.

We also find that trust in information sources is a significant determinant of attitude expression in line with previous literature that emphasises trust as the main attitudinal determinant. Trust in the nuclear power industry, international organisations and the media appear important for attitudes, while trust in the EU and international organisations matters for waste storage risks perceptions. This signals the need of strengthening the communication from these sources of the potential effects both in the short and long run associated with nuclear power.

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Costa-Font, J, Rudisill, C, Mossialos, E (2008) Attitudes as an expression of knowledge and 'political anchoring': The case of nuclear power and radioactive waste in the UK. *Risk Analysis*, 28(5):1273-1288.

Optimism and perceptions of new risks

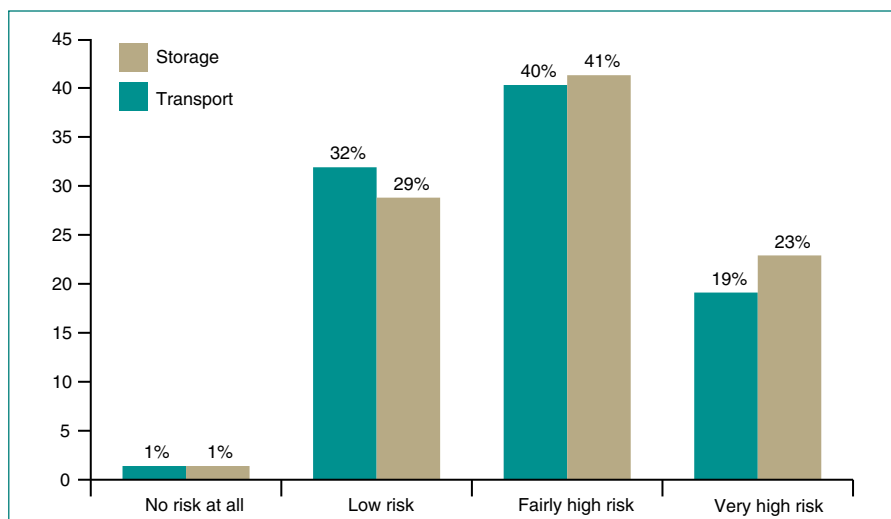
While many risks, especially new ones, are not objectively quantifiable, individuals still form perceptions of risks using incomplete or unclear evidence about the true nature of those risks. In the case of well known risks, such as smoking, individuals perceive risks to be lower for themselves than others, exhibiting 'optimism bias'. Although existing evidence supports optimism bias occurring in the case of risks about which individuals are familiar, evidence does not yet exist to suggest that optimism bias applies for new risks. This paper addresses this question by examining the gap in perceptions of risks individuals have for themselves versus society and the environment, conceptualised as social and/or environmental optimism biases. First, we compare the distribution of risk perceptions about four risks (climate changes, GM food, mobile phone radiation and radioactive waste) with regards to individuals themselves, society and the environment and one technology (genetic testing) with regards to only those risks faced by individuals and society. Because of differences in the way each of these technologies poses varying degrees of risk to the individual and society, we have estimated a measure of optimism regarding each risk. Optimism is defined as the gap between perceptions individuals have about the risks they face themselves and those that society faces as a result of a new technology. Given that there is no objective measure of risk available for these new risks and information about the risks of these technologies is often incongruous, we have adopted a restricted version of optimism, whereby individuals exhibit optimism if they see certain risks as affecting society as a whole more than themselves. After the presence of optimism is identified and measured using survey responses, we then examine the influence of optimism on both risk acceptance and risk-benefit evaluation with regards to these five potential risks.

Findings suggest that social and environmental optimism bias exists especially for risks bringing sizeable benefit to individuals (eg, mobile phone radiation), rather than those more acutely affecting society or the environment (eg, GM food or climate change). Social optimism bias is found to reduce risk perceptions for risks that have received large amounts of media attention, namely climate change and GM food. On the other hand, optimism bias appears to increase risk perceptions about genetic testing.

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Costa-Font, J, Mossialos, E, Rudisill, C (2009) Optimism and the perceptions of new risks. *Journal of Risk Research*; 12(1): 27-41.

Figure 1: Perceptions of risks of nuclear power storage and transport in the UK



Health in developing countries

Wealth, health, HIV and the economics of hope

The LSEAIDS group brings together leading social scientists at LSE to confront the social and economic implication of HIV/AIDS. In this paper Professor Tony Barnett and colleagues consider the critical role of hope in understanding factors affecting HIV transmission.

The association between economic status and HIV infection is not linear and varies between and within different epidemics. The poor may be more susceptible to HIV infection due to lack of education, general poor health and weak access to health services. Conversely, the wealthy may face risks because of their greater mobility and ability to pay for sex. An individual's monetary wealth alone does not explain their susceptibility to HIV infection. Thus, economists have had to turn to non-monetary factors to explain how economics mediates HIV infection.

This paper looks at the potential of hope to explain infection rates. Unlike standard contemporary economic analysis, the study of hope incorporates non-monetary values, and may therefore help fill some of the gaps in our understanding of the factors affecting HIV transmission. We argue that an operationally defined concept of hope may offer new ways of understanding the social epidemiology of HIV/AIDS. Measuring the hope of individuals, as well as groups of individuals, will provide a nuanced understanding of the contextual factors that lead some to risk-taking behaviours.

In this discussion, hope is defined as the ability to adopt realistic plans to achieve future projects. People with hope are less likely to engage in activities in the present that put themselves or their families at future risk. Those without hope, by contrast, place a low value on the future. Without future goals, there is little reason to avoid actions that may cause harm in the future, but do not do so in the present. People may forfeit future gains in favour of present benefits. An individual's perception of what lies ahead can therefore influence HIV infection and prevalence rates. In the case of HIV, risky behaviours, including injecting drug use or unsafe sexual practices, may be more common among those without hope for the future.

In countries affected by HIV/AIDS, surveys of hope may help pinpoint the groups most vulnerable to infection, which can lead to more effective and targeted prevention and treatment efforts. The association with hope implies that a broader approach to HIV prevention is needed – one that addresses the wide range of structural/contextual factors that promote or reduce an individual's hope for the future. At present, most interventions aimed at preventing HIV infection focus on altering individual behaviour, such as promotion of condom use and abstinence. Such interventions rarely take account of the broader, structural factors that determine such behaviours.

Importantly, past research has shown that individuals and communities can identify impediments to their hope and thereby engage in the improvement of their health and their societies.

More research is needed to determine the strength of the links from hope to HIV infection. Hope will not explain the relationship between economics and HIV infection in all population groups – the early infections among men who have sex with men in the US, for example, often occurred amid thriving, energetic communities. It does, however, offer a possible explanation for the links between environment and risk behaviour. Further study of hope may provide information on what factors lead some individuals to undertake risky behaviours, with important implications for policy.

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Barnett, T, Weston, M (2008) Health, wealth, HIV and the economics of hope. *AIDS*, 22(Suppl 2): S27-S34.

Do community factors affect Caesarean section rates in developing countries?

Caesarean section (c-section) rates have risen dramatically in several developing countries, especially in Latin America and South Asia (Figure 1). This raises a range of concerns about the use of c-section for non-emergency cases, not least the progressive shift of resources to non-essential medical interventions in resource-poor settings. There are also rising concerns about the additional health risks to mothers and newborns following c-section. Little systematic analysis exists on how different countries compare in terms of the factors that really influence climbing c-section rates. In particular, it is not clear whether high elective c-section rates are driven by doctors or by women's decisions. Additionally, more needs to be done on how network interaction with peers and relatives has an impact on women's willingness to plan for a c-section. Using random effects logistic regression, Tiziana Leone and colleagues from the University of Southampton analysed the institutional, socio-economic and community factors that influence c-sections in six countries: Bangladesh, Colombia, Dominican Republic, Egypt, Morocco and Vietnam. The aim of this research was to shed more light into the factors that can help us to understand whether it is a supply or demand driven 'epidemic'.

An analysis of over 20,000 births shows that wealth is a risk factor, but not as strongly as expected and it is significant in only three of the six countries analysed. Low parity, increasing age and increasing number of

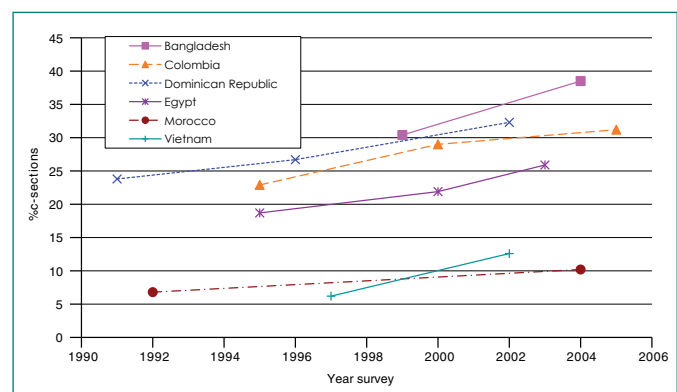
antenatal visits are some of the most significant risk factors. However, the most interesting finding of this study is the negative effect that women's exchange of information with friends and family on reproductive health matters has on the risk of having a c-section. This result is indicative of a need to explore more in depth the possibility of tackling the demand side of unnecessary c-section with a community based approach. It is feasible to think that women that have had a c-section and have experienced associated side-effects will discourage other peers from undergoing one. However, it is also possible that strong support

networks help in having a healthier delivery. The authors, along with other LSE colleagues, are working on new research to better understand the supply and demand interaction of caesarean deliveries.

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Leone, T, Padmadas, S, and Matthews, Z (2008) Socio-economic and network factors of c-sections in developing countries: An analysis of 6 countries. *Social Science and Medicine*, 67(8): 1236-1246.

Figure 1: Percentage of c-section rates in selected countries from the last three Demographic and Health Surveys



Condom use among the Masai

To many Maasai pastoralists in Tanzania, none of the methods most commonly proposed to prevent the spread of HIV are acceptable. Sexual abstinence, fidelity and condom use are not acceptable in a culture that prizes fertility and believes the flow of semen is essential for a girl's body to mature.

This study examined the sexual norms and behaviours of the Maasai in order to understand why condom use was low in the area. Maasai male youths undergo circumcision and are then expected to enter into sexual relationships with pre-pubescent unmarried girls. In theory, the girls choose their sexual partners; however, in reality they are put under pressure by older women or young men and often have little choice. As a result, girls as young as eight who attend clinics have been found to have sexually transmitted infections. The early age of sexual activity, together with high fertility levels, means mother-to-child HIV infection is a serious concern.

The study found that information about condoms was limited and was in Swahili, not in the local language, Maa. Local people also had little access to

condoms. For example, condoms were predominately sold in the bars of tourist hotels, which locals are not allowed to use.

In particular, the study showed that:

- Everyone interviewed had heard of HIV. However, the word used to refer to HIV, 'bitia', means 'to shrink' in the Maa language and covers various different diseases that cause weight loss.
- While 86 per cent had heard of condoms, only 17 per cent knew how to use them.
- Only 15 per cent knew that using a condom was a way of avoiding HIV infection.
- Condoms were viewed as not effective, because the fluid would escape, the condom would be worn incorrectly, or it would burst and cause the woman health problems.
- Young men and young girls would not use condoms, because they believed it is necessary for men to give semen to women.

- There is a perception that husbands and wives could not use condoms, as the purpose of sex was procreation.

- Condoms were considered to be alien. They were described as 'Swahili', rather than 'Maasai'.

New technologies in the fight against HIV are being developed, which could be more culturally acceptable to the Maasai. In addition, microbicides are being developed for women to insert into the vagina. These microbicides, which destroy disease-carrying bacteria without harming sperm, would benefit societies where semen and fertility are highly valued.

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Coast, E (2007) Wasting semen: Context and condom use among the Maasai. *Culture, Health & Sexuality*, 9(4): 387-401.

Integrated health information systems in Tanzania: Experience and challenge

Issues of health service provision are central to any discussion of development. International agencies (eg, UNICEF, WHO) have identified diseases, such as malaria, TB and HIV/AIDS, as major obstacles to poverty alleviation. Health care provision in developing countries has traditionally been organised as standalone vertical programmes to address specific health systems. However, it was recognised that these separate programmes led to duplication of funding, wastage of resources, and lack of coordination, in terms of controlling for specific diseases. This led to a global trend backed by the World Bank and the WHO towards integrating stand-alone programmes by delivering health care to local communities through primary health centres. A key role in this approach was delegated to the development of health information systems to be implemented at the district level to improve the allocation of resources and establishing priorities at the local level.

Apart from isolated experiments, efforts to introduce integrated health information systems at the local level have not had any substantial and long-term impact, as shown through many recent studies. The impetus to introduce these systems has been driven by a managerial rationale of efficiency, which has not taken into account the intrinsically political nature of the health sector at both macro- and micro-levels. Our paper focuses on Tanzania, where a health management information system (HMIS) was implemented in 1994 to improve the efficiency and effectiveness of health planning and monitoring. However, six years since its inception, the HMIS is still not delivering on its promise. While data is, at best, merely collected and reported upwards within the health administration, there has been little improvement in health status at

the local level. Our findings show that at the macro level, individual donor agencies have intervened and appropriated the reform agenda in a more or less piecemeal fashion without any integration in terms of strategy or vision. At the micro level, there are social and political forces that influence the day-to-day provision of health care given the situation of inadequate provision and distribution of resources.

We find that the current impediments in health sector reform cannot be overcome simply through management reform aimed at integrating data sets of various vertical programmes at the local level. We suggest instead that the concept of integration be broadened to include not only integration of data and management procedures, but also integration of administrative, sociological and epidemiological priorities. In terms of administrative priorities, there is a need to provide the district with resources to strengthen

its capacity to collect and analyse locally relevant data. With regards to sociological priorities, new systems of social inclusion need to be established at the village level through committees that address a range of issues related to health, such as sanitation, income poverty and basic education. For epidemiological issues, the HMIS needs to be integrated with analytical tools for assessing disease burdens and for calculating resource allocation.

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Smith, M, Madon, S, Anifalaje, A, Lazarro-Malecela, M, Michael, E (2008) Integrated health information systems in Tanzania: Experience and challenge. *EJISDC*, 33(1): 1-21.



Supporting people with AIDS and their carers in rural South Africa: Possibilities and challenges

AIDS is currently the chief cause of death and illness in sub-Saharan Africa. Rural areas, where people often have limited access to health and welfare services, carry a significant weight of the overall AIDS burden. This paper presents a case study of local community responses to HIV/AIDS in Entabeni, a deep rural community in South Africa, where 43 per cent of pregnant women are HIV positive, and where HIV/AIDS is heavily stigmatised.

The research sought to identify key local HIV/AIDS-relevant actors and agencies in civil society, the public and the private sectors. It did so in the interests of furthering understandings of how social environments support or hinder the coping ability of people dying of AIDS and their carers, and how community strengths and resources might best be identified and supported in areas where external help is minimal.

Aside from care and support from families and neighbours, the main response to AIDS in Entabeni was informal home-based care by local volunteers, nearly all unemployed, untrained and unpaid women who visited households providing basic health education (eg, hygiene, water purification) as well as home-based care for the sick. Two lone missionaries (one from central Africa and one from Norway) also provided care and support, working in self-funded small-scale organisations to build and staff volunteer-run hospices and to provide food and school fees for AIDS orphans.

These forms of support were undermined by counter-productive responses from other local constituencies. Local churches often perpetuated AIDS stigma and demonised condoms. Many traditional healers diagnosed AIDS as the result of the bewitching of a patient by their enemies, providing a convenient smokescreen for residents in denial of the existence of AIDS. Patriarchal local leaders were suspicious of any efforts to empower youth and women (a precondition for these groups to take better control of their sexual health). Private sector agencies in the wider region tended to offer small scale patchy support to AIDS-affected communities close to workplaces, but their reach seldom extended to remote rural areas such as Entabeni.

Under-resourced public sector health and welfare agencies battled to respond appropriately, in rigid and hierarchically structured organisations that lacked the flexibility to tailor their responses to local needs. Most staff were trained in traditional one-to-one methods of health care delivery and welfare grant allocation, which could only reach a limited number of people given resource constraints. Unfamiliar with community outreach strategies, they lacked the skills to work with local people to develop more effective grassroots responses to AIDS. Furthermore, formal public sector agencies were located some geographical distance away from Entabeni, and often hard to access in a context where roads were poor and few could afford costly transport expenses.

The paper discusses ways in which existing and latent networks might best be strengthened and supported, with particular emphasis on the need to target and mobilise local leaders, faith-based organisations, schools and traditional healers to provide a more health-enabling social environment. Dissemination of these research findings to Entabeni community members has led to the development of an on-going community-based intervention (run by an NGO co-directed by the authors of this paper and local volunteers) to train and support health volunteers, and to build the capacity of the health and welfare sector to offer more accessible support and assistance to both the volunteers and the local residents, using an 'empowerment via participation and partnerships' framework.

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Barriers in the mind: Promoting an economic case for mental health in low- and middle-income countries

As part of an ongoing area of work concerning the development of mental health policy and practice in low and middle-income countries, David McDaid and colleagues provide an analysis of the challenges faced when making the case for investment in mental health. Published in *World Psychiatry* and conducted in partnership with the UK-based non-governmental organisation (NGO) Basic Needs, the paper considers how economic evidence can be used to help strengthen this case.

One in four individuals may experience a mental health problem during their lifetimes. The consequences of such poor mental health include increased risks of physical health problems, premature mortality, homelessness, unemployment, contact with the justice system and family strain. All of these factors, coupled with the increase in knowledge of effective interventions, have contributed to a marked increase in mental health actions by policymakers in high-income countries, but the picture in many other parts of the world is less encouraging.

The burden of mental illness is on the increase, projected by the WHO to rise from 12 per cent to approximately 15 per cent of total global disease burden by 2020, much of this increase being in the

developing world. Yet countries accounting for more than two billion people spend less than 1 per cent of their health care budgets on mental health, and 20 per cent do not fund any essential basic pharmaceutical therapies. Meantime policy attention and external resources from donor governments and philanthropic organisations are still largely directed at communicable diseases.

Only a handful of studies have estimated the costs of poor mental health outside the developed world. However, work in India, Kenya, Ethiopia and Zimbabwe all indicate that costs are substantial and fall on many sectors. While there are few economic evaluations of interventions for mental health problems in these countries, those that exist suggest that cost effective actions can be undertaken even in the poorest of countries.

Making the case for more investment requires a multi-dimensional strategy. Key challenges to overcome include the absence of epidemiological data for needs based planning and limited training in primary care to diagnose mental disorders. Economic analysis can play a significant role. It can consider the extent to which mental health interventions may have potential economic benefits for communicable disease,

as already demonstrated in the case of HIV/AIDS. It can also assess interventions that address risk factors for poor mental health, for instance better access to fair micro-credit schemes. NGO's can play a vital role in implementing policy and practice. Not only can they help develop and sustain community-based initiatives, but by working in partnership with government and making economic arguments, as for instance in the case of Basic Needs in Uganda and Sri Lanka, they can also act as a catalyst for greater governmental intervention.

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McDaid, D, Knapp, M, Raja, S (2008) Barriers in the mind: promoting an economic case for mental health in low and middle income countries. *World Psychiatry*, 7: 79-86.

Demography and population

Albania: Trends and patterns, proximate determinants and policies of fertility change

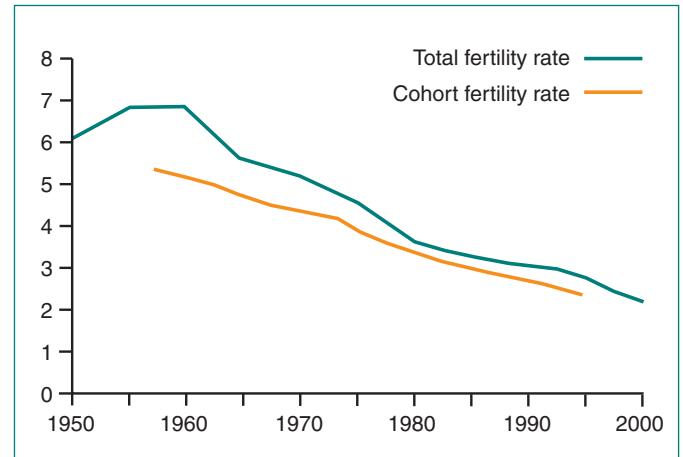
For a very long time, Albania has had one of the highest levels of fertility in Europe. In 2002, the total fertility rate was 2.2 children per woman, placing Albania as the country with the highest fertility rate in Europe. Despite this current, relatively high level, the country has experienced a rapid reduction in fertility in the last 50 years: the rate has dropped from seven children per woman to 2.2 (Figure 1). The reduction has taken place in the absence of contraception and abortion, thus pointing to the importance of investments in the social agenda during the communist regime, which produced policies that had an indirect effect on fertility. The paper uses individual and aggregate data to assess the importance of different factors to the reduction of fertility.

There are a number of factors that have affected fertility rates in Albania over the past 50 years. The first issue relates to the interplay between traditional and modern values with regards to demographic behaviour in Albania, such as marriage patterns and the use of birth control. Secondly, rates have been influenced by a mix of implicit and explicit policies in Albania, notably during the communist period through to the present day. For example, there was no explicit population policy in Albania during the period of communist rule until 1990: ideologically, the government linked population growth to economic growth, and since there was already a high-fertility environment, there was no need for any population policy to help increase the level of fertility, as happened in some Eastern European countries. On the one hand, the government implemented a

number of policies that were aimed at reducing infant and maternal mortality, which indirectly affected the changes in fertility in the country. The significant reduction of infant mortality in a period of 50 years had a strong effect in reducing the level of fertility. On the other hand, the government implemented a considerable number of policies affecting social changes in the country, such as educational reform and, in particular, female education reform, which had the most significant effect in reducing fertility. Equal and full employment policies were again policies that affected the level of fertility in the country and these were followed by complementary policies to help mothers, such as a system of government-sponsored nurseries and kindergartens. All of these policies created a more emancipated environment for women in which to make their own decision with regard to family formation, and had an indirect effect in reducing fertility.

The social and demographic settings for further reductions in fertility in Albania have been present since 1990. Contraception and abortion have been legal and

Figure 1: Period and cohort fertility rates, Albania (1950-2000)



available since the early 1990s, but knowledge of their use is still not widespread in the country. This has been determined to a large extent by the interplay between the traditional and modern norms of Albanian society, and will likely influence future fertility levels.

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Family and kinship networks in the context of ageing societies

Populations in Europe passed through a Demographic Transition with declines in fertility and mortality often in the late Nineteenth century. In the early 1960s a 'Second Demographic Transition' occurred involving a substantial reduction in marriage, and increases in cohabitation, partnership breakdown and in the proportion of births occurring outside. These changes may mean that certain types of kin became more common, but others less so. This research uses a micro simulation model to investigate how the patterns of kin, such as partners, children, sibs, grandparents etc of people in Britain changed as they passed through these transitions in the period 1875-2000.

Marriage rates were particularly low in the 1920s and 1930s, but in the period from 1945 to about 1970 many countries experienced an unprecedented marriage boom and a subsequent substantial decline, not offset by increased cohabitation. The highest proportions in a partnership, marital or cohabiting, over the whole two period, were those in their mid-30s around 1975, but recently having a living former partner is becoming much more common, so that by 2000 about 20 per cent of those aged between the late 20s and mid-60s have a living former partner (married or cohabitee).

Parent-child patterns are changing: the median age for having at least one living parent increased as nearly much in the last 25 years (from 49 to 55 years) as in the previous century (from about 43 to 49 years). In the late Nineteenth and early Twentieth Centuries, a child aged under five was likely to have an average of just over two grandparents alive (mainly grandmothers), but this had risen to about 3.5 by 2000, and children today have an average of at least three living grandparents for most of their childhood. The implications of mortality improvement for adults having grandparents alive are substantial: up to 1950 half of those at age 20 had no living grandparent, whereas in 2000, this point was not reached until after age 30.

Even in 1950, people aged 85 and over had around eight ever-born sibs on average, and even today, those aged 85 and over have about twice as many siblings as those aged now about 60. Although the childhood experiences of these groups over this 125-year period, as reflected in ever-born sibship size are so different, the adult experiences, as reflected in living sibship size, are much more similar especially from about age 65 when all cohorts have an average of about two living sibs, declining to about one at ages 85 and over.

The changing fertility and mortality patterns associated with the first demographic transition have effects may take up to a century to work through the kinship universe. The changing demographic regime, which causes the ageing of populations, will have two main impacts on kin relations, apart from the issue of availability of kin. The first is that there will be an ageing of generational relationships: events that formerly occurred early in life are being pushed back at present, such as the experience of one's parents' deaths. The second is that patterns of repartnering will lead to more partial relationships involving step and supplanted parents, half sibs, former partners and step and supplanted children, and society will need to adjust to these emerging patterns.

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Murphy, M (forthcoming) Family and kinship networks in the context of ageing societies. *Continuity and Change*.

Who keeps children alive? A review of the effects of kin on child survival

Why fertility declines, and why it has declined to such low levels in certain parts of the world, is a puzzle. This puzzle remains unsolved despite the importance to social policymakers of understanding the factors that affect population ageing and population growth. A recent hypothesis has suggested that changes in kin networks may provide part of the explanation for changing reproductive behaviour. As countries modernise, kin networks break down and association with non-relatives becomes more common. This reduces both the practical support available to mothers in raising children and affects reproductive norms, as kin tend to express more pro-natal attitudes than non-kin.

This hypothesis has so far received little empirical testing. Evidence for this hypothesis would constitute, firstly, an indication that kin are important in maintaining fertility levels in high fertility societies; and secondly, that this help declines as societies move through the fertility transition. This paper focuses on the first part of the problem: whether relatives do support mothers in raising children in high fertility societies. In addition, this paper investigates the role of fathers in supporting reproduction in such societies.

This paper reviewed the evidence for whether the presence of relatives affects child survival, which is one (fairly definitive) outcome measure of child well-being. We found 45 studies which have investigated whether the presence of certain relatives affects the probability of child survival. First, we looked at whether the presence of the mother affects child survival, not because we were interested in determining whether the presence of the mother affects child survival –

clearly it does – but because we wanted to determine whether children can survive the loss of the mother, and whether the effect of mother wanes as the child ages. We found evidence from 28 studies that have investigated this effect. Indeed, it is possible for even relatively young children to survive the loss of the mother, and that the effect of the mother does wane quickly, with some studies showing good survival of children even as young as two or three years old without mothers. Clearly such young children are not entirely dependent of adult help, which suggests that other relatives are helping mothers out and stepping in to care for children should they lose their mothers. Our review suggests that this help is unlikely to come from the father; rarely did the loss of the father affect child survival rates (Figure 1). Grandmothers, particularly maternal grandmothers, are much more beneficial. In the majority of cases, the presence of the maternal grandmother improved child survival rates, and in about

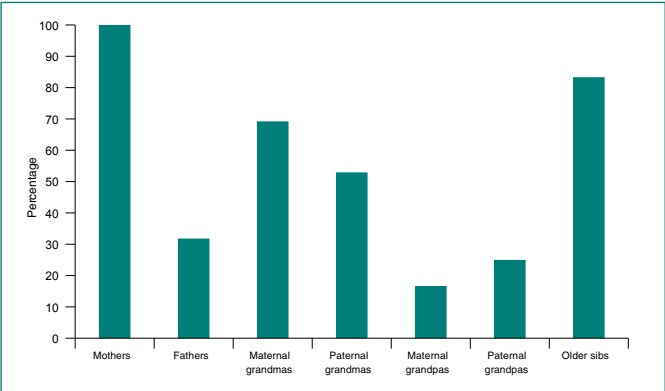
half the populations studied, the paternal grandmother improved child survival. Also important appear to be elder siblings of the child, with the majority of studies which have looked at elder siblings finding beneficial effects of such relatives.

This review provides clear evidence that kin are important in helping women to support child-bearing, and that grandmothers are particularly important in this endeavour. Despite the focus of much family policy on fathers, this research suggests that the importance of the father, and the role that fathers actually play in their children’s lives, needs much more careful study.

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Sear, R, Mace, R (2008) Who keeps children alive? A review of the effects of kin on child survival. *Evolution and Human Behavior*, 29(1): 1-18.

Figure 1: Percentage of studies in which the presence of each relative improves child survival



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The first three books planned for the series are outlined below. For further information contact Elias Mossialos, e.a.mossialos@lse.ac.uk

Performance Measurement for Health System Improvement: Experiences, Challenges and Prospects

Edited by

Peter C Smith (Centre for Health Economics, University of York)

Elias Mossialos (Brian Abel-Smith Professor of Health Policy, and Director, LSE Health, The London School of Economics and Political Science and Co-Director, European Observatory on Health Systems and Policies)

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Information is crucial to the delivery of efficient and effective health care. Not only does it serve as a fundamental resource for securing appropriate treatment and good outcomes for patients, it is a key resource for securing managerial, political and democratic control of the health system. The last 25 years has seen astonishing developments in the scope, nature and timeliness of performance data available in all developed health systems. Yet, there remain many unresolved discussions on the collection of performance data, how to analyse and report it, and on its validity and usefulness as part of an integrated framework of regulation, accountability and health system improvement. This book summarises some of the principal themes emerging in the performance measurement debate, examining experience to date, and offering guidance on future research and policy priorities. It provides a comprehensive policy discussion covering the opportunities and challenges associated with performance measurement; the various dimensions and levels of health system

performance; the analytical tools needed to implement successful performance measurement; the design and implementation of performance measurement systems; and the implications of performance measurement for policymakers, politicians, regulators, and others charged with the governance of health systems.

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Smith, PC, Mossialos, EA, Leatherman, S, Papanicolas, I (eds) (forthcoming 2009) *Performance Measurement for Health System Improvement: Experiences, Challenges and Prospects*. Cambridge: Cambridge University Press.

Private Health Insurance and Medical Savings Accounts: Lessons from International Experience

Edited by

Sarah Thomson (Research Fellow, LSE Health, London School of Economics and Political Science, and European Observatory on Health Systems and Policies)

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For equity and efficiency reasons, many countries aspire to provide publicly-financed health care on a universal basis. However, levels of public finance are often low in poorer countries and may be perceived as unsustainably high in richer countries, prompting interest in private forms of pre-payment. In recent years the role of private health insurance and medical savings accounts (MSAs) in financing health care has emerged as a key policy issue in different parts of the world. This book focuses on the history, politics and performance of markets for private health insurance and MSAs in a wide range of countries. It examines the origins and development of these markets, their relationship with the publicly-financed part of the health care system and the evolution and effects of public policy. Using a country case study approach, the aim is to draw policy lessons by considering financing mechanisms in the context in which they are situated. As financing mechanisms are functions of historical, political and institutional factors, an understanding of context can help to explain why markets for private health insurance and MSAs exist in a particular form, behave in particular ways and result in particular outcomes.

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Thomson, S, Mossialos, E, Evans, RG (eds) (forthcoming 2009) *Private Health Insurance and Medical Savings Accounts: Lessons from International Experience*. Cambridge: Cambridge University Press.

Health Systems Governance in Europe: The Role of EU Law and Policy

Edited by

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Commentators increasingly have highlighted that there is a dissonance in the European approach to health policy. Within the European Union, the Treaties stipulate healthcare as an area of exclusive Member State authority, but issues pertaining to healthcare financing, delivery and provision are affected by other elements of EU policy, particularly via the Single European Market. These impacts have resulted in a growing role for the European Court of Justice in setting precedents, and in turn, have fed into a tension with the social solidarity values that underpin many national health care systems.

What and where are these impacts? What are the emergent tensions? What are the results for national policymakers in Europe and their responses? These are among the questions addressed in this volume. In analysing key thematic and sector issues, and drawing on policy and legal expertise, the book provides not only a comprehensive and topical overview, but a multidisciplinary analysis of developments related to EU law and policies that have an impact on national health care systems within Europe.

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Mossialos, EA, Permanand, G, Baeten, R, Hervey, T (eds) (forthcoming 2009) *Health Systems Governance in Europe: The Role of EU Law and Policy*. Cambridge: Cambridge University Press.

The Economics of New Health Technologies: Incentives, Organisation, and Financing

Joan Costa-Font (Senior Research Fellow and Lecturer, Health and Social Care Department, London School of Economics and Political Science)

Christophe Courbage (Director of Research, The Geneva Association – International Association for the Study of Insurance Economics; Lecturer in Health Economics, Institute of Health Economics and Management, University of Lausanne, Switzerland)

Alistair McGuire (Professor of Health Economics and Health, Department of Social Policy, London School of Economics and Political Science)

Technological change in health care has led to improvements in health services and the health status of populations. It is also pinpointed as the main driver of healthcare expenditure. Although offering remarkable benefits, changes in technology are costly and often entail significant financial, as well as physical or social, risks. These costs and benefits need to be balanced out within the wider health care sector environment of government regulations, insurance contracts, reimbursement schemes, and individuals' decisions to use and consume certain technologies. With this in mind, this book provides a detailed definition of technological change as applied to the health sector; identifies drivers of innovation in several healthcare areas; presents existing mechanisms and processes for ensuring efficient development and use of medical technologies; and, analyses the impact of advances in medical technology on health, healthcare expenditure, and health insurance. This book is relevant to those in health economics and policy, and serves as an important resource for practitioners in both the public and private sectors.

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Costa-Font, J, Courbage, C, McGuire, A (eds) (forthcoming August 2009) *The Economics of New Health Technologies: Incentives, Organization and Financing*. Oxford: Oxford University Press.

Politics of European Union Health Policy

That European Union (EU) health policies exist is undeniable. That EU health policies matter, whether by regulating working hours or putting waiting lists under pressure, is no longer debatable. But all that means is that the political and intellectual questions we now face are more challenging: what is the EU's health policy trajectory, and what would alter it? Who and what can ensure that EU health policy 'works' – improving the health and solidarity of European citizens, while respecting the value in member state and regional experiments? Who and what can ensure that the constitutional change involved in creating an EU power where there was none is compatible with other constitutional values, such as the power and autonomy of regional governments in places like Scotland and Catalonia?

This book answers these questions in the first systematic exploration of the politics and policy-making processes in EU health policies. It draws on original interviews and

other research in the EU and four member states, in particular, as well as existing political science literature of European politics. It first examines the EU in light of the often-heard claims that it is a simple free trade zone that causes 'races to the bottom' and puts welfare states under pressure, and equally common claims that it is the avatar of a 'European Social Model'. Both are misleading, as the real EU is a regulatory machine with weak social policy powers that subjects member states and citizens to its regulations. Those regulations are insufficient to create a European Social Model, sufficient to block the worst kinds of deregulation – and more than sufficient to make the EU a major strategic challenge for health systems.

However, influencing the EU is by no means easy. Its institutional design makes it a challenge to influence or constrain EU institutions – as shown by the fact that if EU member states or citizens had been asked, there would be almost no EU health policies. A review of EU institutions shows how its Court and Commission are capable of setting political agendas and expanding the remit of EU law regardless of whether or not they have much support. The long list of policies that are reshaping health systems in the EU shows that they have been at work. Beyond those, Europeanization has further unintended effects; for example, the power of regional governments, such as Scotland or Wales, is constrained by EU law that they have difficulty influencing.

So how do member states, stakeholders, and citizens gain control of EU health policy? The rest of the book examines the policy-making process, which arguably starts with lobbies. Brussels is the second most-lobbied city in the world after Washington DC, but health lobbies are still in formation. The rules of EU politics shape their work, but there are few capable EU health lobbyists because few professional and other organisations have adjusted to the reality that EU politics affects them and can be influenced by them. Even for those who do not like lobbying, it is what works in EU politics, and a chapter describes the health lobbies and the strategies and pitfalls they face.

But lobbies are not all; after the EU institutions themselves, the member states are unquestionably the most powerful players in the EU. The rest of the book explains how France, Germany, the UK and Spain organise to influence EU health policies. Their approaches differ, as they differ in the key relevant institutions: their constitutions, public administration, model of EU politics, health systems and health ministries. One of the surprises that emerge is the importance in the EU of health ministries that are often weak and not set up to influence EU policy. The different approaches of the various member states, and their different effectiveness, reflect these deeply entrenched and different institutions, which uncomfortably suggest that weakness in EU policymaking is a solution to a different, domestic, problem.

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Greer, SL (2009) *The Politics of European Union Health Policy*. Buckingham: Open University Press.

The Use of Key Figures and its Impact on Activity – The Case of a Hospital

Diagnosis Related Group (DRG)-systems are provider payment systems that have been introduced as a funding method in many countries. This has led to the use of these systems as a management tool at hospital and clinical-unit levels. What is the impact of DRG-systems on healthcare? Do they enable managerial decision making and increase efficiency? Are they used mostly decoupled from clinical practice? Are they a threat to quality of care? Do they inevitably lead to gaming? This book analyses these questions from an activity-based perspective, with a focus on the micro-processes of how DRG-systems are used to manage care at hospital- and clinical-unit levels and how this impacts healthcare.



The author argues that these phenomena should not be perceived in a mechanistic way where, for example, DRG-use within an organisation is entirely decoupled from activities whereas, in another entity, it is coupled with activities. Rather, such phenomena may be observed within the same organisation and involving the same staff, overlapping or even happening at the same time. Initially, health care professionals (clinicians, nurses, managers) had intended to integrate DRG-systems within health care activity, but achieving this was not straightforward. Often, professionals were unsure of how to proceed, while the outcome of the action taken did not always correspond to the initial intention. The integration of DRG-systems within healthcare practice was not a straightforward process, but a highly complex task.

In some situations, the DRG-system could not be integrated in meaningful ways. In these situations, DRG-systems were experienced as a bureaucratic constraint or even as machinery which produced undesired effects such as gaming. Managerial objectives became the primary objective of healthcare. Initially, professionals had no intention of gaming, but eventually saw themselves as the victims of perverse effects: they had to game, even if they did not want to, as this course of action was dictated by the internal logic of the system. In turn, their perception of themselves as victims added to their feelings of hostility towards and frustration about DRG-systems. Lack of dialogue, time and resources, strict top-down management, pressure for short-term results and early stage of the tool-appropriation process were linked with these situations.

In other situations, health care professionals could integrate DRG-systems in a meaningful way, where the focus was on healthcare and not on attaining managerial objectives. DRG-systems were means to reflect on and develop healthcare. This transformation of DRG-systems into instruments for healthcare activity is an inherently situated and interpretive process involving multiple collective inquiries into health care.

Based on an activity-based, tool-use theory, drawing on Vygotski's theory of mediated action and Cassirer's philosophy, it is suggested that DRG-systems do not determine activity, but mediate human sense-making. How to integrate DRG-systems within healthcare is not given – it is healthcare professionals who have to find meaningful ways to integrate these systems. A

lack of dialogue between decision makers at policy-, hospital- and clinical-unit levels and the pressure for short-term results are major obstacles for an effective use of DRG-systems.

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Kern, A (2008) *The Use of Key Figures and Its Impact on Activity: The Case of A Hospital*. Frankfurt: Peter Lang.

Policy Reviews

Members of LSE Health and work undertaken contribute directly to advancements in international and national health policy.

Finnish drug regulation needs overhaul finds LSE review

Facing rising costs pressures from pharmaceutical expenditure, the Finnish government decided to review its system of pharmaceutical regulation in 2006. Two emerging facts highlighted the need for reform: pharmaceutical expenditure as a share of total health expenditure ranked second among OECD countries (16.4 per cent) in 2004; and, between 1993 and 2004, the country had the highest annual growth rate in pharmaceutical expenditure among all OECD countries (5.4 per cent).

The government review identified the need for an external expert review. Following a request made by the Finnish Ministry of Social Affairs and Health, Elias Mossialos and Divya Srivastava at LSE Health carried out a policy review of the Finnish pharmaceutical regulatory system.

The review examined the pharmaceutical policy environment from a health systems perspective, because the complexities of the system warranted a comprehensive approach. The authors considered the context of this environment with respect to policy implications of both supply and demand-side policies, including the regulatory environment; actors in the provision of services; expenditure patterns; implications for patients; prescribing trends, consumption patterns; price trends; and, information technology. Interviews with key stakeholders involved in supply- and demand-related policies were carried out and provided useful insights into the current policy context.

The review identified a number of problems with the current system, including:

- High levels of prescribing many medicines to the elderly, which increases the risk of adverse reactions to drugs.
- Irrational prescribing and over prescribing, particularly in institutional settings.
- High level of user charges places a disproportionate burden on patients, which could affect access and quality of care.
- Lack of transparency in pricing and reimbursement decisions.
- Poor capacity to assess therapeutic value and cost effectiveness of medicine.

Yet despite the challenges within a very developed system of pharmaceutical regulation, the report recommends practical solutions to strengthen the institutional environment and improve the development of pharmacotherapy practices, which include:

- Capacity building, particularly in health economics and clinical pharmacology.
- Stronger incentives for doctors and pharmacists in prescribing and dispensing appropriate and good quality medicines.
- Greater coordination between regulatory authorities.
- Increased information sharing for implementation of policies.
- Policies to consider the current challenge of the two public streams of pharmaceutical financing (social health insurance and municipalities).

The report offers a range of views from an international perspective and it is intended that the study might stimulate further debate on the continuing development of pharmaceutical policies.

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Mossialos, EA, Srivastava, D (2008) *Pharmaceutical Policies in Finland: Challenges and Opportunities*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies; Ministry of Social Affairs and Health, Finland.

Incentives for preventive health care

Individual behaviours contribute significantly to the major sources of morbidity and mortality in our society, including cancer, heart disease, stroke, and diabetes. Although the relationship between individuals' behaviours and the factors that underlie them is complex, we do know that economic incentives can play an important role in understanding behavioural responses.

Identifying interventions that improve health and well-being is the remit of Health England, a national reference group that was established by the Department of Health in early 2007 to report in early 2009. To inform Health England's work, Julian Le Grand and Divya Srivastava at LSE Health undertook a review of economic incentives that could be designed for preventive care-related policies.

The review identified what is known about economic incentive schemes and also considered the potential role of agencies involved in policy that directly or indirectly affects health in these areas. The authors adopted a broad approach, investigating schemes targeted at NHS commissioners, other government agencies, providers, employers and individuals. Five criteria were applied to identify the relative strengths and weaknesses of different schemes: their effectiveness, their cost relative to effectiveness, their impact on equity, their feasibility and their impact on individual and local autonomy.

A summary of the performance of the schemes against the criteria is presented in Table 1. This suggests that the following do well:

- Central government support via *matching grants to commissioners* (PCTs and Practice-Based Commissioners) who fund health promoting or disease prevention programmes.
- *Direct payments* or other subsidies to individuals to engage in health promoting activities.
- Taxes on unhealthy behaviours.

However, other ideas are also well worth considering:

- *Libertarian paternalist policies* also score well on all the criteria, but the scores are more speculative.
- If measures for obtaining long-term health gain can be defined as investment in the stock of health or human capital, then the *PCT capital budget* can be a source of funds. If defining preventive health care this way infringes conventional accounting rules, this may score low on feasibility; but well everywhere else.

- Influencing GPs by adapting the *Quality Outcomes Framework* also scores well on most criteria, but low on feasibility.
- Ring-fenced allocations to PCTs or changing the surplus rules for Practice Based Commissioning* do not score exceptionally well, but would be desirable on other grounds, such as low administrative cost and feasibility. Schemes with local authorities under *Local Area Agreements* to target vulnerable groups do well

on the equity criterion, but their effectiveness depends heavily on the overall effectiveness of the underlying partnerships. In secondary care, *Payment By Results* could encourage providers to engage in preventive services, but under current institutional arrangements, probably only to undertake secondary prevention.

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Table 1: Economic Incentive Schemes: Criteria for assessment

Scheme	Effectiveness	Low cost	Equity	Feasibility	Local or individual autonomy	Total score (unweighted)	Total score (weighted)
PCT formula funding with ring fencing	4	4	3	4	1	17	21
PCT formula funding without ring fencing	2	4	3	5	4	18	20
Matching grants to commissioners	5	5	4	3	5	22	27
Human capital investment rules	4	5	3	1	4	17	21
PBC surplus rules	1	4	1	4	5	16	17
GP and QOF	5	2	3	1	4	16	21
Pharmacists	4	2	3	4	4	17	21
PbR	2	5	2	1	4	14	16
LAAs	3	3	4	5	4	18	21
Matching grants/ NI or tax rebates to employers	5	2	1	3	4	18	23
Direct payments/ subsidies for healthy behaviour	5	2	4	4	5	22	27
Taxes on unhealthy behaviour	4	5	4	3	5	21	25
Libertarian paternalism policies	4	5	4	2	5	20	24
Social Marketing	3	2	4	4	4	17	20

Scoring range: 5 – largely meets criterion, 1 – largely fails to meet criterion.
Note: Scores are indicative and based on subjective judgements by the authors.

LSE Health to produce report on incentives to stimulate R&D for infectious diseases

Antibiotic resistance is a growing problem with major consequences, including higher treatment costs, mortality, increased disease spread, and longer duration of illness. The severity of antibiotic resistance is increasing across a number of infectious diseases, leading to significant economic costs. Data on the costs of antibiotic resistance are scant, but estimates

from 1998 in the US suggest that the societal costs of resistance range from \$4 billion to \$5 billion per year at a minimum.

The growing problem of antibiotic resistance prompted the Swedish government to commission LSE Health to investigate incentives to stimulate greater research and development (R&D) in the area of infectious diseases. The project director is Professor Elias Mossialos, while the project manager is Dr Marin Gemmill-Toyama.

A number of factors contribute to antibiotic resistance, including inappropriate prescribing of antibiotics, underuse (in terms of the length of treatment), and

overuse. Some governments (eg, the Netherlands) have responded with guidelines and information campaigns to optimise antibiotic use; however, this further compounds another factor in the rise of antibiotic resistance – a dearth of novel antibiotics coming to market. That is, policies to reduce antibiotic use reduce expected profits for manufacturers, making research and development in this area less attractive. Other factors, such as increased regulatory burdens for new pharmaceuticals, increasing costs of R&D over time, and the attractiveness of alternative R&D ventures (eg, investment in chronic diseases), have also influenced the decline in antibiotic R&D.

While a multi-pronged strategy is clearly needed to address the problem of antibiotic resistance, a pressing need for the next few years is increased R&D expenditures on antibiotics. Without new and novel antibiotics on the market, other policies will be insufficient. The number of new antibiotics approved by the US Food and Drug Administration (FDA) have declined significantly over the last 25 years, and in the past five years, only five new antibiotics have been launched.

The project is meant to inform EU policymakers about the strengths and weaknesses of potential models of innovation, thereby opening up avenues for future policy development. Given the pressing need for more novel antibiotics on the market, there are a number of actions that governments can take now to induce pharmaceutical and biotech companies to increase antibiotic R&D. Examples of policy levers include wild-card patent extensions, tax credits, fast-track approval, and increased marketing exclusivity. This report aims to fill a gap in research on these innovative methods and inform policymakers about the strengths and weaknesses of innovative options.

When the Swedish government takes the European Union presidency, the results of the report will be presented at a conference in September 2009.

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Ensuring value for money: The role of health technology assessment in the European Union

Almost all Member States have experienced exponential growth in the introduction and uptake of health technologies in recent years. Such innovation provides enormous opportunity for governments, providers, and patients to realise improved health care services and outcomes. With the rapid diffusion of health technology, however, governments and other key stakeholders are continuously challenged with achieving multiple health system goals concurrently – providing high-quality and innovative care to most effectively meet population health needs within the constraints of limited resources, while also safeguarding key principles of equity, access, and choice. Consequently, governments are increasingly required to invest in those services that offer the best value for money. In recent years, various Member States have developed systems to identify innovations that provide the best value, primarily through the use of health technology assessment (HTA).

This book, authored by Corinna Sorenson, Michael Drummond and Panos Kanavos and based on an extensive study supported by the Ministry of Health of Luxembourg, Sitra Finnish Innovation Fund, and Pfizer, provides a detailed review of the role of HTA in the European Union. In particular, it examines related methodological and process issues in the prioritisation and financing of modern health care, and presents extensive case studies on the situation in Sweden, the Netherlands, Finland, France, Germany, and the United Kingdom (England and Wales). A number of

issues are examined in detail, with an emphasis on the responsibility and membership of HTA bodies; assessment procedures and methods; the application of HTA evidence to decision making; and, the dissemination and implementation of findings. It also highlights the roles and terms of engagement of key stakeholders, and captures the opportunities and challenges for the use of HTA in general priority-setting, decision making, and health care provision.

The review of HTA systems in Europe produced a number of key findings relevant to a wide range of stakeholders, including policymakers, HTA bodies, manufacturers, health care professionals, and patient organisations. While outlined in detail in the book, our assessment suggests that HTA can assume a valuable role in health care decision making, but the process must be transparent, timely, relevant, inclusive, and usable. Assessments also need to employ robust methods and be supplemented by other important decision criteria, including broader social and ethical considerations. Specific strategies for attaining these aims are put forth, including enhanced stakeholder involvement, identifying areas of disinvestment, use of 'fast-track' or expedited assessments, incorporation of risk-sharing arrangements, and further methods development.

The overarching findings and themes identified in this book should assist in improving the HTA process in Europe. Maximising the use of HTA will enhance policymakers' ability to implement decisions that capture the benefits of new technologies, overcome decision uncertainties, and support value and innovation in healthcare.

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Sorenson, C, Drummond, M, Kanavos, P (2008) Ensuring Value for Money: The Role of Health Technology Assessment in the European Union. Copenhagen: World Health Organization.

LSE Health to advise on public health in Austria

The term 'public health' in Austria is still fairly new and its understanding is characterised by considerable heterogeneity. As part of the Austrian Health Care Reform 2005, the Ministry of Health, Family and Youth targeted the public health service with the dual aims of defining the responsibilities of relevant stakeholders and facilitating a shift from curative services for the individual to health promotion and prevention focused on the population. In 2009, this reform process is under way and proves to be challenging. Public health topics are now at the centre of discussions and stakeholders are seeking to define their current and future roles in this area.

The Main Association of Austrian Social Security Institutions (*Hauptverband der österreichischen Sozialversicherungsträger*) requested that LSE carry out a research study on the Austrian and the international situation. This study is headed by Elias Mossialos, Sherry Merkur and Walter Holland at LSE Health, along with Joy Ladurner (based in Vienna) and other colleagues.

LSE was asked to undertake a general analysis of the Austrian public health system as well as focus on a set of specific topics: information management and health reporting; health targets; disadvantaged and special need groups; and, the role of health professionals. In addition, two specific case study projects have been commissioned: 1) An exploration of antenatal care in Austria under the mother-child-pass examination programme (*Mutter-Kind-Pass*) and 2) A review of the potentials and limits of the Austrian cancer registry.

Various Austrian public health experts and the President of the Austrian Public Health Association (*Österreichische Gesellschaft für Public Health*) were invited to join a study group at the Hauptverband to define the research agenda and to discuss study progress and findings. Study group representatives work in both research and applied public health.

The report will identify international best practice examples and where appropriate, these will be used to inform the Austrian context. A hearing will be organised in Austria where key stakeholders will be invited to discuss selected topics related to the research study. In addition, a range of national and international experts will contribute to the study through participating in interviews or by reviewing sections of the final research report. The final report will aim to produce evidence-based recommendations and identify areas of potential reform.

The public health study is part of a successful research collaboration between LSE Health and the Hauptverband, which was initiated in 2004 and spans six research projects. Past studies have addressed a wide variety of topics: incentive and payment mechanisms for doctors; pharmaceutical policy reform; health system performance assessment; and, quality in health care systems. In July 2008, the Hauptverband published the reports on its web site at www.hauptverband.at/fokoop. The most recent study on quality was discussed in several national and local print media, and the *Journal of Austrian Social Insurance* has included an article introducing the current study on public health.

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Informing policy debates in the United States: Comparative analysis of European health systems funded by the Commonwealth Fund

In 2007 and 2008, researchers at LSE Health worked on two projects funded by the New York-based Commonwealth Fund, one of the largest foundations in the United States (US) with a long involvement in health policy issues. Both projects reviewed health system performance in selected European countries (Denmark, England, France, Germany, the Netherlands, Sweden and, in 2008, Switzerland) to inform policy debates about coverage, access and costs in the US health system.

The 2008 project involved a new collaboration between LSE Health and the Mailman School of Public Health at Columbia University. Its main focus was to prepare a series of policy briefs for a high-level symposium in Washington DC attended by the US Secretary of State for Health as well as ministers of health from Europe, Australia, New Zealand and Canada. Researchers at LSE Health worked closely with European experts and Sherry Glied at Columbia University to provide policy guidance on issues of immediate concern and interest to US policymakers: ensuring universal coverage and equitable access to health care, strengthening primary care, using health technology assessment and other tools in pharmaceutical pricing and coverage decisions, and investing in information technology to enhance health care quality (electronic or e-health).

Timed to follow the US presidential elections in November, the high-level symposium in Washington DC was well placed to underline the urgent need for health care reform in the US – which had been a key issue during the elections (the economic crisis notwithstanding) – and to identify useful lessons from recent developments in Europe. In line with other comparative work, the policy briefs circulated at the symposium highlighted the ability of European countries to attain higher levels of health system performance than the US at much lower cost. Two further themes were salient: first, the growing emphasis on and effort put into improving value for money in European health systems, suggesting a move away from a straightforward focus on controlling health care costs; and second, the diversity of approaches adopted in European health systems to achieve broadly similar objectives and with relatively small differences in outcome.

The 2008 project was directed by Elias Mossialos and Sherry Glied (Columbia) and co-ordinated by Sarah Thomson. Marin Gemmill managed the production of the symposium policy briefs and liaised with the following experts: Anders Anell (Lund University), Zachary Cooper (LSE Health), Isabelle Durand-Zaleski (University of Paris XII), Robert Leu (University of Bern), Caroline Rudisill (LSE Health and King's College, London), Sophia Schlette (Bertelsmann Foundation and Health Policy Monitor), Corinna Sorenson (LSE Health), Karsten Vrangbaek (Copenhagen University) and Gert Westert (Tilburg University). Elias, Sherry and Julian Le Grand (LSE Health) made presentations at the high-level symposium held in Washington DC in November 2008. Alan Johnson, the UK Secretary of State for Health, gave the keynote speech.

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Pharmaceutical policy in India

The Medicines Transparency Alliance (MeTA) at the Department of International Development (DFID) is an initiative to increase access to high quality medicines in developing countries. Activities include analysis of regulatory frameworks on national drug policies and public reports on pharmaceutical policy. To inform MeTA's work, Divya Srivastava at LSE Health undertook a review of federal pharmaceutical policies in India.

The report's purpose was to collect information on the regulatory environment, key institutions, legislation, licensing of pharmaceuticals, pricing policy and financing of pharmaceuticals.

Overview of institutions

The main regulatory authorities involved in regulation are the Drug Controller General of India (DCGI), which falls under the Ministry of Health and Family Welfare (MOHFW) and the Department of Chemicals and Petrochemicals, which falls under the Ministry of Chemicals and Fertilizers.

The DCGI is responsible for licensing and standards. There is a division of authority between the central drug controller and the state level drug controllers. Within the Department of Chemicals and Petrochemicals, the National Pharmaceutical Pricing Authority (NPPA) is responsible for medicine pricing. The NPPA currently fixes the prices drugs, which account for one fifth of the market by value. There are no official guidelines for setting the prices of medicines not under price control, but increases of more than 10 per cent are subject to government action.

The main issues arising from the current regulatory environment can be grouped into the following themes.

Improve regulation

1.1. Better coordination: A broader approach to pharmaceutical policy making is necessary that considers reform measures from a health systems perspective. There is a need for greater coordination between the Ministry of Health, the Drug Controller and the Department of Chemicals and Petrochemicals to meet on a regular basis to coordinate their efforts. This could be achieved through joint budgeting arrangements so each institution has a greater incentive in policy implementation.

1.2. Private sector medicine distribution: The large unregulated private sector will require greater government attention to regulate markups and put monitoring systems in place. Recent price surveys found that the private sector had better distribution systems. There is a need for the government to increase its collaboration with the private sector and to take advantage of its distribution networks to supply medicines.

Strengthen information

1.3. Data sources: Reliable data on the large pharmaceutical markets in the world's most populous countries, China and India are in short supply. Inpatient data records are available, but outpatient data are lacking. There will be health system pressures partly due to an increase in medicine consumption among the middle class, and expansion of the private health insurance market, which will require a greater system of tracking information and coordination between various bodies that collect data.

1.4. Pharmacoeconomics: The concept of pharmacoeconomics has not come to India because competition has mainly been between generics. As more patented drugs enter the markets, establishing value will require some method of pharmacoeconomic analysis.

Improve market competition

1.5. The growing industry will bring much benefit to the Indian economy, but the implications for the poor are less clear. Clear incentives and fiscal instruments to create price competition will require that the government improve its policies on pricing, and quality control for domestic consumption. A more robust quality assurance environment will have positive implications for the exportation of medicines to countries in the developing world as well.

1.6. In the current environment, markups are not well regulated, which results in high private sector retail prices. This implies that affordability will continue to be problem for low income individuals unless regulation is improved, and well designed insurance schemes are put in place. Policy measures should improve regulation and monitoring of the pharmaceutical supply chain distribution, pharmaceutical marketing practices, and encourage/incentivise physicians and pharmacists to dispense rationally.

For further information contact Divya Srivastava, d.srivastava@lse.ac.uk

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New Research Groups

Centre for the Study of Incentives in Health

The issue of paying individuals to change their behaviours in health-enhancing ways, for example by encouraging them to quit smoking or take regular exercise, is a highly topical policy issue, in the UK and internationally. Yet personal financial incentives are riddled with ethical issues, with concerns regarding their effectiveness, and with further concerns that they may have unintended consequences. For instance, it may be the case that the electorate do not wish to see public money being used to persuade people to do things that many believe they ought to be doing anyway, and/or such incentives may be deemed coercive, particularly when directed towards the poor. Moreover, paying people to undertake particular actions may crowd out their intrinsic motivations for wanting to do those actions, as demonstrated by Richard Titmuss' classic work on blood donations almost 40 years ago.

The feasibility and effectiveness of personal financial incentives is thus highly contestable and contested. Dr Adam Oliver, Professor Theresa Marteau and Professor Richard Ashcroft have recently been awarded a five year grant by the Wellcome Foundation to examine these issues in a new Centre for the Study of Incentives in Health (CSI), which will be launched officially in April 2009. CSI will be multi-disciplinary, embracing the perspectives of economics, psychology and ethics, and will be multi-institutional, spread over LSE, Kings College and Queen Mary College and with collaborators in the Department of Health, NICE and the King's Fund, among others.

For further information visit the website, www.kcl.ac.uk/Schools/biohealth/research/csinentiveshealth/who.html or contact Adam Oliver, a.j.oliver@lse.ac.uk

The Healthcare Information Systems Group

The Healthcare Information Systems Group was established during 2008. It brings together people interested in issues faced by healthcare policy makers, and healthcare organisations as they plan for and introduce substantial healthcare information systems to support administrative and clinical activities. The group's work is concerned with the place of Information and Communication Technologies (ICTs) and new information infrastructures in health policy, as well as the challenges, problems and pitfalls found as new systems are introduced into use.

The current research among the group's members focuses, for example, on questions of transformation, innovation and restructuring as ICTs are applied in health policy making, healthcare management and clinical settings. A particular focus in current work is on questions of implementation strategies, evaluation and organisational learning, and on healthcare professionals attitudes to and perceptions of change in the UK, and other developed and developing countries.

Members of the Group are currently involved in a British Council funded project work relating to developing countries contexts in India and Africa (Dr Shirin Madon). The overall goal of this project is to determine the effectiveness of decentralised health information systems for improving evidence-based decision making in public healthcare delivery. The study evaluates how much of decision making in health is based on the formal and structured health management information systems as opposed to other informal data sources. A component of the project involves developing capabilities amongst local health workers based on epidemiological principles by devising and running training workshops.

Members also participate in two substantial projects funded by the Connecting for Health Evaluation Programme (CFHEP). The first CFHEP project involves Dr Tony Cornford and Dr Will Venters. *Evaluation of the Electronic Prescription Service in Primary Care* (£745,608) is a two and a half year project (2008-11) led by The School of Pharmacy University of London (Professor Nick Barber), and with the University of Nottingham (Professor Tony Avery). The project is to evaluate Connecting for Health's roll out of electronic transmission of prescriptions within primary care. The evaluation focuses on Phase 3 of the CFH ETP rollout, and the transition to Phase 4. The initial focus is on a sample of the initial primary care trusts (PCTs) selected for implementation.

The second CFHEP project, involves Dr Tony Cornford and Dr Ela Klecun. *Evaluation of the adoption of the NHS Care Record Service in secondary care* (£1,500,000) is again a two and a half year project (2008-12) led by the University of Edinburgh (Professor Azziz Sheikh), and including partners at University of Nottingham (Professor Tony Avery, Professor Rachel Elliot), Queens Hospital Burton-upon-Trent, Imperial College and Imperial College Hospitals NHS Trust. The project will conduct a formative evaluation of the national implementation of the National Health Service's Care Record Service (NHS CRS) in secondary care. The findings will inform the continued roll-out of the NHS CRS. The project will also provide a summative evaluation of the impact of the NHS CRS on the quality, safety and efficiency of healthcare delivery.

The group aims in its first year to organise a number of activities, including an open research day for the presentation of ongoing work within the Group, seminars, a research resources web page/blog. We expect that in the future the group can support further research activity in this important area by, for example, monitoring research calls and providing mutual support for funding bids. The group will also provide a useful networking opportunity for PhD students across the school with an interest in healthcare and technology.

For further information contact Tony Cornford, t.cornford@lse.ac.uk

LSE Health – TISS programme on health policy in India

The previous issue of the Digest announced that the Jamsetji Tata Trust had pledged a senior research fellowship to LSE to support research collaboration between LSE Health and the School of Health Systems Studies at the Tata Institute of Social Science (TISS) in Mumbai. In June 2008, Dr Emma Pitchforth joined LSE Health as Jamsetji Tata Senior Research Fellow to develop research collaborations between the two institutes.

The aim of the link is to develop collaborative research addressing key issues relating to health and health policy in India. Teams in both institutes have complementary strengths in health systems and policy analysis, demography and population studies and social sciences. Work is currently being developed in the following key areas: 1) HIV/AIDS, 2) maternal and reproductive health, 3) urban health, 4) health systems, and 5) access to medicines and pharmaceutical policies.

The joint programme involves several streams, including academic exchange between the two institutions. In 2008, Dr Anil Kumar from TISS spent four months at LSE Health. Emma Pitchforth and Dr Mrigesh Bhatia from LSE Health visited TISS in 2008. The academic exchange has provided the opportunity to establish productive research collaboration, which has been evidenced in several seminar and conference presentations and will lead to a series of publications from 2009 onwards.

Academic exchange will continue in the coming year and students at LSE will have the opportunity to take up placements at TISS. A joint research meeting held at LSE Health in April 2009 will see the whole faculty of the School of Health Systems Studies visit LSE Health.

The link programme also involves development of a new master's programme in International Health Policy at TISS. As part of the development phase, two faculty members from TISS have undertaken the MSc in International Health Policy at LSE. LSE Health colleagues will also be involved in the development of the new curriculum, contributing three modules, and teaching when the programme is first run in 2010/11.

For further information contact Emma Pitchforth, e.pitchforth@lse.ac.uk

LSE Health Risk Research Programme

The LSE Health Risk Research Programme brings together staff and PhD student researchers with interests in risk and behavioural decision-making applications to health and healthcare. Our research remit is broad, covering topics ranging from public health-related behavioural decisions to healthcare use decisions and behavioural reactions to food-related risks. Recent research has focused on specific health concerns (smoking and obesity), as well as collective risks such as new technology (genetically modified food) and larger public health threats (avian influenza).

Our research contributions are theoretically informed and address empirical questions on the role of knowledge and information sources in individuals' and societies' risk decision-making processes regarding various health-related contexts. From a policy perspective, the aims of this research are:

- To understand the cognitive processes individuals use when making decisions about their behaviour to correctly inform the public about risks.
- To inform public policy aims of reducing preventable exposures to health risks.
- To provide an empirical basis for informing public health policy proposals.
- To guide how to undertake information campaigns about public health risks by understanding the determinants of risk perceptions.
- Allow for targeting populations with specific public health messages by understanding how population sub-groups may develop risk perceptions differently.

Besides individual risks, we examine attitudes towards health-related decisions, such as organ and blood donation and long-term care as well as attitudes and perceptions about health care services and medicines. This research area examines individual and social motivations behind health-related decision making.

The principal researchers in this programme from LSE Health are Dr Joan Costa-Font, Professor Elias Mossialos, and Dr Caroline Rudisill. The unit also collaborates across other departments in LSE, including with Dr Barbara Fasolo from the Operational Research Group in the Department of Management. Sherry Merkur from LSE Health and the European Observatory is currently undertaking PhD research on risk-related decision making in the public health setting within the programme.

Research from the programme has been published in leading journals, such as *Risk Analysis*, *Journal of Risk Research*, *Risk Management*, *Emerging Infectious Diseases*, the *Journal of Technology Transfer* and *Food Quality and Preference*.

A selection of our recent publications:

- Costa-Font, J, Rudisill, C, Mossialos, E (forthcoming) Consumer demand for health information and the use of the internet. *Economics of Innovation and New Technology*.
- Costa-Font, J, Mossialos, E, Rudisill, C (forthcoming) Optimism and the perceptions of new risks. *Journal of Risk Research*.
- Costa-Font, J, Rudisill, C, Mossialos, E (2008) Attitudes as an expression of knowledge and 'political anchoring': The case of nuclear power in the UK. *Risk Analysis*, 28(5): 1273-87.
- Mossialos, E, Rudisill, C (2008) Knowledge about avian influenza in the European Region (letter). *Emerging Infectious Diseases*, 14(12).
- Costa-Font, J, Mossialos, E, Rudisill, C (2008) Are feelings of genetically modified food politically driven? *Risk Management*, 10(3): 218-34.

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European Health Technology Institute (EHTI) for Socio-Economic Research

LSE Health is participating in an initiative that aims to conduct research on the economics of medical technology and related financing systems and mechanisms in Europe. The research is conducted under the auspices of the European Health Technology Institute (EHTI) for Socio-Economic Research. The EHTI was established in collaboration with three academic partners (LSE Health, London School of Economics and Political Science; Bocconi University, Italy; and, the Technical University of Berlin, Germany), policymakers, and the medical device industry. This innovative model brings together key thought-leaders to address and debate the principal issues impacting the viability and sustainability of medical technology and its link to societal health and wealth.

Current research focuses on two broad areas. The first research area focuses on the financing of medical devices in select European countries, highlighting the key issues associated with different funding and reimbursement systems. The research covers France, Germany, Italy, Poland, Spain, and the United Kingdom, and analyses the following technologies: knee prostheses, implantable cardiac defibrillators (ICDs), incontinence products, coronary stents, laparoscopic gastroenterology, and wound care. The research aims to provide a better understanding on whether and how existing financing systems support the uptake of medical innovation and foster patient access to new technologies.

The second research area examines the social and economic value of medical technology. While it is generally acknowledged that medical technology has resulted in improved patient quality of life and decreased mortality and disability, there is a lack of evidence on the broader social and economic benefits offered by such innovations. This research will address this evidence gap by lending a greater understanding of the unique contributions made by medical technology towards improved health outcomes, high-value health care, and macro socio-economic gains, such as enhanced productivity.

Overall, this research meets an important need, as the existing literature has not yet sufficiently or systematically addressed these issues and rarely from a multisectoral perspective. To this end, the Institute will provide systematic, comparative evidence on medical technology financing and related matters across major European countries to key decision-makers and other stakeholders, with the broad objective of informing policies that support the effective, efficient, and equitable diffusion of and access to such innovations.

For further information contact Corinna Sorenson, c.sorenson@lse.ac.uk, or Panos Kanavos, p.g.kanavos@lse.ac.uk



International Collaboration



The European Observatory on Health Systems and Policies

Supporting evidence-based health policy making, the European Observatory on Health Systems and Policies is a unique partnership between the World Health Organization Regional Office for Europe, the Governments of Belgium, Finland, Ireland, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science (LSE), and the London School of Hygiene and Tropical Medicine (LSHTM).

Staff based at LSE Health have been actively involved in a number of activities this year. In 2008, its tenth anniversary year, the Observatory published around 25 products in a variety of formats. In addition to the policy journal, *Eurohealth*, the London staff produces the quarterly policy bulletin, *Euro Observer*, to serve the health policy community, as well as practitioners, academics and students. In a new 12-page expanded format *Euro Observer* uses concise review articles and case studies to provide essential details on key health policy issues and health care system reforms across Europe. The editions in 2008 have analysed topics, such as health system performance measurement, the role of generics in pharmaceutical policies in Europe, the impact of EU law on European health systems and policies, and an international appraisal of medical savings accounts as part of private medical insurance.

Among its other evidence dissemination activities, the Observatory publishes country-based, analytical reports describing health system organisation, financing, service delivery and reforms in an extensive range of countries – known as *Health Systems in Transition (HiT)* profiles. Each profile is produced by country experts in collaboration with the Observatory's research directors and staff, with the report often being launched in conjunction with a country's ministry of health.

Several books have been published to date as part of the Observatory Series with Open University Press/McGraw Hill, including studies on funding health care, pharmaceutical regulation in Europe, the future of hospitals, the health care workforce in Europe, decentralisation in health care, and mental health policy and practice. Other major studies on the performance measurement for health system improvement, health systems governance in Europe and private medical insurance are almost complete and will be published by Cambridge University Press in early 2009.

The Observatory also publishes its own Occasional Series of analytical studies as well as *Policy Briefs*, which synthesise the key policy lessons on topics as wide ranging as Cross Border Health, Regulating Entrepreneurial Behaviour in Healthcare and Health Technology Assessment. These policy briefs aim to respond to policy-makers' needs by reviewing current evidence, filling gaps, and presenting information clearly and concisely. Indeed, playing an active role in knowledge transfer, this year the Observatory collaborated with the WHO Health Evidence Network to produce over 10 joint policy briefs on topics discussed at the WHO Ministerial Conference on Health Systems in June 2008.

As part of its direct engagement activities, the Observatory also conducted several 'policy-dialogues' throughout the year, bringing together country health ministry teams, senior decision makers and their advisers, and other stakeholders across Europe to discuss a key policy issues that are relevant to the participants' countries or region. Events included the 4th Baltic countries policy dialogue on health system governance for enhancing performance and the multi-country policy dialogue on health promotion and prevention in Switzerland.

For more information, visit the Observatory's web site (www.observatory.dk) to access publications, resources, news and information about health systems and policies in Europe and elsewhere. You can also register for the Observatory's E-Bulletin, an email service that highlights new publications, conferences and press releases to keep you informed on the Observatory's work.

The European Health Policy Group

The European Health Policy Group (EHPG) was established in 2000 in LSE Health to provide a forum for economists, political scientists and policymakers to meet regularly to discuss issues of health policy. The group meets twice each year, in the Spring and Autumn, with each meeting spread over two days and with five or six papers typically presented. Past meetings have been held in Aix, Lisbon, Paris, Berlin, Dublin and Perugia, and future meetings will be held in Bologna, Paris once again, Copenhagen and Rotterdam.

The meetings of the EHPG are organised under a broad theme. Up until 2004, the theme was the general organisation, operation and performance of health care systems throughout Europe, and the output of these meetings were published in special issues of the *Journal of Health Politics, Policy and Law*, and *Health Economics*, in 2005. Between 2005 and 2008, the theme was equity and choice, and a selection of the papers presented at the meetings over that time frame will be published in a special issue of *Health Economics, Policy and Law*, a journal affiliated with LSE Health, in 2010. Currently, the theme of the meetings is governance and incentives.

Over the last five years, the EHPG has been coordinated by Professor Gwyn Bevan. Gwyn will be stepping down from this role in the Spring of 2009, and will be succeeded by Dr Adam Oliver (LSE Health), with support from Dr Jan-Kees Helderman and Dr Zeynep Orr. The EHPG also runs a very active listserve, that acts as a vessel by which to share information and discuss issues of health policy, and which currently has about 400 members, including some of the leading health policy scholars and policymakers internationally.

The next EHPG meeting will be held on 23-24 April 2009 and hosted by the Department of Economics and School of Advanced Studies in Health Policy, University of Bologna, Italy. The theme of the meeting is 'Governance of Healthcare Systems'.

For further information contact Adam Oliver at a.j.oliver@lse.ac.uk



Dissemination



Transferring Health Policy Knowledge from Europe to the English context

A series of interactive seminars organised by LSE Health and the NHS Confederation over the next two years will aim to improve the transfer of practical, highly relevant health policy experience and lessons from Europe to health policy organisations in England.

Many European countries are facing similar challenges in developing and reforming their health systems. An ageing population, combined with the growth of expensive medical technologies and increased public expectations for highly responsive and quality care, has resulted in enormous financial and political pressure on most European health systems. Some countries appear to have made greater strides in addressing certain health policy challenges than others, suggesting a possible opportunity for the transfer of lessons across contexts. The seminar series is designed to explore this opportunity further by drawing on the combined expertise of LSE Health and the NHS Confederation to define an agenda for possible knowledge transfer. The seminars will highlight areas of policy which appear to have been successful in European and possibly other high-income countries and help to ascertain whether there are practical, relevant lessons that could be learnt in England.

The transfer of policy knowledge is a complex process. Not only is it often difficult to identify successful elements of a policy, it is also extremely challenging to ascertain whether they are likely to be transferable to another context. The public, policymakers, journalists and academics alike are often subject to misconceptions about the extent of both European successes and shortcomings of the NHS in England. This has led to ill-developed proposals about the extent to which England should and indeed could incorporate certain experiences from the Continent, while other potentially transferable European achievements go unnoticed. The seminar series will help to address this issue by bringing together a combination of experts designed to harness international academic analysis and experience and employ it for the development of health policy in England.

Future themes for the seminars to examine might include: cancer care, emergency care, hospital payment systems, quality, human resources management, and EU legal developments, although the precise agenda will be demand-led from the NHS and developed in response to current topical issues.

The NHS Confederation is an ideal partner for the interactive knowledge transfer seminars. It has an



independent membership body representing over 99 per cent of NHS organisations and has established networks into the Department of Health and other national bodies. The Confederation's aims to achieve a health system that delivers first-class services and improved health for all in part by influencing policy, implementation and the public debate. More than any other health organisation in England, it is well-positioned to conceptualise, develop, organise and disseminate a series of knowledge transfer seminars. The NHS confederation also works closely with the NHS European Office, based in Brussels, which provides expertise on EU policy developments through the NHS Confederation communication channels. LSE Health, on its part, is uniquely placed in the UK to lead a series of seminars focusing on comparative European health policy. The Centre already supports a number of European research infrastructures, furnishing its staff with extensive relevant contacts and partners and high-level experience of working with non-academic research users.

Funding for this knowledge transfer programme is from the HEIF 4 Bid Fund, a competitive source of funding to support the LSE's efforts in knowledge transfer in the social sciences.

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Eurohealth in 2008

Eurohealth is a publication of LSE Health and the European Observatory on Health Systems and Policies. It aims to bridge the gap between the scientific and the policy-making communities by providing a forum for the publication of evidence-based articles, debates, and discussions on contemporary health system and health policy issues. The primary audience is policymakers in national ministries and international agencies. Secondary audiences include the health care industries, health professionals, academics and international NGOs.

As usual, this year *Eurohealth* has covered a broad range of topics. The first issue of 2008, issue 14.1, included a series of country snapshots originally commissioned and funded by the Commonwealth Fund, New York, USA. The snapshots focus on the health systems in Sweden (Anders Annell), Germany (Reinhard Buse), the Netherlands (Niek Klazinga), France (Isabelle Durand-Zaleski), England (Sean Boyle) and Denmark (Karsten Vrangbæk). Prepared

in a common format, they provide an opportunity to compare and contrast coverage, revenue generation, delivery system organisation, quality, efficiency and cost control in each country.

We were also delighted to include a contribution from historian Louis Galambos, Professor of History, Department of History and the Institute for Applied Economics and the Study of Business Enterprise at Johns Hopkins University, USA. Professor Galambos highlights challenges for the global vaccine industry and how these parallel past events. In an economic downturn, cost pressures may first be felt in areas viewed as low priorities. All too often public health research can suffer. As well as the potential lost health benefits, the economic consequences of reduced investment into vaccine research and development may be substantial: Europe currently produces around 90 per cent of the world's vaccines. Professor Galambos argues that we should focus on the long-term benefits of vaccines to society, rather than just being mindful of short-term budgetary requirements.

Healthcare systems are under continuous pressure to deliver high quality services that meet ever higher public expectations. They are also acutely aware of the need to contain costs. The direction of pharmaceutical policy is one challenge; for instance what pricing mechanisms help facilitate greater value for money? As Thomas Ceuni and Jim Attridge note in respective articles in issue 14.2, the benefits of pharmaceutical innovation to Europe are substantial, but in the prevailing economic climate how can Europe protect and support these industries and safeguard innovation? Moreover, to what extent should restrictions be imposed on access to new medications? It is to these complex issues that we devoted issue 14.2 of *Eurohealth*, bringing together perspectives first aired by the authors at last year's European Health Forum Gastein.

Issue 14.3 majors on the topic of medical devices, which are vital to the functioning of healthcare systems. In their overview article, Elio Borgonovi, Reinhard Busse and Panos Kanavos argue that much more can be done to optimise the value, effectiveness and efficiency of medical devices in Europe. They call for further evidence to demonstrate the numerous benefits arising from investments in such technology, and, in parallel, to look at how the dynamics of coverage, procurement, reimbursement, and diffusion operate across different health systems and regulatory environments. Contributions looking at different approaches and experience in Italy, Germany and England also feature in this issue.

Additionally, in 2008 *Eurohealth* welcomed perspectives from beyond the European continent, with articles covering countries as diverse as South Africa, the USA, Canada and Japan. Some articles seek to highlight how European health systems can learn from experiences of other OECD countries, while others focus on the way that European development aid affects health systems in low-income countries.

Issues of *Eurohealth* are available at www.euro.who.int/observatory/Publications/20020524_26



Euro Observer

The health policy bulletin, *Euro Observer*, is produced by staff working in the London hub of the European Observatory on Health Systems and Policies, based at LSE Health. Published quarterly, the bulletin serves the health policy community, as well as practitioners, academics, health system stakeholders and students of health policy.

In a new 12-page expanded format, *Euro Observer* uses concise review articles and case studies to provide essential details on key health policy issues and health care system reforms across Europe. Building on its repertoire of policy-relevant analysis, the issues published in 2008 targeted a selective range of topics, such as health system performance measurement, the role of generics in pharmaceutical policies in Europe, the impact of EU law on European health systems and policies and an international appraisal of medical savings accounts as part of private medical insurance. The upcoming year will see the bulletin focus its attention on the revalidation of health professionals, public health priorities and the use of IT in health care.

All published issues of *Euro Observer* can be downloaded from the Observatory's website (www.observatory.dk) or www.lse.ac.uk/collections/LSEHealthAndSocialCare/documents/euroObserver.htm

To join the mailing list for hard copies contact Champa Heidbrink, c.heidbrink@lse.ac.uk



Journals

Health Economics, Policy and Law (HEPL)



health-policy process. Its Editors-in-Chief are LSE Health academics, Adam Oliver and Elias Mossialos, and the journal's editorial office is based within LSE Health.

HEPL places considerable emphasis on rigorous conceptual development and analysis, and on the presentation of empirical evidence that is relevant to the policy process. In addition to original research articles, it publishes lively debates between leading academics, perspective articles, guest editorials and book review essays.

In 2008, editorials commented on emerging health care reform issues in the US presidential debate, the medical axis-of-power in Japan and European mental health policy. Research articles ranged in scope from defining hospital markets for antitrust enforcement in the Netherlands, public-private partnerships in the Danish health sector, nursing home performance in resident care in the United States and addressing legal and political barriers to global pharmaceutical access, while debates and perspectives provided robust views on developing methods that value the 'Q' in the QALY, whether or not systematic reviews 'work' in informing decision making around health inequalities, and consumer-directed health care. The fourth issue capped off the year with the journal's first Special Issue – on social capital and health – and featured articles on modelling social capital and health, associations between social capital and self-assessed health in Norway, access to psycho-social resources and health in France, aging, social capital and health care utilisation in Canada and social capital and the social formation of health-related preferences and behaviours.

With the next three issues to be published in 2009 already at an advanced stage, arrangements are being made to make new articles available online using Cambridge Journals' 'First View' facility. Along with the journal's successful inclusion in Medline, these developments will ensure that *Health Economics, Policy and Law* will continue to cement its reputation as a quality academic resource available to the medical profession, scholars and the health policy community.

All published issues of *Health Economics, Policy and Law* are available online, upon subscription, from the Cambridge Journals Online website: <http://journals.cambridge.org/action/displayJournal?jid=HEP>

Health Economics, Policy and Law (HEPL), published by Cambridge University Press (CUP), completed its first three years of successful publication in 2008. This peer-reviewed, international journal focuses on the confluence of economics, politics and legal considerations in the

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Globalization and Health



LSE Health has expanded its journal affiliations to include *Globalization and Health*. *Globalization and Health* is an open access, peer-reviewed, online journal that provides an international forum for high

quality original research, knowledge sharing and debate on the topic of globalisation and its effects on health, both positive and negative. Globalisation, namely the intensification of flows of people, goods, and services across borders, has a complex influence on health. The journal publishes material relevant to any aspect of globalisation and health from a wide range of social science and health-related disciplines (eg, economics, sociology, epidemiology, demography, psychology, politics and international relations). Recent papers have addressed wide ranging issues from the global affordability of fluoride toothpaste to the role of transnational tobacco companies in undermining public health. The output of the journal is useful to a wide audience interested in global health, including academics, policymakers, health care practitioners, and public health professionals. The editorial team, comprising LSE Health academics (Elias Mossialos, Emma Pitchforth, Corinna Sorenson and Divya Srivastava) and Dr Greg Martin (UCL Genetics Institute), heads an international editorial board.

The journal is committed to accessibility and seeks to use its open access forum to develop innovative means of dissemination and engagement with readers. The journal is working with John Hopkin's University to produce a series of podcasts on global issues, which will be launched in January 2009. *Globalization and Health* recently received seed funding from the Department of Health to support further development and ensure the journal is equally accessible to contributors and readers throughout the world.

For further information contact Emma Pitchforth, e.pitchforth@lse.ac.uk or visit the website, www.globalizationandhealth.com

LSE Health Working Paper Series

The LSE Health Working Paper Series in Health Economics and Policy enables staff and student researchers based at or affiliated with LSE Health to make recent work and work in progress available to a wider audience. It is intended to reflect the range and diversity of theoretical and empirical work relating to health policy and economics carried out at LSE Health. In 2008, the series continued to grow with the addition of the following papers.

- *Exploring the Pathways of Inequality in Health, Access and Financing in Decentralised Spain* by Joan Costa-Fonta and Joan Gilb.
- *Conflict in the Doctor-Patient Relation and Non-Adherence: A Game Theory Approach* by Charitini Stavropoulou and Dionysius Glycopantis.
- *Reflections on the Development of Health Inequalities Policy in the United Kingdom* by Adam Oliver.
- *Decomposing Cross-Country Differences in Levels of Obesity and Overweight: Does the Social Environment Matter?* by Joan Costa-Font, Daniele Fabbri and Joan Gil.

Papers are available on the LSE Health website.

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Policy Appointments

LSE Health staff are active as advisors and consultants to policy-making bodies across a number of countries. Examples of current policy appointments and specific activities from 2008 are highlighted below.

Sara Allin has been involved in advising health policymakers in Austria, Portugal and Spain.

Mara Airoidi collaborates closely with two English Primary Care Trusts and advises them on methods to set priorities.

Gwyn Bevan is currently a member of the Department of Health policy and technical advisory groups on the weighted capitation formula used for resource allocation in England: the Advisory Committee on Resource Allocation and the Technical Advisory Group. His *Review of the Weighted Capitation Formula*, a report to the Secretary of State for Health was published by the Department of Health in 2009. He is also an adviser to WHO.

Mrigesh Bhatia has attracted project grants to strengthen government of India's capacity to undertake health sector reforms, and for undertaking collaborative research on assessing equity in financing and delivery of health care in Asian countries. He has also organised training programmes on health sector reforms for senior Ministry of Health officials.

Tony Comford is a consultant on electronic prescribing systems in secondary care for Connecting for Health.

Celia Davies is Director of the Research for Patient Benefit Programme in the National Institute for Health Research. This is a research funding scheme that operates in all ten strategic Health Authority Regions in England, with a budget of nearly £26 million.

Ama De-Graft Aikins assisted Ghana's Ministry of Health in developing a strategic plan for its Regenerative Health and Nutrition Programme and producing a report on the reduction of maternal mortality.

Arjan Gjonca has acted as an adviser to different international organisations and national governments, including the World Bank, UNFPA, UNDP and the Albanian government.

Walter Holland chairs the Research Committee of the Northern Ireland Chest, Heart and Stroke Association and Recovering from Stroke in Richmond. He is a member of the Richmond and Twickenham PPI Forum and the Research Council of 'Changing Faces'.

Panos Kanavos is currently participating in the European Pharmaceutical Forum as advisor to the European Commission.

Julian Le Grand is Chairman of Health England, the National Reference Group for Health and Well-being for the Department of Health. He is also a member of the Group of Societal Policy Analysts advising President Jose Barroso of the European Commission.

Tiziana Leone is advisor to the Lesotho Statistical office on maternal mortality estimation.

David McDaid is a member of the Public Health Interventions Advisory Committee, as well as a

member of two expert advisory groups, all at the National Institute for Health and Clinical Excellence in England and Wales. He is a special advisor to the European Commission DG Health and Consumers on mental health matters and also an advisor to the Welsh Assembly Government Health Promotion Division and the National Office for Social Inclusion in England. He also provides policy advice and support to a number of governments, think tanks and charities in the fields of mental, public and musculoskeletal health.

Alistair McGuire is on the International Expert Panel for IQWiG in Germany and has acted as an advisor to numerous UK government offices and research councils (including the ESRC and the MRC), as well as an economic consultant to a number of foreign governments, domestic and foreign corporations, and pharmaceutical companies.

Peter Miller has conducted extensive field work in a range of major corporations such as Caterpillar and Intel, as well as in various public sector organisations.

Alec Morton was Visiting Senior Fellow at the National Audit Office (2008).

Elias Mossialos is an adviser to the World Bank, WHO, and a number of health ministries across Europe. In February 2008, he advised the Prime Minister and several ministers of the Republic of Kazakhstan on social policy developments (higher education, health and social assistance reforms). He is currently completing a report, commissioned by the Swedish government, on incentives to stimulate R&D for antibiotics.

Mike Murphy has acted as an adviser to a number of British Government Departments and international organisations.

Adam Oliver serves on the Public Health Interventions Advisory Committee at NICE.

Harald Schmidt is deputy director of the Nuffield Council on Bioethics.

Corinna Sorenson is a member of the Executive Committee of the European Health Technology Institute for Socio-Economic Research (EHTI). She has also acted as a consultant to governments, professional associations, and industry on health technology assessment and public health policy. Recent (2008) consultations include the Quebec and Chinese Ministries of Health. Corinna is currently a member of the European Council for HTA.

Sarah Thomson and Elias Mossialos addressed the Employment Committee of the European Parliament on 5 May 2008, a public hearing organised by the EP Employment Committee on 'The future of the social security systems and pensions: financing and the trend towards individualisation' on 3 June 2008 and the Social Protection Committee of the European Commission on 18 September 2008. Sarah is also working (with Thomas Foubister) on a policy brief on the financial sustainability of health systems in Europe, commissioned by WHO and the Ministry of Health of the Czech Republic for the Czech Presidency of the European Union in 2009.



Seminars and Annual Lecture

LSE Health and Social Care hold a regular formal seminar series throughout the year, as well as a number of other seminars, workshops, and keynote lectures. The selected list of seminars below shows the range of experts speaking in 2008 on diverse health-related topics.

Choice, price competition and complexity in markets for health insurance: The case of Switzerland, Richard G Frank, Professor of Health Economics, Department of Health Care Policy, Harvard Medical School

On the economics of evidence-based supported employment for people with severe mental illness: what we know, what we don't know, and a few speculations, Dr Eric Latimer, McGill University

Merck Foundation Lecture, German health care 2008: Learning from others, or to learn from?, Professor Reinhard Busse, Berlin University of Technology and European Observatory on Health Systems and Policies

NICE Times, Professor Sir Michael Rawlins, National Institute for Clinical Excellence

Private health insurance in Australia, Professor Jane Hall, Professor of Health Economics, University of Technology, Sydney

How much can we expect of our health care system? The New Zealand reform period and its aftermath,

Professor Peter Davis, Department of Sociology, University of Auckland

Health Equity Network Annual Lecture, Inequality in health in a global context, Professor Michael Marmot, University College, London

LSE Health and Social Care Annual Lecture 2009

Title:

Robots, rabbits and radicals: moving from a targeted to a systematic approach to improving quality in the NHS

Speaker:

Professor Lord Darzi of Denham KBE, Parliamentary Under Secretary of State (Lords), Department of Health, UK

Chair:

Professor Julian Le Grand, Richard Titmuss Professor of Social Policy

Venue:

New Academic Building, LSE,
10 March 2009, 6.30-7.30pm

For further information about the formal seminar series, please contact
Corinna Sorenson, c.sorenson@lse.ac.uk



LSE Health Teaching

The mission of LSE Health is to advance, transmit and sustain knowledge and understanding through the conduct of research, teaching and scholarship at the highest international standards, for the benefit of the international and national health policy community.

LSE Health staff contribute to a number of taught courses within LSE, in addition to being responsible for running the MSc in International Health Policy and the MSc in Health, Population and Society. Substantial contributions are made to the MSc in Health Policy Planning and Financing. Staff have also run short courses on specific aspects of health economics and health policy.

NEW executive-style MSc degree in Health Economics, Policy and Management

LSE Health is launching a new modular MSc programme in 'Health Economics, Policy and Management'. This executive-style MSc programme enables students to work full-time, while also gaining formal educational qualifications in a variety of subjects across health management and administration, health economics, cost-effectiveness and statistical analysis, pharmaceutical economics, epidemiology/clinical trials, health policy and health information systems. The programme is led and

organised by Professor Alistair McGuire, Professor Elias Mossialos and Dr Caroline Rudisill.

The objectives of this programme are to help professionals accelerate their careers or change focus within their existing careers, explore new options within the pharmaceutical and healthcare fields, enhance their existing set of health management, economics, and policy skills, gain a theoretical and conceptual understanding of health-related topics, and encourage networking among fellow students.

The first intensive session starts in December 2009. The MSc will take two years to complete with two intensive sessions each academic year – December 2009, June 2010, December 2010 and June 2011. It will require a total of 41 days in London for teaching and examinations split into these four two-week intensive teaching blocks and a one day examination and programme closure event in September 2011. These intensive sessions will include a combination of academic lectures and seminars, individual meetings with faculty tutors, revision sessions and invitations to lectures from visiting academics and policymakers. Following the completion of coursework, participants will undertake a dissertation with individual supervision from a member of the LSE Health staff. Certificate and diploma options are also available if students are not able to complete the total number of units required for an MSc.

The programme involves LSE faculty affiliated with Department of Social Policy, the Department of Management, the European Institute and LSE Health as well as subject experts from other UK academic institutions.

We offer four compulsory courses:

- Health Economics
- Financing Health Care
- Resource Allocation and Cost-Effectiveness Analysis
- Health Administration and Management

Elective options include courses from the subject areas of health economics, health policy and processes, epidemiology/clinical trials and health information systems. In total, participants will attend eight half unit courses each taught over four and a half continuous days.

This programme has been designed to meet the needs of mid-career professionals who seek formal qualifications in health economics, policy and management, but do not have the flexibility to participate in a traditional MSc program. We encourage a diverse range of applicants currently employed or seeking employment in the government, healthcare delivery and pharmaceutical and medical devices

LSE Health Teaching continued...

industries. We welcome participants from all over the world with particular course focus on Europe, North America and developed countries. We assume no previous formal training in health economics or policy, but those with training in these areas can choose more advanced options.

For further information or to request a programme brochure contact, HEPM@lse.ac.uk

Doctoral Research

LSE Health has an active PhD programme, investing over £400,000 in the past five years to support PhD students. LSE Health attracts high quality research students from diverse national and academic backgrounds. At any given point, there are more the 25 full-time PhD students associated with LSE and a further few working part-time.

Our programme emphasises interdisciplinary research that cuts across the sometimes arbitrary boundaries that exist between social science disciplines. LSE Health academics have developed strengths both in high calibre academic research and its application to problems relevant to academic audiences and policymakers. Both theoretical and empirical research is performed. The PhD programme is designed to equip students with an in-depth knowledge of the core fields of public policy, health policy and politics, and health and behavioural economics, which can be applied to their chosen area of interest. Each student is regarded as a fully-fledged member of our academic research unit. They are invited to participate in academic conferences seminars and research related activities. Our PhD students are also very active in research, publishing in leading academic journal, as well as presenting at conferences in their area of speciality.

LSE Health has recently published a LSE Health: Research Student Programme which provides a profile on current PhD students. The brochure is available from Maria Lluch, m.lluch@lse.ac.uk or can be accessed via www.lse.ac.uk/collections/LSEHealth/pdf/LSE_Health_research_student.pdf



Recent PhD students joining the Centre include:



Maryam Ali's research explores how medical informatics are implemented in the National Health Service. It specifically explores the attitudes and views healthcare providers hold towards Information

Technology in relation to their clinical responsibilities and roles as medical professionals. The aim of this research is to understand and describe patterns of technology perception and use, and how these patterns may affect the integration of IT into healthcare settings. She has employed qualitative methods to closely study a large Clinical Data Repository in a London Teaching Hospital. This study is informed by information systems literature and the sociology of medicine. Institutional theory is employed as a structural frame for interpreting the findings.

For further information contact Maryam Ali, m.m.ali@lse.ac.uk

Claudia Mollidor's research considers health sector representations of teenaged mothers, and implications for their well-being. As a widely stigmatised group, low self-esteem and negative social identities are barriers to good health for young mothers in the UK, as health and social identity are positively correlated. A further health risk for teenaged mothers, who are more likely to come from socio-economically deprived backgrounds, is the positive correlation of SES and health. Claudia analyses the impact of social representations held by health professionals working with teenaged mothers on the latter's self identity and well-being.

In a first instance, professionals working closely in the ante- and post-natal period with mothers between the age of 16 and 18 in South East London are interviewed to establish an understanding of how they conceptualise and respond to young mothers. The research then examines how these representations are interpreted by teenaged mothers, as well as identifying the coping mechanisms they use to resist the internalisation of stigma and to establish a positive sense of self.

Using the participatory research method of Photovoice, which has been found to empower participants and improve their health choices, the projects seeks to address how the interrelated health barriers of stigma and low self-esteem can be reduced as teenagers are adapting to their new roles as mothers.

For further information contact Claudia Mollidor, c.m.mollidor@lse.ac.uk

Barbara Osborne's research looks at 'Understanding Repetitive Strain Injury: Identity Consequences and Adaptation'. Repetitive Strain Injury (RSI) is a work-related musculoskeletal condition, which can result in chronic pain and permanent disability. About 400,000 people in the UK suffer from work-related musculoskeletal disorders, leading to the loss of four to five million working days every year. To date, there has been little social psychological investigation of how those living with RSI make sense of their experiences, and the identity and adaptation consequences of RSI. Analysis of detailed narrative life history interviews has found that similar to individuals living with other chronic illnesses, people living with RSI often lack the social support needed to successfully adapt to their changed life circumstances. By intensifying the struggle for credibility and support, and thus complicating personal efforts to protect and/or reconstruct identity and adapt to changed life circumstances, the combined issues of 'disputedness' (on account of unknown aetiology of RSI) and 'work-relatedness' set the experience of RSI apart from that of other chronic conditions. Research participants believed that the political and economic consequences of recognising RSI as a bona fide work-related injury often made employers, medical professionals and government agencies reluctant to offer support. Despite their plight, however, people with RSI sometimes report positive as well as negative identity consequences of living with RSI. The research argues that RSI can result in biographical and identity reconstruction as well as biographical and identity disruption, if credibility for suffering is acknowledged and sufficient social support is forthcoming from key actor groups to facilitate successful adaptation.

For further information contact Barbara Osborne, b.c.osborne@lse.ac.uk

Cora Peterson's research examines the long-term health impact of the United States National School Lunch Program. Cora received an MSc in Social Policy from LSE and an undergraduate degree in History from Wesleyan University. She has worked for international health organisations in several locations in southern Africa, as well as an economic research company in the UK. Her research project will examine population participation in the US National School Lunch Program in connection with nutrition-related health trends in the United States, including obesity. The research will also examine the impact of the policy's funding structure on programme implementation and nutrition goals at the state and local levels, focusing on the donation of federal agricultural commodities to schools.

For further information contact Cora Peterson, c.peterson1@lse.ac.uk



Lucia Kossarova's research focuses on measuring health system performance in Slovakia. Lucia's main interests are in health system performance, quality and financing of health care. Her thesis examines

health system performance, how it is measured and whether insurer type or other determinants explain differences in the quality of care delivered to patients. The changing and increasingly more important role of health insurance companies as purchasers of health care in Central and Eastern Europe reveals the importance of carrying out research in this area. The focus of her thesis is the case of Slovakia, a country with a mandatory social health insurance system and multiple health service purchasers. In this context, a number of areas will be studied. First, Lucia will examine changes in avoidable deaths across the different regions of Slovakia and how these are related to resource allocation. Second, she will study hospitalisations for ambulatory care sensitive conditions and the factors that may help to explain unnecessary hospital stays. Third, Lucia will study the differences in post-hospitalisation follow up treatment and how it varies across private and public insurer. Finally, the thesis will study health outcomes for particular conditions taking into consideration risk adjustment. The findings of Lucia's research should not only contribute to the existing body of evidence in this area but also provide useful answers to policymakers and health experts in Slovakia and the rest of the region where health systems are dealing with similar issues.

For further information contact Lucia Kossarova, l.kossarova@lse.ac.uk



Jihyung (Innie) Hong's research aims to examine the determinants of medication and resource use in schizophrenia in various health care systems in Europe as well as in Asia. In principle, a

variation in the consumption of pharmaceuticals and resource utilisation should reflect inter-individual differences in severity of illness and needs, conditioned in part by pertinent features of local arrangements, such as the availability of resources. Nonetheless, other factors that are not related to clinical uncertainty, such as patient or doctors' characteristics, culture, and the health care funding system, may also play an important role. However, there is little international comparative research that examines the dynamics of inputs, process and outcomes in the treatment of schizophrenia.

Her study attempts to: 1) assess the level of variation in resource use and costs in treatment of schizophrenia across 15 European countries (Western as well as Central and Eastern European countries) and three Asian countries (South Korea, Taiwan and Malaysia); 2) examine the factors that could explain such variation; and, 3) explore the relationship between the level of resource use and patient outcomes, such as quality of life.

Innie has an MSc in Health Economics from the University of York. After completing the MSc in 2003, she has been working with Eli Lilly & Company, mainly covering economic evaluations of drugs and health outcome research in the area of mental health.

For further information contact Innie Hong, j.hong@lse.ac.uk

Adebusoye Anifalaje's thesis focuses on understanding the role of information systems for decision making, within the context of decentralised healthcare structures in Nigeria. The research highlights the intricacies of evidence-based planning, particularly in delivering primary healthcare services. The research will analyse the challenges of developing responsive health systems. Specifically, the study will examine how local communities' engagement with formal health systems might reveal divergent multiple rationalities which weaken health systems. The role of information systems is studied against the backdrop of this user-provider interface. Conceptually, the study adopts decentralisation frameworks (eg, decision space) and health seeking behaviour models.

For further information contact Adebusoye Anifalaje, a.a.anifalaje@lse.ac.uk



Morten Skovdal's research examines the psychosocial well-being and coping strategies of children taking care of their sick or elderly caregivers in western Kenya and proposes community-based

capital cash transfers as a mean to facilitate coping and health.

Through photography, community mapping, drawing, essay writing, individual and group interviews, this participatory action research project highlights not only the needs and vulnerabilities of young carers in Africa, but more importantly, the coping strategies they draw upon to deal with adversity. The thesis explores in detail how the children's agency and opportunities for participation in community life can contribute to their psychosocial well-being and coping through a negotiation of access to social support, constructions of social identities and resource-generating activities – levels of participation that Morten conceptualise as a social psychology of coping.

The thesis is a result of Morten's experience with international NGOs in Kenya and his involvement with the World Bank on social protection and cash transfer policies in Kenya. Morten advocates and actively implements community-based capital cash transfer initiatives in western Kenya through WVP Kenya.

For further information contact Morten Skovdal, m.skovdal@lse.ac.uk



Cathy Vaughan's thesis aims to reach a better understanding of how outsiders (be those researchers, health workers, or international donors) can support young people to take control of their health

in the wider context of contemporary Papua New Guinea. Her specific research aims are two-fold: to establish how young people make sense of HIV and the many other factors impacting on their health in a local context, and to explore the role of youth participation in the process of young people developing actionable strategies for reducing their vulnerability to poor health outcomes. In working with youth groups in the Highlands, she has primarily used Photovoice as a research methodology to explore young people's perceptions of health and how these intersect with their social environment. Photovoice also allowed study of the psycho-social processes associated with participation, as it happened, in the research project. Cathy's research emerged from several years of experience working with international NGOs and AusAID programs on responses 'targeting' young people's HIV risk. This experience reinforced that development of HIV prevention initiatives must be grounded in an understanding of the complex contexts in which viral transmission occurs, and informs the emphasis on local experience of context in this thesis.

For further information contact Cathy Vaughan, c.m.vaughan@lse.ac.uk

Mercy Nhamo's research looks at understanding and strengthening the role of grassroots church groups in fighting HIV/AIDS in rural Zimbabwe. HIV/AIDS stigma is increasingly regarded as one of the key drivers of the HIV/AIDS epidemic in sub-Saharan Africa through the role it plays in undermining the ability of individuals, families and societies to protect themselves from HIV, to provide assistance to those that are affected, and to access services and adhere to treatment if they become infected.

Increasing reference is made to the importance of building social capital and promoting the participation of local community members in anti-stigma efforts. However, whilst community participation is repeatedly advocated, there is less clarity regarding precisely what community members should participate in, and through what networks this participation should take place.

Mercy's thesis begins to fill this gap through examining the role of the church, the most well-established social network, which forms a vital and under-utilised community health resource, especially in settings with limited access to health and welfare support and services. Church members often provide spiritual and practical support to people with AIDS, yet churches play a key role in perpetuating the cruel stigmatisation of sexuality and of people living with HIV/AIDS.

This multi-method study uses large quantitative surveys, in-depth interviews and action research (using the community conversations method) to explore the possibility of expanding the role of the Pentecostal, Anglican and Catholic churches, to play a more active and positive role in HIV/AIDS management.

For further information contact Mercy Nhamo, m.nhamo@lse.ac.uk



Chantal Morel's research focuses on improving access to medicine via an exploration into market conditions and incentives to enhance discovery, development, and distribution of technology

for neglected diseases. A key area of Chantal's doctoral work focuses on how to improve the chances that existing technologies reach patients who need them, especially in poor areas. Governments, economists and the pharmaceutical industry are increasingly looking to more socially optimal global pricing schemes to cross-subsidise between countries and groups of different economic status, to give poorer parts of the world access to desperately needed vaccines, diagnostics, and drugs, while maintaining incentives for innovation. This price differentiation by ability to pay is being explored at both the global level and within national boundaries in the case of some middle-income countries. However, price differentiation and the ensuing low procurement prices for low-income markets do not necessarily translate to low prices for the patient. Limited past experience with such schemes suggests that the ability to reduce patient prices to affordable levels is more complex than lowering initial procurement prices.

Part of Chantal's work looks at the structural, legal, and local economic conditions that can help protect against the distortion and dilution of cross-subsidies from equity-driven differential pricing in the medium to long term. Another key area of Chantal's work concerns mechanisms to spur innovation in new prevention and treatment technologies for neglected diseases. This project examines how companies can be motivated to undergo expensive research and development for technologies from which little return is expected under normal market conditions. More specifically, it seeks to answer the question of how large purchasers can better use monopsony and push/pull incentives to drive innovation for key neglected diseases. This work uses basic principles of finance and its mathematical underpinnings to explore mechanisms that combine push and pull characteristics to mitigate risk and optimise product selection in order to maximise the likelihood of discovering appropriate, life-saving technologies for use in underresourced parts of the world.

Chantal has been involved in health economic research in developing countries for six years, both as an academic research fellow and as an impact assessment adviser for a large international NGO with health programmes throughout sub-Saharan Africa and South Asia. Her work has focused on the area of neglected diseases such as malaria and HIV. She has numerous publications regarding the economics and pharmaceutical policy considerations in this area.

For further information contact Chantal Morel, c.m.morel@lse.ac.uk



Azusa Sato's research focuses on access to medicines in developing countries. Medicines account for a large proportion of overall health spending in developing countries, although such

expenditures remain relatively low compared to richer nations. Issues of affordability, sustainable finance, health and supply systems, rational use, quality and investment in research and development are explored.

Medicines policy is a topical issue not just in health, but also in light of broader development goals, especially those outlined by the UN Millennium Development Goals. This is evident in WHO's medicines strategy for 2004-07, which prioritises expanding access, especially to those affected by HIV/AIDS, TB and malaria. Similarly, the 'Good governance for medicines' programme launched in 2004 promotes safeguarding medicines and resources for the poor, with estimates of up to 25 per cent of global public health being stolen or corrupted annually. The department for International Development is currently spearheading the 'medicines transparency alliance' (MeTA) which provides funding and technical support to 'build transparency and accountability around the selection, procurement, sale and distribution of essential medicines to tackle excessive mark-ups, corruption and mismanagement'.

This alliance brings together key stakeholders including national governments, non-governmental organisations, pharmaceuticals and the private sector, the World Bank, Health Action International and the World Health Organization. Using key survey data from MeTA and fieldwork in one or two of the following countries (Ghana, Uganda and Zambia), Azusa's PhD thesis will examine to what extent government and regulatory frameworks impact on equitable access to medicines. Other key issues include the role of procurement, pricing and distribution channels and the way in which international organisations shape national health policies. The thesis aims to provide policy recommendations to the chosen countries.

For further information contact Azusa Sato, a.sato@lse.ac.uk

Branwyn Poleykett's research focuses on 'Health as a space of radical conflict: the regulation of commercial sex in Senegal'. Specifically, her PhD looks at the regulation of female commercial sex work in Dakar, Senegal. The Senegalese state has closely regulated sex work since independence and this system of state regulation is often cited as a factor in Senegal's strikingly successful national response to the AIDS epidemic. The vast majority of women involved in commercial sexuality in Dakar, however, choose not to register with the state. Branwyn's research is based on ethnographic work with state and non governmental actors and focuses on the relationships negotiated between these women who reject state regulation and the non governmental organisations that provide services and advocate on their behalf. Siting these encounters between the state and its agents, non governmental actors and women selling sex in the wider economy of HIV/AIDS interventions, this research project seeks to ask questions about health as a space of radical conflict over ethico-judicial norms out of which social action is generated.

For further information contact Branwyn Poleykett, b.poleykett@lse.ac.uk

New Staff

LSE Health has welcomed several new staff members in the last year.



Scott L Greer has joined LSE Health as Senior Research Fellow and continues to hold position of Assistant Professor, University of Michigan School of Public Health. Scott is a political

scientist interested in the relationship between health policymaking and territorial politics issues, such as federalism and European integration. He has done research in Canada, France, Germany, Spain, the United States and the EU, and in the UK has dedicated much of his time to understanding the politics of health policy in England, Northern Ireland, Scotland and Wales since devolution. Most recently, he has focused his research on the developing system of EU health policy and on the general consequences of decentralisation for health policymaking. His research has been funded by the ESRC, Kings Fund, National Science Foundation (US), Nuffield Trust and the Social Science Research Council and his most recent books are the edited *Devolution and Social Citizenship in the UK* (Policy, 2008) and *The Politics of European Union Health Policies* (Open University Press, forthcoming).

Scott can be contacted at slgreer@umich.edu



Emma Pitchforth joined LSE Health in June 2008 as Jamsetji Tata Senior Research Fellow. Before joining LSE, she worked as Lecturer in Social Science and Health at the University of Leicester and Research Fellow at

the University of Aberdeen. Her research has focused on maternal and reproductive health and quality and organisation of maternity services both in the UK and developing countries, although she also has broader interests in public health. Her research has involved qualitative, quantitative and mixed methods approaches. At LSE Health, Emma is co-ordinator for the link programme between LSE Health and the Tata Institute of Social Science (TISS), Mumbai. This currently involves active involvement in academic exchange between the two centres and the development of a joint research programme addressing key health policy issues in India.

Emma is also Co-Editor-in-Chief of *Globalization and Health*, an open access online journal addressing key issues in global health and the influences of globalisation upon health, both positive and negative.

Emma can be contacted at e.pitchforth@lse.ac.uk



Valentina Lichtner is joining the Health Information Systems Group to work as Research Officer on two projects for The Connecting for Health Evaluation Programme (CFHEP): 'Evaluation

of the adoption of the NHS Care Record Service in secondary care' and 'Evaluation of the Electronic Prescription Service in Primary Care'. Valentina recently completed a PhD in Human-Computer Interaction at the Centre for HCI Design, at City University London. Her PhD thesis, 'Patient Identity, Identification and Technology', investigates the process of patient identification and related technology, with a field study of a walk-in centre. Approaching this research topic from a systemic perspective, her research shows how the socio-technical context supports or hinders the process of patient identification and offers systemic reasons for the occurrence of identification errors. While completing her PhD, she also worked at City University on a European research project, carrying out the workplace evaluation of a context-aware, work-integrated learning system.



Dimitra I Petrakaki is joining the Health Information Systems Group as a Research Officer. Dimitra has recently completed her doctoral research in the department of

Organisation, Work and Technology, Lancaster University Management School, while being a lecturer in Information Management in the University of Wolverhampton Business School. Her research interests revolve around the managerial and IT-led changes in the context of public sector reform and particularly in e-government initiatives. Her work explores the organisational and political aspects that surround such programmes of public sector change, as well as their implications on officials' work practices and public service accountability.



Helen Vieth joined LSE Health as External Affairs and Project Development Manager in January 2009. She is primarily responsible for the Centre's external relations and promotion, and the development of new collaborative partnerships, research projects and funding opportunities.

She will also be involved in some research, notably on the mobility of health professionals in Europe. Prior to joining LSE, Helen worked as a researcher in issues related to minority rights and poverty at non-profit organisations in London, and as a consultant in the area of social determinants of health and investment for health for the World Health Organization. Previously she was a Country Manager at WHO's Regional Office for Europe in Denmark, where she worked closely with the field offices and the executive management team on issues relating to the management and implementation of WHO's work in countries, covering a range of countries across Central and Eastern Europe and Central Asia. She has also worked as a project coordinator for the European Observatory on Health Systems and Policies. Helen holds an MSc in human rights from LSE, where she focussed on development and social policy and wrote her dissertation on a rights-based approach to poverty eradication through the regulation of international commercial activity. She also has a BA (joint honours) in French and German from King's College London. Before returning to the UK, Helen lived for many years in various European countries and travelled extensively in the Middle East. She speaks/writes fluent English, French and Danish, good German and elementary Russian.

Helen can be contacted at h.vieth@lse.ac.uk

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