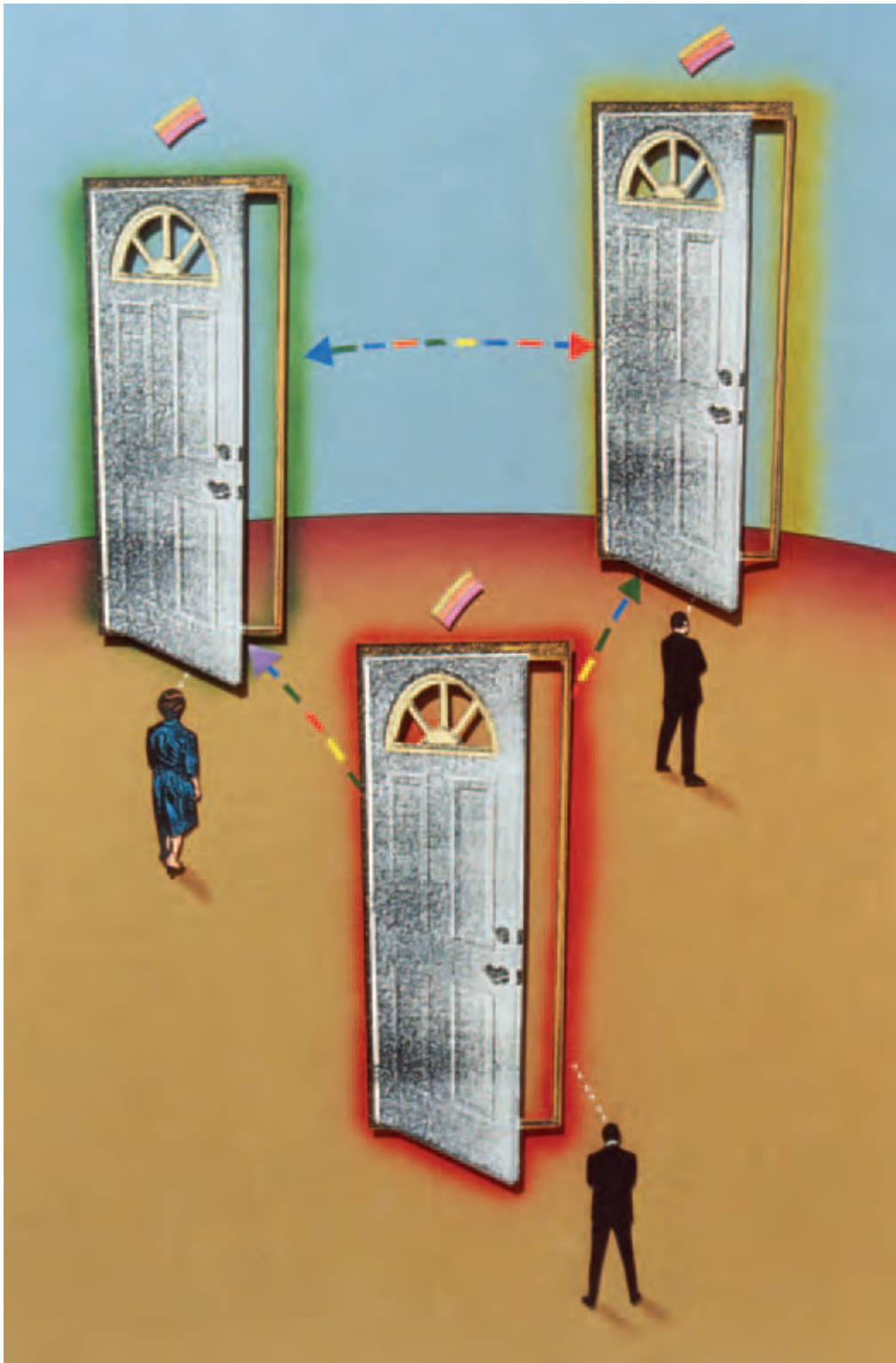


# eurohealth

## Citizen empowerment: Opportunities or threats for health management?



Patient choice and  
citizen empowerment in  
the UK and Sweden

The role of the physician  
in implementing patient  
choice in Sweden

Consumer preferences in  
Europe

Understanding the  
nature of health care  
relationships

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Published by LSE Health and Social Care and the European Observatory on Health Systems and Policies, with the financial support of Merck & Co and the European Observatory on Health Systems and Policies. News section compiled by Eurohealth with some additional input from EurohealthNet.

*Eurohealth* is a quarterly publication that provides a forum for policy-makers and experts to express their views on health policy issues and so contribute to a constructive debate on public health policy in Europe.

The views expressed in *Eurohealth* are those of the authors alone and not necessarily those of LSE Health and Social Care, EuroHealthNet or the European Observatory on Health Systems and Policies.

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Design and Production: Westminster European,  
email: [westminster.european@btinternet.com](mailto:westminster.european@btinternet.com)

Printing: Optichrome Ltd

ISSN 1356-1030

# C O M M E N T

## To choose or not to choose? That is the question

When it comes to health care it is virtually impossible these days to pick up a newspaper, watch television or listen to the radio without encountering buzzwords like 'patient empowerment' or 'consumer directed choice' In truth, we live in a remarkable time where many of us can expect both to live longer than ever before and also have a higher quality of life. As is the wont of man, this is never enough. We also live in an age where the consumer is supposedly king. Not only do we want rapid access to high quality care but, increasingly, we are told that we wish to take full control over health-related decisions. No longer is it enough to assume that the doctor knows best. We want to maximise the number of potential choices we have, not only over possible treatment decisions but also about the possible locations for treatment.

As papers in this issue of *Eurohealth* demonstrate, choice is a complex concept. Reconciling notions of choice and empowerment with the fundamental principles of universality and solidarity found in European health systems is no easy matter. Moreover, how do we reconcile the need for good health and well-being through the promotion of better lifestyles and policies to address some of the underlying socioeconomic determinants of poor health, while at the same time responding to demands to allocate an ever greater share of resources to health care? Have we access to sufficient levels of information to make informed choices? What implications does choice have for the principal-agent relationship between doctors and their patients?

Yet do we really want as much choice as all the buzzword and rhetoric would have us believe? What difference has it actually made on the ground? As we see from experience in England and Sweden reported in this issue, the implementation of mechanisms promoting greater choice does not always progress as anticipated. To choose or not to choose may well be the question, it may be some time before we have an answer.

*David McDaid*  
Editor

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# Citizen empowerment: *Opportunity or threat for health management*

David Chinitz

One of the persistent mantras accompanying the wave of health systems reform in European countries over the last two decades has been “to empower patients.” Patient centred care, choice, and responsiveness to patients were the headlines of the verses of the song for which patient empowerment was the chorus. Whatever else was done to or by health systems, all stakeholders, especially elected politicians, seemed to share a consensus that citizens and patients ought to be not only well taken care of, but also well satisfied and involved in decision-making regarding their own care.

There are a number of reasons for this focus on patient empowerment. One is, put simply, that unhappy citizens and dissatisfied patients spell trouble for bureaucrats and politicians who find themselves at the place where the health care buck stops. Another more cognitive/organisational, reason is that since health system outcomes are difficult to measure, attending to those factors which contribute to patient satisfaction seems both a warranted and attractive option for decision-makers. In addition, many reforms have been market oriented and, in markets, the consumer is supposed to be sovereign. Finally, the feeling that health systems, both private and public, had lost sight of the ultimate goal of health care, patient well-being, made the latter the centrepiece, or at least a key element, of most reforms.

While there is obviously much positive that can be said about the intention to strengthen the role of and

focus on consumers and patients, both real world experience and philosophical reflection suggest that the issue of empowerment poses more challenges and dilemmas than meet the eye. Sensitive to these unresolved issues, the European Health Management Association (EHMA) devoted its 2004 Annual Conference, held in Potsdam in collaboration with the Berlin Technical University, to the subject of *Citizen Empowerment: Opportunities and Threats for Health Management*. This meeting followed on from one devoted to the challenges facing the health work force in Europe and preceded the 2005 meeting on innovation in health systems. In this issue of *Eurohealth*, some of the papers from the 2004 conference are presented and give some idea of the broad range of perspectives elicited by the conference.

The papers presented here, representing experience in at least four countries (Netherlands, France, United Kingdom, Sweden) as well as a European wide perspective, address the philosophical underpinnings of health care relationships (Beneken et al. and Dumond); the mechanisms of individual choice in health care (Fotaki and Spångberg); the perception of consumers and consumer preferences held by managers and policy makers (Stoopendaal and Wats) and the manner in which national health targets reflect and integrate the desires of collectives of citizens at different governmental levels (Teil). Characteristic of EHMA’s membership and activities, the papers combine academic and managerial approaches as well as offering conceptual frameworks and specific tools for future health policy making and management in Europe.

The papers offer a number of lessons and insights. First, while the logic of market-oriented reforms implies citizen and patient centredness, the con-

sequent transformation of health organisations often leads to the opposite. Physicians are encouraged to follow guidelines more, relating somewhat less to patients as individuals and objects of care. Executives run the risk of becoming too far removed from patients. Second, and related, while citizen empowerment and patient choice may be the policy of choice for macro level decision makers, implementation is dependent on the awareness and cooperation of key stakeholders, most importantly physicians, and the latter are not always “on board.” Finally, if this is true within countries, *a fortiori* when trying to implement European Union policies founded on notions of open markets and individual choice. Patient empowerment is a highly contingent affair, dependent on underlying philosophies of care, organisational structures and technologies, and the behavioural tendencies of health consumers who may be discovered to desire choice somewhat less than policy makers assume. Hopefully, the papers presented here and others presented at the conference have gone some way to converting citizen empowerment from a mantra to a realistic proposition taking account of other goals and institutional constraints in health systems.

On behalf of EHMA, thanks to Professor Reinhard Busse and the Technical University of Berlin for hosting the conference, to *Eurohealth* for helping to assemble and publish some of the papers, and to all of the participants for their input. The 2006 EHMA Conference, to be held in Budapest this coming June, will deal with *Entrepreneurial Behaviour: Opportunities and Threats to Health*. EHMA welcomes participants and abstracts aimed at furthering our understanding of health system management in Europe in the 21st century (see [www.ehma.org/annual\\_conference/default.asp](http://www.ehma.org/annual_conference/default.asp) for details).

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# Patient choice and empowerment – what does it take to make it real?

## *A comparative study of choice in the UK and Sweden under the market-oriented reforms*

*Marianna Fotaki*

*“Choice is now seen both as a means to achieve various policy outcomes and as an end with its own intrinsic value.”*

### **Introduction**

The UK Government has introduced policies to increase patient choice to enable users of the NHS services to participate directly in decisions about the place, time and the way treatment is offered and provided.<sup>1</sup> Choice is now seen both as a means to achieve various policy outcomes and as an end with its own intrinsic value. Choice has also gained an increased importance on the national health policy agenda in Sweden.<sup>2</sup>

Individual patient choice is currently being launched as a new and ground breaking idea in the English NHS. However, increasing patient choice is not a new policy objective. There is some previous experience with choice in the NHS from the market-oriented reforms in the 1990s, and there is also experience of introducing patient choice under public competition models in several county councils in Sweden.

This article examines whether the proclaimed ‘choice’ actually became a reality under previous reforms in both countries. It attempts to answer the question as to why patient choice and empowerment was not promoted effectively within market-oriented reforms, an effect that was particularly strong in the UK, and points out the lessons that can be learned for current policy implementation in both countries.

It does so by reviewing the evidence evaluating the impact of the quasi-market reforms of the 1990s in the UK and Sweden and concludes by identifying what are the necessary preconditions for a new choice initiative to become a reality in England\*

learning from more advanced developments in Sweden.

### **Background**

In the early 1990s a set of competitive reforms aimed at improving efficiency, and increasing the responsiveness and quality of care, was introduced into the health systems of both Sweden and the UK. An internal market was implemented in the UK, while public competition was followed in 13 county councils in Sweden. Competition among providers for contracts from purchasers, and for patients who would freely choose among them, was the chief means relied upon to achieve the goals of reform in both countries.

Patient choice was seen both as an instrumental feature in bringing about these improvements and as a desirable goal in itself. Policy makers in both countries believed that the introduction of market elements into health care would enhance efficiency and simultaneously tackle the principal shortcomings of the both systems, such as rigidity, bureaucracy and unresponsiveness.

Before the 1990s, while it was possible to choose a general practitioner (GP) in the UK, in practice this choice was rarely exercised. Choice of specialist care (with the exception of privately purchased services) was needs-based and determined by the patient’s GP. In Sweden, there was less freedom of choice in primary care provider, which was determined by area of residence, but there was a greater degree of choice in specialist care without the need for prior approval by a gate-keeper – a role fulfilled by GPs in the UK.

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\* Patient choice reforms are mostly confined to England; health is now a devolved responsibility in the four countries of the UK.

In 1997 the incoming Labour Government in the UK abolished the internal market which it saw as inequitable and divisive. However, in 2003 it re-introduced patient choice to achieve greater responsiveness to users' needs, to increase efficiency, to enhance quality of services and most contentious of all, to improve equity.<sup>1</sup> The underlying belief was that service users' decisions implemented via a patient choice mechanism within a public health system would better reconcile all these potentially conflicting objectives, ultimately improving health and patient outcomes of care.

By contrast, the patient choice policies introduced through different public competition models in several county councils in Sweden had not been entirely abandoned. In 1995, a temporary reversal in policy followed the political change from a conservative to social democratic government but most changes initiated through pro-market mechanisms have since expanded in a rapid fashion. In 2002 the central government of Sweden for the first time decided to extend the benefits of choice nationwide.<sup>2</sup>

#### **Did quasi-markets improve choice?**

Although a general commitment to better freedom of choice was seen as both a means and an end of the market introduced to both health systems in the 1990s, there are very few studies specifically examining the impact of the market-oriented reforms on patients' choice in either the UK or Sweden.

Empirical research looking into the impact of these market-orientated reforms on choice in the UK, found that there was very little change in the choices exercised by either patients or GPs.<sup>3</sup> These evaluations suggested that the choices promoted were in potential conflict with other objectives of the reforms, such as efficiency or the reduction of waiting times for treatment.

Similar evidence about the conflicts involved in increasing efficiency while simultaneously promoting patients' choice were also seen in Sweden,<sup>4</sup> although direct choice in both family doctors and secondary care providers by patients was much higher, notwithstanding the geographical variations and equity implications

present.<sup>5</sup> Certainly the availability of choice of medical provider was significant in areas with a high concentration of specialist facilities, which in some parts of the country extended across the boundaries of county councils.

A comparative analysis of these reforms in outer London and Stockholm that looked at choices open to cataract patients' has suggested that in fact these quasi-markets had a negative impact on both the choice of provider and the modalities of treatment.<sup>6</sup>

In England, the choice of hospital for treatment was limited for most patients, with an exception of patients of GP fund-holders,\* mostly because of the financial disincentives involved in referring patients outside defined administrative areas (Health Authorities). Also, few patients decided to change their GP or requested a choice of hospital when they registered with a GP.<sup>6</sup>

Studies from Sweden confirm that patients made little use of the opportunity to exercise choice as they preferred to be referred for treatment within their local neighbourhood, and would rather wait longer than travel further away from home.<sup>7</sup>

Cataract patients, for example, did not express a strong desire to be involved in decisions concerning their treatment, possibly in part because of their advanced age and also because of their limited access to information. The overwhelming majority of respondents in the UK were not aware about the reforms at all, let alone feeling empowered, although such awareness was higher in Stockholm. In the UK, the increase in access to information, which in any case was very modest, was primarily tailored to meet purchasers' requests.<sup>6</sup>

Another study from the same period, although not specifically related to these reforms, confirmed that the written information given to patients in the UK was inadequate, out-of-date and did not meet their needs.<sup>8</sup> Research evidence suggests that patients' involvement in treatment decisions and willingness to choose may depend on their personal characteristics, health condition and the nature of the procedure involved. A study from Sweden for example found that younger, more educated patients, particularly women, wanted more involvement in the choice of doctor

*“Choices promoted were in conflict with other objectives of the reforms”*

\* The General Practitioner (GP) fund-holding scheme, introduced under the quasi-market reforms in health care in the UK in the early 1990s, enabled GPs who were eligible and wished to join the scheme to purchase elective care services from different hospitals on the basis of price and quality on behalf of their patients up to the value of £5000.

and treatment.<sup>9</sup>

The overall conclusion from evaluations of the impact of these reforms suggest there was little or no impact for most patients. In fact in some cases they might even have had an adverse impact on choice; an effect that was particularly strong in the UK. The impact of choice on other proclaimed reform goals under the quasi-market such as quality, responsiveness and patient empowerment, also varied.

Although it is widely accepted that GP fund-holders succeeded in providing more effective and better quality of care for their patients, some evidence now suggests that the internal market in the UK may actually have had a negative impact on quality of care measured as mortality following a heart attack.<sup>10</sup> In Sweden, there was no negative impact on quality apart from providers' perception that it had declined.<sup>11</sup> However, one study on the UK published in 2004 suggests that patients value knowing that they have a choice of hospital, even if they do not make use of this choice, while the implications on GP time in terms of explaining and offering choice may not be as substantial as initially feared.<sup>12</sup>

*“Policy makers seem to have overestimated service users’ willingness to opt for choices in health care”*

### **Why did market-oriented reforms fail to promote choice in the UK and Sweden?**

The evidence presented suggests that both patient choice and empowerment, introduced as policy objectives into the UK NHS in the 1990s, have failed to materialise and instead have ended up becoming largely rhetoric accompanying the implementation of NHS reform. In Sweden however, choice did have some limited success as the county councils did decide to introduce a public competition model. What are the general conclusions to be drawn from the results of this experience and what could be the possible explanations? More importantly, what do they signify in terms of lessons to be learned for implementing current policy options?

An important conclusion is that changes in both the control system and incentive structures resulting from market-oriented reform highlight the complexity involved in choice and user empowerment within the dynamics of a health care environment. The difficulty, if not the impossibility, of attaining the conflicting objectives stated in reform agendas, was once more reiterated. Pro-market reforms have also exposed the explicit nature of the resources required to increase choice.

In the 1990s policy makers, somewhat inconsistently and/or naïvely, proclaimed that all these occasionally mutually exclusive goals such as choice, quality and efficiency could be achieved simultaneously. Nonetheless, evaluations of market reforms indicate that any improvements in efficiency and quality were mainly or only possible because of some limited choice.

Notably, the response to incentives was more vigorous in Sweden where incentives were sharper and service users were more articulate in expressing their opinions. The Swedish experience, where reforms were determined at local government level, and gradually implemented to differing degrees in some county councils was in some respects different to that in the UK. One important difference was that all the new models for the purchaser-provider split involved a greater degree of freedom of choice than any prior arrangements in the Swedish health system. During the life span of the Stockholm Model there was some commitment to offer choice of provider to service users, though this was quickly abandoned in part because of the costs entailed. In contrast in the UK some form of choice had previously existed, although it was rarely used.

Another important conclusion is that liberally minded policy makers seem to have overestimated service users' willingness to opt for choices in health care without paying enough attention to their largely unmet need for usable and appropriate information. It became apparent that market incentives alone were not enough to generate sufficient information for patients' needs. It also turned out that patients' motivations for choosing whether or not to participate in health care decisions depend on a number of factors, some of which are only partly understood.

Overall, the factors that impeded successful outcomes in terms of patient choice and empowerment were primarily the underestimation of the trade-offs involved between these different objectives, the existence of occasional disincentives and a lack of support to help individuals exercise choice. Nevertheless, and contrary to the current rhetoric, the legacy of market oriented reforms in both the UK and Sweden is indelible. More recent developments in the English NHS, with choice and responsiveness as strategic objectives, indicate a reversal to the 'old' language and objectives associated with market reforms. In Sweden the increased choice over location and type of treatment that resulted from market



oriented reforms in some county councils has now been extended nationwide.

### **What does it take to make choice real?**

The 'Patient Choice' reforms in England are moving fast, towards an ambitious target of offering all patients choice at the point of referral by December 2005, but their goals are not always clear and may even be conflicting. The reforms have several important objectives: to increase efficiency and to reduce waiting lists; to make services more responsive to patients; to promote equity by extending choice beyond the well off or articulate; and to empower patients by giving them more control over decisions about their health. Choice is also being seen as an extension of both local democracy and democracy in health.

But can 'Patient Choice' really fulfil all these objectives simultaneously, or are there trade-offs or compromises that will have to be made? There are at least two major irreconcilable areas of tension resulting from policy conception and formulation that are likely to affect implementation and results.

One problem relates to the conceptual flaw in assuming that the mutually exclusive aims of equity and choice, or choice and efficiency, to name but a few, can be achieved simultaneously. However, there will always be tension between individually defined wants that choice might express, and efficiency defined in the societal terms that concern public health systems. This might mean that if public health systems are to continue to provide the maximum benefit to the largest number of beneficiaries only those procedures which are cost-effective should be promoted, which in turn may not be conducive to individual choice. Evaluations of market reforms suggest that improvements in choice, whenever they happened, were confined to geographically limited areas (Sweden) or schemes (UK) and did not involve whole populations of either country.

The magnitude of potential tensions and inbuilt conflicts between policies aimed at offering patients genuine choice over primary and specialist provider, form of treatment, and the core values and goals of public health systems such as equity and efficiency has to be recognised and taken into account. An overall conclusion is that potential gains, conflicts and trade-offs involved in implementing choice to pursue

multiple policy goals need to be openly pronounced for any choice initiative to succeed. The experience of previous market orientated reforms serves as a reminder of the need for clarity in defining policy objectives beforehand, especially when they are visualised and launched on a large scale, as in the case across the whole UK, and more recently England or Sweden.

Furthermore, access to appropriate, usable and relevant information is a prerequisite for choice to work. The evaluation of the quasi-market reforms indicates that providing information was not a high priority for neither policy makers nor providers. However, there is a need to establish effective mechanisms to enable all concerned to obtain relevant and adequate information on the options available, technical aspects of quality and clinical effectiveness. This has to be seriously considered by policy makers who aspire to empower health service users and respond adequately to their needs.

It is also clear that policy makers who introduced quasi-market reforms had even less awareness and comprehension of how patients make choices. Choice can be used as an effective means to increase responsiveness in meeting certain patient needs, but policy makers have to take account of users' perceptions of aspects of choice that are most important to them and therefore provide support for their enactment. In another words, service users should be given the opportunity to choose how much or what they want to choose depending on their health condition and personal circumstances.

### **Conclusion**

To sum up, market oriented reforms in the UK and Sweden may not have had the impact that their advocates hoped. The resultant changes nonetheless stressed the necessity for a more developed approach, since they have exposed the mechanistic nature of the theoretical assumptions that underlie much of their policy goals. In addition, they have brought to light and articulated the need for change, while paving the way for current developments. Furthermore, it became clear that the incentives introduced into both health care systems have to be powerful enough to achieve their purpose thus underlying the need for a proper evaluation of how they work and subsequent consideration of the results of evaluation.

Looking at the evidence of the success and failure of choice in promoting proclaimed

*“trade-offs between different, conflicting policy objectives have to be clearly spelled out”*

policy goals under the market oriented reforms in both countries enables better understanding of opportunities and limitations involved in promoting individual patient choice. It also reiterates the need for clarity of policy formulation and realistic statements about about policy objectives that are being currently pursued in England and Sweden. These are essential preconditions both for credibility and for policy success when value laden concepts such as promoting patient choice and empowerment are at stake.

The evidence suggests that introducing choice reform is a much more complex task than it may at first appear. Turning this into reality, even within the current limited agenda focused on elective surgery and reducing waiting lists, requires considerably more thought. There are many issues such as the asymmetry of information between service users and providers as well as differences among patients in their attitudes to choice, in addition to the resource implications of choice, which need to be addressed. More fundamentally the likely trade-offs between different, conflicting policy objectives have to be clearly spelled out and considered in any reform implementation process.

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# The role of the physician in implementing patient choice in Swedish healthcare

*Ulrika Winblad Spångberg*

## Introduction

A policy was introduced in Sweden in the early 1990s with the intention of giving patients the right to choose their healthcare provider.<sup>1</sup> This was a new phenomenon in the Swedish context; patients had previously been restricted to using the nearest medical facility. The new policy states that not only can patients choose a primary care centre but also which hospital or private clinic to turn to right across the country.

Even though the policy is meant to empower patients, physicians remain highly involved when it comes to

realising a patient's choice. Firstly, a referral from the physician is usually needed when a patient wants to choose hospital care. Moreover, physicians are still the main source of information for patients about specific rules, waiting times and differences in quality between alternative settings for treatment.

A study was undertaken to explore whether physicians have indeed implemented this specific policy of patient choice. That is, do they actively support and help patients to choose a care provider, for instance by informing them about their right

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to choose or providing information about different referral alternatives and waiting times? If this is not the case, the next task is to identify the reasons why physicians do not take actions to fulfil the political objective of free choice of provider.

## Methods

In order to investigate physicians' roles in putting this policy into effect, a survey was conducted of 960 physicians in one county council in Sweden. Only physicians who referred patients and/or admitted referred patients were included in the study. After two reminders the response rate was 71%. After exclusion of answers from retired physicians and physicians who worked in other occupations the effective response rate was 60%.

## Results

### *Are physicians active in helping patients choose care providers?*

First, physician attitudes towards the policy were investigated and most reported having a positive attitude. They also stated that patient choice had led to more effective healthcare and furthermore that the quality of care had improved through the introduction of competition into the system.

On the other hand, a positive attitude towards the policy per se does not necessarily imply that physicians feel that they need to be involved in the actual choice situation. The next step was therefore to find out how helpful these doctors were in helping patients choose. The results indicated that they did not regularly help patients to choose health care providers. For instance, only 17% of the physicians 'always' informed the patients about their right to choose. The majority (40%) only informed patients who actively asked for advice. Instead, referrals were mostly based on medical grounds; the desire of the patient was of lesser importance.

### *Are physicians able to implement the policy?*

The next question was why physicians did not encourage patients, in the referral situation, to choose healthcare providers. Three hypotheses were proposed to explain this physician behaviour. To achieve the policy goals, physicians must (a) *be able* to implement these changes; (b) *understand* the intentions behind these changes and the actual rules; and (c) *be willing* to implement change.<sup>2</sup>

The 'able' hypothesis investigates whether physicians are able to comply with the pol-

icy goals. Are there structural obstacles in the system that make it difficult for physicians to help patients choose healthcare providers, for example, referring patients to wherever they want to go? Or, stated differently: do the organisational conditions in which physicians work create sufficient incentives to implement this policy?

According to the survey undertaken, physicians stated that they did not feel particularly restricted by organisational factors in helping patients choose a health care provider. There were no direct financial disincentives that could discourage referring patients to their choice of provider since the individual physician was never responsible for the cost of a referred patient. One problem, though, is that the county council has done very little to disseminate information about the rules. For instance, only one in every ten doctors had been invited to participate in courses or information meetings where the content of the policy were discussed. On the whole however, there seems to be no direct limitation at an organisational level that would prevent physicians from helping patients choose their care provider.

### *Do physicians understand the intentions of the policy?*

The 'understand' hypothesis deals with physicians' interpretation of the motives behind the policy as well as their actual knowledge of the policy. The idea is that the less knowledge the physicians may have about policy motivation, the less motivated they are to inform patients about their right to choose.

The survey favoured this explanation. Physicians were unsure about the motives behind the policy. Just over half of respondents felt that the intention of the policy was to increase patient empowerment, a low number considering that this was the main rationale behind the policy. More interesting perhaps is what knowledge physicians had about the actual rules concerning patient choice. Seven out of ten physicians knew, for instance, that patients were allowed to choose a public hospital within the boundaries of the county. On the other hand, only seven per cent knew that patients have the right to choose a care providers anywhere in the country. To sum up, even if the respondents were quite knowledgeable about the rules applying to their own county council, their level of knowledge was still not sufficient to affect change.

*"Only 7% of physicians knew patients had the right to choose care provider..."*

*“Physicians have done little to change their behaviour in accordance with policy directives”*

*Are physicians willing to implement the policy?*

The third hypothesis (the ‘willing’ hypothesis) assumes that physicians do not approve of the new policy and are therefore unwilling to help patients choose a care provider. The idea of free choice of provider challenges the traditional medical role in which the physician is devoted to medical issues and determines where a patient should be referred. Furthermore, there is also a chance that physicians are unwilling to help the patient choose a certain care provider since they might fear that a patient may make a medically inferior decision and therefore risk health and recovery.<sup>3</sup>

The hypothesis is divided into three dimensions. The first dimension investigated how physicians believed that patients might choose inferior care providers. Nearly 70% admitted they would refer a patient to a medically inferior alternative if the patient insisted, but only if the patient had been informed about risk and only as long as the quality of the alternative was at least of a certain standard.

The second dimension of the hypothesis investigated whether these physicians felt that their internal autonomy, i.e. their clinical work was negatively influenced by the choices made by patients, which therefore meant they would choose to oppose the policy. Only 15% agreed that their internal clinical work had been influenced by the policy. One comment illustrates the way that one of these doctors felt affected. “I sometimes begin an examination and am almost finished with the diagnosis. All of a sudden the patient becomes dissatisfied (for example, has not received medication) and decides to change physician. The new physician has to start all over with the examination since the patient does not volunteer information about this change.”

The third dimension of the hypothesis investigated whether their external autonomy was negatively influenced by the policy, i.e. if helping patients to choose care provider required too much time and resources. Very few physicians perceived the policy as being too costly for their daily work (only 5.9%). At the same time, some physicians commented that losing patients always involves the loss of prestige. However, opinions on whether it took too much time to inform patients about the new policy were divided. One third stated that helping the patient choose took too much time, one third of them were indif-

ferent, while the remaining third did not agree at all that the policy was time-consuming. General practitioners were, as shown in many other questions, significantly more negative in this respect.

To sum up, the ‘willing’ hypothesis assumed that the physicians in the survey did not approve of the new policy and were therefore unwilling to help patients choose care provider. The answers did not provide much corroboration for this assumption. Rather, the results suggest that physicians today do not feel particularly threatened by the policy under investigation. One exception seems to be general practitioners (GPs), who are, as a group, more willing to admit that the policy has impacted negatively on their working conditions.

*Correlation among the hypotheses*

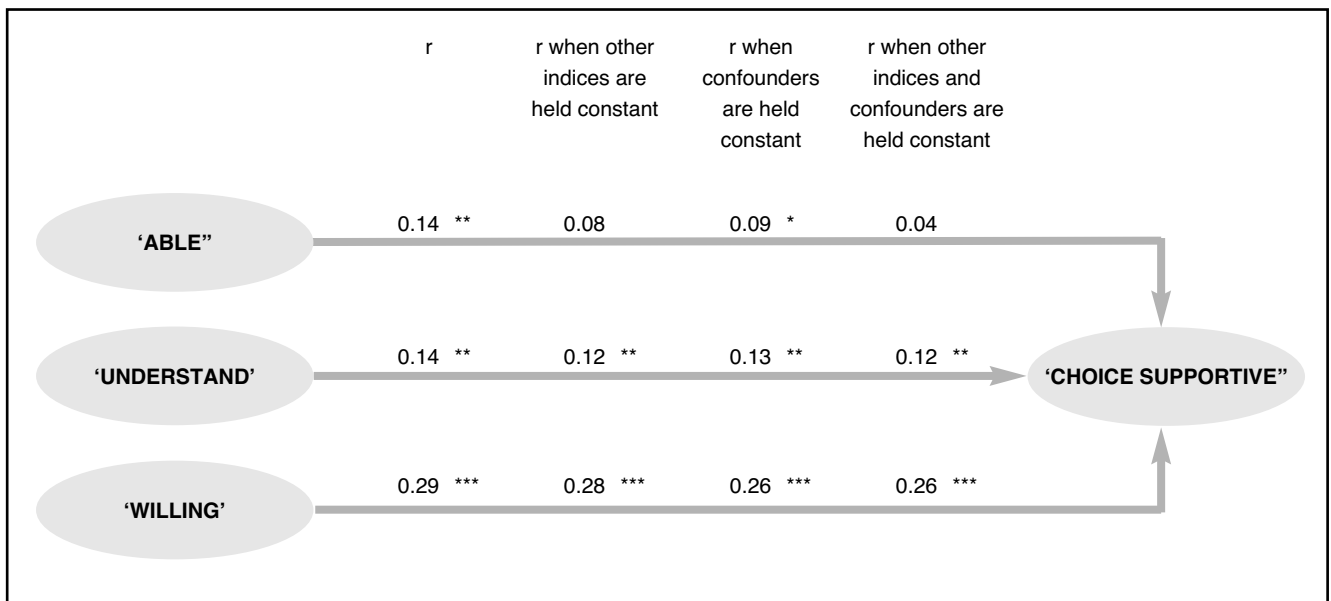
In the last part of this study, the focus is shifted to answering the question of whether or not there is a correlation between the separate hypotheses ‘able’, ‘understand’ and ‘willing’, and whether physicians assist patient choice through information about rights in general and on the alternatives that patients might choose (‘choice-supportive’). In order to investigate the correlation between the hypotheses, four indices were constructed out of questions in the survey. Each index was the mean value of answers to a group of questions, measured in an ordinal scale from 0 (negative towards patient choice) to 1 (positive towards patient choice). The selection of questions to be included in each index was validated by factor analysis. The partial correlations between indices, i.e. when the effects of other indices and the confounders (age, physician’s speciality and type of employer of the physician) were held constant, were computed using the Spearman rank test (see Figure opposite).

There was an insignificant correlation ( $r=0.04$ ) between organisational factors (‘able’) and the degree to which physicians help patients choose care providers (‘choice-supportive’). This means that a physician who feels restricted by organisational factors is not less willing to help patients choose care provider, as compared to a physician who does not feel restricted.

As for the ‘understands’ hypothesis, the analysis reveals a (moderately) significant correlation between the physicians’ understanding of policy and their actual behaviour when it comes to informing patients about their right to choose ( $r=0.12^{**}$ ). Physicians who are more knowledgeable about the actual rules are more likely to

**Figure**

The coefficient of correlation,  $r$ , between “able”, “understand”, “willing” and whether the physicians are ‘choice-supportive’ (n=504, \*:  $p<0.05$ ; \*\*:  $p<0.01$ ; \*\*\*:  $p<0.001$ ).



assist patients in choosing a care provider at the hospital level.

The statistical analysis also shows a significant correlation between whether the physicians perceived that their working conditions had changed and whether they were willing to help patients choose care provider ( $r=0.26^{***}$ ). The physicians most threatened by the policy were much less willing to inform patients about patient choice and vice versa.

### Discussion

The first lesson to be learnt from this study is how difficult it is to change clinical practice with political initiatives. The success of a policy is highly dependent on what happens when the policy becomes reality and is incorporated into daily routine. Although the policy was introduced 15 years ago physicians have done little to change their behaviour in accordance with policy directives. Whilst doctors appear to recognise the importance of patients' views, these views ultimately take second place to clinical judgement. The physicians still do not involve patients in decisions about referrals. Instead, strictly medical assumptions seem to be the basis of referral. Even if political support has been strong, it does not seem as if this enthusiasm has reached all the way down to the actual physicians who are supposed to put this initiative into practice.

It is also worth considering that even if only a few physicians felt threatened by the policy at present, it is still important to

note that when physicians are threatened by the policy they are still less willing to help patients. The study also showed that few patients today demand to be referred to a specific care provider. However, this development is prone to change. There are many signs that the patients of tomorrow will be more knowledgeable about their conditions and also more demanding. This might also lead to a development in which physicians experience the policy as becoming more threatening to their working conditions. The attitudes displayed toward the policy by GPs is one early sign of this. GPs generally seem to have a more negative attitude toward the policy and are also less willing to help patients choose. One interpretation may be that this reflects their negative experiences of the GP reforms introduced in Sweden in the early 1990s; reforms that dramatically changed their working conditions.

The failure in implementation also raises questions about the ability of the state and county councils to manage the healthcare sector through political initiatives. Little action was taken at either the national or county council level to structure the implementation process for this policy. Supposedly, politicians considered this policy to be a gift to the patients, rather than something that involved healthcare personnel. This is a quite a naïve assumption; patients at hospital are in fact highly dependent on their physicians when it comes to exercising their right to choose their healthcare provider.

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# The preferences of health care consumers in Europe

*Margrietha Wats*

*“Governments, the medical profession and health insurers all wish now to know what the patient actually wants. It matters!”*

This article focuses on European consumers and what they can expect from health care services. This was also the central question of the Fourth Clingendael European Health Forum.\* An investigation into the wishes and preferences of health care consumer is in itself not surprising. The time when ‘patients’ were expected to act as passive recipients of care, enduring their illness without complaint, as the very word patient implies, is long gone. While health care consumers remain in a very different position to consumers of other goods, for example, someone buying a car, they have indeed been emancipated in terms of their relationships with other parties in the health care sector. ‘Demand-driven services’ is no longer an empty slogan. Governments, the medical profession and health insurers all wish now to know what the patient actually wants. It matters!

## **Does the ‘European consumer’ exist?**

The next question to consider is whether the ‘European’ health care consumer really exists. The fact that we should be asking such a question is perhaps a little more surprising. The answer is still no, or at least not yet. There are clear differences between Belgian, Dutch, French, UK and German health care consumers. Nevertheless, it seems likely that convergence will continue in terms of their expectations, rights and obligations. After all, the European internal market, with its ‘free movement of people, capital, goods and services’, is becoming ever more important, not least in the health care sector. The influence of the EU on many aspects of daily life, including health care, continues to grow. Moreover, the challenges facing national health care systems across Europe are broadly similar. In seeking solutions, countries are looking to each other; there is clear evidence of convergence. Thus while the European health

care consumer or customer is, for the time being a notional figure, it is one whose significance must be acknowledged.

There is a close correlation between the structure of a health care system, the organisation of services provided and the manner in which a patient is able to approach health care providers. We now know much about the differences between individual countries in terms of the organisation of services and the insurance funding systems. Significant differences remain between member states in terms of health care supply and demand. The Netherlands Institute for Health Services Research (NIVEL) has examined, compared and described the systems in Belgium, France, Germany, the Netherlands and the United Kingdom. However, relatively little research has been conducted into differences between European consumers in terms of their behaviour and viewpoints. In order to rectify this situation, at least in part, the Dutch Council for Public Health and Health Care (RVZ) commissioned TNS NIPO (The Dutch Institute for Public Opinion and Market Research) to conduct a study in these countries. Choices that consumers wished to enjoy at different times during the health care process, their preferences with regard to innovation; and their attitudes to undergoing health care treatment in another country were all examined.

Country profiles were prepared by the RVZ and while it is a perilous undertaking to attempt to draw any firm conclusions from such a comparison, nonetheless a number of interesting observations may be made. Firstly it appears that if consumers have more options, they are likely to value these options more highly. Another observation is that if they are offered the choice between visiting their own general practitioner or a specialist, they will not neces-

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\* The objective of the Netherlands Institute of International Relations, known as ‘Clingendael’, is to promote the understanding of international affairs. The fourth Clingendael European Health Forum, organised under the joint auspices of the American Embassy in the Netherlands and the American Chamber of Commerce was held on 4 December 2003 at Clingendael House, The Hague.



sarily opt to visit the specialist. In countries with insurance systems, consumers are willing to pay more if they clearly receive added benefits, but only Dutch consumers expressed a desire for even greater freedom of choice and health care treatment options than those currently available. They also have a relatively positive attitude towards innovation and using health care services provided in other countries.

#### Future customers

The 'European customer' will result from developments and reforms in the various national health care systems that are occurring as part of this convergence process. However, this does not mean that there will be one homogeneous group. In fact, two distinct groups of customers may emerge, each with their own wants and preferences. One group is prepared to travel and willing to pay for greater choice. The other prefers to enjoy health care services close to home and is less willing to pay more. Despite the obstacles that would face any pan-European health care system, certain factors can be identified that will accel-

erate its emergence. The RVZ provides an impression of a European health care sector based on the preferences of these two consumer groups.

For those unwilling to travel, the European health care system will retain a strong regional dimension. This is particularly the case for older people and those with chronic conditions. Low-complexity care services for other groups will also remain regional; services will be marked by their diversity, flexibility and efficiency. European centres of excellence may well be created to cater for another segment of health care provision, high-complexity services, as well as for the care of those with limited treatment options, including Alzheimer's and Parkinson's Diseases.

Looking at health insurance systems, the RVZ envisages advantages in having a pan-European basic health policy. However, whether any such policy will ever be introduced remains to be seen. Moreover the manner in which solidarity can be created, and the extent of that solidarity, are unclear.

## New Journal Launched - Health Economics, Policy and Law



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# Health care executives and ‘their’ patients

## *How do they keep in touch?*

*Annemiek  
Stoopendaal*

*“In larger  
organisations  
executives tend to have  
fewer contacts with  
patients”*

### **Introduction**

In their offices at the end of long and silent corridors, executives usually do not meet patients. Either they walk through their organisation in the same anonymous way as their patients or they are known as the ‘executive’ and kept at a distance because of their status. Questions arise: do we know something about the number and the type of contacts health care executives and patients actually have? How does the executive, in an environment of growing distance, stay in touch (to speak in marketing terms) with their ‘product’ and their ‘clients’? Where do they meet?

This article explores the contact patterns between patients and health care executives. Firstly, the tools actually used by health care executives to become aware of the needs of their patients will be described. This is achieved using data from a questionnaire sent to 900 Dutch health care directors, working in different health care organisations, with a 46% response rate<sup>1</sup> and by analysing 12 interviews with Dutch health care executives from different backgrounds and different types of care institutes.

Secondly, to get a notion of how the contacts with clients influence health care executives in their behaviour and policies implemented, two executives of different Dutch institutes for health care were observed in their normal working roles.

Thirdly, the most intimate contact with the role of patient is to become a patient yourself. Do health care executives change their policy and vision once they have experienced the patients’ role? To get an insight into the experiences and behaviour of executives on becoming patients, five inter-

views, published in 2004 in *ZorgVisie*, a Dutch magazine for health policy and management, were analysed.<sup>2</sup> Based on these findings, prudently, a few conclusions can be drawn.

### **Research context**

This paper results from a long running project ‘Caring for Management’ that studies the work and behaviour of health care managers.\* Much has been written about health care systems, governance questions, and organisational transitions. Health care managers, however, have been ‘invisible’. This project will attempt to change that. It started in 2000 with a literature review<sup>3</sup> on the role, behaviour and competences of health care managers and was followed by an extensive survey in the same year.<sup>1</sup> These data provide the background for further qualitative exploration of real-life managerial work and behaviour in health care. The focus of the qualitative part of the research project is based on the analysis of current trends in Dutch health care, namely that:

- Health care institutes are scaling up by merging.
- More than 50% of the executives of health care institutes are now educated in economics and management. A ‘managerial revolution’ seems to have taken place.
- The structure of Dutch health care organisations has changed from functional based to process based divisions
- The management of health care institutes has changed. Due to the growing span of control of managers, and the

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\* The research project ‘Caring for Management’ is supervised by Professor Dr P Meurs (Erasmus University Rotterdam) and Dr M Noordegraaf (Utrecht School of Governance).

increasing number of organisational layers we see a decrease in 'hands-on' management.

This analysis leads to the conclusion that the distance between the executives and primary processes is increasing.

### Contact patterns

How often do executives actually meet their patients? The survey<sup>1</sup> shows that 66% of the total number of contacts of health care executives are internal contacts and 34% are external contacts, but only 6% of the internal contacts are contacts with patients and/or clients. At most 7% of the contacts of executives of institutions for people with intellectual disabilities take place within the institution; in respect of home care this represents only 4% of internal contacts.

In larger health care organisations, executives tend to have more managerial contacts and fewer contacts with professionals and patients/clients.<sup>4</sup> Contacts with clients are less than 4% of the total amount of contacts of the average health care executive. Based on these figures one could easily draw the conclusion that patients are not considered to be an important factor in the daily work of the executive. Is this conclusion correct? To check this, executives were asked how they keep in touch with primary processes and with their clients.

Twelve health care executives were interviewed about the phenomenon of an increasing distance between executives and the primary processes in their growing organisations. The executives considered growth to be an unavoidable social reality arising from technical developments, specialisation and an increase in part-time working.

These executives do indeed encounter some of 'their' clients at meetings of the patient council, or they meet a specific patient or his family following a complaint about care received. They also meet specific groups of clients at external consumer boards. A more abstract form of meeting the patient and identifying their needs is by investigating patient satisfaction. This method was not mentioned much. Some executives walk around to have informal chats with patients in the corridor or in the organisation's restaurant. The executive of an organisation providing care for older people for example, walks through the care unit or joins Sunday morning concerts. In organisations for people with intellectual disabilities, clients often bring coffee or

simply walk in for a little chat. This used to be the same in psychiatric institutions but as these organisations became bigger, the office of the executive turned out to be too far away: "I had a room where patients dropped in...". Particularly in hospitals there seems to be little contact between executives and patients. Most patients stay in hospital for a short period and the patient population is diverse. Due to this, hospitals are crowded with people, like big shopping centres. Walking through the hospital, the executive is as anonymous as the patient.

Most executives do strive for contacts with primary processes; they try to make regular visits to the work floor. Although most of these executives consider making regular work visits important, they are aware that they in fact are not acting accordingly. Only one of the 12 executives built in monthly work visits as standard into his planning. During these visits, most executives are passively informed, although a few do partake themselves in the physical work of care giving.<sup>5</sup>

Some of the executives interviewed do not in fact visit the work floor at all. They rely on their former experience in the primary process, and believe monitoring and delegating contacts through the layers of their organisations should provide enough information. They may also simply feel uncomfortable disturbing the privacy of their patients and the autonomy of the professionals working on the ground.

### Contacts in practice

Knowing how often executives and clients meet and knowing on which occasions they meet does not tell us if, and how, executives use this information as part of policy-making. Therefore, we need to have more inside (real life) information.

Two executives, a hospital director and an executive of a organisation for people with intellectual difficulties, were observed for five days. The days were chosen from the diaries of the two executives. We selected days with the most diverse meetings, a work visit or other moments of contact with clients, managers or professionals.

The first of the two observed health care executives leads one of Holland's largest hospitals with five sites and 2,500 employees. Being a mathematician he is not formally educated in the care sector but is well versed in its practice. Previously, he used to be the executive of an organisation for people with intellectual difficulties. During this

*"executives should pay attention to the dilemmas that health care professionals confront in their daily work"*

period of observation there was no contact with patients at all, although he accompanied his daughter to be treated in his own hospital and referred to this in one of the meetings with managers. He regularly mentions his wife, a nurse in another hospital, and uses her opinions and experiences. A lot of his daily contacts are with medical professionals and he sometimes visits wards.

In the organisation for people with intellectual disabilities, he had a lot more contact with clients and their families. Now, in this hospital, where he does not have a connection with the patient, his behaviour is driven by a more abstract notion of the patient. In meetings he always tries to imagine the experiences of patients and advocates their needs, using the slogan: 'patients first'. In his welcome speech to new employees he tells them to like their work and love their patients. To be in contact with primary processes the executive and his colleague, an economist, are strongly involved with quality improving projects of the organisation. Although this executive does not meet the patients in person, his vision of patients' needs and wants, is strongly personal.

Executive 2 leads an organisation for people with intellectual disabilities, scattered across 120 locations and employing 1,600 staff. Primarily educated in care giving and latterly in management, his professional and managerial career have all occurred in this specific sector and mainly in his current organisation. He is strongly committed to the ideology of 'community care', which means supporting disabled people to live a life as normal as possible. He writes about this and has a firm knowledge and notion of the evaluation of this kind of care all over the world. He is acquainted with and well known by his personnel, makes structural monthly visits to different parts of the organisation and wants to be in contact with the work-floor and patients to fine-tune his vision.

During the observation period, there were many contacts with clients as they work in the organisation's restaurant or while they deliver mail. On his monthly visit he talked with many of the clients and played chess with one of them. In a meeting with the client board, where professional attitudes were discussed, the executive used all his free time to chat with clients.

He seems to be very involved with clients but this 'ideological attitude' has another consequence. In this organisation employ-

ees complain that this executive gives too much attention to clients and too little attention to the professional dilemmas that the ideology of community care brings up.

Thus while both executives are involved with their patients their behaviour differs as their organisational contexts differ. Executive 1 uses the experience of his relatives to build an image of the experience of patients. He compares this image with the allocation of attention to the work of professionals. He tries to imagine how a patient will experience the care given in his hospital and he stimulates his employees to do the same.

Executive 2 has a lot of contact with clients and their families and has a firm vision of how care should be provided. However, he does not have as many contacts with professionals and this firm vision has negative as well a positive influence on professionals; a phenomenon which is also found in other empirical research.<sup>6</sup> In this situation the knowledge of clients seems to work out as a system of 'planning and control'.

### Effects of experienced care

The final question in this paper is whether the experience of being hospitalised changes the contact patterns of executives, and whether 'mental maps' and policy are influenced. In 2004, the Dutch magazine *ZorgVisie* published five interviews with executives who experienced being a patient or a close relative of a patient.<sup>2</sup> The published texts of these interviews were analysed.

All of the executives had both good and bad experiences and their opinions vary from annoyance to admiration. The annoyances were mostly raised by periods of waiting and by insensitive attitudes of staff. The practice of keeping patients waiting for a long period, without informing them why things take such a long time, made the executives angry, especially when the desk officer in charge did not make any kind of contact. These health care executives experienced a strong feeling of dependency and the longing for confidence and attention.

They also noticed that some treatment decisions were not inspired by care but by economic or efficiency concerns. For example, the mother of one of the executives who was staying in an institution for care after having a stroke was moved from a small dining table, where she had nice contacts despite her problems in talking, to a big table where she had no contact at all during dinner. These big tables were

*"Another way of personalising care was to provide more and better information for patients"*

deemed more efficient for serving dinner. The executives experienced that this kind of decision-making is hard to accept for patients, especially when things go wrong.

These self-experiences changed neither contact patterns, nor the number of contacts with patients, but they certainly changed the 'mental maps' of the executives, and they became aware of three main issues:

- Management, alone, is not providing better care
- Patients are not clients: dependency makes you lose your tongue
- The attitude of caregivers is very important

When these executives returned to their organisations, they changed their policy based on these insights. First, due to their insight that individuals need personal attention, they tried to improve care by making it more personal, for example, by appointing personal patient coaches but predominantly by devoting more time, money and attention to the training and assessment of attitudes of health professionals and other personnel. Another way of personalising care was to provide more and better information for patients. Second, executives who experienced the patient role directly, showed more respect for the work of professionals and had come to understand the importance of supporting their work.

### Conclusion

Bridging the distance between executives and patients seems to be not a matter of quantity but a matter of quality. Executives who experienced care themselves, did not increase their contacts with patients but changed their 'mental maps'<sup>7</sup> and their policy. If health care executives are more responsive to patient perspectives, they are more willing to change into more empathic organisations.<sup>8</sup> Hopefully, executives will stay healthy but they can improve their imagination of being a patient. Their image of the patient perspective can be strengthened by sharing the real experiences of the clients of their organisations.

It also became clear that it is important for executives to pay attention to the dilemmas that health care professionals confront in their daily work. When we typify management as the process of allocating attention<sup>9</sup> we see that health care executives have to allocate their attention to at least two perspectives, the perspective of the patients and the perspective of the professionals.

Patient experiences and professional dilemmas can give input to the imagination of the patient and professional perspectives. They will lead to the involvement of the health care executives and to management behaviour which consists of supportive leadership and personalised care. If we underwrite the assumption that leaders influence employees' attitudes then this behaviour and policy will lead to more empathic health care organisations.

*“executives who experienced the patient role directly showed more respect for the work of professionals”*

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# Public health targeting processes in Europe

*Alice Teil*

*“Who defines health strategies and what is their underlying logic?”*

Since the 1970s, industrialised countries have implemented a number of different health system reforms in order to try and halt the inexorable increase in health care costs. This has led to the strengthening of constraints on funding and the introduction of mechanisms similar to those found in the market.

Despite these reforms, costs continue to increase, but without a similar rise in both accessibility and quality. Trapped between the search for equity on one hand and the search for economic efficiency on the other, many countries have reached a stalemate in the political decision-making process. Having tried first to control costs, some European countries have slowly moved to implement a different approach to health care policy based on a system of setting health priorities and targets.

These priorities and targets are associated with three trends: the first is a necessary expansion in what is considered to be a health issue so that this is not only confined to the health care system, but to the broader range of factors that act as determinants of health. The second is the necessary integration of service users and citizens into the policy decision-making process. The third is the need to define common programmes for all stakeholders, not just health professionals, across the entire health care system.

Within this context, this article will demonstrate that governments determine health policy objectives in different ways. This is in terms not only of their nature and impact but also in terms of the respective responsibilities of different stakeholders, making decisions relative to the funding and implementation of strategic choices in health policy. Two major questions constitute the basis of this work: Who defines health strategies and what is the underlying logic of these strategies?

In order to respond to these questions, a three step process has been adopted. Initially literature on objective concepts, priorities, and health strategies, as well as national public health plans were collected and analysed. From this analysis scientific and policy experts were interviewed in

England, Finland, Spain and Sweden. A questionnaire was subsequently sent to health system representatives in all 15 old EU countries in order to complete and validate information.

In the first section objectives and priorities are defined. The description of these systems allows us to analyse current trends in the decentralisation of decision-making processes. Then the processes at work are shown, as well as the points of convergence and divergence between the different countries studied.

## **Health policy: a combination of curative and preventive approaches**

Both countries operating through a federal or decentralised system develop their health policy on both health care and health promotion taking account of research findings on national cohesion, common purpose, and transparency. Because the principles by which their political structures have developed differ, disparities across these countries are strong in terms of social, economic and political matters, including access to health services. Thus, the issue of inequalities in health is an overriding objective that helps to define their health policies. In countries where independent institutions are responsible for managing the health care system, it was observed that the barriers between health and social policy actions are more pronounced. This compartmentalisation between sectors, at a time when health policies are influenced by a holistic World Health Organization (WHO) definition which states that health is “a complete state of mental and physical well being”, is an important issue because it reduces the capability of systems to address the broader determinants of health.

In looking at different mechanisms used to develop health policy, the structures in each of the countries examined were allocated to one of three broad categories: multiple, dual or integrated systems.

## **Multiple systems**

This first category includes the systems found in Germany, Austria, and Italy. They are characterised by having both objective targets set at a federal level in line

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with health targets recommended by the WHO Regional Office for Europe, while also developing different types of health programmes within regions.

In Germany for example in April 2003 seven health targets were set. Five related to specific conditions (diabetes, breast cancer, cardiovascular disease, chronic back pain and depression), one is relative to individual behaviour (tobacco consumption) while the other focused on a specific population target group (the under twenties). In Austria, health targets are set out in the federal government's triennial public health plan. In both countries the regions set their own health care policy.

In Italy meanwhile, the distribution of resources to the different regions is determined by a national funding plan which itself stems from health targets set out in a biennial national health care plan. For the 2002–2004 period, fifteen objectives and ten strategic projects were defined. Each objective was linked to actions on priority interventions, ensuring that these priorities were integrated into local and regional plans. Regional plans translate health targets into financial and organisational measures in the health care system, taking into account regional needs. Thus the link between the direction and priorities of the national plan and regional programmes is guaranteed by the central mechanism of budgetary allocation.

In all three countries the systems are characterised by an important division in the allocation of responsibilities and the great challenge of trying to reconcile these different roles within a common strategy. That is why it remains difficult to monitor changing trends in the mechanisms used to develop local health strategies.

### Dual systems

Finland, The Netherlands, Spain and Sweden all fall into the dual system category, where systems are characterised by a strong concern over inequality in access to and the quality of health services. Two characteristics of health policy have thus developed. The first focuses on health care services and: (1) defines principles of accessibility, (2) sets regulations linked to professional skills, and to the quality and risks associated with services, (3) includes health insurance benefits within the social security system, and (4) permits intervention by both the private and public sectors. The second specifically deals with prevention: communicable disease, prevention interventions targeted at children and adolescents,

promotion both of nutritionally balanced diets and greater physical activity, improved health in the workplace, and measures to prevent pollution.<sup>1</sup> The approaches adopted in these four countries are enshrined in national legislation intended to define common objectives for health while being mindful of the need to respect human dignity and equality between individuals.

### Integrated systems

Within the devolved health care environment in the UK, the system found in England falls within this third category. The starting point for policy is to define public health priorities. For each priority health targets are developed and a group of recommendations relevant both to health care and prevention are set out. Here, different interventions for health are integrated into a global public policy that considers how health priorities can be implemented not only within the health care system but also how to address some of the broader determinants of health. Here the health care system is treated as one component of national health policy rather than being a stand alone structure; medical and social actions to meet the goals of national health policy can to some degree be integrated.

This system achieves a suitable level global consistency in approach and a decent level of completeness inasmuch as it defines choice criteria at both the regional and local level. It also introduces mechanisms for assessment, including the development of indicators to grade performance.

At this point in the analysis it can be observed that priorities, tools used at the national level and the degree of regional and local autonomy vary greatly from one country to the next. Two main issues meet: that of the health care system and that of the broader considerations of public health, with their implications for the entirety of health determinants. The intersection between these two issues is narrower in the 'multi-systems'. In contrast mechanisms used for integration deal with both issues in a recursive and associated manner. Nevertheless, despite the differences in these approaches, we observed a certain degree of convergence in the health policy decision-making process.

### Health policy: a combination of local and global factors

Vertical decentralisation can be defined as the dispersion of decision making powers within State bodies, and horizontal decentralisation as the dispersal of such power

*“There is a common will across countries to return strategic choice making to the local level”*

*“A strong ambiguity exists between the objectives of public health and those of the health care system”*

through non-governmental organisations (agencies or private companies). The power of any decision lies in the capacity to act upon potential choices. Decision making power thus contains several expression zones. The model developed by Paterson<sup>2</sup> can be used to draw out four components of the decision-making process. First, choice rests on how information is handled and analysed by experts: the expertise. Then on the basis of this expertise, the decision-maker makes a choice. This choice, before being implemented, must be financed, and occasionally subject to third party authorisation, for instance through a parliamentary vote or approval by an inter-ministry committee. This authorisation and financing constitutes the third component of the decision-making process. Execution is the final component as choices may be implemented where there is some margin for action.

While again there are important differences in political and administrative structures, again some convergence in the distribution of powers and responsibilities can be seen. This can be explained by the coming together of health issues within these countries. This common experience is due to the combination of central and local thinking on one hand, and the combining of individual and collective thinking on the other. Health issues are the subject of global and local articulation, where the latter sheds light on health services' daily reality for the former, which in turn provides some necessary hindsight for local delivery. There is a common will across countries to return strategic choice making to the local level, with the central level fulfilling a leadership role and providing support.

#### **Framed decentralisation**

The English system is the most centralised. Some horizontal decentralisation in some activities has been introduced inasmuch as a direct negotiating mechanism between service providers and local purchasers serving between 100,000 and 200,000 people (Primary Care Trusts –PCTs) exists. This allows purchasers to buy services from both public and private service providers. Local PCTs negotiate directly with hospitals over service provision.

The Department of Health at the central level retains control over the power of expertise, authorisation, and financing as well as defining objectives and strategies. PCTs commission services on the basis of local needs taking into account national targets such as National Service

Frameworks. Funding is distributed from the central level on the basis of weighted capitation. Local service providers are the subject of a system of performance assessment and evaluation by a central government body. There are financial incentives for trusts to perform well. This type of decentralisation can be called framed decentralisation because it allows more flexibility for action by stakeholders while framing this strongly by incentives and controls including the use of financial mechanisms.

The process of decentralisation in England has also evolved through allowing health care suppliers, including independent foundation trust hospitals to participate in defining their own strategies within the framework of national objectives and strategies. Even in the case of independent foundation trusts, the State as a last resort where performance is poor, retains the right to regain managerial responsibility.

#### **Coordinated decentralisation**

Countries operating through a federal structure in theory should have the greatest degree of decentralisation. This also applies to countries with other governance structures such as Spain where the responsibility for the delivery of health care is a matter for the 17 Autonomous Communities and also in Sweden where county councils play a similar role. In Germany, Belgium, Spain and Sweden, at a central level a country-wide common programme is set out together with a list of recommendations.

In the most decentralised of countries, there is nevertheless a will to create national institutes of public health responsible for producing national epidemiological studies and disseminating information. This will deter duplication in studies undertaken at local and regional level, while reducing unnecessary expenditure on research and data collection.

Strongly decentralised countries seek to improve cohesion by tackling health and social inequalities between regions. This is why at a national level ministries of health set common principles, objectives and the general direction for policy. These items are set out for informative purposes so as to pinpoint the global needs of society. Setting a common aim and purpose for action is one of the first tools in coordinating individual activities. The priority in the public health care systems of all these countries is to ensure a level of homogeneity nationwide with a set of minimum entitlements for all.

It is then at the regional or local levels that actual health priorities are set, taking into account the common framework defined at the central level, but having latitude in how they define key activities and financing priorities. In certain autonomous regions, these regional programmes will be the subject of a regional parliamentary vote. Funds in decentralised countries can be collected at the central, regional and local level. In this way, regions have the possibility of financing their own programmes while central funding is thus concerned only with core national programmes. Eventually, the central level may define a set of indicators for evaluation and control, but this is just for information; the State holds no power over local initiatives.

We qualify this as coordinated decentralisation inasmuch as the regional and local levels determine the order in which they wish to resolve health care issues. The State then occupies two principal roles. The first is to provide support and supply information, scientific research, advice and coordination as well as act as a regulator guaranteeing equality and mobility nationwide. This can include regulation of professional bodies, as well as having measures of activity and quality control. In consequence, the State becomes a coordinator facilitating the emergence of the needs of public health from the promotion of scientific studies, taking into account local activities and their interactions within the global context. The State establishes a set of recommendations and guidelines giving the different actors the means to negotiate and make decisions. Ultimately, the State's position is that of a regional coordinator and regulator in the distribution of funds. A secondary role is in implementation. Indeed, the State may promote and intervene in the direct financing of integrated health plans for each priority area. The central level, positioned as a health policy actor working on national strategies for treatment and prevention, manages these plans.

### Conclusion

A number of conclusions can be drawn from this analysis. First, it must be emphasised that currently a strong ambiguity exists between the objectives of public health and the objectives of the health care system. This ambiguity is exacerbated by the ambiguities concerning the contents of these objectives. Moreover, there is sometimes confusion between objectives and strategies, where strategies are simply the objectives restated a little more precisely,

but still with little visibility. In addition, recommendations on the ways of defining health objectives set out by international and European organisations often create the conditions for feedback on the differences between strictly national and international thinking. In some circumstances a strong disconnection between the practical consequences of these two approaches in a country may be reinforced by international seminars and discussion that highlight the divergence between national and international thinking.

A second conclusion concerns the compartmentalisation between health care treatment and preventive actions to address the broader social determinants of health. More attention is being paid to public health, with countries seeking to integrate broader health determinants within strategies. Nevertheless, the current mechanisms are much too fragmented, with funding received in separate ways, while the required skills and training of professionals differs. Moreover, the cross cutting impacts of the different fields are not very well known and difficult to identify. To this can be added the challenge of economic constraints faced by different sectors, such as employers, in respect of funds available for health promotion. This compounds the difficulties public administrative bodies have in negotiating with a variety of stakeholders over how to address these wider determinants of health. Consequently, countries both horizontally and vertically have decentralised the health decision-making process in order that discussions between stakeholders can now take place at the local rather than at the national level.

Thus in the quasi-market environment, the State is positioned as the guarantor of society's values and choices concerning inter and intra-generational solidarity and individual insurance. The third strong point is dependent on one condition: a governmental examination of citizens' social expectations and the linking of these different expectations within a common framework. It is open to question in a situation where the State has positioned itself as one of the actors, to what extent it can remain the guardian of social values given that it is already embedded in competing economic interests.

Today one of the most inferior components of health policy is the training of professionals and citizens on health issues. This work raises major questions because each step of health policy questions the motivation, interest, and commitment of actors.

*“Current mechanisms are too fragmented”*

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# Feelings of debt, obedience to authority and opportunism between stakeholders within health care systems

Jean-Paul Dumond

*“The gift is one of the most essential elements of the health care relationship”*

Understanding the relationship between patients and health service providers in order to empower patients requires an analysis of the main features of their relationship. Is it based on the market model allowing each actor to defect regardless of the consequences for the partner?<sup>1</sup> Are their relations socially compelled and, in this case, what is the source of the obligation? Can they be construed as a unique relationship, or conversely is it more relevant to differentiate their ties according to different criteria which should be identified? On the responses to those questions depend the means of empowering patients.

From the Middle-Ages to the 20th century, health care systems have been structured by gift exchanges: hospitality and care offered by monks to the poor and the sick, money and presents given to hospitals and foundations by rich owners, dedication to the cause of patients by professionals and lastly, patients sacrificing themselves or being sacrificed to science and further generations.<sup>2</sup> The gift has been one of the most essential bases of the health care relationship. Nevertheless, most health care services belong to public systems in which the State plays a major financial and social role which is becoming partially and ambiguously undermined by the New Public Management. For these reasons, the anti-utilitarian approach of social and economic relationships which distinguish three economic spheres based on the gift, redistributive and negotiated exchanges appears especially relevant to the study of relationship within health care systems.

This article describes the anti-utilitarian analysis of relationship, its pertinence in the field, and finally, the consequences of this model for approaches to empowering patients within health care systems.

## **The anti-utilitarian analysis of relationship**

Further to the works of Polanyi,<sup>3</sup> Hirschman<sup>1</sup> and Caillé and Godbout<sup>4</sup> notably, there would appear to be three main types of social relations. The three

sphere model is called anti-utilitarian because it stresses the importance of exchanges, such as gifts, which do not follow the instrumental rationality of the utilitarian philosophy of Bentham.<sup>5</sup>

In the first sphere, social relations are governed by norms and rules which are impersonally applied, that is to say, disregarding the individuals who are at stake. Those who give orders, as well as those who receive and obey them step aside in favour of principles which are invoked. As Douglas says, institutions think through all of their members<sup>6</sup> and *obedience* to authority is the main basis of that type of relationship. It presents a considerable advantage: every citizen is equitably treated according to the features of his or her situation.

In the second sphere, individuals *bargain* with each other and are encouraged to display such behaviour. Opportunism is tolerated if it remains legal.<sup>7</sup> Each one tries to maximise his interest. To regulate conflicts, implicit or explicit rules of the game<sup>8</sup> define the framework within which each player can pursue his or her interest.

The third type of relationship is based on *gift giving*. It is constructed through the ternary circle highlighted by Mauss:<sup>9</sup> to give, to receive and to give back. Schematically, the donor first conveys by a gesture towards another person that the latter is not an anonymous human being and that the donor acknowledges the receiver's singularity. Through acknowledging the other, the giver offers him a place in his psychic world and through transferring something personal (a belonging, a comforting word, or a mere presence), he transfers a part of himself.

Second, the recipient accepts the specific acknowledgement which has been granted to him, together with what has been transferred. Through accepting both the transferred item and the associated acknowledgement, the no longer anonymous individual, having been granted the privilege of existing as a specific person, feels indebted to the donor (who has allowed him the

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privilege of existing as a specific person).

Finally, in the third stage, since he feels indebted to the giver, the receiver gives in turn and becomes a giver. Thus, a personalised tie is constructed, based on a special recognition, a transmission having a personal value and a place given voluntarily to the other in the psychic world of those concerned. Strangers to each other, they become linked by the fact that they each possess a specific place in the psychic world of the other.

The initial giver and the final receiver may not be the same person. Three or more individuals may be concerned, as with intergenerational gifts. The sign of a specific acknowledgement may also vary. It may be a belonging having a particular meaning for the receiver, a service without any expectation of a counterpart, a lapse of time spent with a person or devoted to preparing a gift (a meal, for example), an expensive present or a benevolent gesture.

The gift may be defined as an act consisting of bringing out the other benevolently from anonymity, in particular by the transmission of something personal which arouses a sentiment of debt and the desire to convey in turn a benevolent interest.<sup>10</sup> In this approach, the sentiment of debt constitutes an essential feature, since it enables a clear identification of acts defined as gifts.

The anti-utilitarian framework seems particularly relevant for analysing the relations between stakeholders within health care systems for two reasons. First, it may give an account of most relations, attitudes and behaviours which are observed within health care systems. Prescriptions, such as directives to patients, implicit professional norms which are learnt during the training courses, compulsory policies engaged by the State, and redistributive exchanges from well to sick people, all constitute an important aspect of health care systems and belong to the first sphere. Negotiations play at the same time an important role between professionals and civil servants who define their wages, between departments within hospitals, between hierarchical levels as well as between professionals when they need to obtain as swiftly as possible a remote diagnosis or a bed for a patient. The third sphere is also present through blood and organ donation, and dedication to the patient, even though dedication seems less important than it used to be. In hospitals, dedication is never far from feelings of debt toward ill or dying people: health care professionals often feel

that they ought to do their best for their patients or that they ought to have done more for them.

Second, several crucial transformations which are sharply perceived by professionals can be accounted for by a shift between the three spheres. A qualitative and a quantitative study of perceptions of hospital mergers can be used to illustrate complementarities between spheres.

### Current trends within health care systems and the proposed framework

The analysis is based on a study of 13 hospital mergers which have profoundly transformed their internal social relations. The mergers were studied in order to define the perception of employees (medical staff, registered nurses, technical and administrative staff) of the merging process.

A first qualitative inquiry was carried out: around 100 individuals were questioned, either during one-to-one interviews, or during collective meetings. A second quantitative inquiry was based on a closed item questionnaire. The items dealt with occupational evolution, norms and values and, lastly, with attitudes toward work. Given to non-selected groups of physicians, nurses and administrative staff (people who were present and available when the study was proposed), the questionnaire seems to have produced reliable data, coherent with the qualitative inquiry. The sample has moreover the main features (functions, activities, age) of the hospital staff.

Concerning occupational evolution, the results show that all staff perceive mergers as a major change in their professional activity (Table 1).

For a very large majority, the transformation is not linked to mergers, but to the global evolution of health care systems. Norms and professional values are one of the main evolutions that professionals outline. In the questionnaire, staff had to rank different values which they had to take into

*“Relationships based on gift exchange are declining”*

**Table 1**

<b>My professional activity is different from what it was before the merger</b>	<b>Agree</b>	<b>Disagree</b>	<b>No opinion</b>
<b>Administrative staff</b>	<b>51%</b>	<b>49%</b>	<b>0</b>
<b>Medical staff</b>	<b>44%</b>	<b>56%</b>	<b>0</b>
<b>Nursing staff</b>	<b>37%</b>	<b>62%</b>	<b>1%</b>
<b>Total</b>	<b>44%</b>	<b>55%</b>	<b>1%</b>

Table 2

	Dominant values	
	Before	After
1	Team spirit	Respect of written rules
2	Human contact	Adaptability
3	Respect of written rules	Good practice
4	Good practices	Team spirit
5	Experience	Human contact

Table 3

Social acknowledgement of my profession is declining	Agree	Disagree	No opinion
Administrative staff	13%	77%	10%
Medical staff	58%	41%	1%
Nursing staff	31%	60%	9%
%	37%	56 %	7%

*“Professionals place more importance to formal relationships and the ability to change”*

account in their job before and after the merger. Their response (Table 2) show a significant evolution: they consider that before merger the main values were team spirit and human contact, while regard for written rules and adaptability have become the most respected values afterwards.

Values which are related to a humanistic and a traditional approach to relationships are declining while professionals place more importance on formal relations and the ability to change in an evolving context. As has been said previously, these transformations are not the result of mergers, but an effect of the evolution of the whole care system.

Moreover, the medical staff perceive a painful loss of acknowledgement (Table 3). Medical perception is quite different from that of other occupations.

At the same time, some of the medical staff (44%) convey disenchanted feelings toward hospital reorganisation and the health care system evolution. To account for their disillusion, they point out their loss of autonomy at work because of greater interdependence between health care professionals. Diagnoses, as well as treatments, have to be discussed among medical staff, or even within the whole team and decisions must take into account the professional norms for the disease concerned. In addition, medical recruitment processes are nowadays discussed among medical staff and the administration, while medical activities and

research are steadily embedded in strategic projects in which hospital management has become a determining stakeholder. Mergers, like other important projects, are initiated by management. Finally, physicians are no longer able to decide and prescribe alone: they have to negotiate between themselves, with hospital management, with nurses, and furthermore, with patients.

The results of this study show therefore an evolution which can be easily described within the anti-utilitarian framework. Relationships based on gift exchange are declining. Trust, personal commitment at work and self-fulfilment are no longer the main bases of relationships while the acknowledgement of professionals, namely physicians, are becoming common. At the same time, relationships based on negotiations are increasing since more actors, each having his own world vision, conceptions, purposes and interests, are involved in clinical processes.

The anti-utilitarian model seems therefore particularly relevant for understanding relationships between stakeholders within health care systems. Could this framework be useful for describing and analysing the specific relationship between professionals and patients ?

**The relationship between health care professionals and patients**

The previous framework can in fact be applied to the relationship between health care professionals and patients. Their relationship can firstly be construed as based on prescriptions. Professionals prescribe in the name of science and professional norms to which they submit, while patients obey their prescriptions. Obedience to medical power and therefore the legitimacy of physicians to prescribe treatments constitute requisites of that relationship. To that extent, hospitals remain bureaucratic even though they can no longer be considered as professional bureaucracies.<sup>11</sup>

Interactions between professionals and patients may also consist of bartering and negotiating, for instance, over: when to be operated on or to leave hospital; the surgeon that will lead an operation; implementation of treatment; or the quality of accommodation.

The relationship based on gift exchange can at the same time prevail, for example, when a patient opens up to a physician while professionals devote their time to trying to find the adequate treatment, when professionals having been granted infinite acknowledge-



ment recognise in turn their patients for the medical progress they have allowed. Is it possible in fact for a physician or a nurse to barter one's time or the treatment they are giving in front of a dying child? Is it possible to be totally impersonal and to implement procedures mechanically when patients are in distress, even though professionals need to protect themselves against an over emotional load? Feelings of debt in care relations are often subterranean, infinite and reciprocal, from patients to professionals as well as from the latter to patients. They also structure their relationship.

In health care systems, the relationship between professionals and patients seems to be particular in that different types of relationship coexist, while other organisations are structured in just one sphere. For instance, purely bureaucratic organisations should be based on the first model whatever the claimant. Besides, a pure bartering relationship can also be imagined. Conversely, different relationships are found in hospitals and patient empowerment has to be considered according to the three types of relationship.

Depending on how the patient/professional relationship is regarded, patient empowerment may present different features:

*In a bureaucratic relationship*, empowerment should mean increasing the patients' rights in order to protect them, namely through new laws and bills, applying them rigorously, that is to say, anonymously, disregarding the person of the claimant.

*In a bartering relationship*, the ability to choose physicians and hospitals should be the guarantee allowing patients to defend their interests. Empowerment should mean establishing a fluid market where patients could switch service provider whenever they want.

*In the gift relationship*, empowerment in hospitals is problematic because of the parallel often drawn between gift and sacrifice. Pain, illness, and sometimes death have been considered as a necessary sacrifice and a gift, required to obtain the forgiveness of sins or to allow scientific progress. Patient empowerment needs to put an end to that perspective and, on the contrary, to consider every patient as a person, that is to say, as an individual who is unique, partly autonomous and irreducible to the judgments which have been constructed about him/her. Considering patients as people means differentiating clinical processes, nursing approaches and even treatments, with face-to-face relations with each individual. It also requires receptiveness of mind in order to consider each one's particularities and to bring out the other from anonymity.

Patient empowerment may therefore have a very different perspective according to the sphere in which the patient/professional relationship is embedded. The first perspective may be relevant when procedures are sufficient to define quality of work. The second type of empowerment seems to be pertinent when patients are able to choose hospitals and physicians, are fully informed and therefore able to defect. The third type of empowerment is particularly relevant when the relationship between patients and professionals are a key point in therapeutic processes, for instance, for mental illness and older people. These different cases are summed up in the figure below.

Citizenship empowerment has therefore to be considered differently according to the specific relationship between professionals and patients that is at stake, and especially, according to the prevailing sphere in which this relationship is embedded.

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Figure

	Relationship based on ...		
	prescription and obedience	bartering and negotiating	gift exchange
<b>The dominant behaviour</b>	Obeying norms and prescriptions invoked in the name of science or tradition.	Negotiating what can be negotiated	Acknowledging care and cure as gifts
<b>Actions for empowerment</b>	Defining patients' rights more precisely and assessing their implementation	Giving patients the possibility to choose physician and hospital	Avoiding considering illness, pain and hospitalisation as sacrifices Considering patients as people
<b>Examples of implementation</b>	Where procedures are sufficient to define quality of work (for well-known treatments)	Where patients are able to defect (for minor surgery)	Where the relationship is a key point in the therapeutic process (for mental ill and older people)

# A just policy for family care

*DM Beneken  
genaamd Kolmer,  
A Tellings,  
HFL Garretsen,  
IMB Bongers*

*“self responsibility has  
now reached the arena  
of care”*

Since the end of World War II modern society has seen a general increase in affluence, greater freedom for citizens, and increasing individualisation. In most west European countries, the welfare state of the seventies and eighties was replaced by another kind of state in the nineties: the management state.<sup>1</sup> In this model of the state, efficiency and effectiveness take the place of goods such as group solidarity and social security. Moreover, the management state emphasises citizen self responsibility.<sup>2</sup> This self responsibility has now reached the arena of care. Economic and policy changes such as reduced health care expenditure and changing attitudes to community care have resulted in a shift from inpatient to outpatient care for many with serious illness.<sup>3</sup> This results, among other things, in increasing care giving responsibilities for family and friends.<sup>3</sup> Often, seriously ill people have most of their care needs met by family and friends rather than by paid professionals or volunteers. The increased care giving responsibility places great demands on informal caregivers<sup>3</sup> and threatens, for instance, their physical, emotional and mental health, quality of life, social life, financial situation, housing, support systems, and relationships.<sup>4</sup> In this article the notion of a just policy for family care is considered and an optimal balance between the care responsibilities of the state and citizens is sought.

## **The care responsibilities of individuals: an excursion into philosophical anthropology**

Many philosophers have considered the relationships between human beings and implicitly or explicitly also thought about why and how we should care for each other. For the past few decades, many views, including those of Nel Noddings<sup>5,6</sup> have garnered attention as the ‘ethics of

care’. Here philosophical views from the period before the ethics of care emerged are discussed. The former, more than the latter, similarly acknowledge both the importance of human relations as a foundation for existence and the fact that humans in some way will always remain strangers towards each other, keeping a certain distance. This contradiction between the desire for relationships with others and providing care, while at the same time maintaining a sense of individualism, detached from loved ones, in our view characterises the relationship between the patient and family caregiver.

Why *do* we care, and why *should* we care for each other at all? The philosopher Martin Buber<sup>7</sup> points to the fact that long before a small child can say “I” and can reflect on things, she lives a relationship with others. The child has an innate desire and inclination to enter into relationships with others, first with the mother and then with other people. Only within and through such relationships can the child perceive the world in a meaningful way. Buber distinguishes between I-Thou (you) relations and I-It relationships. I-It designates a subject-object relationship, in which an active subject controls and utilises a passive object. I-Thou designates a subject-subject relationship, one of mutuality and reciprocity. The I in the I-It relationship is a lonely observer and manipulator, whereas the I in the I-Thou relationship exists only within the context of the relationship, this “I” cannot be viewed independent of the Thou.

Human beings need I-It relationships in order to have a firm grip on the world and survive. They need I-Thou relationships to live a meaningful life, to remain human. A balance between giving and receiving based on legitimate mutual interests, rights and needs are central features of I-Thou relationships. A healthy human being interacts with and between these two types of relationships. Buber’s philosophy implies that people *do* care for each other out of an inborn desire to live in relationships with others. It also implies that people *should* care for each other in order to be really human and live a meaningful life.

For Levinas,<sup>8</sup> the relationship between mother and child is the starting point for a

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more general view on the relationship between human beings. Levinas does not view this relationship as symmetrical, but as essentially asymmetrical. It is the vulnerable baby that appeals to the responsibility of the mother and thus the baby constitutes the mother as a responsible human being. The mother gives unselfishly, not expecting something in return, and she loves and accepts her baby unconditionally. The responsibility of the mother is non-transferable and in this sense infinite. Responsibility is not a burden but something which makes one a unique human being. I become a unique and a moral being because the other person appeals to me as a responsible person. I can only answer the other person's appeal to responsibility if she is different from me, and thus she is a stranger to me. Only if she is different from others, can I treat her as a subject instead of an object. Thus, Levinas does not put the I center stage but the other, who liberates the I from complacency.

From this viewpoint we *do* care for each other because the existence of the other appeals to our sense of responsibility. We *should* care for each other because this makes it possible for us to become detached from ourselves and live in a world with others. In contrast to Buber, Levinas sees the relationship between human beings as rather detached and altruistic.

Ricoeur,<sup>9</sup> just like Buber, sees the relationship between the other and I as symmetrical. He acknowledges that, initially, the relationship is asymmetrical, either because the vulnerable other appeals to one as a strong person or because I as a strong person take the initiative to care for the other. Yet this asymmetry turns into symmetry because the stronger can recognise the vulnerability of the other as something that is, or one time will be, part of his own life; and both the strong and the weak can experience the strength of the latter because her making an appeal for help is in a certain sense also a way of being strong. Thus, the symmetrical relationship originates in acknowledging that the other is both vulnerable and strong, just like I. Apart from seeing that others are just like me, I also have a personal identity, I have something in which I am different from all others. This being just like others but also different from all others is combined in what Ricoeur calls the 'moral identity' of the person. I uncover who I really am by living a good life for and together with others, based on self-respect and respect for others. However I can only respect others like

myself when I respect myself, and I can only respect myself, when I respect others like myself.

Ricoeur<sup>10</sup> also asserts that human beings give unto each other because the world and existence have been given to them. This distinguishes between *do ut des* – I give so that you will give – and *do quia mihi datum est* – I give because something has been given to me. In the first instance giving occurs with the (sole) intention of receiving something in return. It is a selfish kind of giving, in contrast to the giving in the second phrase preferred by Ricoeur. Both types of giving imply some kind of reciprocity: giving requires giving in return. This reciprocity counters unique and extreme forms of commitment such as those taken up by Gandhi or Martin Luther King: love your enemies or do good to those who hate you. These forms of commitment are seen as undesirable because they presuppose a type of action that demands nothing in return. Ricoeur's approach is a plea for a form of reciprocity that is more than well-understood self-interest but also less than sainthood!

Thus this approach is based on the notion that we *do* care for each other because we receive benefits from the other; caring is a way to do something in return. We *should* care for each other because this enables us to develop a moral identity: a balance between being similar to and different from others, based on self-respect and respect for others.

A final thinker briefly mentioned is the psychiatrist and family therapist Boszormenyi-Nagy<sup>11</sup> because he deals explicitly with family relationships. In his 'contextual approach' he emphasises loyalty as one of the key elements that underlie these relationships. This loyalty is not based on emotions, nor on attachment, attraction, dependency or subjugation. Instead it is based on irrevocable family ties, instituted through blood and strengthened by what family members do for each other in daily life. Parents who bring children into the world thereby commit themselves to raise them. Parents deserve the gratitude of their children because they have given them life and raised them. A different type of loyalty is shown by spouses, who commit themselves to spend much of their lives together. They deserve loyalty because of this dedication. Thus, Nagy thinks relatives do care and should care for each other out of loyalty, a loyalty based on irrevocable blood ties. Therefore it is an 'existential' loyalty, based on giving service

*“Loyalty is one of the key elements in relationships”*

*“Governments could enable patients to choose their own care arrangements”*

and obtaining service in return.

This brief excursion into philosophical anthropology demonstrates that individuals not only have a moral or existential duty to care for each other for the sake of that other, but also for their own sake. We can only be true human beings with meaningful lives if we care for each other. Where does this responsibility end? Levinas and Nagy seem to view this responsibility as, on principle, endless: as long as the individuals live. Buber restricts this to symmetrical relationships alone, while Ricoeur compromises between seeking a middle between sainthood and selfishness. All in all, these authors are not very explicit about the boundaries of individual caring responsibility. Perhaps we could add that care responsibility ends where it starts to cause the opposite of what it is intended to achieve. When our care responsibility becomes so much a burden that it, for instance, threatens the symmetrical relationships we have with others (Buber), or threatens to drive one back into some state of complacency (Levinas), we have transgressed the boundaries of the caring responsibility. The caring responsibilities of liberal states are now examined.

### **Liberal states and health care responsibility**

What should constitute the health care responsibility of liberal states? A closer look can be taken at the important philosophical distinction in liberal states between primary goods and secondary goods. Primary goods<sup>12,13</sup> like freedom of thought and a basic income are necessary preconditions for the full participation of individuals in society. They have universal validity and are shared by all (reasonable) conceptions of the good or they predate these conceptions. ‘Whatever the differences between individuals’ plans of life, they all share one thing: they all involve leading a life’.<sup>14</sup> The idea of primary goods presupposes the existence of human nature and human needs, cross-culturally invariable and of a historically constant nature.<sup>15</sup> Secondary goods derive from benefits and harms that vary with conceptions of the good life of which they are a part.<sup>15</sup> For example, there are different opinions about whether or not euthanasia or abortion should be performed. Opinions are coloured by differing perceptions of the good. Secondary goods do not have universal validity and they are not ideologically neutral. Therefore, liberal states ought not to support secondary goods, rather they

ought to take a neutral stance. Yet liberal states should fund institutions representing primary goods so that notions of the good life can be pursued.<sup>16</sup>

Is health care a primary or a secondary good? Considering health care as a secondary good would make health care part of a specific conception of the good. Needing health care would then be subordinate to particular views of the good life. Most philosophers agree that health care is a primary good, it is a necessary condition to be a fully participating member of society. Rawls’ survey<sup>13</sup> of the requirements of a liberal society mentions a basic level of medical care provided for all. He argues for a functional approach to health care, its goal being to enable citizens to (again) become fully participating members of society. It restores the fair equality of opportunity that is compromised by their illness.

According to Rawls two matters are essential. The degree of urgency for different kinds of health care should be estimated as well as the extent to which the health care needs should have priority over other pressing societal issues. Treatment that restores individuals to good health, enabling them to resume their normal lives as full participants in society, has great urgency. From this viewpoint cosmetic surgery is not in any way a priority. With respect to a comparison of different priorities, Rawls refers to Daniels<sup>17</sup> who considers health care to be a primary good for citizen needs. From Daniels’ survey of health care institutions it can be concluded that health care as a primary good (i.e. one which the state should support) involves cure and recovery supportive nursing as well as nursing without cure. The provision of the latter is essential to maintain the dignity of the most vulnerable groups in society. Rawls and Daniels do not really differ on the duty of care we have toward all human beings, however severely disabled. They do differ on the underlying principle on which that duty is based. Rawls has based his philosophy on the ultimate goal that every citizen should be able to participate in society and care should be given by the state to encourage this. Thus in his thinking there is still room to give care to those who will never be able to participate fully in society, although this viewpoint is not fully elaborated. Daniels in contrast based his philosophy on the principle that everyone has the right to receive care from a humanitarian point of view. Rawls and Daniels give us tools to point out that the

state should care for ill citizens whether or not they will be able to fully participate in society.

### Care responsibilities of individuals and of states: how can they be combined?

What does this discussion of the care responsibilities of states, and that on individual care responsibilities imply for the fine-tuning of both? At first sight it seems difficult to relate such divergent philosophical viewpoints. Nevertheless, views from these two domains meet when actual health care policies are developed. Such policies set out the actual tasks of governments and therefore also the responsibilities placed on individual citizens. The link between the two perspectives need to be considered if there is a desire to develop a *just* health care policy, that is, a policy which does justice to the patient, family caregiver, and the government.

Both groups of views are consistent with the following criteria for a just governmental health care policy:

1. They define health care as a primary good.
2. They provide health care to help patients regain their status as free and equal citizens.
3. They provide health care for those who will never again become totally free and equal citizens.
4. They enable individuals to care for each other so that they can lead meaningful lives.
5. They prevent family caregivers from becoming overburdened.

The first three criteria in particular place an emphasis on the care responsibilities of the state whereas the last two make room for individuals to perform care tasks without becoming overburdened. The latter two criteria most notably lead to practical health care policies. The most appropriate approach may be a policy in which governments stimulate and enable patients to choose their own care arrangements, allowing family caregivers to provide care without becoming overburdened. However, if individuals and their relatives cannot, or will not do this, the government provides health care. Since care giving is increasingly becoming a private matter, the discussion is not so much about whether or not relatives can and will care for each other. It is rather about how relatives can receive sufficient and qualitatively good support to be able to

care for their loved ones now and in the future. The government should guarantee this. To enable the government to fulfil this task, family caregivers and their so-called agents should inform governments about their needs and desire for support. Communication between governments, family caregivers, patients, professionals and agents will contribute to preventing family caregivers from being unduly burdened. Such a communication can result in a policy in which family caregivers are able to provide a fair level of care to their loved ones, where the quality of care is *good*, in terms of the medical condition and also in a families ability to cope with caring. A just policy for family care does justice both to the patient, the family caregiver, while recognising the responsibility of governments.

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# Mythbusters

## *Myth: Seeing a nurse practitioner instead of a doctor is second class care*

Depending on where you live in Canada, nurse practitioners are either new or familiar figures on the healthcare scene. Sometimes known as 'outpost nurses,' they are registered nurses who have additional education and who can perform tasks that go beyond traditional nursing and into basic medicine.

While nurse practitioners are currently working in most provinces and territories, Canadians are more likely to receive treatment from a nurse practitioner if they live in areas that have trouble attracting doctors, such as rural and remote communities. This has led to the widely held belief that they should only be used when a doctor can't be found. However, the truth is nurse practitioners actually function as well as doctors in a variety of circumstances, and they can perform some tasks better than doctors can.

Because of their skills, governments tend to rely heavily on nurse practitioners when they reform their primary healthcare systems. In Canada, for example, they are usually able to diagnose patients and refer them to specialists, and in many provinces they can write prescriptions as well.<sup>1</sup> In Ontario, some primary healthcare nurse practitioners even have the authority to practice independently from a physician, and operate their own practices.<sup>2</sup>

### **Tried and true**

Since the 1970s, research has shown the benefits of nurse practitioners. In 1971 and 1972, for example, a landmark Canadian study of nurse practitioners looked at a family practice in Burlington, Ontario.<sup>3</sup> Two family doctors were swamped and hadn't accepted new patients for two years.

They believed that two of their office nurses could, with appropriate additional education, take on additional responsibilities and allow them to start accepting new patients again. The nurse practitioners took care of 67% of patient visits for two years, and all measurements showed the patients in the nurse practitioner group were as healthy and satisfied with their care as the patients who saw the doctors. Perhaps most notably, the practice was able to expand its coverage dramatically and provide health services to almost 1,000 new families.

More recent research confirms nurse practitioners can and do work very well in a range of situations. The studies have looked at nurse practitioners working in both urban and rural sites, in doctors' offices and on their own.<sup>3-9</sup> In one study of a general practice in England, 86% of patients were managed by a nurse practitioner without ever having to see a doctor, which allowed the physicians to see patients with more serious problems.<sup>6</sup> Only 21% of the nurse's patients had to see a doctor in the practice about the same illness within two weeks, and most of those appointments were follow-ups booked by the nurse practitioner when she first saw the patients.<sup>6</sup> Also, in a study of how well nurses could treat depression, the percentage of patients who showed a substantial improvement was the same in both the nurse and the physician groups.<sup>8</sup>

### **Patients are prospering**

For minor injuries and illnesses requiring same day care, patients who see nurse practitioners tend to do as well as those who see physicians. Research shows patients who see nurse practitioners about minor illnesses or injuries are just as healthy in the six months following the treatment as those who see doctors.<sup>3,7,10</sup>

Nurse practitioners are very effective in health promotion and management as well. Research shows nurse practitioners are able

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Mythbusters are prepared by Knowledge Transfer and Exchange staff at the Canadian Health Services Research Foundation and published only after review by a researcher expert on the topic.

The full series is available at [www.chsrf.ca/mythbusters/index\\_e.php](http://www.chsrf.ca/mythbusters/index_e.php). This paper was first published in 2002. © CHSRF, 2002.

to help patients with a range of chronic problems, including hypertension, Parkinson's disease, obesity, depression, diabetes, and asthma.<sup>4,8,11,12</sup> In fact, Canadian and international research has shown that patients with hypertension respond better to nurse-practitioner care than to physician care.<sup>11,12</sup>

Nurse practitioners tend to ask more questions and offer more information and choices. They also tend to spend slightly longer with their patients (an average of one or two minutes longer than doctors).<sup>7,9</sup> Studies indicate patients appreciate the nurse practitioners' communication skills and the extra time spent;<sup>3,4,7,10,11,13</sup> in one study, 99% of patients in the nurse practitioner group said they would see a nurse practitioner again for a similar problem.<sup>7</sup>

### Moving forward

Most of the research on nurse practitioners compares their safety and effectiveness to the care provided by doctors; and that research clearly and consistently demonstrates nurse practitioners can provide care that is safe, effective, and comparable in a range of situations. The few remaining barriers to best realising the benefits of nurse practitioners may be found in the structure of the system itself, such as payment models and funding mechanisms.<sup>14</sup>

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## Obesity Prevention and Public Health

Edited by  
David Crawford and  
Robert W. Jeffery

Oxford: Oxford  
University Press, 2005  
ISBN 0-1985-6600-X  
352 pages. Hardback  
£49.50

Obesity is recognised as a population-wide problem that has reached epidemic proportions in many countries. The incidence is continuing to increase in children and adults and the associated health and social care costs are substantial. This is not only seen in the developed but also now in the developing world. Despite this there has been relatively little population-based research that has focused on the prevention of unhealthy weight gain.

This book edited by David Crawford, from the Centre for Physical Activity and Nutrition Research, Deakin University, Australia and Robert W Jeffery, at the Division of Epidemiology and Community Health, School of Public Health, University of Minnesota, USA, brings together data on obesity trends worldwide together with a detailed analysis of the causes of obesity: behavioural, social and environmental. The case for prevention and potential innovative measures are outlined. The book includes a review of the evidence on the cost effectiveness of preventive measures against obesity as well as a discussion of the potential health and resource benefits of investing in effective strategies.

*Contents:* Introduction, D Crawford and R Jeffery; The epidemiology of obesity: a global perspective, J Seidell; The role of nutrition and physical activity in the obesity epidemic, L Harnarck and K Schmitz; The role of socio-cultural factors in the obesity epidemic, K Ball and D Crawford; Evolving environmental factors in the obesity epidemic, R Jeffery and J Linde ; The implications of the nutrition transition for obesity in the developing world, BM Popkin; Population approaches to promote healthful eating behaviour, S French; Population approaches to increasing physical activity among children and adults, J Salmon and A King; Population approaches to obesity prevention, R Jeffery and J Linde; The cost-effectiveness of obesity prevention, R Carter and M Moodie; Opportunities to prevent obesity in children within families: an ecological approach, K Krahnstoever Davison and K Campbell; Drawing possible lessons for obesity prevention from the tobacco control experience, SL Mercer, LW Green, AC Rosenthal, L Kettel Khan, RNathan, CG Husten and WH Dietz; The potential for policy initiative to address the obesity epidemic: a legal perspective from the United States, EJ Fried; The potential of food regulation as a policy instrument for obesity prevention in developing countries, M Lawrence; The need for courageous action to prevent obesity, MB Schwartz and KD Brownell.

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## Systematic Reviews in the Social Sciences. A Practical Guide

Mark Petticrew and  
Helen Roberts

Oxford: Blackwell  
Publishing, 2005  
ISBN 1-4051-2110-6  
352 pages. Hardback  
£29.99

It is increasingly difficult to interpret the enormous amount of original research in the social sciences. There is clearly a need for policy makers to have information on the existing evidence base prior to commissioning original research or implementing policy. Simple literature reviews are insufficient, they can be biased and misleading. The systematic review using a rigorous scientific approach can help in appraising, summarising, and communicating the results and implications of otherwise unmanageable quantities of data. The work of the Cochrane and Campbell Collaborations provides powerful practical evidence of the power and usefulness of such reviews. Despite this success the use of the systematic review outside very narrow clinical areas of health care remains limited; some argue that the complexity and multi method approaches to evaluation undertaken in the social sciences render such reviews impossible.

This book debunks some of myths concerning systematic reviews, for instance illustrating how evidence from a range of study designs, not just randomised controlled trials can be included. Written by Mark Petticrew, Associate Director of the MRC Social and Public Health Sciences Unit at the University of Glasgow and Coordinator of the ESRC Centre for Evidence-Based Public Health Policy, and Helen Roberts Professor of Child Health at City University, London, it provides an excellent step by step guide to undertaking complex systematic reviews across the social sciences.

*Contents:* Preface; Why do we need systematic reviews? Starting the review: refining the question, deciding on the scope and estimating costs; What sorts of studies do I include in the review? Deciding on the review's inclusion/exclusion criteria; How to find the studies; Quality assessment of the included studies; Synthesising the evidence; Investigating heterogeneity and publication bias; Disseminating the review; Systematic reviews: urban myths and fairy tales; Glossary; Appendix 1: The review process; Appendix 2: MOOSE Guidelines; Appendix 3: Example of flow diagram from a systematic review; Appendix 4: Example data extraction form; Appendix 5: Variations in the quality of systematic reviews.

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**Centro di Ricerche sulla  
Gestione dell'Assistenza  
Sanitaria e Sociale  
(CERGAS)**

[www.cergas.info](http://www.cergas.info)

CERGAS (The Centre for Research on Healthcare Management) at Bocconi University was founded in 1978 to promote, design and develop basic and applied research in the health care, welfare and educational systems. It coordinates and participates in several academic and professional networks at both a national and international level and is linked to three Observatories; on public procurement, drugs, and Italian hygiene companies. Information on publications to download, events and the collaborating networks are provided. The documents are available in both English and Italian.

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**Unit of Health Economics  
and Health Technology  
Assessment**

<http://hecon.uni-corvinus.hu>

The Unit was established in 2003 and is based the Department of Policy and Management at Corvinus University, Budapest. It is a member of the International Network of Agencies for Health Technology Assessment (INAHTA). Information is provided on staff, publications (mostly in Hungarian), current research interests, links to other sites and information on the 6th European Conference on Health Economics which will be held in Budapest in July 2006.

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**Health Protection Scotland  
(HPS)**

[www.hps.scot.nhs.uk](http://www.hps.scot.nhs.uk)

Health Protection Scotland was established by the Scottish Executive in November 2004 to strengthen and coordinate health protection. HPS takes over the functions of the Scottish Centre for Infection and Environmental Health and works in partnership with others, to among other things protect the Scottish public from being exposed to hazards which damage their health, monitor the quality and effectiveness of health protection services, facilitate the effective response to outbreaks and incidents, and commission national reference laboratory services. The website provides news, documents that may be downloaded, and links to other websites that cover specific areas of their work. The website is the main gateway to information and knowledge on health protection issues in Scotland.

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**The Irish Medical  
Organisation**

[www.imo.ie](http://www.imo.ie)

The Irish Medical Organisation was formed in 1984 by the amalgamation of the Irish Medical Association and the Irish Medical Union, to act as the national representative medical organisation linking all branches of the medical profession in Ireland and is the sole negotiating body on behalf of all doctors in the country. The website provides information on the latest news and developments, and a number of publications including a recently launched collection of position papers. Submissions to the government are also made available. The website also contains links to a number of key external reports on different aspects of the Irish health care system.

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**Netherlands Organisation  
for Health Research and  
Development (ZonMw)**

[www.zonmw.nl](http://www.zonmw.nl)

ZonMw is a national organisation that promotes quality and innovation in the field of health research and health care, initiating and fostering new developments. Based in The Hague, the organisation's independent experts assess and evaluate the design, execution and evaluation of national programmes. Their primary concern is to establish and monitor standards and instruments for research. Although the majority of information is provided in Dutch, the website also has English pages.

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**The Swedish Institute for  
Health Economics (IHE)**

[www.ihe.se](http://www.ihe.se)

IHE is a non-profit research institute and a wholly owned subsidiary of Apoteket AB, the National Corporation of Swedish Pharmacies. Operating in Lund since 1979, IHE aims to contribute to well-founded decision-making in the health care sector by providing health economic assessments and policy analyses for public discussion. Information is available on staff and their research interests, publications, the quarterly newsletter as well as news and events, including their annual conference, the IHE-Forum. The website is available in both English and Swedish.

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**European Observatory on  
Health Systems and  
Policies/Health Policy  
Monitor**

[www.observatory.dk](http://www.observatory.dk) and  
[www.healthpolicymonitor.org](http://www.healthpolicymonitor.org)

The European Observatory on Health Systems and Policies and Health Policy Monitor, a project initiated by the Bertelsmann Foundation, have begun to combine their activities. The Observatory supports and promotes evidence-based health policy-making; its outputs include the detailed country profiles, policy briefs, topical books, and other publications. Health Policy Monitor provides up-to-date information on health policy developments in 20 industrialised countries. The country information pages of the Observatory website will be supplemented by half-yearly policy analyses of reforms provided by Health Policy Monitor. Users of both websites will now find country-specific links from one site to the other.

## European Commission Green Paper

### ***Promoting the Mental Health of the Population. Towards a Strategy on Mental Health for the European Union***

How can the mental health of the EU population be improved? That was the key question that Markos Kyprianou, European Commissioner for Health and Consumer Protection, put to stakeholders at a conference on mental health in Luxembourg on 24 October. Over 100 participants, comprised of a number of EU health ministers (including UK Presidency Minister Rosie Winterton), MEPs, WHO representatives, NGOs and academics, looked at how to approach the task of reducing mental illness, which affects over 25% of the European population. Discussions centred on various actions that may be taken to improve mental health throughout the EU.

The Commissioner used the event to formally launch the Green Paper on Mental Health, adopted by the Commission on 17 October, and discussed the strategy and action plan that will be developed on the basis of the Green Paper public consultation. The aim is to promote greater visibility for mental health in all policies, develop better knowledge-sharing on this topic, and build consensus on what all actors can do to contribute to better mental health. A report by the European Platform for Mental Health Promotion and Mental Disorder Prevention (IMHPA) was also presented, giving a first overview mental health promotion, related policies and underlying challenges in EU countries.

Speaking at the official launch Commissioner Markos Kyprianou stated that,

“Most of us will know at least one person, probably more, with a mental health problem. And many of us will find it difficult to deal with this situation, because it’s often difficult to know what to say or what to do.

“This highlights the fact that mental health is everybody’s business.

“However, it is a subject that has remained in the shadows for far too long. Happily, times are now changing. Mental health is gaining more and more prominence on the policy agenda. In many Member States mental health has become one of the priorities of public health policy. For several years now, it has been a priority of Public Health Programmes at Community level.”

The Commissioner emphasised the support of the Commission in implementing the strategy set out in the WHO European Ministerial Conference on Mental Health in January 2005, and outlined the part that could be played by the Green Paper. He stated that,

“Some might argue that the disparities between EU-Member States are too big and might not easily allow meaningful work at Community level. But while such disparities are indeed great, the Commission’s objective is to improve the mental health of the population by opening up a framework for exchange, coordination and cooperation between countries and policy areas, stakeholders and researchers.

“Through the consultation on the Green paper we want to construct a strategy and an action plan, to identify the key priorities and actions for the EU, among those agreed in Helsinki. The strategy and action plan should allow for mutual learning, the comparison of situations and the monitoring of actions.

We plan to construct this mental health strategy in the light of a broad consultation. We want to promote greater visibility of mental health in the health and non-health policies and amongst stakeholders. We also want to promote greater sharing of the considerable knowledge that already exists about evidence-based actions.”

He stated that actions would be taken to encourage a whole range of stakeholders including service users, employers and health professionals to participate in the consultation process on the Green Paper. Three groups will be created and three thematic meetings will be held to work out priorities and action points for an EU strategy and action plan. The first meeting, *Promotion and Prevention in Mental Health* takes place on 16–17 January, with further meetings on *Social Inclusion and Fundamental Human Rights in Mental Health and Information, Data and Knowledge in Mental Health* taking place on 16–17 March and 18–19 May respectively.

The Commission will also screen its own policies and activities to find out whether their contribution to improving mental health can be increased and whether available financial instruments could be better used. In late 2006, the Commission intends to present its analysis of the responses received together with, if appropriate, its proposal and/or initiatives for a strategy on mental health for the EU.

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*Presentations from the launch event are available at [www.europa.eu.int/comm/health/ph\\_determinants/life\\_style/mental/green\\_paper/ev\\_20051024\\_en.htm](http://www.europa.eu.int/comm/health/ph_determinants/life_style/mental/green_paper/ev_20051024_en.htm)*

*Contributions to the consultation process should be sent to the Commission by 31 May 2006 by :*

*(a) email to [mental-health@cec.eu.int](mailto:mental-health@cec.eu.int), or:*

*(b) post to: European Commission  
Directorate-general for Health and Consumer Protection  
Unit C/2 “Health Information”  
L-2920 Luxembourg*

## Informal meeting of EU Health Ministers: Pandemic Flu Preparedness

Health Ministers of the 25 EU Member States, the Health Commissioner and Ministers and delegations from Bulgaria, Romania, Croatia and Turkey held an informal meeting on 20–21 October. Discussions covered three themes: values and common principles in health systems, EU patient mobility and pandemic flu preparedness.

Ministerial discussion on flu preparedness followed a technical briefing from Dr Margaret Chan, the Assistant Director-General of the WHO responsible for pandemic preparedness. Ministers stressed the critical nature of clear and objective communications with the public to reduce the likelihood of confusing messages. It is important to distinguish between avian flu, normal seasonal flu and pandemic flu.

The Ministers noted the discovery of highly pathogenic H5N1 avian flu in birds in Turkey and Romania. At present there are no reported cases of avian flu contracted from birds in humans in the EU. The advice from the WHO and the European Centre for Disease Prevention and Control is that the current outbreaks of avian flu pose a very low risk to Europe. There have, so far, been only very isolated cases of human infection by avian flu in South East Asia, in all cases these have been people in extended, close contact with infected birds. They noted the advice that poultry and poultry products were safe to eat if properly cooked and agreed that it remained important to keep the state of preparedness in the EU for an outbreak of human pandemic flu under constant assessment.

The WHO confirmed that was no increase in the level of risk of pandemic flu, but stressed that vigilance and surveillance needed to remain high. In order to become pandemic, the avian flu virus would need to change to allow it to transmit easily between humans: to date, there was no evidence of such a change. It stressed the need to increase efforts to prepare for a pandemic: whilst there were positive signs that preparations in the EU were often ahead of those in other parts of the world, there was no room for complacency;

in particular every country needed to develop its own pandemic plan.

Commissioner Kyprianou outlined the main findings from replies from the Member States to his recent letter asking for information about the state of pandemic preparedness. The Commissioner said that levels of preparedness varied significantly between Member States. He stressed that more work was needed on how vaccines and anti-viral drugs would be made available in the event of a pandemic. He also outlined plans for a preparedness exercise 'Common Ground' a simulation focusing on communication between key players in the event of a pandemic flu outbreak.

EU Health Ministers considered their existing EU obligations and requirements in the area of pandemics. These centre on requirements on Member States to collect surveillance information and to share this in a form that allows comparison across Europe. Member States are also committed to sharing with each other and the Commission informa-

tion about action to protect human health from the risks of pandemic flu. There was strong agreement that Member States needed to continue to coordinate their efforts in the face of the risk of a human pandemic, accepting, however, that this does not mean that the Member States are bound to take identical action across the EU. The close working that had been established between the UN agencies (WHO in particular) and the EU institutions, and between veterinary and human health experts, was strongly endorsed.

The Ministers emphasised the need not only for planning across Europe, but for testing that plans drawn up were likely to work. They welcomed the technical meeting planned later in October between the EU and WHO (European Region) to report back on case studies in a number of countries; and the 'Common Ground' scenario exercise by the end of November. They asked for a report back from the Commission on the lessons learnt from both these exercises at the Health Council in December.

### **"Bird flu shows need to strengthen Europe's defences against infectious disease" says ECDC Director Zsuzsanna Jakab**

On 27 October Zsuzsanna Jakab, Director, European Centre for Disease Prevention and Control (ECDC), called on Europe to strengthen its defences against infectious diseases. Speaking at a press conference in Budapest ahead of a meeting of the ECDC's Management Board she said that the spread of A/H5N1 avian influenza (bird flu) showed the importance of European and international cooperation to control the spread of emerging new diseases. Mrs Jakab briefed the Centre's Management Board on the steps the ECDC has already taken to address the threat to human health posed by H5N1 bird flu and discussed plans for future action. The Management Board also examined the ECDC's wider strategies on issues such as reinforcing and developing disease surveillance, improving scientific cooperation between Member States and ensur-

ing a rapid reaction to health threats.

"The risk to human health from bird flu is low but the way this virus has spread across Asia and into Europe should give us pause for thought. In the modern world, Europe's defences against infectious disease depend almost as much on what is going on in other parts of the world as what happens in Europe. We need to continue to invest in our health defences in Europe, but we also need to engage more actively with the countries next door to us." said Mrs Jakab.

"We should not waste time speculating when the pandemic will happen, or whether it will be caused by H5N1 or some other influenza strain. The important thing is to act now. All the countries participating in ECDC have preparedness plans. We now need to make sure those plans are effective."

## South-eastern European health and finance ministers sign agreement on health and economic development

A two day subregional forum, for health ministers held in Skopje on 25–26 November concluded with the signing of a pledge on closer cooperation and increased investment in health. Organised jointly by the WHO Regional Office for Europe, the Council of Europe and the Council of Europe Development Bank ministers of health and finance from eight south-eastern countries in the WHO European Region (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Moldova, Romania, Serbia and Montenegro and The former Yugoslav Republic of Macedonia), came together. They discussed how to improve the effectiveness of health systems and increase domestic and external resources for health.

Bigger budgets for public health and more political and organisational effort can achieve real improvements in health, stressed the forum's participants. "Investing in health - through health systems and through non-health sectors - is an integral part of the overall strategy to achieve sustained economic growth and poverty reduction," said Dr Marc Danzon, WHO Regional Director for Europe. "Public health services remain comparatively weak and underfunded. It is one of the main areas that still need to be developed in the reform process."

In some south-eastern European countries, total annual expenditure on health is less than US\$ 5 per capita, which is significantly below the average for the European Union. In some countries, health received as little as 6% of the total government budget in 2002. The painful economic and social transition severely affected the health of the population in the subregion.

For most health indicators, south-eastern European countries show, on average, poorer health status than the wealthier EU countries. This gap is

widening, not narrowing.

"Access to good health services requires adequate financial investment, and we know that countries are struggling to secure that. However, one cannot postpone the priorities of the day hoping that tomorrow they will cost less; therefore, health system reforms must continue," said Mr Krzysztof Ners, Vice-Governor, Council of Europe Development Bank.

The Skopje forum came four years after the first ministerial forum for south-eastern Europe, in 2001 in Dubrovnik, Croatia, which established the South-eastern Europe Health Network: a framework set up to coordinate and implement health projects in the subregion. As result of the current agreements in Skopje, the Network will develop new programmes: to increase resources for health from domestic sources and development assistance, and to strengthen health systems and eliminate institutional constraints, enabling greater absorption of increased resources.

"The regional projects will allow the health systems to catch up with the current level of development in greater Europe," said Mr Alexander Vladychenko, Director General of Social Cohesion, Council of Europe. "The agreements reached in Skopje are beyond usual rhetoric on cooperation - they are real challenges and commitments for all Europe."

"This initiative has remarkable achievements and a great potential impact on people's lives," stressed Mr Michael Mozur, Deputy Special Coordinator of the Stability Pact for South Eastern Europe. "It operates under the auspices of the Social Cohesion Initiative of the Stability Pact and we reiterate our commitment to supporting it and making sure it is firmly embedded in the regional context."

## Open consultation on improving patient safety

Following a Patient Safety summit in London under the UK Presidency in November, the European Commission has launched a consultation on improving patient safety. Healthcare-associated infections (HCAI), often referred to as nosocomial infections, affect an estimated 1 in 10 patients and lead to considerable increase in illness, mortality and costs. These infections are not constrained by national boundaries and can rapidly spread between countries evidenced by international spread of MRSA as well as SARS. Stepping up action in this area may be urgent also in light of the importance of infection control during a possible pandemic to contain or at least delay the spread of the influenza-virus. It is to be expected that the HCAI will constitute an increasing burden of disease in European societies.

Other challenges that make action particularly pressing are the increased patient mobility, the ageing society, rising public expectations and the advances in medical treatment. Health systems across Europe face common challenges as they adapt to constant developments in medical science. Although these health systems are primarily the responsibility of the Member States, cooperation at European level has great potential to bring benefits both to individual patients and to health systems overall.

The Commission believes it may be appropriate to make recommendations in the area of infection control. Since addressing this problem will require a multi-sectoral approach it is essential that the many professionals and stakeholders involved can provide their input. Comments are requested by 20 January 2006.

More information can be found at [http://europa.eu.int/comm/health/ph\\_threats/com/comm\\_diseases\\_cns01\\_en.htm](http://europa.eu.int/comm/health/ph_threats/com/comm_diseases_cns01_en.htm)

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Further information on the forum is available from the web sites of the WHO Regional Office for Europe  
[www.euro.who.int/eprise/main/WHO/Progs/SEE/network/20050511\\_1](http://www.euro.who.int/eprise/main/WHO/Progs/SEE/network/20050511_1)



## Should patient decision aids (PtDAs) be introduced?

PtDAs are designed to help patients discuss treatment options with their clinicians, and make choices. A new report from the Health Evidence Network, prepared by Annette O'Connor and Dawn Stacey from the University of Ottawa, shows that PtDAs significantly improve the quality of patients decision-making when the choice of treatments is difficult and depends on patients attitudes towards the benefits and harm.

More information available at [www.who.dk/Document/E87791.pdf](http://www.who.dk/Document/E87791.pdf)

## What evidence is there about the effects of health care reforms on gender equity, particularly in health?

A report written by Piroška Östlin from the Karolinska Institute for the Health Evidence Network, assesses the impact of four key health care reforms: decentralisation, financing, privatisation and priority setting. One finding was that a range of gender biases have been revealed in priority setting methodologies, such as DALYs, which lead to the underestimation of women's burden of disease. These systematic gender biases are generated through various technical and conceptual limitations.

The full report is available at [www.who.dk/Document/E87674.pdf](http://www.who.dk/Document/E87674.pdf)

## Resource allocation, health policy, and health services management in Ireland

The Health Economics Association of Ireland will hold their next meeting on 30 March in Dublin. They wish to provide an opportunity for colleagues from all backgrounds and countries to share evidence-based views and ideas about the development of Irish health services. A key criteria for presentations however will be their relevance to the Irish context. Abstracts should be submitted to HEAI Chairman Douglas McCulloch by 28 February.

E-mail: [dwmcculloch@ulster.ac.uk](mailto:dwmcculloch@ulster.ac.uk)

## Council of Europe declaration on the prevention of violence

The Youth Ministers of Council of Europe Member States adopted a final declaration setting out several measures to curb and prevent all forms of violence impacting on young people.

More at <http://portal.coe.ge/enews/EEkZIEkpyykWGFKKYa.php>

## Health Technologies and Decision Making

This book by the OECD analyses the barriers to, and facilitators of, evidence-based decision making in OECD health-care systems. It examines how countries can successfully manage the opportunities and challenges arising from health-related technology by optimising decision-making processes, recognising the value of innovation, dealing with uncertainty, and producing and co-ordinating health technology assessment. It also considers the capacity of health systems to respond to the particular challenges of fast-developing health-related biotechnologies

[www.oecdbookshop.org/oecd/display.asp?lang=EN&sf1=identifiers&st1=922005021p1](http://www.oecdbookshop.org/oecd/display.asp?lang=EN&sf1=identifiers&st1=922005021p1)

## NHS market futures: Exploring the impact of health service market reforms

The UK government has re-introduced competition to health services (in England) over the past three years. The market now emerging is the product of a series of separate policy developments – including extending choice of provider, expanding the role of the private sector and introducing payment by results. This King's Fund report written by Richard Lewis and Jennifer Dixon analyses the UK government's market reforms in England, considering whether they can meet the core aims of the NHS, looking at the challenges they present, and exploring options for meeting those challenges.

[www.kingsfund.org.uk/resources/publications/nhs\\_market.html](http://www.kingsfund.org.uk/resources/publications/nhs_market.html)

## 2005 drugs report: new states, new trends

The Lisbon based European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has published its annual report for 2005. Bulgaria, Romania and Turkey are included for the first time. The report presents an overview of drug problems in 29 European countries as well as the latest trends and social and political response. Drug abuse is increasing across the EU according to the report, with cocaine and ecstasy becoming the drugs of choice for new users. In recent years, EU strategy has shifted to prevention rather than punishment for drug use. The report reveals that EU drug decriminalisation measures and treatment programs have proven effective.

It can be downloaded at <http://ar2005.emcdda.eu.int/download/ar2005-en.pdf>

## Policy Brief: Health Technology Assessment

A new policy brief written by Marcial Velasco-Garrido and Reinhard Busse for the European Observatory on Health Systems and Policies provides an introduction to HTA, examines the role of evidence, and identifies the structure in Europe.

It is available at [www.euro.who.int/Document/E87866.pdf](http://www.euro.who.int/Document/E87866.pdf)

## WHO report on preventing chronic diseases

This WHO global report presents a state-of-the-art guide to effective and feasible interventions, and provides practical suggestions on how countries can implement these interventions to respond successfully to growing epidemics.

More at [www.who.int/chp/chronic\\_disease\\_report/en/](http://www.who.int/chp/chronic_disease_report/en/)

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