

Eurohealth

RESEARCH • DEBATE • POLICY • NEWS

Volume 12 Number 1, 2006

A close-up photograph of a hand holding a dark brown pen with a gold-colored tip. The hand is positioned over a white document with printed text. The text on the document includes "M.D.", "Label", "Substitution", and "Prescription". The background is a solid purple color.

Patient choice

Nurse prescribing

**Communicating risks and
benefits of medicines**

Pandemic flu

**Reform of gate-keeping in
France**

Living on the interface of research and policy • The future of public health care in Canada
Health care reform in Turkey • Road traffic injuries • Networking HTA in Europe

COMMENTS

Research · Debate · Policy · News

To kick off our 12th year, we are continuing to incorporate exciting changes to *Eurohealth* to ensure that it remains a unique forum for those involved in health policy to express their views on the key issues and challenges faced across Europe.

A new series of *Eurohealth debates* will facilitate deliberation between leading thinkers who hold opposing views on issues of wide relevance. In this issue, Julian Le Grand and David Hunter discuss choice and competition in the National Health Service in England, while Molly Courtenay and Alan Maynard exchange views on the merits of nurse prescribing.

Eurohealth continues to publish contemporary *public health perspectives*, with this issue focusing on the potential impact of any new influenza pandemic, as well as on meeting the perennial challenge of reducing road traffic accidents. *Health policy developments* remain a core focus, here looking at reform in France (primary care), Turkey (health insurance), and Canada (managerial versus financial reform), as well as discussing approaches that may help to bridge the ever-present gap between research and policy.

Our cooperation with the Canadian Health Services Research Foundation has allowed us to reproduce enlightening *Mythbusters* revealing evidence opposing conventional wisdom. We are delighted that they will now be augmented by contributions from *Bandolier*, an independent journal providing a synthesis of knowledge on evidence-based health care. *Risk in Perspective*, a publication from the Harvard Center for Risk Analysis is also featured, exploring pertinent topics on risk and decision science.

'Grey' literature publications, including reports from governments, international agencies and public health institutes, do not always come to the attention of the health policy community. We intend, where relevant, to feature even more of these in our publications section. We are also continuing to expand our news coverage, for instance to provide even more in-depth analysis of proceedings at the European Court of Justice, as well as enhancing our analysis of developments at country-level.

We hope that you find these changes stimulating and useful. As ever, we would welcome feedback on ways to further improve our publication, so as to provide you with engaging and informative articles.

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Eurohealth in perspective

Objectives

The aim of Eurohealth is to bridge the gap between the scientific and policy-making communities by providing an opportunity for the publication of evidence-based articles, debates, and discussions on contemporary health system and health policy issues.

Features

- Debates
- Public Health Perspectives
- Health Policy Developments
- Evidence-based decision making for health care
- Monitoring the latest EU and country-level developments plus information on new publications, health-related websites and much more

Backed by experts

The Editorial Team is based at LSE Health and works with an Editorial Board. Eurohealth is also supported by an international Advisory Board, which is comprised of a distinguished list of academics and policy-makers from leading health policy research centres, national Ministries of Health and international organisations, such as the World Health Organization and the European Parliament. Eurohealth is also able to draw on the expertise of the European Observatory on Health Systems and Policies, which brings together eminent academics and research centres from across Europe.

Feedback

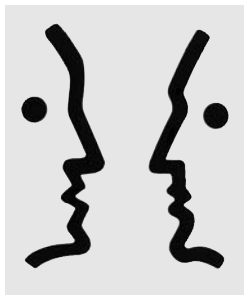
We very much value your continued feedback and suggestions on future topics and potential contributions. These can be sent in the first instance to the Editor, David McDaid at d.mcdaid@lse.ac.uk

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Debate:

Choice and competition in the British National Health Service



Julian Le Grand

When Tony Blair's government came to power in Britain in 1997, it found a

National Health Service that was creaking at the seams. A year after the government was elected, 185,000 patients were still waiting more than nine months for elective surgery in England and 67,000 for more than twelve months. The system was inefficient, wasteful and unresponsive to patients' needs. Even equity – the founding principle of the NHS – was not achieved, with specialist and preventive services favouring the better off.

Part of the problem was money. And spending is now going up substantially. But money was not the only problem. Although the resources that are being put in are historically unprecedented in magnitude, previous governments have put large sums into the NHS before – and have not had the results.

This was because they did not address the key problem of NHS provision: its monopoly. NHS patients had little choice over where, when and how they were treated. This was bad in and of itself, because it disempowered patients. But, even more importantly, it was destructive because it meant there were little incentives for providers to improve. Giving providers a monopoly has never been a good way to improve a service of whatever kind; and the 'old' health service was no exception.

So some kind of reform was essential.

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The question was: what form should this take? One strategy for dealing with monopoly is top-down performance management: telling providers that they have to provide a good service, setting targets and imposing penalties for failure. This has been a part of the government's strategy so far, and it has been quite successful. Most NHS targets have been met, and some aspects of service delivery (particularly waiting times) sharply improved, at least in England.

So performance management can work – at least in the short term. But heavy performance management from the top is not trouble free. A ceaseless bombardment of instructions from above demotivates and demoralises providers – especially when those providers include professionals used to a high degree of autonomy and trust. Also targets have their own problems. They distort priorities: what is not targeted is ignored. And they can lead to 'gaming': straightforward fiddling of the figures, or more subtle changes of behaviour that mean the target is attained but with long-term consequences that are undesirable.

Performance management is not a long-term solution. What is needed instead is a system with incentives for reform embedded within it. Then providers will automatically provide a high quality service without orders from the top. And these incentives should come from the users of public services: for it is the user's needs and wants that have to be satisfied, and he or she is the ultimate authority on what those needs and wants are.

Now one way of empowering users is through strengthening the institutions of 'voice'. 'Voice' mechanisms are ways in which users can express their dissatisfaction by some form of direct communication with providers. This could be through informally talking to them face to face or more formal methods, such as complaints procedures.

Strengthening voice has its place in NHS reform. But it is not the answer to the fundamental problem: the absence of incentives. Without choice, voice mechanisms provide little by the way of incentives for improvement. If a provider has a monopoly on the supply of a service, it can ignore the complaints of its users with relative impunity. Only if it knows that the dissatisfied can go elsewhere does it really have an incentive to improve. Choice gives power to voice.

Another problem with voice is that it favours the better off. The loud voices and sharp elbows of the middle classes mean that they are much better at manipulating bureaucratic systems than the poor. It is not surprising that the 22nd British Social Attitudes survey found that it was the poor and disadvantaged who wanted choice more than the better off; for the latter were doing all right from the system as it stood.

So if we cannot rely upon performance management or 'voice' to reform the health service, what can we do? The answer lies in choice and competition. There are three key elements to this: patient choice, money following the choice, and new forms of provider.

To begin with the foundation of the policy: patient empowerment through choice. As noted above, this is desirable in and of itself, because it directly empowers patients. But it is also essential from a system perspective. For it is a way of breaking down the monopoly power of providers and providing incentives for them to improve.

However, certain conditions have to be fulfilled if choice is to work in the way desired. First, the money must follow the choice. If being chosen has no favourable consequences and not being chosen has no unfavourable ones, then choice will not deliver the required incentives. Hence payment-by-results whereby hospital and other providers get paid according to

the treatments they actually provide.

This encourages providers to be attractive to would-be users, and to be efficient in their use of resources. For, if providers can raise quality on the same resources, they will attract users and make a surplus: a surplus they can spend on improvement of services, pay and working conditions.

A second condition for choice to provide appropriate incentives is that there must be alternatives from which to choose. The illusion of choice is worse than none at all. Moreover, research evidence from other sectors of the economy suggests that the entrance of new providers is the best way of driving up productivity. Hence the policy towards developing new forms of provider, including foundation trusts and independent sector treatment and diagnostic centres.

Now of course there are many other conditions to be fulfilled if incentives are to work properly and the injection of choice and competition is to achieve the ends that we want. If patients and parents are to make choice on the basis of quality, they have to have good information on quality – not always easy to provide. There have to be ways to deal with failure; what to do about hospitals and schools that are not chosen. And what about excess demand: by giving power to patients, will they demand more than can be realistically supplied, and, if so, how can this be managed in a fair way and one that does not frustrate legitimate expectations? The challenge for government policy is to design the choice and competition reforms so that they can avoid or directly overcome these difficulties.

Some kind of NHS reform is essential. This could include stronger performance management, or strengthening the institutions of voice. But, although reforms of this kind have their place, they also have severe limitations as the principal instruments of reform. There seems ultimately to be no alternative to the introduction of reforms involving choice and competition. And, if they are properly designed, then the outcome will be a high quality, responsive, and equitable health service.

David J Hunter

The government's diagnosis of the NHS's ills described by Julian is not in dispute. The problem lies in its prescription and in a naïve belief that the traditional tools favoured by economists of incentives and competition

will transform the NHS. Choice and competition existed in the days before the NHS. Indeed, the problems to which they gave rise then led to its creation.

A preoccupation with choice in health care has come not from the public but from politicians and their advisers. Paradoxically, we do not have a choice about choice – it has been deemed inherently good for us. Yet successive public opinion surveys, and exhaustive reviews by think tanks, consumer organisations and the parliamentary public administration committee, are either opposed outright to choice, seeing it as irrelevant at best and as widening inequalities at worst, or are wary of its alleged virtues.

There is also the matter of whose choice. Julian focuses on user choice, but how does this square with payer choice and the government's determination to strengthen commissioning? Then there is the vexed question of information asymmetry. Who wants and can exercise choice when ill? Would not people simply turn to a third party (i.e. their General Practitioner) to make that choice for them? The limits to choice and its paradoxes are ignored.

The alternative of top-down performance management is problematic for all the reasons Julian states although the claims he makes for its success are over-stated. The terror by targets regime has resulted in a variety of stratagems designed to deliver what the centre wants at considerable financial cost. Far from being good management, as the government's adviser, Derek Wanless, concluded, the target culture is an acknowledgement of management failure.

And there's the rub. Julian sidesteps the issue lying at the heart of the NHS problem which has dogged it from the outset. It suffers from chronic poor management and leadership, especially in respect of clinician engagement. In their place is a curious form of political management whereby success comes from divining and delivering what politicians want rather than what would most contribute to health outcomes. It is by no means self-evident that the government's market-style remedies will cure the patient rather than hasten his/her demise.

Julian Le Grand

I am glad that David agrees with me about the diagnosis of the NHS's ills – although

it might be better to say that he agrees with me about the symptoms of the illness, since his diagnosis of the cause of the illness, and his preferred prescription, are rather different from mine.

What is his prescription? It is a call for better management and leadership within the NHS. Well, of course, that is (part of) what we need, and indeed it is what many outside commentators have called for over many years. The question is: how do we get there? Do the politicians simply tell NHS institutions to manage themselves better? Given David's distrust of top-down instructions (and of politicians), I think he is unlikely to want that. So do we just trust the institutions to deliver better management on their own? Given the record of over fifty years of poor management and delivery, that seems unlikely to produce the goods. Or do we acknowledge that the reason why there is such a long-term record of poor management among NHS institutions is because, with most of them sitting on comfortable monopolies, they have had little incentive to improve? And, if we do acknowledge that, then the obvious answer is to provide such incentives through choice and competition.

On a more specific point, David claims that a pre-occupation with choice comes not from the public but from politicians and their advisers. But politicians (and even some of their advisers) are often more in touch with the public than academics. Extensive surveying by MORI and most recently by the authoritative British Social Attitudes Survey shows substantial majorities in favour of choice in the NHS among all groups – especially the less well off. There are indeed surveys that show the public would prefer a good local service to choice. But that is a nonsense question: if you were offered a perfect television or a choice of televisions, you would obviously choose the former. The real question is how to obtain a good local service: one that the critics of choice and competition have yet to answer.

Choice and competition in health care: friend or foe?

David J Hunter

Choice and competition in health represent another social experiment being imposed on an already beleaguered health system reeling from an avalanche of policy initiatives since 1997 when the Labour govern-

ment first entered office. The NHS has become the government's plaything.

There is no guarantee that the ambitious and high-risk reform agenda on which the government has embarked with such reckless abandon will deliver its policy objectives. These call for a paradigm shift in favour of primary and community care and public health, and away from the dominance of hospital-based acute care.

The problem is not a lack of ideas or fanciful theories – special advisers shower these on ministers like confetti. It lies in the jigsaw policies of private finance, payment by results, practice-based commissioning, and patient choice. Instead of being joined-up, and despite the post hoc rationalisations offered to demonstrate their coherence, they push and pull against each other without an evidence base to back the grand claims made for them.

Of course, it is conceivable that the changes will work, as Julian and other proponents of market-style mechanisms believe. But the jury is out and the stakes and risks are high – with the genie out of the bottle there is no turning back. Far-reaching structural and other changes are occurring at a time of considerable financial instability. They are also being pushed through largely by stealth without proper public debate.

Take choice – a slippery term in the hands of politicians. Julian cites surveys supporting the introduction of choice into public services, but many others have shown that people remain either opposed to, or unenthusiastic about it. Choice is presented as empowering people, especially those who have hitherto been unable to exercise it. But choice can also be bewildering, confusing, stressful and disempowering.

Choice is claimed to drive up quality and user-responsive services. But it is also likely to drive up transaction costs as services aggressively market themselves to win business. For choice to be meaningful there needs to be excess capacity. But is capacity not wasteful in respect of an expensive resource like health care? Will it lead to improved health outcomes or make their achievement less likely? Rather than investing in more health services, improved health might result from rather fewer with the resources being spent elsewhere.

Perhaps the most controversial and prob-

lematic aspect of choice concerns its role in either reducing health inequalities, as its advocates claim, or widening them, as its critics assert. They cannot both be right. The issue goes to the heart of the NHS's key founding principle, namely, equality of access for those in equal need. The weight of opinion from the public and informed observers is that patient choice seems likely neither to improve equity of access nor health outcomes.

Even the government's favourite think tank, the Institute for Public Policy Research which is essentially pro-choice, is sceptical concerning the government's motives in driving the choice agenda. If it is simply being invoked to create a market rather than to improve outcomes and reduce inequalities, then it risks worsening inequities in health care. If, on the other hand, choice strengthens citizen empowerment and challenges paternalism, then few could possibly oppose it. But this is not the language in which choice for the most part is being couched. More often, it is linked to markets, individualism, consumerism, competition and contestability. Advocates of progressive choice deplore this conception. For a government committed to narrowing the health gap this issue cannot be ignored.

Choice is regarded as axiomatically 'a good thing'. It exists in other aspects of our lives so why should health escape? But as some economists and others are discovering, all this choice and excess in our lives is not making us any happier. We are 'doing better, feeling worse'.

If choice and being an informed consumer is complex, time-consuming, costly and stressful because we dread making the wrong choice, then why are policymakers and their advisers so seduced by it? In part because they believe that public services as we know them are impervious to change and have had their day. It is a verdict supported by selective and partial evidence at best.

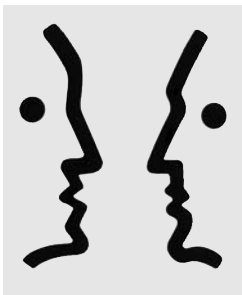
Paradoxically, many of the earlier reforms introduced by the government are beginning to take effect and show positive results – maybe not fast enough and not everywhere, but service redesign is happening on the ground. However, instead of building on these local successes and putting their political weight behind them, ministers have chosen to join the neo-liberal global consensus which insists that marketising public services is essential for their survival.

There is an infallible belief that governments can control events. Nothing is further from the truth as the sudden departure of the NHS chief executive for England shows. The government has set in train a set of changes and dynamics over which it will be able to exercise very little control. Once competition gets a grip and a diversity of service providers become entrenched in the NHS, many of them sharp and slick commercial corporations based in the US and elsewhere (cuckoos in the nest?), the government will find it all but impossible to regulate the new market it will have helped unleash. Powerful evidence exists to support the claim that governments in general lack capacity to manage public-private relationships and tackle market imperfections.

I accept that an enduring problem with the NHS has been the corrosive politicisation of its management, which has hampered effective leadership and the introduction of desirable changes. But politics cannot be taken out of health. We need to find a better way of managing the tension that will always be a feature of health policy.

Elsewhere in the UK, post-devolution Scotland and Wales may offer an alternative way forward. It is early days but the casual observer can only be struck by the different nature of the political discourse in those countries. If nothing else, the language is different with market-style options having been largely eschewed in favour of more integrated, inclusive approaches. Marketeers will argue that such old-style monolithic bureaucracies cannot survive and will eventually go the way of the dinosaur. But these small countries have embarked on a long-term project to find a different way of modernising complex public services that does not rely on choice and competition.

More may mean less. Perhaps we should embrace certain voluntary constraints on our freedom of choice instead of rebelling against them on the dubious grounds that the X-box, MTV, consumerist-driven generation will stand for nothing less. Just because it is not politically fashionable does not mean we should avoid the debate. After all, it was precisely following such a debate that the NHS was conceived, putting communal endeavour ahead of individual consumption.



Debate: Nurse prescribing

Molly
Courtenay

Independent prescribing

The role that nurses play in the management of medicines has undergone a major transformation in the United Kingdom. Since primary legislation permitting nurses to prescribe a limited range of drugs was passed (Medicinal Products: Prescribing by Nurses Act 1992) over 28,000 district nurses and health visitors have become qualified to prescribe independently from a limited list of appliances, dressings, Pharmacy (P) and General Sales List (GSL) items and some Prescription Only Medicines (POMs) included in the Nurse Prescribers' Formulary (NPF).

Independent extended prescribing

More recently, the introduction of independent extended prescribing in 2002¹ and supplementary prescribing in 2003² has expanded the prescribing powers of nurses even further. Qualified independent extended nurse prescribers are able to assess, diagnose and prescribe independently from a list of nearly 250 POMs, GSL and P medicines for a range of over 100 medical conditions described in the Nurse Prescribers Extended Formulary (NPEF). In Spring 2006, despite opposition from the British Medical Association (BMA), the NPEF is to be further expanded to include the full range of licensed medicines (apart from controlled drugs) described in the British National Formulary (BNF).³

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Supplementary prescribing

In contrast to independent extended prescribing, supplementary prescribing takes place after an assessment and diagnosis of a patient's condition has been made by a doctor, and a Clinical Management Plan (CMP) has been drawn up for the patient. The CMP, agreed upon by the patient, nurse and doctor, includes a list of medicines (within the supplementary nurse prescriber's area of competence) from which the supplementary prescriber is able to prescribe. This mode of prescribing is best suited to patients with long-term medical conditions such as asthma, diabetes or coronary heart disease. Specialist nurses are the most likely candidates to take on this new role.

Long-term conditions are areas emphasised in the new GP Contract Quality and Outcomes Framework (QOF).⁴ It is in these areas that supplementary prescribing provides an ideal framework through which practices are able to achieve and maintain the quality indicators. For example, the attendance of diabetic patients at the supplementary prescribers' clinic until good control of the condition is achieved and maintained, enables quality criteria to be met (and so helps practices to benefit financially from the rewards offered by the contract).

Unlike independent prescribing, there are no legal restrictions on the clinical conditions for which supplementary prescribers are able to prescribe. A close partnership between the doctor and the nurse is essential for the successful implementation of supplementary prescribing. Access to the patient's medical records and to a prescribing budget are other necessary pre-requisites.

There are now nearly 7,000 nurses able to prescribe as both independent extended and supplementary prescribers. The intention is to roll out independent extended and supplementary nurse

prescribing so that, by the end of 2006, there are 10,000 trained nurse prescribers.

Education and training

Training for independent extended and supplementary prescribing is combined; nurses successfully completing the programme are awarded both the dual qualification of independent extended and supplementary prescriber. Nurses entering the programme must be registered as a nurse, have the ability to study at degree level (level 3), and have at least three years' post-registration clinical nursing experience. The programme is three to six months in length and includes 26/27 taught days (although distance learning programmes are now available), plus twelve days learning in practice with a medical mentor.

Academic qualifications and experience

Although the guidance for prescribing training requires nurses to have a minimum of three years' qualified nursing experience, and be able to study at degree level (level 3), these requirements are exceeded by the majority of prescribers. Most of the nurses entering the prescribing programme have more than ten years post qualifying nursing experience.⁵ During this post qualifying period, many of these nurses have acquired qualifications at degree level, or higher, and some have PhDs.^{5,6} Additionally, many of these nurses have undergone training in specialist areas of practice.⁵

The benefits of nurse prescribing

Despite the concerns raised by the BMA, evaluations of nurse prescribing practice have been positive. The vast majority of qualified independent extended/supplementary nurse prescribers prescribe medicines and report that they are confident in their assessment and diagnostic skills and it is evident that they are prescribing

clinically appropriate treatments.^{5,6}

Some of the benefits of nurse prescribing for nurses include more effective use of their skills, increased job satisfaction and autonomy, and the ability to be able to deliver complete episodes of care. Patient benefits include the ability to access their medicines faster and so receive more timely and convenient care.⁶⁻⁹ For doctors, there are fewer interruptions during consultations to sign prescriptions, and a reduced workload.^{6,10} For the NHS, this more efficient use of resources means the provision of a higher level service.

People are positive about the prescription of medicines by nurse supplementary prescribers.¹¹ One of the main benefits includes greater standardisation of care, i.e. prescribing decisions are made from the sound evidence base made available through the CMP. Supplementary prescribing also enables a more cost effective means of gaining QOF points within the existing primary health care team. For example, a nurse with a supplementary prescribing qualification would not have to interrupt the doctor during a patient consultation, in order to obtain a signature on the prescription she has written. Added to this, once a CMP is in place, patients only need be seen by the supplementary prescriber for the treatment management of their condition (including prescribing). The doctor only needs to review the care of these patients at yearly intervals. This clearly reduces the workload of the doctor.

Conclusion

Nurse prescribers are highly qualified and have a wealth of clinical experience. They are confident in their assessment and diagnostic skills and are able to prescribe clinically appropriate medicines independently. Supplementary prescribing provides support for the new GMS contract and facilitates the delivery of high quality care. The benefits to be gained by the prescription of medicines by nurses means that patients are provided with a higher level of service. The concern by the BMA that patient safety will be compromised is unfounded.

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Alan Maynard

The Blair Government has invested heavily in the UK NHS since 2000, driving up expenditure to

9% of Gross Domestic Product. In exchange for this investment Blair required that the NHS "act smarter" and use available resources more efficiently. One aspect of this policy is the erosion of the monopoly power of the medical profession in prescribing prescription only medicines.

In common with many other aspects of the NHS reforms, the development of nurse prescribing is a social experiment lacking systematic evaluation of its costs

and benefits. Graduate nurses after 26 days of instruction followed by twelve days of supervised practice are to be allowed to prescribe the full formulary except for some dangerous drugs.

Will nurses prescribe drugs as effectively and as efficiently as physicians? Or can we expect them to perform better than their medically trained colleagues by adhering to diagnostic and treatment guidelines and enhancing patient compliance in drug use? The research literature shows that there is considerable variation in clinical practice and this includes prescribing.

How much will nurse prescribing, appropriate and inappropriate, add to the rate of growth of pharmaceutical expenditure as the industry focuses its marketing efforts on a new and potentially vulnerable group of prescribers? 'Conference tourism' can create inappropriate adoption of new and existing pharmaceuticals as ethical good practice guidelines for marketing are abused.

At present, the answers to questions about the costs and benefits of nurse prescribing are scarce. The research literature is very small in quantity and with the extent to which it exists, the design of the studies is weak, relying on descriptive methods rather than well designed quantitative trial design that includes economic variables. Unlike other nations such as the Swedes who have evolved this policy area cautiously, the English are indulging in rapid, unevaluated change that may be described as a "success" in the absence of good evidence. But that is the essence of the Blair Government's reforms!

Molly Courtenay

The majority of nurses undertaking prescribing programmes have in excess of ten years

nursing experience and are qualified to degree level or higher. Many have Masters qualifications and some have PhDs. Nurse prescribing will only legalise what is already taking place. It is a waste of both the nurse's and patient's time for the nurse to have to seek out the doctor in order to sign a prescription for a condition she/he has already diagnosed. Nurse prescribing will ensure that professional lines of accountability are clearer and that the nurse's contribution to patient care is recognised. Diagnostic and therapeutic interventions will be timelier. Patients will have wider access

to medicines and increased choice.

The nurse prescribing programme is a rigorous course of study. It is heavily monitored and assessed. Doctors leave medical school and are able to prescribe any medicine they want; however, they do not undertake any such training. Over 50% of medicines are prescribed by doctors inappropriately. Nurses will perform better than their medically trained colleagues, as historically nurses are better at adhering to guidelines. The amount of 'conference tourism' amongst nurses is low. Nurses are too busy for such an activity. Furthermore, nurses are less likely than their medical colleagues to be swayed by incentives to change their prescribing practice. Pharmaceutical companies will have to develop different ways of working with nurses.

The research literature examining nurse prescribing is, in the main, descriptive. This is out of necessity as prescribing is such a new role for nurses. However, these studies are rigorous and it is evident that nurses are prescribing medicines safely and effectively. Nurse prescribing has developed for several reasons in other countries. In Sweden, it was introduced to enable access to health professionals in remote areas.

By contrast, nurse prescribing in the UK has followed the development of the role of the nurse. Nurses with advanced knowledge and skills are the only nurses able to prescribe medicines.

Nurse prescribing: ensuring consumer protection

Alan Maynard

In an ideal world uninhabited by politicians wanting a 'quick fix', innovations in policy and practice would be piloted and rigorously evaluated, preferably using randomised controlled trials or at least controlled before and after methods. In the real world, particularly where in health care practitioners are allowed to experiment on their patients in the absence of evidence of clinical and cost effectiveness and outside of a proper trial, providers of health care increasingly alter care pathways. This is evidenced, for instance, by doctors using drugs in ways which are not based on the clinical indications derived from trials and set out in product licences.

The English decision to take nurse

graduates, usually with ten years experience of practice, and after minimal training allow them to prescribe the full formulary except for dangerous drugs such as morphine, is an unevaluated social experiment. Its advocates point out that nurses have in many instances been de facto prescribers for many years and that with doctor supervision, patients do not appear to have been harmed. The evaluation of this change in skill mix is poor and unconvincing, with much of the literature being qualitative and of poor design in terms of sample selection and use of comparators. Assertions that the contrary is unconvincing, as the evaluators practice in most cases ignores guidelines for good practice for the design and execution of clinical and economic evaluations.¹

This being so, what are the potential dangers and how might this radical change in practice be evaluated even now that system change has been undertaken and randomisation is impossible to ensure consumer protection?

Firstly, it has to be emphasised that the environment into which nurse prescribers (and pharmacist prescribers too) are being deployed in the English NHS is very different from that of the last ten to fifteen years when many primary care practices have used nurses as de facto prescribers.

The Government has invested heavily in the NHS since 2000 and expenditure as a percentage of GDP has risen from about 6% to nearly 9%. This is a product of expenditure growth rates averaging 7% for seven years. This increased funding has improved the quantity and quality of care offered to patients, but it is clear that the full potential of the increased spending has not been achieved and much of the expenditure has increased providers' salaries with little productivity gain in terms of activity or patient outcomes.^{2,3}

The Government is embarrassed by the absence of productivity gains or what the Prime Minister calls "acting smarter". To remedy this failing, public investment in private provision for NHS patients is now being funded to create "contestability". Contestability creates uncertainty for providers as if NHS consumers do not choose your service you may go out of business and patients will be cared for by the private sector.

It is likely that private suppliers may create primary care capacity that is nurse led and provided. This is a nice challenge

to the monopoly power of the medical profession. However, there is an absence of evidence of cost effectiveness for such changes in skill mix.⁴ Furthermore because of the large pay awards given to general practitioners that have made them and their hospital consultant colleagues the best paid doctors in Europe, the relative price of nurses, even after their pay increases, has declined, thereby increasing the potential financial advantage of nurse provided care.⁵

The new supply of nurse prescribers and demand for their services from new providers may bid up their cost, affecting their relative cost effectiveness. However, the nice issue is whether the error rate of nurses is greater or less than that of doctors when prescribing. There is evidence that there are errors in treating one in ten hospital inpatients⁶. Then again, despite much policy discussion of errors, there are few data for primary care, with consultants asserting that 'significant' numbers of emergency admissions are the products of inappropriate prescribing. The case for investing in improved data collection about errors in primary care is clear, and this would facilitate the appraisal of the comparative performance of alternative prescribers.

There is qualitative opinion that nurses may adhere to treatment guidelines more rigorously than doctors. However, the latter have been pummeled by pharmaceutical marketing for decades and nurses have yet to experience the full power of the industry's capacity for dubious sales practices.⁷ There is a clear risk that the 'free lunches' given to doctors over recent decades to shift their prescribing will, when extended to nurses, damage the cost effectiveness of their prescribing. Little attention appears to have been paid to this aspect of evidence based medicine produced by big pharma.⁸ To assert that nurses are "too busy" to indulge in conference tourism is naïve; like busy doctors they will be targeted and changed in their practices.

Nevertheless, in nursing the problems may be even greater than with doctors. It seems that Government funding of continuing professional development has been cut and nurse prescribers will be solely dependent on the industry for funding of education. This, in combination with poor clinical governance arrangements, in particular the continuing lack of clarity about liability when care is deficient and poor errors measure-

ment and management, may lead to outcomes in the interests of neither practitioners nor patients.

Nurse prescribing has potential for improving efficiency and patient care. However, like so many of the Blair reforms, this radical social experiment has been designed and implemented in a hasty and ill thought out manner. Its potential dangers in terms of expenditure inflation, inappropriate treatment, unclear legal responsibilities and clinical governance should be noted nationally and internationally. Good intention without efficient evidence based policy design and proper evaluation is a fine recipe for disaster! Such outcomes can only be avoided if the policy is radically revised and properly managed and evaluated. Without such prudent behaviour, which currently appears to be absent in Government and much of the profession, consumer protection will be inadequate.

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Road traffic injuries in Spain: will we ever conquer this public health problem?

María Seguí Gómez

The magnitude of the problem

Injuries arising from traffic crashes are the fifth leading cause of all deaths in Spain.¹ Crashes are also one of the leading causes of death in most of Europe, although the proportional magnitude of that toll is larger in Spain. Approximately 5,000 people were officially recorded as road traffic victims by the Traffic General Directorate (DGT) in 2004. Whether one divides this figure by total population, kilometres driven, or by vehicles available, Spain has one of the highest rates of road traffic victims in the 15 original EU Member States. Counts on non-fatal injuries are equally dramatic. In 2004 there were 113 deaths per million people, only Portugal and Greece with 123 and 153 deaths per million respectively had higher rates. The lowest rates were to be found in the Netherlands, Sweden, and the UK with just 50, 54 and 56 deaths per million respectively. With the exception of Malta, (which has the lowest rate of all) road traffic fatalities are even higher in all of the new Member States, with rates in excess of 200 reported in Latvia and Lithuania.²

In 2001, when Spain announced that it was signing up to a health objective calling for a 50% reduction in fatalities by 2010,³ the news was warmly welcomed. As with any other health problem, setting a political goal defining the mission

seemed an appropriate initial step in the right direction. This type of normative decision must however be followed by detailed planning, and thus, a Road Safety Strategic Plan 2005–2008 is about to be released by our national authority.⁴

But before we get into the details of this Plan, it might be relevant to evaluate why we are in such terrible state in Spain when it comes to road traffic safety. As in many other southern countries, our good climate encourages people to travel on foot and by motorcycle. While almost everybody is a pedestrian at one time or another, about 12% of the population hold a moped or motorcycle license, accounting for 25% of all licensed drivers. This is an under estimate of the situation as motorcycles comprise 13% of all motor vehicles in the country, and the actual number of people who ride them is not recorded.⁵ Not surprisingly, pedestrians comprise 14% of deaths while another 16% are either drivers or passengers of two-wheeled vehicles?

How many of those on motorcycles suffer injuries (whether fatal or not) because they are not wearing a helmet is a difficult question, since helmet use is not routinely recorded in either police crash reports or health-related datasets (including emergency department records or hospital discharge data). However, some estimates have suggested that the lack of use among users involved in a crash amounts to 25%.⁶ If roadside observations shed any light on this issue, it may be noteworthy to point out that some 15% of motorcycle drivers and 35% of moped drivers do not use helmets.⁷ Moreover, experience in other countries suggests that those individuals in the general population not wearing helmets are also the ones more likely to be involved in crashes.

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When it comes to another big safety ally, the seat belt, information on its use amongst car crash victims becomes equally elusive. We can only report on roadside observations that suggest that 40% of drivers travel unbelted in urban settings, whereas 14% do so in non-urban settings. The rate of non-use increases as one looks at other motor vehicle occupants, reaching as high as 73% for rear-seated adult occupants⁸. Child restraints are not used by 27% of infants and by as many as 79% of children aged seven to nine.⁹ As with the situation for two-wheeled vehicle users, experience from other countries suggests that those who ride around unrestrained or improperly restrained are, at the same time, those more likely to be involved in a crash and sustain fatal or non-fatal injuries.¹⁰

Of course, many other factors could be added to the list of risk factors for fatal and non-fatal road traffic victims, including alcohol consumption or the speed of travel. Yet, as public health experts will agree, when trying to improve the health of the population, one must not focus on factors just because they have high relative risks, (that is, their presence increases significantly the risk of death or injury amongst those exposed to it) but also because they have a high population attributable fraction (that is, the population prevalence of the risk factor, coupled with a moderate or high relative risk makes them responsible for a high proportion of injuries that could be prevented in the whole population using a preventive measure).¹¹

Unfortunately, in Spain and in most of

Europe, road traffic injuries have not been addressed within a proper public health framework. Historically, road traffic victims, whether fatal, non-fatal or permanently disabling, have been addressed in a homogeneous manner that prioritises the reduction in the number of accidents, as opposed to a reduction in the number of injuries that lead to death or disability. Accidents are a necessary but not sufficient condition for injuries to occur.

The new Spanish Road Traffic Safety Strategic Plan

This much anticipated document begins by setting out a political goal of a 40% reduction in fatalities by 2008 (instead of the 50% reduction by 2010 set in the original EC White Paper). The definition of this goal is operationalised as a decrease in the death rate per million of the population. Additional goals are set, for example, for reductions in the death rate per 100 accidents with victims, or reductions in the total number of accidents with victims, although the quantification of such goals is not stated. But as Figure 1 illustrates, motor vehicle-related deaths have been so detrimental to our society for so long that setting goals lower than those recommended at the European level and waiting still further before implementing preventive measures seems not only a waste of time but also a waste of lives. We should have started ‘yesterday’ working towards their achievement.

The Strategic Plan moves on to outline the development of actions across a number of areas including education and

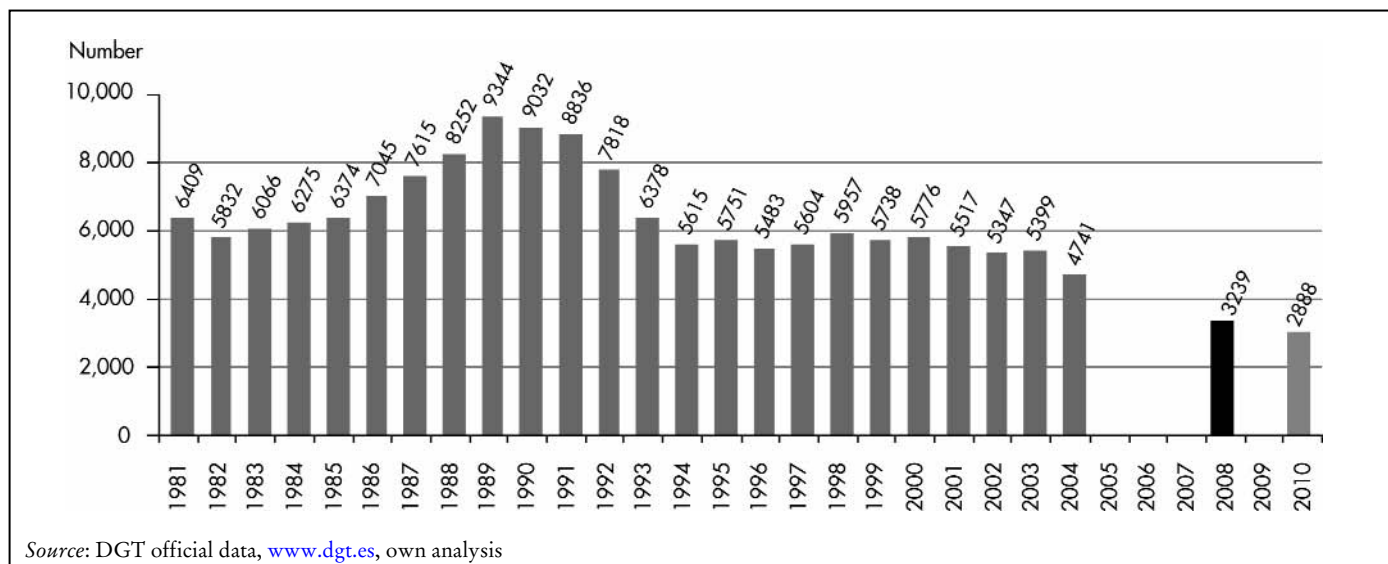
training, surveillance and infrastructure development. Looking at education, for instance, they include using various mechanisms to promote awareness among drivers, pedestrians and other groups. Goals and targets are outlined; they include incorporating road traffic education into the school curriculum and preparing educational materials for people of all ages.

However, it is in the analyses of the key actions and the goals for some objectives where the connection between political health objectives, operational health objectives, and strategies to achieve them become blurred. For example, the links between many stated actions and the overall objective of the Plan are not obvious. For instance, how “the number of meetings by the High Council for Road Safety” is going to affect “the total number of fatalities” or what is the relationship between “improvements in the procedures for issuing driver licenses” and the “number of fatalities or seriously injured people” remains unclear.

More importantly, it is difficult to comprehend why the target on the wearing of helmets by motorcyclists by 2008 is set at 95% and 75% for drivers and passengers respectively rather than at 95% or 100% for both. Nor is it clear why the rate of uptake of seat belt use is set at 90% for drivers and 70% for rear seat passengers and not at 95% or 100% for both. Granted 100% is a difficult target to reach, but why should we be satisfied with just 70% restraint use amongst our car occupants, including our children?

It seems that interventions which we

Figure 1: Spain – trends in fatalities within 30 days of road crash and 2008 and 2010 objectives



know work, for which there is much room for greater uptake, and that have been successfully introduced in other countries, should be implemented and enforced immediately. Obviously, on top of enforcing these measures, we must continue to work towards identifying interventions which could generate additional benefits and conduct additional research to further understand how to reduce those remaining injuries not addressed by any currently available measure.

The Golden Pill

It is in this paradigm that the DGT have presented their most heavily advertised safety measure, the Penalty System Driving Licence (which is one of the key actions in the Strategic Plan and deemed to be of “high priority”). This idea, which after a year and a half of discussion will finally be introduced on July 1st, is already being used in other European countries, including the United Kingdom (since 1982), France (since 1992), and Germany (since 1999). Conceptually, the aim is to shift the existing idea of a driving license away from a simple authorisation to drive towards the notion of a social credit, which will be lost through the deduction of points ‘earned’ as a result of serious road safety offences. No one can question the potential efficacy of such an idea in an ideal world. However, as with most other interventions, rigorous evaluations of its effectiveness in a real world are still lacking.

But what we want to highlight from this intervention is the disconnection between a specific goal and the selection of specific interventions intended to achieve it. For example, in the proposed system, higher penalties are assigned to risk factors associated with higher relative risks (for example, driving more than 50% above the speed limit). Yet, the public health paradigm and the paradox of preventive medicine¹² are once more forgotten.

In the real world, the majority of cases attributable to a particular risk factor occur among those sections of the population exposed to moderate levels of that risk factor. The proportion of the population exposed to very high levels of risk is usually negligible. How many drivers actually drive more than 50% above the speed limit? And more importantly, how many road traffic casualties are victims of such an offence?

Besides not having answers to either of

these two questions, due to the lack of an information system that would provide such data, the international literature tells us that while the risk per high speed accident is high, very few accidents are related to this extreme behaviour —thus, the population attributable fraction of this measure is relative low.

The penalty for driving between 21% and 30% above the speed limit is just two points, yet the reality is that this ‘lesser’ road safety infraction, because it is a common offence committed by many more drivers, ends up being associated with a much larger numbers of victims, including pedestrians —an example of a high population attributable risk situation. The same argument could be applied to the plan for a three point penalty for not wearing a seat belt or helmet, or the lack of any penalty if one fails to properly restrain child passengers.

Lets bring policy and science together

We applaud the political commitment to reduce road traffic injuries both in Spain and elsewhere. We further applaud the political commitment to translate these goals into actions.

However, in road traffic safety, as with any other public health problem, good ideas and good intentions must be followed by good data, good science and a good rationale.¹² Once a nation sets up the machinery to develop health-related strategic plans and because of the time and effort that developing these plans require and the opportunity costs entailed, health-related priority selection principles should also come to the table. Promising efficacious interventions, which have not been evaluated in real world settings, must be set apart from those proven to be effective and efficient; the latter meriting immediate implementation.¹³ If seat belt use and appropriate helmet use are associated with a 50% reduction in fatality risks amongst crash victims, we are currently forgoing saving the lives of at least two Spaniards every day. Not emphasising this means not being true to the spirit of the policy that we have signed up to. A sincere adherence to evidence-based commitments is the only path to conquer this problem.

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Pandemic Flu: encouraging a positive population response

Hilary Pickles and Robin Goodwin

Background

The world is preparing for pandemic flu. Currently, we are in the World Health Organization's (WHO) pandemic alert phase 3, with isolated cases of human disease from a new virus subtype, H5N1, caught directly from birds.¹ For a world-wide pandemic to be generated, we need not only a novel flu virus that causes significant illness in humans, but also a virus that spreads readily from human to human. It is assumed that the new pandemic will arise from H5N1, but it could come from another subtype.

The big questions for us all are not only when the pandemic will strike, but how severe will it be? It could end up giving humans a mild disease. On the other hand, it could be as severe as in 1918/19, when some 50-60 million died world-wide. We will get a better feel for this when we are in WHO phase 5, when clusters of local spread are becoming more common, showing the virus has increasingly adapted to humans. From then, there may be only a very short time, a few weeks maybe, before the world-wide pandemic is upon us.

Planning for the pandemic

The current situation is that there is intense international activity attempting to understand how best to stamp out an incipient pandemic, whilst preparing on the assumption that those measures will fail. Building on its considerable success

in SARS (severe acute respiratory syndrome), the WHO is at the centre of international collaboration, setting the policy framework.² Scientific interest is immense, with many international teams hard at work, for example into details of virology, vaccine possibilities and modelling how the spread of infection might be interrupted. With the inevitable time lag in vaccine production (which can only start once the nature of the pandemic strain becomes known), the planning assumption is that the first wave of pandemic will have to be faced without any substantial vaccine protection.

Individual states have been urged to do their own contingency planning, which many are now doing, including all European states. The population groups most vulnerable to the pandemic are unclear until the responsible subtype emerges, but in 1918 it was young adults who were most susceptible, and it could be the same again. The pattern and severity of illness will only become clear when the pandemic starts, but for most of those affected, a week or so away from work might be expected.

In national planning, most attention is being given to the clinical burden from those who have severe illness, including those that die. Modelling of the potential burden of disease reveals a huge challenge for health services, especially on the ability to ventilate those with pneumonia. Rationing of access to healthcare facilities may be needed to a degree not witnessed in Europe for generations. Timely disposal of the dead may become an issue, as it did in 1918/19.

The main interest and emphasis of the pandemic planners to date seems to have been on combating the medical consequences of infection. There are plans to track the spread of influenza and take learning from the first cases and apply it

to the clinical management of those that come later. The availability and use of antiviral drugs and experimental vaccines is a potentially divisive issue, since supplies internationally will be very limited. Most nations will have to manage without either vaccine or antiviral, at least for several months. Fortunately, there are also non-pharmaceutical measures available, such as increasing social distance, environmental cleaning, and reducing the opportunity for the spread of nasal secretions.³ Although the use of face masks by the general population is of very dubious value, and might even be counterproductive, frequent washing of hands can be embraced by all.

The European setting

Modern Europe is very much more populous than in 1918, with large urban areas. Travel is a fact of life for many, both domestic and international. Business is increasingly efficient, with ordering just-in-time to keep costs down. Stockpiles are small, with reliance on frequent re-supply. Goods and services are traded across wide areas. Families are small, with many women out at work even when they have children. Deaths in children are uncommon, and even expected deaths of the elderly mostly take place in hospital in some countries like the UK. The media is international and communication through websites and the internet impossible to control. European society does not feel prepared for what an influenza pandemic might throw at it.

The pandemic scenario

As the pandemic unfolds, the media will make sure all European citizens know what is coming their way. As the pandemic rolls forward into communities, the numbers off work may be at least 10% above normal, and considerably more for those with caring responsibilities. As well as sick relatives to care for,

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there will be the children too, since schools may need to close, and even if they do not, parents may be unwilling to send their offspring to places where infection can easily spread. For some groups, like the largely female health care workers, planning needs to be for 30% or more staff absenteeism. The SARS epidemic showed that while all groups of health care workers are likely to feel stressed by a pandemic, nurses are particularly likely to report low morale and job satisfaction and to require peer support.⁴

The effect on the workforce may drive the impact locally. Many supply chains may be stretched to breaking. As shortages start appearing in the shops, the response of many may well be to hoard what they can, when they can. Even just the rumour of a supply shortage may be enough to ensure one happens. As in any shortage situation, there will be entrepreneurs ready to fill the gap, including black marketers, and some everyday products might reach exorbitant prices. Few now in western Europe have experience of coping with hunger, or are practised at managing without life's luxuries. If supplies hold up, then where this is available many may turn to internet shopping, as was seen in Hong Kong during SARS.⁵

Politicians will come under intense pressure to respond. The differences between member states and their preparations may become more of an issue than the common ground. Some nations may have the face masks, and others the antivirals, but most will have insufficient of either. Deaths will mount. There will be pressure to stop the infected crossing borders, although the clear advice is that this will be irrelevant to spread at the pandemic phase.³ The media and informal communication networks may be unkind, and civil order may be hard to control. So, in order to better inform the best way to respond to this potential unfolding disaster, it is important to go beyond dealing with the direct effects of the virus.

Lay perceptions of illness

How we will deal with any outbreak is likely to depend in part on our existing beliefs about illnesses. We all hold perceptions about disease in the 'modern world', the types of people most usually at risk, and 'common sense' notions of the best way to cope with illness. Such beliefs help us cope with the challenges and threats in our world, including those

posed by new pandemics. Of course many of these beliefs may bear little resemblance to the advice being given to deal with any pandemic, but they are still likely to be important in informing our behaviour. Such 'common sense' beliefs are rarely, however, taken into account by the medical profession, who tend to approach risks as 'objective' hazards. Unfortunately, at times of crisis, such beliefs can also be deeply divisive for any society.

In the SARS and Ebola virus outbreaks, associations with Chinese or African 'others' allowed Europeans to distance themselves from the apparent risks posed.⁶ SARS emerged of course in a polluted, crowded, East Asian environment, where, to the Western reader, an almost primitive and medieval alliance persisted between people and their animals. Blaming (usually foreign) 'others' is common when faced with threatening disease. They are often thought of as 'bringing it on themselves' perhaps because of their ways of living or outdated practices. So it may be easy to target Chinese populations in Western countries, particularly those that associate most closely with apparently 'risky' professions (for example, restaurateurs). In Toronto, some Chinese suffered for their association with SARS.⁷

For most people, the similarities between the recent SARS outbreak and avian influenza may also make them unwilling to follow official health guidelines. SARS was also presented by the media as a disease that could kill millions, yet it virtually disappeared in a few short months. Leading commentators in national newspapers across Europe have already begun to question whether this is just 'another' false alarm, and have placed considerable suspicion on leading politicians.⁸ Already low levels of trust, particularly in the former Communist nations of Eastern Europe, make a suspicious public sceptical of official health warnings, leading them to wonder "why are they telling us this?"

We saw this following the Chernobyl nuclear disaster, when official advice about what was and was not suitable to eat often conflicted with both widely held beliefs about food safety - and the real everyday practicalities of poor societies. As a result, such advice was often disregarded.⁹ Fatalistic attitudes, particularly amongst the elderly and the poor, as well as a generalised mistrust of any who

work in a 'selfless' health sector, may make important behaviour changes difficult to achieve. It may be necessary to ensure that health messages come from respected international (European, rather than US-based) agencies, rather than apparently 'compromised' national governments. The power of the internet to challenge the accuracy of any such proclamations needs to be recognised, but the internet could be actively mobilised too to provide vital information and counter unproductive rumours.

Planning for an alternative scenario

A preferable approach to pandemic planning might be to appreciate that this as a major and general disruptive challenge, rather than a largely medical problem. Society as a whole will be stressed, and society will need to respond, based on the core response to any major disaster, with specific flu elements added on. Sick rates mean few businesses will be unaffected, so all need to prepare for managing through a lean period, concentrating on the essentials. Some, like those involved in health and social care, will face the double challenge of increased pressure from their patients and clients and a reduced number of staff. With the right encouragement and advance planning, volunteers from less essential industries should be able to help out. The pandemic will be a real opportunity for whole communities to pull together, to be encouraged to go beyond self-help to neighbour help.

As with all emergency planning, the best way to develop this model may well be to build on existing structures and relationships, building up from the neighbourhood and commune. Nationally and internationally there may need to be action to remove barriers both to cooperation, and to the extreme effort needed in a pandemic situation (like the restricted hours of the working time directorate). The final judgement may well come down to how any community looked after the most vulnerable, such as those with learning disability or mental illness held in residential institutions, where transmission is likely to be exceptionally difficult to control. For this high ideal of a truly civilised response, the basis needs to be a better understanding of the likely population response, one that is wider than just the direct reaction to the influenza virus.

While attention is focussed on the pan-

demic situation, there will be other urgent business that needs to continue. The economic impact will be very considerable, and some individuals and businesses will need sympathetic handling.¹⁰

The end game

The pandemic is inevitable, although it may prove to be a damp squib. What really matters is the recovery phase and thereafter. If all goes well, we will have a society at peace with itself, looking back in pride at surviving a terrible time, together. In spite of the shortages and rationing and loss of life, the aim is a lack of recriminations. The internet means it will not be possible to conceal mistakes, so instead we need to seek to learn from them, not forgetting the cover up is always worse than the original error. For this we need leadership at international, national and local level.

Good planning for this need not cost much, except in time. We need to get the attitudes right, with society understanding about its vulnerabilities and the need for prioritisation. Brave policy makers will be planning for openness and

trusting the public. Together we will rise to the challenge.

Conclusion

It is important to keep this pandemic in proportion. Even if it proves as bad as 1918, the majority of the world's population will survive with full physical health. The onus is on us to ensure society as a whole comes through well too.

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Communicating risks and benefits of prescription medicines

How stakeholders communicate messages about the risks and benefits of medicines is critically important when considering how best to provide balanced and reliable information to European patients.

Introduction

Jeffrey L Sturchio

When asking what kind of information European patients want and need about health care and about the medicines that they take, one of the most salient responses from multiple stakeholders is the need to communicate the benefits and risks of medicines more adequately. Providing access to accurate, balanced, evidenced-based and comprehensive medicines information would allow patients, working with their health care providers, to assess for themselves the expected benefits, risks, and associated side effects of treatment. In the long run, based on available studies, readily understandable information about prescription medicines improves patient adherence, which should improve health outcomes.¹

In the last decade, the dramatically increased availability of health information on the internet and through other media has had a significant impact on the patient empowerment movement. Of course patient empowerment does not mean that physicians, the learned intermediaries in treating illness and disease, will not continue to have a role in providing information to patients along with other health care professionals (including pharmacists and nurses). In fact, according to recent surveys, the most trusted source of health information is still the

physician, followed by family and friends.²⁻⁴

Often the only information available to patients is the patient information leaflet, which is derived from the Summary of Product Characteristics that the European Medicines Agency approves when medicines are introduced in Europe. It is commonplace to observe that the patient information leaflet is not particularly user-friendly and does not provide any detail in understandable language on many of the questions that are foremost in patients' minds – Who should be taking the drug? Why a drug is needed? What are its benefits? How it should be taken and when to avoid side effects? Who is likely to experience a side effect and what to do when they occur?

The reality, however, is that for most European patients the only form of readily available medicines information is this package leaflet. It is fair to say that hardly anyone is satisfied with these patient information leaflets as effective communications tools and there have been many calls in recent years for more robust approaches to providing European citizens with the information they need about their medicines.⁵

Patient perceptions of risks and benefits vary according to a wide range of factors, including cultural background, education level, gender, religious beliefs, severity of illness, age and preferences on how to treat their health, among others. From time to time we all experience the sometimes confusing and often unsettling notion of risk. Without proper context

and explanation, the real risks and true benefits of a medicine are not always fully understood. Pharmaceutical companies, which have the best information about the drugs they discover, develop and manufacture, have a legitimate role to play, in partnership with patients, physicians, health care professionals and other stakeholders, in explaining to patients the risks and benefits of medicines.

This concept of the risks and benefits of medicines is multi-faceted and requires input from all stakeholders. Patients, their families, physicians, other health care professionals, as well as academic researchers, the pharmaceutical industry and regulators all have a role to play in communicating risks and benefits. We also often overlook the role of the media, an important vehicle by which most people learn information about medicines and about their benefits and risks. We have only begun to appreciate the ways in which the media influence public attitudes and understanding toward health care and medicines.⁶ How all these stakeholders communicate messages about the risks and benefits of drugs is critically important when considering policy and regulatory changes to the mechanisms by which balanced and reliable information is provided to European patients.

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Spreading the word: a view from the media

Geoff Watts

Some people who work in health care continue to equate health and medical journalism with education. This is a mistake: journalism is not about health education any more than it is about political or arts education. It is about stories that interest people. Nor do reporters and broadcasters owe their first loyalty to the health care community. Their loyalty is to their readers, listeners and viewers – who will go elsewhere if they are unsatisfied.

This is not to suggest that journalism should have a licence for irresponsible reporting, or that journalists should disregard the consequences of what they say and write. But medical professionals and policy makers who believe that the media exist solely to disseminate their particular view of health care will be disappointed.

Besides the obvious pitfalls in the relationship between medicine and the media – the complexity of science, the intricacies of policy, their often impenetrable jargon – there are also more subtle hurdles. The widely held belief, for example, that the word “scientific” means “definitive” rather than just “the best explanation currently to hand”. The public may become confused or suspicious when changes in understanding lead to changes in advice.

Risk and probability are two more perennial sources of conflict. Typical of this

was the 1995 UK contraceptive pill scare when a large number of women stopped taking this for wholly inadequate reasons. The UK regulatory authority had issued a statement saying that certain newer brands were twice as likely to cause blood clots. Twice a very small risk is still a small risk....

Researchers seeking to disseminate their findings and so influence practice often face a difficulty: the media are about real life whereas – for example – a randomised controlled trial (RCT) is not. Real life is about opinion, emotion, prejudice, instinct, fashion, style and scores of other honourable or disreputable forms of human outlook and behaviour. The RCT sets out to discount these things. Imagine the average newspaper stripped of all such attributes. Even a textbook on philosophy would offer a more gripping read. This is not, of course, to disparage the austerity and the intellectual clarity of clinical trials; but it does mean that their ethos is not one that sits comfortably within everyday journalism, which thrives on black and white, not carefully modulated shades of grey.

A different problem, particularly for public service broadcasters, is even-handedness. Balancing one view with another may work in political reporting, but not always in scientific medicine. The UK, for example, has witnessed fierce controversy over the claims of one doctor that the MMR (mumps/measles/rubella) vaccine can cause autism. A vociferous patient lobby has kept the story alive – and each time it is resurrected, both viewpoints are reported. Lay people have begun to think doctors must be equally

divided. If they are not, why do we keep hearing both sides of the story?

Difficulties also stem from the professional hierarchy within news journalism. A story on biomedicine will start with the medical or science correspondent; if it becomes more prominent it may acquire a political element. Political journalists will then take charge, often to the detriment of the scientific content of the stories. As a report prepared for the House of Lords Committee on Science and Technology has demonstrated, this is what happened during national newspaper reporting on the alleged health and other risks of genetically modified (GM) foods in the UK.

One Swedish medical journalist and doctor, Ragnar Levi, has written a book arguing the case for a new approach. *Medical Journalism – Exposing Fact, Fiction and Fraud*¹ points to what Levi sees as the weakness of “balanced reporting” – as in the MMR example above. His alternative, “critical medical journalism”, is rooted in journalistic best practice – checking the facts, checking the sources, asking the difficult question – but he also expects properly trained reporters to know about randomised controlled trials, meta-analysis, “numbers needed to treat”, and all the rest of what constitutes reliable evidence in scientific research. It is a journalistic equivalent of evidence-based medicine.

Personally, I suspect that few journalists would want to take on a responsibility of this kind. Nor would their readers wish them to. If there is a remedy to be found it lies in understanding what the media want, and what individual journalists need. In broad brush terms, doctors and policy makers should remember that even the best journalists have to work at speed (it is no use returning their call next week); need something to catch the public imagination whether this be novelty, rarity, importance, or some other characteristic; and will inevitably shape stories according to their own requirements. The relationship can work for both parties – but it may take some negotiation.

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Communicating with patients on the risks and benefits of pharmaceuticals

DK Theo Raynor

Most written information we currently give to people about their medicines is poor. In our research with people with asthma, they talked about medicines information as being “too small, folded and in the box”; “you throw them away, don’t you”; “they don’t inspire you”; “people who suffer should help write leaflets”.¹ Information about the risks of medicines is one of the top priorities for patients, but our leaflets do not provide this side effect data in a way which is useful to the reader. We tend to give:

- a complicated description of the side effects;
- little indication of how likely they are to happen;
- little guidance about what to do if they do happen.

We need to use words that patients will understand, everyday words like “tingling” and “lumpy rash”. That is exactly the way we should be talking to people about side effects: individuals can recognise a “lumpy rash”. There is no point in giving them information about side effects unless they can actually recognise them.

Once they can understand and recognise a side effect, the patient then wants to know how likely this is to happen. In 1998, the European Union produced a guideline which described some verbal terms that might be used to describe risk.² These were “very common”, “common”, “uncommon”, “rare” and “very rare”. However, our research found that the public interpreted these terms very differently from the regulators.³ The guideline suggested that “very common” should be used for side effects occurring in 10% or more of people. The average figure we found from our studies was that individuals thought this would mean occurring in over 50% of people.

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“Common” was meant to denote 1–10%, but the public thought on average that this would occur in over 30% of people.⁴

This means that we cannot use verbal descriptors on their own. The options include percentages (like “10%”), and natural frequencies (like “1 in 10”). Unfortunately, not everyone understands percentages – as with words, many people have literacy problems with numbers. Although there is still not a universal understanding, natural frequencies appear to be better for patients than percentages. The conclusion of a UK government working group on patient information was that a combination of verbal terms and natural frequencies (“this side effect is rare, affecting less than 1 in a 1,000 people”) might be the best way in which to describe side effect risk.⁵

In terms of what patients should do if they think they have a side effect, the same EU guideline suggests that we should use the term “immediately” for those situations where the most urgent action is needed, such as when a side effect is suspected. “As soon as possible” was suggested for used for less urgent situations. Our research showed that there was no substantive difference in the way people interpreted these two options.⁶ Again we needed to go to the people who took these medicines and determine how they actually interpreted information, rather than going ahead based on how we think they would interpret this.

The good news is that there is now an opportunity to make medicine leaflets better. Since 30 October 2005, across the European Union, all new medicines must have their leaflets tested through consultation with target patient groups, to ensure they are fit for purpose, before the medicine can be granted a licence. This is a real opportunity to improve package leaflets. The requirement for testing is mostly being taken forward through what is known as ‘User Testing’. This is performance-based testing, where the tester sits down with individual people (who are potential users of that medicine), and hands them the leaflet to read. They then ask them to find, and explain in their own words, 15 key points related

to the safety and efficacy of the medicine. We have found, through our University spinout company www.luto.co.uk, that User Testing is a potent way of finding out whether these leaflets are meeting patients’ needs.

As well as User Testing, we need more research on wider issues relating to how to best provide the population with information about their medicines. The systematic review we have just completed for the UK National Health Service Health Technology Assessment Programme revealed relatively few studies which met the inclusion criteria.⁷ So there really is a lot more research needed to find out the best way of providing this important information to the public.

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The following summarises some of the key points to emerge from a Panel Discussion on information for patients, held during the European Health Forum Gastein on 5 October 2005 in Bad Hofgastein, Austria. Panellists included Fred Harms, Anders Olauson, DK Theo Raynor and Geoff Watts.

Trust and medicines information

All panel members agreed that trust, and the sources of information trusted, are critical to create public awareness and understanding of medicines information. Scientists, who research and study medicines, have varying levels of public trust based on who they work for: the academic world, government or industry. The public have tended to place their faith in non-governmental organisations far more than they have in any governmental or industrial source. As a result, some non-governmental organisations have begun to abuse that trust by manipulating the media. They know exactly which buttons to push and can do this more often and more effectively than governmental or academic organisations. This too has contributed to the public's overall scepticism of information and the trustworthiness of those sources.

Anders Olauson (Founder, Chairman and CEO of the Agrenska Institute, Sweden) speaking from the perspective of a European patients' organisation, believes that trust is clearly a key issue in providing information on medicines to patients. He suggested that the public need not only to trust information sources, but also to believe in and value those sources. For example, pop idols and stars are not necessarily trusted to understand a lot of things, but their opinions of different things will have a value and an impact. Therefore, it is important to understand the context into which individuals take in information and then act upon this information. Anders pointed out that by identifying individuals and institutions that the public value, it is possible to reach individuals who might not otherwise receive and act upon messages.

The patient and medicines information in Europe

Over the last ten years, the shift from a physician-directed to a patient centred

approach in health care, spearheaded by patient organisations, has paved the road for patient empowerment and information seeking. Since the 1970s, patient organisations have increased significantly, resulting in a power shift toward patient autonomy. In Europe today, there are multiple patient organisations covering a wide variety of diseases, illnesses and disorders. The realisation has dawned that if we want to know more about a specific disease then the best people to talk to are those living with the condition. Therein lies the challenge of how to provide effective communication about the risks and benefits of treatments and therapies to so many groups. One solution to this problem is to ask patients what kind of information they want, how it should be delivered to them and from what sources. Anders reinforced the notion that a multi-stakeholder approach is necessary, but with patient need as the focal point of any action.

Patients need to have access to information in everyday language and in a context they can comprehend in order to make informed decisions about their disease and treatment. Currently there is no central repository of medicines information for European patients. They can read the patient information leaflet (PIL), talk to their physician and/or pharmacist and seek advice from a patient organisation, friend or family member. Credible, reliable and accurate information available to European patients on websites is typically in English only. Translating PILs into the twenty-two or more official European languages makes it less readable because the printout has to be smaller to fit in important risk and benefit information.

One of the dangers of the lack of easy access to comprehensible, yet accurate, information is that many Europeans are turning to websites that have not been subject to vetting by physicians or regulators and may contain misleading and possibly false information. Website credibility brings yet another dimension to the issue of communicating the risks and benefits of medicines. Because no

information is without bias, all four panel members agreed that some quality mark such as a stamp of authority or seal of approval should be mandatory for websites that aim to provide information about prescription medicines from a variety of sources.

A multi-stakeholder approach

Most of the information known about the side effects of medicines comes from the research that pharmaceutical companies conduct through the clinical trial process, which ultimately leads to regulatory review and approval. Information on drug interactions, food and alcohol interactions, what you should take or what you cannot eat with medicines and the range of side effects are all things that emerge from clinical trial data. But, with the exception of the PIL, companies are prohibited in Europe from actually conveying that information to the public in general, nor to patients or to family members who care for them.

The panellists were of the view that the best information should be available to patients when they need it and that the most appropriate approach to delivering information, especially on risks and benefits of medications, is through multiple stakeholders. Anders commented that a one-portal approach to information is not sufficient; patients want to have the ability to look at different high quality information sources and then make their own judgment based on that information. This of course does not imply the physician/patient relationship is limited when it comes to the exchange of information and shared decision-making. In fact, the opposite is true because oral information, particularly from medical professionals, is often valued most highly by patients. However, even Fred Harms (Head of the Health Care Competence Centre Basel) conceded that a multi-stakeholder approach is needed to build trust with the public.

Communicating the risks and benefits of prescription medicines presents many challenges and opportunities. Accurate, reliable, trusted and balanced information from multiple sources, in a language and context understood by the target audience, offers the best solution to the information gap experienced by many European patients.

Can physician gate-keeping and patient choice be reconciled in France? Analysis of recent reform

Laure Com-Ruelle, Paul Dourgnon and Valérie Paris

Reforms to the structure of the French health care system were introduced in August 2004. They aimed to improve the health care system's efficiency whilst better guaranteeing financial sustainability. Aside from issues of governance, the coordination of care was a core component of these reforms. This was primarily addressed by a new scheme for 'preferred doctors' (*médecins traitants*), coupled with the creation of an electronic patient record (*dossier médical personnel*).

The French health care system is generally acknowledged to be both of high quality and to have facilitated equitable access to medical care. It has however often been considered as inefficient (with the notable exception of the World Health Report 2000¹), being likely to encourage the over prescription of medicines as well as generate redundant medical consultations and examinations.² Thus, the idea of introducing a gate-keeper into the system to enhance efficiency is not new. The concept has been progressively gaining acceptance since the early 1980s and has

been promoted by various experts and policy-makers, well as by one of the general practitioners' professional associations, MG France, which viewed this reform as symbolic, forming part of a broader strategy, aimed at enhancing the status of general practitioners (GPs) compared with that of specialists.³

A first attempt at introducing a gate-keeping system was implemented in 1998 following a national agreement signed by MG France and the French health insurance funds. Under this scheme, doctors who volunteered to be 'referring doctors' invited patients to sign individual contracts. By signing the contract, the patient accepted this GP as their first point of entry into the health care system. In exchange for a per capita annual payment (€46 in 2001), these referring doctors committed themselves to participate in public health programmes, to keep patients' medical records (not a legal requirement in France), to accept direct third-party payments* and to prescribe cheaper drugs. This scheme, however, was opposed by most of the physicians' professional associations, and was eventually only adopted by 10% of GPs and just 1% of patients.

The opposition to this scheme occurred against the backdrop of a very tense relationship between the National Health Insurance Fund, the government and specialists' professional associations during 1996 to 2002. The main professional association (the CSMF – *Confédération des Syndicats Médicaux Français*) refused to sign any national agreement from 1997

and the authorities were forced to regulate the system unilaterally. It was only when a right of centre government came to power in 2002 that negotiations with the government recommenced. In January 2005, the CSMF and two other representative professional associations signed the new national agreement introducing the regular physician scheme set out in the health care reforms of August 2004.

The preferred doctor scheme

The scheme sets up a system of coordinated care pathways for individuals using the health system. It has three main features:

1. A contract between the preferred doctor and the patient

Each patient over the age of sixteen is invited to choose a primary care doctor, with whom he/she signs a contract. This physician will then be the first point of contact with the health system. The regular physician provides primary care and if appropriate, will make a referral to specialised secondary care services. In the case of a referral, the patient remains free to choose a specialist without any constraints. From 2007, physicians will also be responsible for maintaining patient electronic medical records that could contribute to a consistent follow-up of patients. In contrast to the previous 'referring physician' scheme, preferred doctors are not committed to undertake additional tasks beyond providing appropriate follow up for their patients and assessing their need for specialised care.

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The opinions expressed and arguments employed here are the responsibility of authors and do not necessarily reflect those of their institutions.

* The physician is paid directly by the health insurance fund for the reimbursable part of the doctor's visit. Patients without a referring physician pay the physician and are subsequently reimbursed through the social security system.

Table : Physician fees and reimbursement by health insurance funds for medical consultations (January 2006)

Pathway	Coordinated care Reimbursement rate: 70%		Non-coordinated care Reimbursement rate: 60%
	Preferred Doctor	Other Physician via referral	Physician
GP sector 1	Fee €20 RA €13	Fee €22 RA €14.40	Fee €20 + \$ RA €11
GP sector 2	Fee €20+ \$\$ RA €13	Fee €20 + \$\$ RA €13	Fee €20 + \$\$ RA €11
Specialist Sector 1	Fee €27 BR €25 RA €16.50	Follow-up contacts:** Fee €27 RA €17.9	Fee €27+ \$ BR €25 RA €14
		One-off consultation: Fee €40 RA €27	
Specialist sector 2	Fee €27 + \$\$ BR €23 RA €15.10	Fee €27+ \$\$ BR €23 RA €15.10	Fee €27 + \$\$ BR €23 RA: €12.80

Key

Fee = full charge to patient

BR = Basis for reimbursement

RA = Reimbursement amount*

\$ = possible supplemental fees charged by physicians in sector 1, limited to 17.5% of the official fee

\$\$ = possible supplemental fees charged by physicians in sector 2, no limitation (other than 'tact and moderation')

* The reform of 13 August 2004 introduced a €1 deductible for each medical contact (effective from 1 January 2005). Reimbursement amounts are calculated by applying the relevant reimbursement rate to the basis for reimbursement and deducting €1. Unless otherwise indicated the fee is equivalent to the basis for reimbursement.

** The official rate for the majority of specialist physicians is €27 but some specialists can charge more: cardiologists (€48), psychiatrists, neuropsychiatrists or neurologists (€50 for the first consultation and €40 for follow up consultations).

While the preferred doctor typically can be the patient's GP, the possibility of choosing a specialist is not excluded. The system permits patients to change their preferred doctor at any time by simply informing their health insurance fund.

2. Financial incentives principally directed at patients

The preferred doctor scheme is not compulsory but is based on incentives directed at patients rather than physicians. The physician does not receive any per capita

payment for the follow-up of registered patients, except for those suffering from severe chronic diseases (including those with diabetes, severe hypertension, HIV etc), all of whom are exempt from co-payments. In this case, the attending physician receives an annual payment of €40 per registered patient for drafting a care protocol.

If an individual chooses not to register with a preferred doctor, then the rate of reimbursement he is entitled to from his

health insurance fund is reduced from 70% to 60%. The same applies if a patient visits a GP other than his/her preferred doctor (except in an emergency) or if the patient consults a specialist without a referral. In the case of specialist consultations the maximum fee level on which reimbursements rates are based is also reduced. In any of these three situations, GPs and specialists in sector 1* are entitled to charge a supplemental fee, up to 17.5% of the official rate. The result is a complex set of rules that are certainly difficult for the public to comprehend (see Table).

There are some exceptions in respect of access to specialists. Direct access to gynaecologists, ophthalmologists, psychiatrists, neuro-psychiatrists and neurologists is permitted without penalty in certain circumstances (for instance, for contraception advice, cervical cancer screening, and the prescription of eye glasses). As the coordinated care pathway does not apply to children under sixteen, consultation with a paediatrician is also not dependent upon a referral from a preferred doctor.

It is worth noting that the penalties incurred by patients as a result of not following the rules are profitable for both the health insurance funds and physicians who can gain from charging supplemental fees.

3. Provisions on complementary insurance

In order to make financial incentives effective, the reforms had to tackle the 'problem' of any offsetting effects from the comprehensive coverage against out of pocket payments offered by complementary insurance funds. In September 2005, the government requested that complementary insurers develop responsible contracts (*contrats responsables*), in which financial penalties due to non-compliance with the coordinated care pathway are not compensated under complementary insurance policies. In return, responsible contracts will benefit from tax deductions. Not-for-profit institutions that provide complementary insurance are expected to offer these contracts to their policy holders as they have been generally supportive towards the new gate-keeping scheme.

* 85% of GPs and 65% of specialists practice within sector 1 and charge fixed 'official fees', according to a fee schedule negotiated with health insurance funds, in exchange for tax deductions. The remainder work in sector 2 and are always allowed to charge supplemental fees, which according to Public Health Code (article R.4127-53) have to be determined with "tact and moderation".

Objectives of the coordinated care pathway

The reforms include both qualitative and quantitative objectives. The first objective is to support GPs in their role as primary care physicians. It is argued that GPs will benefit from having access to extensive information on their patients' health via their Personal Medical File. They will also be able also to coordinate complex treatments involving outpatient or inpatient care with other health care professionals. The second objective of the reform is to prevent unnecessary GP or specialist consultations. The new system is expected to limit the excessive consultations that were encouraged both by the freedom of individuals to consult any physician and the rather low rates of cost-sharing (at least for the vast majority of the population who benefit from having complementary health insurance covering user charges).

Surprisingly however, these goals are based on two assumptions which are not supported by evidence. First, the central role of GPs seems to have existed already, albeit in an implicit form. By 2002, nine out of every ten members of the public reported having a usual GP. This proportion was even larger among health system users.⁴

Second, previous studies did not find any evidence of excessive and avoidable consumption of medical services.⁵ Unnecessary multiple contacts with physicians by patients for a single poor health episode, although difficult to identify, have been estimated to have had an inflationary impact on outpatient costs of only 0.1%.⁵ Moreover only 5% of health care pathways in 2003 were engaged by direct access to specialists included in the current gate-keeping scheme.⁶ Whether these visits were medically justified or not is difficult to assess, but the potential gain from reducing unnecessary direct consultations with specialists seems to be marginal.

First results and expected impact

In 2005, surveys suggested that nine out of ten people were considering moving to the preferred doctor scheme⁷ and in March 2006, 76.8% of patients had nominated a preferred doctor,⁸ 99.6% of whom are GPs. Overall, the proportion of patients with an official preferred doctor will probably be no different to the proportion of patients who claimed to have a GP prior to the reform.

Turning to the regulations limiting access to specialists, one might expect to see some direct impact on both GP and specialist activity. Although the results are blurred by the changes in the physicians' fee schedule that occurred at the same time as the reforms were introduced, GP incomes have increased since mid-2005 by about 10%.⁹ However, this income growth may be driven partly by the introduction of per capita payments linked to the management of severely-ill patients. This is estimated to amount on average, to €2,000 per GP per year (leading to an estimated total cost of €200 million a year to the health insurance funds).

Meanwhile, eight specialities and sub-specialities (including dermatology, ear, nose and throat, cardiology and rheumatology) have faced a fall in income. While no information has been published yet, informal estimates suggest that losses could have reached 4% per annum on average per physician. A national agreement, signed in March 2006 between the physicians' associations and the health insurance funds, has now made provisions so as to compensate these losses through subsequent modifications of the fee schedule. Consequently any efficiency gains arising from the substitution of GP contacts for specialist contacts may be partly offset by such adjustments.

Aside physician income, the potential effects of the reforms are of two types. First, the specific per capita payment for patients suffering from severe chronic illness may be an incentive for physicians to classify their patients in this category (with the additional effect of exempting them from co-payments for health care related to the declared chronic disease). If this happens, it may result in greater costs to the health insurance funds. This will be to the benefit of complementary insurers which generally have borne the greatest share of these co-payments. However, if changes are justified by the health status of patients, they will lead to a fairer distribution of costs between the basic and complementary health insurance funds.

Second, the reform's impact on equity seems not to have been considered by its proponents. During the 1990s, specialist care was associated with the highest level of social inequality in health care consumption in France.¹⁰ The 2000 reform explicitly targeted the inequalities in access to care that arose from differences in ability to purchase complementary insurance. It enabled those with lower

incomes to benefit from a means tested publicly funded complementary health insurance (CMUC – *Couverture Maladie Universelle Complémentaire*) and has helped to reduce the gap in consumption between lower socio-economic groups and the population average,¹¹ but the reforms of 2004 may reverse this trend. Inequalities in access to specialists, and how they might impact on health outcomes, should therefore be monitored.

Conclusion

The new preferred doctor scheme is not clearly orientated towards a British NHS style gate-keeping system. Although it introduces a light capitation income flow via health insurance/social security to the preferred doctor for every chronic patient, it principally regulates patient choice of physician through financial incentives rather than compulsory patient pathways. The patient's free choice has indeed been emphasised, at least in the rhetoric that has accompanied the reforms.¹² The extent to which this reform is the first step towards a stricter gate-keeping system is unclear. This 'soft gate-keeping' appears to be a compromise between the original patients' freedom of choice and the regulators' desire to encourage a more rational consumption of health care.

Short-term efficiency gains have been partly offset by concessions to physicians and the potential for future savings remains to be seen. Nevertheless, the reform is expected to have a positive impact on the quality of care as a result of better coordination of health care provision and the use of electronic patient records (if they are introduced). On the other hand, substantial changes to both the monetary and non-monetary costs required to access specialist care services may increase inequalities in use of such services between different socioeconomic groups.

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Health Care Reform in Turkey

Mehtap Tatar and Panos Kanavos

Turkey is a middle-income developing country, which has recently been accepted as a candidate for EU Membership. The most recent and internationally comparable health care expenditure statistics indicate that in 2000 Turkey spent US\$13 billion on health care (or using Purchasing Power Parity (PPP) US\$30 billion), corresponding to US\$194 (or US\$PPP 443) per head of the population. This expenditure is estimated to be equivalent to 6.4% of Gross Domestic Product (GDP), of which 61.7% comes from the public purse, including 35.7% from social security organisations. Out-of-pocket payments accounted for 28.6% of total health expenditures.¹

Health and health care challenges

The country faces several major health care problems including poor health status indicators compared with other European, particularly for infant mortality (see Table). There are also high regional inequalities in health status, with poorer health found in rural compared with urban areas;² moreover, the north and eastern regions have lower levels of health. Variations in the infant mortality rate (IMR) can again be given as an example. In a recent demographic and health survey it was reported that the IMR was 22 per 1,000 live births in the west compared with 41 per 1,000 in the eastern part of the country.² Turkey has a significant poor population of some 20 million

citizens who live on less than US\$PPP 4.30 per day.⁴ They are at greater risk of having poor health because they do not have any social security support for any health expenditure they incur.

Both health care professionals and the general population are dissatisfied with the health care system.⁵ Only two-thirds of the population are covered by health insurance schemes. However, insurance funds have varying benefits packages and access opportunities. Moreover, the insured population experience problems in accessing services that they are eligible for. As a result, access to health care is variable and often inadequate. Although poorer health status is observed in rural areas, available resources, particularly physicians, are concentrated in major urban centres. Past attempts to introduce a 'compulsory service' for physicians in deprived areas have not succeeded in redistributing resources, as they have not been accompanied by incentives.

There is regular duplication of services and a 'clientelistic' approach to service provision. Irregular flows of patients and resources between public and private practice have resulted in a waste of scarce public resources, while the need for informal payments in order to obtain specialist services remains significant.⁶

The inefficiencies in the health system and the low level of funding for publicly provided services are also manifested through the lack of a gate-keeping system for referring individuals from primary to secondary care services. This results in an inappropriate use of some hospital services. For example, hospital outpatient departments, including university hospitals, are usually the first point of contact for even minor complaints. At the same time, there is also a underutilisation of hospital beds; the average general hospital occupancy rate is 64%.

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Table: Major health status and health system indicators in Turkey and selected EU countries

Indicator	Turkey	Spain	UK	France	Poland	Italy
Infant mortality rate (per 1000) ^a	29 ^a	4.1	5.3	3.9	7.0	4.3
Under-five mortality rate (per 1000)	37 ^a	4.00 ^c	6.50 ^{c,d}	5.50 ^{c,d}	7.00 ^c	6.00 ^{c,d}
Total fertility rate	2.23 ^a	1.24 ^e	1.64 ^d	1.89	1.25 ^d	1.2 ^e
Life expectancy at birth (males)	66 ^a	77.2	76.2	75.8	70.5	76.9
Life expectancy at birth (females)	71 ^a	83.7	80.7	82.9	78.9	82.9
Crude birth rate (per 1000 population)	20.9 ^a	10.49 ^d	11.27 ^d	12.76 ^d	9.25 ^d	9.44
Crude death rate (per 1000 population)	7.0 ^a	8.87 ^e	10.22 ^d	9.01 ^f	9.4 ^d	9.77 ^e
Hospital beds (per 10 000 population)	25.5	38	42	77	56 ^d	44
Physicians (per 1000 population)	1.4 ^b	3.0	2.2	3.4	4.1	2.5
Dentists (per 1000 population)	0.2 ^b	0.5	0.5	0.7	0.3	0.5

Sources: All data from OECD Health Database, 2005 or WHO Health For All Database, 2005 unless otherwise stated.

a: Data from Hacettepe Institute of Population Studies, 2004.²

b: Sağlık Bakanlığı, 2004.³

c: World Bank, World Development Indicators, 2003.

d: Data for 2002.

e: Data for 2001.

f: Data for 2000.

Furthermore, weak management capacity at both macro- and micro-levels of government and managerial inefficiencies both within the Ministry of Health (MoH) and service providers indicate a need to employ people who have skills in health care and hospital management, and health care financing.

The persistence of multiple health system problems has acted as a catalyst for successive governments to embark on health sector reform since the early 1990s, but with only limited success. However, recent reforms have begun to reshape the health system and attempt to address the growing dissatisfaction with an inefficient and inequitable system. The challenges of both creating a universal health care system and the cost of improving service delivery have also forced the government

to address the overall cost of the system.

Health sector reform initiatives

Attempts at health sector reform undertaken in the early 1990s were consistent with approaches suggested by the World Bank. The World Bank supported a Project Coordination Unit at the MoH with the responsibility of preparing, implementing and evaluating specific reform elements as well as the overall reform process. Despite an apparent political commitment to reform the system, it was only in 2002, in part because of the turbulent political and economic conditions, that concrete steps were undertaken. Following a long period of coalition governments, a single party government was elected to office with a mandate for extensive reform in all public policy sectors including health. This was

reflected in the health care reform proposal entitled the "Health Transformation Programme".⁵

The aim of this programme was to organise, finance and deliver health services in line with the principles of equity, efficiency and effectiveness. Other reform principles included financial sustainability (establishing a self-sufficient social security system), continuous quality improvement, community participation with a special emphasis on the participation of all stakeholders in the policy development and implementation process, consensus building among different parties including the public and private sector and providers and financiers, decentralisation and provider competition. The notion of a purchaser-provider split was the major principle underlying the reform programme. The programme included three major initiatives:

- the introduction of a General Health Insurance (GHI) scheme,
- strengthening of public health care and the introduction of a family practitioner scheme, and
- enabling hospitals to have financial and administrative autonomy.

The major aims of the General Health Insurance scheme are to eliminate fragmentation in health financing and to deal with related inefficiencies such as underinsurance. Currently there are four major insurance schemes each with varying benefits packages both in terms of depth and breadth of coverage. The poor population, upon proof of their financial status, is covered by the government financed Green Card scheme whose benefits have only recently been expanded to cover ambulatory care in addition to hospital based services. In theory the majority of the Turkish population should be covered by different insurance schemes, but nearly one third of the population is not covered or underinsured. These people are usually not working in the formal economy and thus do not make any social security contributions. Their dependents also do not enjoy health insurance coverage. This has resulted in a high level of out-of-pocket payments and informal payments to health care providers.

The proposed GHI scheme merges all existing insurance schemes (including the Green Card scheme) under one umbrella.

Thus, there will be a single insurer (GHI scheme) that will purchase services from various providers. However, all benefits under existing arrangements are retained. The premiums of the poor (those below the poverty line) would be paid by the government. Individuals will be free to obtain services from family practitioners and hospitals. The new scheme with its monopsony (single purchaser) power will be the major purchaser of services from competing public and private health care providers. The Bill for a GHI scheme was submitted to Parliament in 2005 but there was still no legislation in place in March 2006.

The strengthening of public health care and the introduction of a family practitioner (FP) scheme constitutes one component of supply side reform initiatives. Although a primary care infrastructure has existed in the country since the early 1960s, these services are weak and insufficient both in rural and urban areas. The introduction of a FP scheme is thus seen as a major policy initiative. FPs will act as gate-keepers and provide primary health care to populations of between 3,000 and 5,000 registered citizens. The FPs will be paid on a capitation basis, and it is intended that the system is rolled out in phases after evaluation of a pilot that took place in one of the provinces in 2005. One challenge, however, is that the available number of physicians who have specialised in family practice remains far from adequate to serve the entire population. The government is planning to provide training to other physicians, particularly those with no specialisation, through tailor-made short courses.

Enabling hospitals to have financial and administrative autonomy is the second component of supply side reforms. The reforms intend to decentralise non-teaching hospitals. Hospitals will have an autonomous financial and managerial status and an internal market (purchaser-provider split) is expected to be established. Financial autonomy includes autonomy in generating and spending resources, whereas managerial autonomy includes autonomy specifically in terms of staffing procedures and contracting-out services. Hospitals will contract with the GHI organisation and compete with each other to provide patient care (money will follow the patient). However, because hospitals are highly centralised they have few incentives to operate efficiently and to provide high quality health

services. The reforms therefore will require the introduction of highly complex management systems, with a special emphasis on contract management.

Furthermore, other proposed initiatives include:

- The transformation of the MoH into a policy-making and regulating authority with a view to developing policies, defining standards, controlling health care providers and monitoring the appropriate use of resources. The Ministry will mainly be responsible for the central planning of the health sector.
- Development of a health information system, with a view to supporting evidence based policy-making, in order to shed light on problems and priorities of the health care system and to assist in planning, monitoring and evaluating health services.
- Establishment of incentive mechanisms, such as improving payment levels.
- Development of quality and accreditation standards for all providers.
- Promoting the rational use of pharmaceuticals and medical equipment. For instance, a national institute is planned that will oversee the use of pharmaceuticals and reimbursement policies and place special emphasis on promoting the rational use of drugs.

Conclusion

The reform initiatives almost replicate those proposed in the early 1990s. But why has Turkey waited fifteen years to implement these policies? The reasons are complex. Turkey has experienced two waves of change in recent years. In the early 1990s, the country went through a radical ideological and political shift. The early reform initiatives in the health sector were one reflection of this change; however, after the first stages of preparation, enthusiasm subsided. One reason has been the lack of a strong government with a parliamentary majority. This led to reliance on weak consensus-building mechanisms (including coalition governments), political and economic crises, and strong lobbying by interest groups against the reforms.

The second wave of reforms commenced in 2003 following the election of a single party government. Although the country has been trying to recover from a severe

economic crisis, the concrete steps taken thus far are significant. These include initiatives such as the merger of hospitals and the transfer of control to the MoH, setting up a pilot project for the family practitioner scheme, and ongoing attempts to enact the GHI law.

In conclusion, despite its paramount problems, the Turkish health care system is now well on its way to structural change. The driving force behind the current momentum is the prospect of EU membership, coupled with having a majority government that is able to command the support of the legislature. Many critical steps have already been undertaken. However, success will be measured by whether the country is able to create a system with improved equity, quality and efficiency in a sustainable fashion, as well as the ability of the authorities to enforce new legislation and do away with outdated and inefficient practices.

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Managerial versus financial reform and the future of public health care in Canada

Gregory P Marchildon

An already vigorous debate concerning the future direction of public health care in Canada has become even hotter during the past year. Historically, the positions in this debate fell into one of two broad camps, each emphasising fundamentally different levers for health reform. The first camp stressed major changes in the way that health care has been administered and delivered including the reallocation of budgetary resources from downstream illness care to upstream prevention and population health services. The second camp emphasised financial change, particularly the revenue and payment approaches that underpin the Canadian model of single-payer, universal health care.

Before explaining the most recent developments, it is important to have a clear understanding of the Canadian variant of single-payer financing and administration including the health services it includes and excludes as well as the political and legal framework within which it operates. Public coverage is highly segmented in Canada. Most hospital, physician and primary care are 100% covered under the ten provincial and three territorial single-payer plans, and are collectively known as Medicare – not to be confused by the federal American programme of the same name. To protect the integrity of public Medicare, and ensure that public

resources are not diverted to private care, individual provinces either prohibit private insurance for Medicare services or prevent public cross-subsidisation of privately-provided Medicare services by requiring physicians to choose whether they will work within Medicare or opt-out completely from the public system. This complex patchwork of laws and regulations has served to prohibit and/or discourage a parallel private system for Medicare services.¹

Hospital, diagnostic, physician and other services deemed medically ‘necessary’ or ‘required’ were considered ‘insured services’ under successive federal laws that provided transfer funding to provinces if their single-payer systems were publicly administered, universal, comprehensive and portable. In 1984, the *Canada Health Act* replaced these previous laws, and a fifth funding condition – accessibility – was added. This condition, along with a further provision concerning user fees, stipulated that provinces which permitted health facilities or physicians to bill patients directly for any portion of a Medicare service would be subject to dollar-for-dollar reductions in federal transfers. This largely eliminated user fees for Medicare services. Today, Medicare services, broadly defined by the federal government but regulated and administered by provincial governments, constitute about 43% of total health expenditures.²

To summarise, the two key features of the single-payer model of universal health care are:

No substitutive insurance: there is no significant private tier competition with Medicare because provincial governments prohibit private Medicare insurance and/or discourage cross-subsidisation.

Narrow but deep first-dollar coverage:

universal coverage is narrowly segmented but deep in that provinces discourage user fees in order to avoid federal transfer deductions.

Managerial versus financial change

Beginning in the early 1970s, provincial governments introduced an array of new public health care services including prescription drug plans, home care services and targeted nursing home subsidies. These services and subsidies varied widely across the country, as there was no national framework or federal transfer funding to enforce a set of national principles. Few of these services were universal in nature and virtually none were provided on the first-dollar coverage basis.

By the late 1980s, growing health care costs combined with slower revenue growth and growing debt sparked an array of officially commissioned studies. Almost all of these reports recommended organisational changes, with provincial governments moving from passive health insurers to active managers of a broad range of public health care services through geographically-based and public arm’s-length units generically known as regional health authorities (RHAs). By the mid-1990s, almost all provinces had regionalised.*

In carving out regions with defined populations, provincial governments expect that regional health managers, governed by local boards, can better respond to the

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* Currently, nine of the ten provinces are regionalised. In 2005, Prince Edward Island (population 140,000) abandoned regionalisation, while Ontario (population 12.4 million) became regionalised through the establishment of 14 Local Health Integrated Networks.²

particular needs of their respective populations than more centralised health ministries. RHAs are also expected to have the managerial capacity to improve the continuum of care between hospital services (universally covered under the *Canada Health Act*) and other provincial public health care services. In addition, RHAs are expected to redistribute resources from downstream illness care to upstream illness prevention, public health and health promotion services.

At the very time that the regions were first being established, however, provincial governments were reducing public expenditures in order to reduce the public debt that had accumulated over decades. Lower investment in health care eventually led to bottlenecks in parts of the system: the availability of advanced diagnostic equipment such as MRIs and CT scanners; nurse and physician shortages in some parts of the country; and for the first time, long waiting lists for some types of procedures, including hip and knee replacements.

Although most provincial governments had begun to reinvest heavily in health care to make up for past disinvestment, public dissatisfaction continued to grow. In response, the governments of Quebec, Saskatchewan and Alberta commissioned major new studies in 2000, all of which had reported by January 2002. All three studies recommended further steps in terms of managing existing systems, including a fine-tuning of the work of RHAs, acceleration of primary care reform, and more central administration of waiting lists in order to reduce waiting times.³ However, the Saskatchewan and Alberta reports arrived at opposite conclusions on one important issue.

Strongly supporting the Canadian single-payer model, the Saskatchewan report argued that new investment in public health care was not required; instead, significant administrative efficiencies could still be wrung from the system through further changes in the organisation and delivery of services.⁴ The Alberta report argued that the limit had been largely reached in terms of administrative efficiencies and that more private investment was required to supplement public finance, perhaps through increased individual patient participation or user fees. By describing Canadian Medicare as an inflexible monopoly, and by supporting user fees, the Alberta report implicitly (if not explicitly) challenged the key features

“the Chaoulli decision has upset the balance between reform initiatives that focus on management and delivery and those that focus on financing and payment systems”

of the Canadian single-payer model. It did not, however, put forward a coherent alternative funding model.⁵

These provincial reports were followed by two national reports – one a federal Royal Commission chaired by Roy Romanow and hence known as the Romanow Commission established by the Prime Minister and the other a standing Senate committee.^{6,7} Both recommended a limited increase in public finance mainly through increased federal transfers to the provinces to make up for the relative decline of these transfers during the 1980s and 1990s. In their final reports of October and November 2002, the Royal Commission and the Senate committee supported the two key features of the Canadian single-payer model, temporarily putting the matter to rest at least until the Supreme Court of Canada’s final decision in the *Chaoulli v. Quebec (Attorney General)* case in the spring of 2005.

The Supreme Court of Canada and the Chaoulli decision of 2005

A Montreal physician and anti-Medicare activist, Dr Jacques Chaoulli was a long-time supporter of a parallel private tier who had worked, at various times, outside the public Medicare system as a non-participating physician.⁸ Along with his patient, Georges Zeliotas, he sued the Quebec government for the time spent on a public waiting list for knee surgery. After losing their case in successive Quebec courts, they appealed to the Supreme Court of Canada. In a four-to-three split decision, the Supreme Court allowed the appeal, deciding that the Quebec government’s ban on private health insurance for Medicare services was contrary to the protection of the right to life and personal security under the Quebec Charter of Human Rights

and Freedoms in a situation where the province’s quality and timeliness of Medicare services was unreasonable. The Supreme Court subsequently gave the Quebec government twelve months in which to comply with the ruling.⁹

The *Chaoulli* decision unleashed a major debate concerning the merits and demerits of publicly-administered and financed Canadian Medicare, polarising the anti- and pro-public health care forces in the country. Of great note has been the shift of the Canadian Medical Association (CMA) back to a more oppositional position on Medicare. At its annual meeting in August 2005, the CMA passed a resolution that “when timely access to care cannot be provided in the public health care system patients should have access to private health insurance to reimburse the cost of care obtained in the private sector.”¹⁰ Even more striking were the results of a major public poll conducted at the time of the CMA resolution showing that while 83% of doctors viewed the decision favourably, 88% of doctors continued to favour single-tier Medicare, if adequately resourced and timely, rather than the status quo or a private pay/insurance option. This compared to 52% of Canadians who viewed the decision favourably and 77% who favoured a properly resourced and timely Medicare system relative to the status quo or a private pay/insurance option.¹¹

One of the political consequences of the *Chaoulli* decision is that it has upset the balance between the reform initiatives that focus on the management and delivery of health services to those whose focus is on financing and payment systems. This can be seen in terms of how various governments, provincial and federal, have responded to *Chaoulli*.

Government action and reaction

In response to the *Chaoulli* ruling, the provincial government of Quebec made a number of changes in February 2006. The province changed its law to permit the purchase of private health insurance for three elective procedures, hip and knee replacements and cataract surgery, with a waiting time guarantee of six months for Medicare patients. If they wait longer than six months, Quebec residents will be sent for immediate treatment at a public facility in another part of the province; after nine months, they can obtain treatment outside the province or at a private clinic within the province at government

expense. With this one exception, the Quebec government continues to prevent 'opted-out' physicians from treating Medicare patients. In addition, the province will continue to maintain its prohibition of private health insurance for all other Medicare services but has issued waiting time guarantees for cancer surgery, radio-oncology, and tertiary cardiac care.¹²

For years preceding the *Chaoulli* decision, the provincial government of Alberta had been criticising aspects of the universal, single-payer model as well as the *Canada Health Act* whose funding conditions on federal transfers supported the model. Consistent with this, Alberta Premier Ralph Klein viewed the *Chaoulli* decision as an opportunity to introduce some private-pay elements into the public system.^{13,14}

Recently, the Klein government released its ten-point strategic health plan, with a ninth point stating that patients will be permitted to pay to obtain better access and more choice "while protecting the public system." The report goes on to say, however, that since the Alberta 'market' is insufficient to support a private-pay (non-Medicare) practice, Alberta laws preventing the public subsidisation of physicians who have opted out of Medicare will be revamped to permit such physicians to work on both sides of the public-private street.¹⁵ Thus far, these 'proposals' have not been implemented and, the 'consultation' phase, has drawn a mainly negative response both inside and outside Alberta.

At the national level, the newly-elected Conservative minority government under Prime Minister Stephen Harper has embraced the Quebec response to the *Chaoulli* decision while distancing itself from the Alberta proposals.^{16,17} Similar to the Liberal minority government that it defeated, the Harper government has repeatedly stated its intention to enforce the funding conditions stipulated in the *Canada Health Act*, including the universality condition which stipulates that every Canadian obtain Medicare services on uniform terms and conditions. Contrary to the government's statements, it could be argued that Quebec now has in place a regime of preferential access based on ability to pay for a subset of Medicare services, hip and knee replacements and cataract surgery, that though elective in nature, have always been treated as 'insured services'.

Conclusion: what does the future hold?

Most provinces have been attempting to avoid the Quebec scenario by shortening their waiting times for various medical procedures. Unlike Alberta, few are considering radical changes to the single-payer system. At the same time, however, all are being forced to shift their emphasis from major managerial changes such as regionalisation and primary care reform to the narrower issue of better managing waiting times. Although this objective may be laudable as part of a larger reform agenda, on its own, it will hardly lead to the kind of transformative change envisaged by the proponents of major managerial change.

Provincial governments are currently working out a national Patient Wait Times Guarantee with the federal government but this effort may inevitably focus even more attention on matters of financing and payment and away from potentially more important organisational reforms on the ground. While the emphasis on waiting times may be unavoidable given the Supreme Court decision, it will likely end up diverting scarce resources, including the political capital required to implement major change to the administration and delivery of public health services in Canada.

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Research and policy: living on the interface

Martin McKee, Josep Figueras and Suszy Lessof

Two communities

There is often a yawning gap between research and policy. Researchers and practitioners have been described as “strangers in the night, dimly aware of each other’s presence”,¹ while others have argued that “in public policy making, many suppliers and users of social research are dissatisfied, the former because they are not listened to, the latter because they do not hear much they want to listen to”.² These are manifestations of what Innvaer et al. have described as the “two-communities thesis”,³ in which researchers see themselves as rational and objective, but policy makers as indifferent to evidence, whereas policy makers see themselves as pragmatic but researchers as naïve and jargon-ridden.

A recent paper by Choi et al.⁴ explicitly uses parody to highlight the differences between these two communities, and while the descriptions are deliberately stereotypical, there is much truth in them. They see policy makers’ speciality as “reading bullet points” while “scientists speak their own language that normally consists of at least some Greek letters and mathematical symbols”.

The reasons for these failings are well recognised. The solutions that are

required to tackle the complex problems that policy makers face can rarely be translated directly from one setting to another. They typically involve the interaction of many different actors, with differing motivations, they are heavily influenced by contextual factors, and are often constrained by starting conditions, or what is termed path dependency.

For example, attempts to transfer social insurance systems that work well in countries such as Germany to the successor states of the Soviet Union have been fraught with problems, in part because of the failure to recognise that the western European systems of social insurance are embedded in a complex set of relationships involving trade unions, employers associations, and the state. In many countries seeking to implement this model, the corresponding institutions were weak or non-existent and had not developed the

necessary ability to work collaboratively.

It may be that the wrong questions are being asked, a subject addressed by the method known as ‘realistic evaluation’.⁵ While much research asks “what works?”, realistic evaluation asks “what is it about this intervention that works for whom and in what circumstances?”

Yet realistic evaluation, in which the process of defining the question to be answered accounts for a substantial part of the task and which draws on insights from numerous, diverse sources of evidence using a variety of disciplinary perspectives does not fit into the discrete compartments that funding bodies often seek. Reviewers are often unable to see beyond the disciplinary boundaries that define them or to support methods that are innovative yet untested (Box 1).

As has often been noted, it is unlikely

Box 1: Researchers and policy makers

The research community	asks questions:	we already know the answer to
		... using discrete, established methodologies
		... that don’t challenge the scientific consensus
	does not ask questions:	that are difficult to answer
		... using unorthodox methods
		... drawing on multiple disciplinary perspective
The policy community	wants simple answers to difficult questions	... delivered yesterday
		... proposing answers that will lead to results tomorrow
		... set out in three bullet points on half a sheet of paper
		... costing as little as possible

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that Galileo or Copernicus would have been supported had they needed to raise money from a funding body composed of the then establishment. Reviewers frequently fail to appreciate which questions are policy relevant and results that are contextually embedded challenge those who see good science as that which provides universally generalisable answers. Those undertaking this type of research can expect little credit for it in conventional judgements on their work, such as the United Kingdom's Research Assessment Exercise.

There is, however, a danger that the blame for the failure of communication is focused exclusively on the research community. As Choi et al. have noted, the policy community also has a responsibility.

Politicians must, of course, take account of many factors when deciding what to do. Yet it is reasonable to expect them to be aware of the relevant evidence and to state their reasons if they choose to reject it.

As several commentators have noted, too often they implement policies with only a superficial understanding of the issues, taking pride in their ability to develop a vision unencumbered by detail, and are then surprised when the detail prevents their vision from becoming reality.

Others place ideology above evidence, rejecting research that conflicts with their vision of the world⁶ (Box 2) or even seeking to distort the scientific process to ensure that the answers do comply with their viewpoint. Similarly, policies may be pursued or discarded simply because of personal ambition, as policy makers use reforms as a tool to progress to the 'top of the greasy pole'.

What can be done?

How can the gap between researchers and policy makers be bridged? Systematic reviews have identified several strategies for success. Strategies to get evidence into policy include:^{3,10}

For researchers:

- Provide decision-makers with a brief summary of their research, with clear policy recommendations
- Ensure that their research is perceived as timely, relevant and of high quality
- Include effectiveness data
- Argue that the results of their research

Box 2: Post-modernism in politics

In the USA:

"The aide said that guys like me were 'in what we call the reality based community,' which he defined as people who 'believe that your solutions emerge from your judicious study of discernable reality.' I nodded and murmured something about enlightenment principles and empiricism. He cut me off. 'That's not the way the world really works any more,' he continued. 'We're an empire now, and when we act we create our own reality.'"

In Europe:

"If I am being honest, which I will be ... I don't think I have anything to lose by being honest at this stage in my political career" – Peter Mandelson on being appointed as a European Commissioner

"It was a fascinating insight. He talked about being honest as if it was something you might take up at a certain age, like angling or DIY, an optional extra tacked onto your life" – Simon Hoggart, British journalist

Source: Osborne⁶

are relevant to current policy and demands from the community

- Avoid getting involved in power and budget struggles
- Be aware of the high turnover of policy-making staff

For policy makers:

- Creation of policy networks that bring researchers and policy makers together
- Provide appropriate support for front line staff

For both:

- Maintain personal and close two-way communication
- Establish trust

Ongoing dialogue emerges as a key factor. Lavis et al. report that "factors such as interactions between researchers and health care policy makers and timing/timeliness appear to increase the prospects for research use among policy-makers",⁷ while Pawson et al. emphasise the importance of continuing dialogue between researchers and decision makers.⁸ Lomas has described the value of "linkage and exchange" between researchers and policy makers, a policy that he has applied with considerable suc-

cess in the Canadian Health Services Research Foundation and Lavis et al. have identified a role for knowledge brokers, trusted intermediaries who can translate the findings of research for policy makers.⁹

The European Observatory – an approach to bridging the gap

The European Observatory on Health Systems and Policies is one organisation that seeks to support the use of research by policy makers, with several commentators identifying it as a successful 'bridge' that offers a model that might be applied elsewhere.⁴ It is a partnership of different stakeholders involved in health policy*, which generates two interlinked types of evidence.

The first involves describing and analysing what is happening. *The Health System in Transition* (HiT) profiles are detailed descriptions of the health system in each country of the European region. They are based on an extensively tested template, supported by a glossary to ensure comparability of terminology. Each provides insights into the reality of the health system, juxtaposed with the formal structures. For example, by redefining the concept of ownership of a facility as "who has the power to dispose

* The partners include national governments (Belgium, Finland, Greece, Norway, Spain, Sweden), a regional government (Veneto - Italy), a non-governmental organisation (Open Society Institute), international agencies (World Health Organization, European Investment Bank, World Bank) and universities (London School of Economics and Political Science, London School of Hygiene and Tropical Medicine, Centre de Recherche Public - Santé Luxembourg).

of this property”, it helps explain why some countries have so little success in rationalising hospital provision.

The profiles are written by a team of Observatory staff and national authors, so that the process of writing provides an opportunity for stakeholders to clarify goals and policies, as well as identifying areas that require further research.

A second activity seeks to conceptualise complex issues and provide practical solutions. Recent examples include studies on the future role of the hospital and pharmaceutical policy in Europe as well as more specific topics such as the health implications of European Union enlargement. Below we recount seven lessons that we have learned from the experience of the Observatory and which we believe may be relevant to others engaged in similar dialogues.

Involve and engage with relevant stakeholders

Conventionally, either a policy maker identifies a question and then seeks researchers to answer it, or a researcher proposes a study and seeks someone to fund it. In contrast, the Observatory fosters collaborative working among those who generate evidence and those who implement it.

This is facilitated by the structure of the Observatory as a partnership of different organisations. Some are primarily information users, others information producers, and some, such as the World Bank and World Health Organization, are both users and producers.

Ideas for possible analytic studies can be proposed by any of the partners. These topics are worked up into concrete proposals by the research directors, in association with the partners, and the decision to proceed is taken after an external review again that involves both researchers and policy makers.

As far as possible, the outputs are written by a group that includes both researchers and policy makers, normally drawn from different countries and academic disciplines. The initial draft is reviewed at a workshop to which a wider group of practitioners is invited and the final draft is reviewed by partners and external policy makers. By these means, a two-way dialogue is maintained throughout the project.

Policy dialogues have proven to be a par-

“Policy dialogues are a valuable mechanism for fostering interaction”

ticularly valuable mechanism for fostering interaction. They are based on the evidence that face-to-face contact is most effective for getting research into policy.³ They are a means of bringing together Observatory staff, key stakeholders from one or more countries, and members of the Observatory’s extensive expert network (over 400 researchers have contributed to its projects) to explore specific problems and potential solutions.

Limiting the number of participants and maintaining a clear focus ensures that the dialogue is relevant to the participants’ circumstances and allows them the opportunity to explore complex concerns in a non-confrontational setting.

The involvement of a multiple stakeholders, including those from outside government, is facilitated by the fact that several of the Observatory partners, such as the Open Society Institute, the World Bank, and the World Health Organization have a presence in many of the countries concerned. Furthermore the European Commission and in particular, DG Health and Consumer Protection, have proved extremely supportive in building Europe-wide networks.

Listen to the question

Too often a policy maker will ask one question and a researcher will answer a different one. In some cases this is because the question asked is essentially incapable of being answered. A classic example is “how many hospital beds does my country need?” It would, however, be inappropriate to dismiss such a question out of hand. The original question conceals a series of others that can be answered and which actually address the concerns of the person asking the original question. For the example above these research questions could include: How many beds do different countries have? Why do we need beds? What are the alternatives to beds? Will changing the number of beds increase or reduce costs? What can we learn about introducing change?

The policy dialogues offer a way of overcoming this problem, although it is important to ensure that they do not simply become a series of lectures covering the totality of evidence on a particular issue. Instead, it is necessary to work hard to develop their interactive nature in a way that allows both policy makers and researchers to agree on the questions that are both important and answerable.

Understand the context

Context is often treated by researchers as what is left over when the measurable factors have been dealt with. Yet for evidence to be relevant it has to take account of the diverse contexts in which it was generated and those where it will be applied. Lavis et al. have noted how, if research is to be relevant to the needs of policy makers, researchers must be able to answer three types of question.¹⁰

- What are the best solutions to tackle a particular problem?
- What are the best ways to fit these solutions into complex and often overstretched and under resourced health systems?
- What are the best ways to bring about the necessary changes in health systems to make the solutions possible?

In the Observatory’s work differences in context are seen as an opportunity to challenge assumptions and to expand understanding. The process of writing the HiTs is an especially valuable means of understanding the reality, rather than the rhetoric, of health systems, recognising that the same words can have many different meanings. The Observatory explicitly draws upon established frameworks for transferring ideas and understanding the factors that facilitate or obstruct this process.⁵

Respond in a timely manner

Policy makers often need answers quickly. There are windows of opportunity that, if missed, will stay closed for a long time. The Observatory seeks, where possible, to respond rapidly to requests.

In some cases, all that is needed is for the enquirer to be directed to a relevant publication or a particular expert. In others, more in-depth exploration of the issue is called for, for example in a rapid briefing note that can be prepared within a few days (regrettably, this often seems to be at weekends!) but more often is undertaken over a few weeks, drawing on the

wide network of key informants that the Observatory has established through previous collaborations.

In others cases the Observatory fills the 'evidence' niche through rapid response policy dialogues, which convene a group of individuals who can collectively provide an academic overview and practical experiences.

Disseminate through multiple channels

Although the Observatory is perhaps best known for its books and its HiTs, it utilises a wide variety of other channels to communicate its findings.

In addition to its website (www.observatory.dk), from which its products are freely downloadable, other Observatory publications include a bulletin (*EuroObserver*), containing brief topical articles, this journal (*Eurohealth*), which has more detailed accounts of practical experiences and policy debates, and policy briefs.

Other dissemination vehicles include a list serve (*Observatory E-Bulletin*)*, papers in academic journals directed at the research community, and presentations and workshops at conferences.

Build trust

The Observatory's experience substantiates the finding from several studies that trust between policy makers and researchers makes a difference, albeit one that is difficult to quantify. Three elements have been important in developing it.

The first is credibility, achieved by the involvement of established experts from a range of disciplines who deliver demonstrably high quality work and by having policy makers with a track record of achievement taking an active part in shaping the various products.

The second element is the provision of objective evidence. While advice can never be completely value free (for example, the Observatory implicitly accepts that the goals of a health system should include effectiveness, efficiency and equity), it is important to present the evidence dispassionately and not to become identified with any particular political viewpoint.

The third element is the development of long term relationships. The intensity of interaction between its various con-

“There is no point in generating knowledge if there is no capacity to absorb it”

stituencies, in both the research and policy communities, not only in Europe but also in North America and Australasia, has created webs of familiarity and exchange that facilitate links that survive the regular political changes within countries.

Build capacity

There is no point in generating knowledge if there is no capacity to absorb it. The Observatory has, from the outset, engaged in a process of capacity building, strengthening the ability of those involved in policy making to frame appropriate questions, to absorb evidence, and to implement change. It has done so through its own summer schools and, more recently, involvement in initiatives run by others, such as the World Bank Flagship Programme.

Reflections

Maintaining a dialogue between researchers and policy makers is not easy. The incentives acting on both groups frequently seem to conspire to drive a wedge between them. Yet, as the experiences of the Observatory, and organisations such as the Canadian Health Services Research Foundation show, it is possible to link the two communities.

There is a consistent set of messages coming out of these initiatives. The probability that policy makers will draw on research evidence is maximised when that evidence is driven by, and organised around, their policy questions; when its dissemination is timely (taking advantage of policy windows) and is targeted at the key stakeholders; when policy makers are involved from the formulation of the question to the development of the answer; and where there is mutual trust.

Ultimately, however, it is important to avoid the naïve view of the world that

research should dictate policy. It is important to accept that policy makers will always consider other issues such as the political values of their constituencies. The challenge is to ensure that, as they decide, they do so on the basis of the best available evidence, even if they choose to ignore it.

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IS THERE A ‘CANCER PREMIUM?’

James K Hammitt and Jin-Tan Liu

“...we estimate that respondents are willing to pay about one-third more to reduce a risk of environmentally related cancer than for a comparable reduction in the risk of a similar chronic, degenerative disease. We also find that people are willing to pay more to reduce an immediate risk than a latent one.”

Many environmental regulations are intended to reduce the risk of cancer and other diseases, but most of the empirical literature on valuation of health risk relies on estimates of the wage differentials that workers receive for bearing risks of traumatic injury in the workplace.¹ The applicability of these wage-differential estimates to environmental health risks, is uncertain.

Environmentally-induced diseases differ from fatal occupational injuries in several ways that may affect people’s preferences between them. One difference is that the environmentally caused disease is often cancer, and cancer may evoke dread and other qualitative factors that lead to greater fear than fatal workplace injuries.^{2,3} Another difference is that environmentally caused diseases often have an extended latency period between the time a person is exposed to the pollutant and the onset of symptoms. Since decisions about preventive measures must be undertaken before exposure occurs, comparing the benefits and costs of reducing exposure requires an estimate of people’s willingness to pay now to reduce the risk of fatality in a future period.

We recently conducted a contingent-valuation study to investigate how people’s willingness to pay (WTP) to reduce mortality risk depends on whether the risk is associated with cancer or some other disease, and how WTP depends on whether the risk is immediate or latent. (For the full study, see Hammitt and Liu, 2004).⁴ Our survey of approximately 1,200 randomly selected respondents in Taiwan suggests that there is a cancer premium. Although the effect is not quite statistically significant in our preferred model,

we estimate that respondents are willing to pay about one-third more to reduce a risk of environmentally-related cancer than for a comparable reduction in the risk of a similar chronic, degenerative disease.

We also find that people are willing to pay more to reduce an immediate risk than a latent one. We estimate that WTP to reduce the risk of a fatal disease with a 20 year latency period is about one-quarter smaller than WTP to reduce an immediate risk of the same disease, which implies that WTP falls at a rate of about 1.5% per year of latency. The value that respondents place on risk reduction also appears to depend on the affected organ, environmental pathway of the exposure, or payment mechanism: estimated willingness to pay higher prices for consumer goods to reduce the risk of lung disease from air pollution is about twice as large as estimated willingness to pay higher water utility rates to reduce the risk of liver disease from contaminated drinking water.

The “cancer premium”

Consistent with risk perception research that finds elevated fear of particularly dreaded risks, the value of preventing a fatal cancer is often considered to be greater than the value of preventing fatal trauma in a workplace or transportation accident.^{2,3} Cancer is also frequently viewed as more threatening than other degenerative conditions, such as heart disease.⁵ However, it is not obvious that people’s WTP to reduce cancer risk exceeds their WTP to reduce accident risk, since some might perceive that dying of cancer is not as bad as dying in a fatal accident, because cancer includes a period of illness during which one may

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prepare for death by reconciling with family or putting financial affairs in order.

Despite the plausibility that there may be a cancer premium, empirical support is limited. We are aware of no prior studies that compare individual WTP to reduce one's own risk of cancer and other fatal risks, although several studies are suggestive.

Jones-Lee et al.⁵ asked respondents to choose between public programmes that would reduce the number of people dying in the next year by 100 from one of three causes (motor vehicle crashes, heart disease, and cancer), and to indicate how much they would voluntarily contribute to reducing the number of deaths from the cause they chose. A majority of respondents (76%) chose to reduce cancer deaths and the mean voluntary contribution was larger for cancer than for the other causes. If the mean contributions are interpreted as estimates of WTP to reduce own risk, the implied value per statistical life (VSL) is about \$40 million for cancer, \$20 million for heart disease, and \$10 million for motor vehicle accidents. (These values are substantially larger than conventional estimates of VSL which are around \$5–9 million for the United States.⁶)

McDaniels et al.⁷ estimated WTP for programmes to reduce a wide range of health risks using a small contingent-valuation study with only 55 respondents. The programmes were described as public goods that would reduce risks to the relevant populations, not only to the respondent. The authors also elicited risk perception variables, such as dread. They found that dread had a positive association with WTP.

Savage⁸ asked survey respondents to allocate a hypothetical \$100 contribution to research intended to reduce risks of stomach cancer, household fires, commercial airplane accidents, and automobile accidents. He found that respondents would allocate the largest amount to stomach cancer (\$47) with much smaller amounts (\$15 – \$21) to the other risks. Although this study suggests greater WTP to reduce cancer risks, it does not measure individual WTP to reduce one's own risk.

Effect of latency on WTP

Standard economic theory suggests that the appropriate procedure to account for

latency between exposure and risk of fatality is to value the risk using the value of statistical life that represents the individual's WTP to reduce fatality risk at the time he may die, and to adjust for the fact that money can be invested at the time of exposure to yield a larger amount at the time the risk may prove fatal.

An individual's future WTP to reduce future risk (i.e., his future VSL) is not necessarily equal to his current WTP to reduce current risk (his current VSL). His future VSL may differ from his current VSL because of two factors: he will be older, and the date will be later. Age affects VSL because the individual's life expectancy, health, earnings, savings, opportunities for spending on other goods, and other factors vary with stage of the life cycle. Time or date affect VSL through secular changes in productivity, the ongoing development of medical and other technologies that affect longevity, and other factors. A number of theoretical and empirical studies have examined the effects of age on VSL, with equivocal results, and the effect of date has received little attention.

Intuitively, one might expect that WTP to reduce a latent risk must be smaller than WTP to reduce a current risk by the same amount, since reducing a current risk increases the chance of surviving both current and future periods, while reducing a future risk increases only the chance of surviving the future periods. This intuition is misleading. Preferences for reducing either current or latent risks depend on the utility associated with different periods of life. WTP to reduce future mortality risk can be less than, equal to, or greater than WTP to reduce current risk by the same amount.

Consider a person suffering a painful disease from which he will recover, with certainty, in ten years. Suppose the disease is so painful that if he knew he would die before recovering from it, he would prefer to die sooner rather than later. In this case, the only benefit to the individual of reducing the chance that he will die this year is that it increases his chance of surviving at least ten years. If an intervention to reduce his risk of dying in the ninth year from now has a larger effect on his probability of surviving at least ten more years, then he will prefer that intervention to an intervention that reduces his chance of dying this year. In this case, he would be willing to pay more now to reduce his mortality

risk nine years in the future than to reduce his current mortality risk.

Contingent-valuation survey

To estimate the effects of disease type and latency on WTP to reduce the risk of dying in a single year, we conducted a contingent-valuation survey. Respondents were questioned about their WTP to protect themselves and other household members from each of four environmental health risks; liver cancer, liver disease, lung cancer, and bronchitis. The risks varied among respondents and differed with respect to whether the disease was latent or acute, cancer or non-cancer.

To enhance the credibility of the scenarios, the risks associated with liver disease were described as being produced by a contaminant in tap water, and the risks associated with lung disease were attributed to industrial air pollution. The payment mechanism differs accordingly. In the liver case, respondents were asked about their willingness to pay higher water bills to cover the cost of additional treatment at the water utility. In the lung case, respondents were asked about their willingness to pay higher prices for consumer goods in order to reduce air pollution.

Because the affected organ, environmental pathway, and payment mechanism are confounded in our design, we cannot distinguish their individual effects on WTP. In addition, because the proposed interventions reduced risks to other community members in addition to those in the respondent's household, estimated WTP may include some component of altruism.

The risk reduction is described as an intervention to reduce current exposure to environmental contaminants. Respondents asked about acute disease were told that if someone in their household develops the stated disease, symptoms will begin within a few months and they will live only about two to three years longer. In the latent case, they were told the person won't know if he or she was sufficiently exposed to develop the disease until symptoms begin about 20 years in the future.

Our results indicate that WTP to reduce the risk of cancer is one-third larger than WTP to reduce the risk of an alternative disease. WTP to reduce the latent risk is estimated to be about one-fourth smaller

Table: Results – estimated value per statistical life (VSL) in million US\$

Disease type	Latency	Organ/pathway	VSL
Cancer	Latent	Lung	1.6
Cancer	Acute	Lung	2.1
Non-cancer	Latent	Lung	1.1
Non-cancer	Acute	Lung	1.5
Cancer	Latent	Liver	0.7
Cancer	Acute	Liver	1.0
Non-cancer	Latent	Liver	0.5
Non-cancer	Acute	Liver	0.7

than WTP to reduce the acute (more immediate) risk, which implies respondents discount for latency at an average annual rate of about 1.5%. WTP to reduce the risk of liver disease from water pollution is estimated to be only half as large as WTP to reduce the risk of lung disease from air pollution.

WTP is significantly associated with some of the respondents' socioeconomic characteristics. Estimated WTP declines as the age of the respondent rises at a rate of about 2.3% per year. WTP increases with household income, and college-educated respondents are estimated to value risk reduction about 40% more than respondents with less education. In contrast, WTP is not significantly associated with the number of household members, nor is there any significant association between WTP and either gender or marital status.

The table reports estimates of VSL as a function of disease type, latency, and organ/environmental pathway/payment mechanism. These are calculated using the corresponding estimates of WTP from regression models to predict median WTP for the average respondent. The values are smaller than typical estimates

for the United States, presumably because of the smaller incomes in Taiwan, but are comparable to other estimates we have obtained for Taiwan (for example, Liu et al., 1997; Liu and Hammitt, 1999; Fu et al., 1999).⁹⁻¹¹

Conclusion

Environmental regulations are frequently intended to reduce risks of cancer and other fatal diseases. To date, there is little evidence regarding the extent to which individual WTP to reduce fatal risks differs by characteristics of the risk, including the type of disease or trauma and the latency period between exposure to the hazard and fatality.

In a contingent-valuation study in Taiwan, we find that WTP to reduce risks of fatal cancer due to environmental pollution is larger than WTP to reduce risks of another degenerative, fatal disease, and that WTP declines with latency between exposure and manifestation of disease. For evaluating environmental regulations, our results suggest that benefits of mortality-risk reduction should be reduced at a small annual rate to account for the latency period between exposure and manifestation of disease. They

further suggest the existence of substantial differences in VSL associated with specific diseases. In particular, people may consider reductions in the risk of fatal cancer more valuable than comparable reductions in risks of other fatal disease. Values of risk reduction may also be sensitive to the affected organ and environmental pathway. These results require confirmation and further refinement for use in policy analysis.

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Rationing critical care beds

Limited availability of healthcare resource in the face of permanent or temporary excess demand leads inevitably to rationing. Hardly news, that, though the R word is perhaps the hardest to use. Given that rationing is a fact of life, it behoves us to have some idea of the consequences. A systematic review of rationing of critical care beds¹ tells us that more people die who might have lived.

Systematic review

A widespread literature search without language restriction used many databases, plus handsearching of abstracts, plus contacting authors and experts. Inclusion criteria were adult patients who were seriously ill and considered for admission to an intensive care unit, retrospective or prospective cohort study, rationing based on reduced bed availability or triaging of patients referred for admission, and with outcomes including severity of illness, length of stay, or mortality. Medical, surgical, trauma, neurological or mixed intensive care units, intermediary care units, or step-down units were allowed.

Excluded were cost effectiveness studies, evaluation of protocols to make triaging decisions or rationing or triaging studies of coronary care units. Three different types of study were recognised:

1. Triaging studies comparing patients admitted to an ICU and those refused a bed in ICU.

2. Rationing bed studies comparing patients admitted during at least two different periods of time, one of which had reduced bed availability.
3. Single cohort studies of patients either admitted or refused admission during a single period of bed shortage.

Results

Ten studies were available. Five were triaging studies, three were rationing studies, and two single cohort studies. There were considerable differences in the studies, though most reported patient outcomes and nine had follow-up rates above 90%.

The most useful information came from the triaging studies, four of which reported mortality rates for 1,220 patients admitted and 558 not admitted to an intensive care bed (Figure 1). In each of these four studies mortality was higher in patients refused admission to an intensive care bed. These studies were performed in Israel (2), Hong Kong, the UK and the USA.

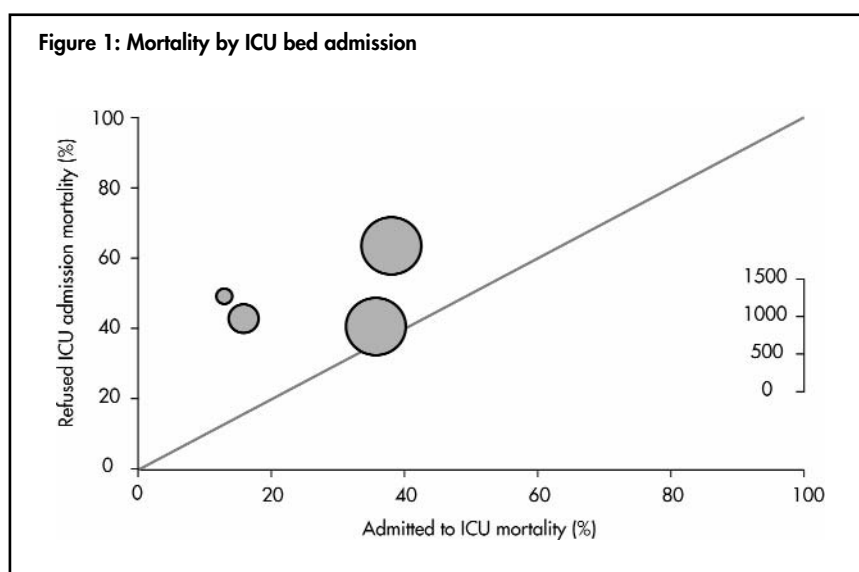
Overall mortality was 29% (357/1,220) in those admitted to ICU, compared with 50% (280/558) in those refused an intensive care bed (relative risk 1.7; 95% confidence interval (CI) 1.5 to 1.9). For every five patients refused an intensive care bed, one more died (95% CI 4 to 6) than would have been the case if they had been admitted to intensive care.

Comment

This is a headline result from some quite complex data, though any results other than this headline should probably not have much weight because they mostly come from single studies. But this remains an important heads up for those responsible for the provision of health care and the use of resources. Rationing comes with the price, for intensive care beds, of more deaths in those refused admission. Clearly a topic that demands more research, especially because saving money might mean spending it elsewhere in the system.

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Bandolier is an independent monthly journal about evidence-based healthcare, written by Oxford scientists. Articles can be accessed at www.jr2.ox.ac.uk/bandolier

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Mythbusters

Myth: The cost of dying is an increasing strain on the healthcare system

In the ongoing quest to identify the cause of growing healthcare budgets, fingers are pointed in a number of directions — the ageing population and expensive new technology in particular.

There is a widespread belief that healthcare systems are spending more and more to provide intensive and aggressive care to older patients living out their final months. These 'heroic efforts' to treat the dying are becoming a bigger spending factor than in the past, so the myth goes, due to the availability of more expensive technology.

The image of teams of doctors, nurses and other healthcare professionals gathered around elderly patients, with an arsenal of the best drugs and equipment at their side, is a convenient one – but how close is it to reality?

Thirty years of evidence

The perception that the cost of treating the dying drives up healthcare budgets is not new, but it has also been debunked by more than 30 years' worth of evidence. Research on healthcare spending shows that end-of-life costs tend to account for a minority of total costs to healthcare systems; research from both North America and Europe shows that acute healthcare costs during the last year of life account for only about 10–12% of total healthcare budgets.^{1,2}

The American Medicare plan, which covers only healthcare for senior citizens, has been particularly well-researched. Studies dating back to the 1970s have shown that the 5–6% of senior citizens who die each year account for about 27–30% of that programme's costs for treating the elderly.^{3–6}

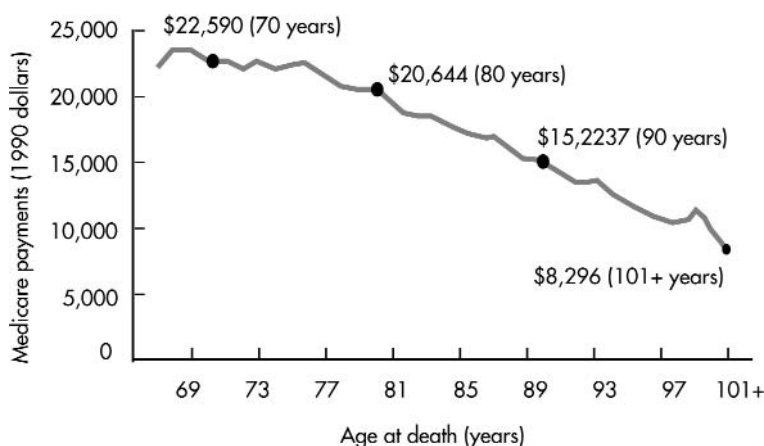
Spending steady since 1960s

This myth stays alive for a couple of significant reasons. First, the increasing number of seniors in the population has led to the belief that the costs of treating them will overwhelm the system – a myth refuted by another Mythbuster on the ageing population.⁷ Second, improvements in care in recent years, largely due to new and more expensive technology, have led to the belief that these resources are too often being used in last-ditch efforts to keep patients alive – and causing increases in healthcare budgets.

Despite these developments, the data appear to show that the proportion of healthcare spending going to care for those at the end of life has largely remained stable over time.³ In the United States, for example, the money being spent in the last year of life has remained steady since the late 1960s, when their Medicare program was first introduced to provide hospital and physician coverage to senior citizens older than age 65.^{4,8,9}

And despite changes to the technology available, the fact is most people still die without an expensive, high-tech struggle.¹ Indeed, a major study of Manitoba patients

Figure 1: American Medicare payments on hospitals and physicians in the last two years of life decline with increasing age at death.¹⁴



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
This paper was first published in 2003. © CHSRF, 2003.*

found that 38% of seniors in that province died after only two weeks or less in a hospital,¹⁰ and 46% of Medicare recipients in the United States received no hospital treatment at all in the year before they died.¹¹

Nursing homes affect costs

Research shows that the older people are when they die, the lower the medical costs incurred during the final year (see Figure 1).^{5,12-14} Instead, these individuals appear to be using nursing home services to a much greater degree.¹⁰ American research has shown nursing home costs make up 62% of spending in the last 18 months of life for people who were older than 85 when they died, and 24% of spending for those who were between the ages of 65 and 74 when they died.¹¹

In addition, recent studies of Manitoba's nursing homes show that because individuals being admitted to nursing homes are spending more time living in the community before they go into a care home, they are older and frailer when they enter a facility, and they die after a shorter stay.^{15,16} The Manitoba research shows that while admission rates have remained stable in that province, the average number of days spent in a care home declined by about 20% between 1985 and 1999.¹⁶

Research can't do everything

Clearly, research has debunked the myth that the cost of dying is growing and overwhelming the healthcare system. The question that research will never answer, however, is whether that spending is too high – that's a question of values, which number-crunching will never answer.

Even if society does decide that spending at the end of life is too high, it is unclear what could be done about it. Research has shown some likelihood of reducing costs with increased use of hospice and advance directives,² but there are other critical and possibly disturbing policy implications that will emerge as people try to decide how aggressive medical care at the end of life should be and how costs can be reduced.

In the end, it is difficult to predict which patients receiving treatment will live and which will die (with the exception of some

forms of terminal cancer). In other words, care in the last year of life is not so much 'spending on the dying' as it is just providing regular medical care for people who have serious health problems.^{4,5,17}

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EUnetHTA and health policy-making in Europe

Finn Børlum Kristensen on behalf of the EUnetHTA Partners

Health care, innovation and technology development

Health care provision is increasingly subject to policy scrutiny and its effectiveness is often evaluated by third party payers or regulatory agencies. Moreover, health professionals, researchers and industry all work across borders. The challenge is how best to serve unmet health needs with effective health interventions, given budget constraints. New technologies with the potential to improve health by improving care delivery can improve resource allocation. Those technologies that have the highest proven effectiveness should be promoted whilst taking organisational, societal and ethical aspects into consideration.

Health Technology Assessment (HTA) is increasingly used in many European countries to assist decision-making and policy-making in the health field. Several European countries, such as the Netherlands, England and Wales, France, Sweden, Denmark and most recently Italy, have now formally build HTA into certain policy, governance, reimbursement or regulatory processes. Therefore, the EU and Member States in 2004 considered that there was an urgent need for a sustainable European network for HTA to share information and experience across European borders.

Health Technology Assessment

HTA provides an approach for improving the knowledge base for health care policy-making and decision-making. Health technology is the application of

scientific knowledge in health care and prevention. HTA is a multidisciplinary process that summarises information about the medical, social, economic and ethical issues related to the use of a health technology in a systematic, transparent, unbiased, robust manner. Its aim is to inform the formulation of safe and effective health policies that are patient-focussed and seek to achieve the best value. HTA endeavours to provide a structured, evidence-based input to the policy-making process. It provides input to decision-making in health care policy and practice through systematic interdisciplinary processes. Furthermore, HTA covers all interventions and procedures in health care, including diagnostic and treatment methods, medical equipment, pharmaceuticals, rehabilitation and prevention methods and organisational and supportive systems within health care.

Research fields contributing to HTA

HTA builds firmly on research, yet targets its products to feed into policy- and decision-making. The most significant contributing research fields are:

- Systematic literature searches and reviews, including: library and information sciences, and meta-analysis
- Health economics analysis
- Research on organisational management and development processes in health care
- Research on patient aspects
- Ethics
- Policy analysis

Background

Currently sixteen European countries. Currently sixteen European countries. Previous European collaboration, including the extensive work of the EUR-ASSESS and ECHTA/ECAHI projects, has resulted in common internationally accepted and used HTA methodologies

that rely on the systematic, rigorous and crossdisciplinary analysis of the implications of using health technologies.^{1,2} There are now sixteen countries in Europe with one or more HTA agencies linked to national or regional government and in 2004, the European Commission and Council of Ministers targeted HTA as “a political priority”, recognising “...an urgent need for establishing a sustainable European network for HTA”.³ Subsequently the Commission awarded funding to a new project coordinated by the Danish Centre for Evaluation and HTA (DACEHTA).

The EUnetHTA project

The European Network for Health Technology Assessment (EUnetHTA) was established by the EU Commission and Member States in January 2006 as a project developing a sustainable information resource to inform health policy-making. The website www.eunethta.net provides information and news services. The overall strategic objective of the EUnetHTA is to connect national HTA agencies, research institutions and health ministries to enable an effective exchange of information and support to policy decisions by EU Member States (See Box 1). The aim is to achieve rapid uptake and use of effective health technologies, which is expected to contribute to major improvements in patient outcomes and promote a wise investment of resources.

EUnetHTA project outcomes

EUnetHTA will facilitate the transferability of reports among Member States by:

- establishing ‘core’ information about the effectiveness and safety of technologies that can be shared among Member States, thus avoiding duplication of effort;
- outlining the cultural, economic, social

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Box 1: EUnetHTA project objectives

To provide a robust multi-faceted input to decision-making
To reduce duplication of work, thus using limited resources to undertake a wider range of HTA
To gain a better understanding of the links between HTA and policy-making in different Member States
To support countries with limited HTA experience.

and ethical issues to be considered in national contexts; and

- supporting and assessing the transferability of national HTA reports to other contexts.

The network will monitor emerging health technologies to identify those that will have the greatest impact on health systems and patients, and will support countries without institutionalised HTA activity. The project will include the development of a variety of tools to improve the responsiveness of HTA to its consumers, two pilot projects for two different types of technologies (creating the core HTA and transferring it to various contexts) and internal evaluation of the network.

In addition, a communication and information platform (and a clearinghouse facility to be implemented at a later stage) will be developed which could promote effective exchange and use of evidence-based information on health technologies.

EUnetHTA methodology

EUnetHTA builds on previous EU supported HTA projects^{1,2,4} and the OECD Project on Health Technologies.⁵ The project is organised within eight work-packages to achieve the vision of coordinated, rapid, influential HTA work to inform health policy in all EU Member States. Overarching advocacy and communication strategies will be developed, which will focus on the needs and perspectives of HTA users.

Other networks related to HTA that are partners in EUnetHTA

The International Network of Agencies for Health Technology Assessment (INAHTA) provides a global forum for

the identification and pursuit of interests common to HTA agencies. INAHTA defines itself as a network where most activities are coordinated by the Network secretariat. INAHTA manages the HTA Database with the Centre for Reviews and Dissemination at the University of York in the UK. www.inahta.org

The Cochrane Collaboration is an international non-profit and independent organisation, dedicated to making up-to-date, accurate information about the effects of health care readily available worldwide. It produces and disseminates systematic reviews of health care interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions. The major product of the Collaboration is the Cochrane Database of Systematic Reviews. www.cochrane.org

The European Information Network on New and Changing Health Technologies (EuroScan) is a collaborative network of HTA agencies for the exchange of information on emerging new drugs, devices, procedures, processes and settings in health care. www.euroscan.bham.ac.uk

Health Technology Assessment International (HTAi) focuses uniquely on HTA and provides the key forum for all those working in health care, academia and businesses interested in the science, development and application of HTA. Their mission is to support the development, communication, understanding and use of HTA around the world as a means of promoting the introduction of effective innovations and effective use of resources in health care. www.htai.org

The WHO Regional Office of Europe's Health Evidence Network is an information service for public health and health

care decision makers. HEN provides summarised information from a wide range of sources, such as websites, databases and publications, as well as national and international organisations and institutions. www.euro.who.int/HEN

The Guidelines International Network (G-I-N) is an international not-for-profit association of organisations and individuals involved in clinical practice guidelines. G-I-N seeks to improve the quality of health care by promoting systematic development of clinical practice guidelines and their application into practice, through supporting international collaboration. The Guideline Library contains regularly-updated information about G-I-N membership. www.g-i-n.net

Stakeholder involvement

Key stakeholders in health care policy and decision-making include patients, health managers, health professions, industry, third party payers and government. Each one of them has legitimate interests in the search for and handling of information on the best use of health technologies that go into policy processes. EUnetHTA plans to establish a Stakeholder Forum as an open and flexible environment to ensure transparency and early involvement of HTA relevant stakeholder groups in the development process, depending on the needs of the stakeholders and the project. Initially, it will be a virtual web-based forum.

Member State and international involvement

Development of EUnetHTA to ensure the timely and effective production, dissemination and transfer of HTA into useful policy advice will require the involvement of many health-related organisations world-wide. Consequently, the EUnetHTA project involves 60 organisations and official contact points in the Ministries of Health in those EU Member States that do not have an organisational representation in the project. A total of 35 associated partners contribute financially, and additionally 25 entities are collaborating partners providing scientific excellence and ensuring the establishment of effective links and synergies. In total, 24 EU Member States, two EEA countries and Switzerland represent Europe in EUnetHTA, led by DACEHTA, the main partner of the project and host of the EUnetHTA Coordinating Secretariat.

Another EUnetHTA objective is to build collaborative relationships with relevant international organisations in the HTA field beyond the European borders. Participation has currently been secured from relevant organisations in Australia, Canada, Israel and the United States. International organisations such as the OECD and the Council of Europe will also participate in the project as collaborating partners.

The EUnetHTA vision for the future

In the future, preventing the duplication of HTA activities across Europe and increasing standardisation of HTA methods and procedures will allow a wider range of HTAs in Europe to be undertaken and also help improve links between technology assessment and deci-

sion making. By means of an increased application of HTA procedures, a more transparent and effective use of available health care resources will be possible when introducing new health technologies or making reimbursement decisions.

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Canada: a HiT just in time

The European Observatory on Health Systems and Policies has recently published a Health Systems in Transition (HiT) country profile on the Canadian health system.

This report, written by Gregory P. Marchildon and edited by Sara Allin and Elias Mossialos, provides an insightful examination of the past, present and future of the system. The HiT illustrates the geographical, economic and political context in which the Canadian health system is situated and describes the organisation

of the health system. It draws comparisons with the health systems of Australia, France, Sweden, the United Kingdom and the United States, revealing the many similarities between the Canadian and European models of health care.

In summary, Canada has a predominantly publicly financed health system with services provided through private (for-profit and not-for-profit) and public (arm's-length and direct) bodies. Each province/territory runs its own single-payer, universal system of hospital and primary physician care (Medicare) that evolved from a series of reforms following World War II. The Canada Health Act, the legislative underpinning of the Canadian health system, outlines the five conditions that provinces must continue to meet in order to receive funding from the federal government: universality, public administration, comprehensiveness, portability and accessibility.

Spending on health in Canada is high – 10% of GDP in 2003 – which is the fourth highest among OECD countries. The main source of financing is taxation (70% of total health expenditure), while private financing is split between out-of-pocket payments and

private health insurance. The administration of public health services is highly decentralised, owing to at least three factors: (i) provincial responsibility for public health care; (ii) the historic arm's-length relationship between government and providers; and (iii) recent regionalisation reforms in which sub-provincial organisations now hold the majority of the health care budget.

One of the highlights of the Canada HiT is the comprehensive description it provides of health care reform initiatives that have taken place since the 1980s. These reforms can be grouped within two different stages. The first stage (1988–96) was marked by public fiscal constraint due to high government debt; the second (1997 to present) is characterised by increasing health expenditures influenced by a more buoyant economy and lower public debt. Ongoing discussions are taking place about the fiscal sustainability of public health care, and increasing

The Canadian HiT and summary are available for download from the Observatory website www.euro.who.int/Document/E87954.pdf

Hard copies can be ordered from the University of Toronto Press for CAD\$25

www.utppublishing.com/pubstore/merchant.ihtml?pid=8748&step=4

debates about market-based reforms predicated either on private finance or private delivery. Moreover, as a result of growing public dissatisfaction and long waiting lists, provincial governments have invested heavily in their systems, addressing human resource and medical equipment shortfalls.

The report also provides an original analytic framework for assessing the Canadian health system by focusing on the three sectors – public, private and mixed. The concluding section addresses the challenges facing the Canadian health system, such as lengthy waiting times and the growing cost of pharmaceuticals. The publication of this HiT comes at a time of potentially great significance for the future of the health system. With possible changes to the financing of health care on the horizon – following the recent Supreme Court ruling questioning the Government of Quebec's prohibition on private health insurance – and ongoing changes on the delivery side through the regionalisation reforms, this publication will serve as a vital tool to inform future debate.

Health Systems Action Network (HSAN)

www.hsnet.org/index.html

First proposed at the April 2005 World Health Organization meeting on 'The Montreux Challenge: Making Health Systems Work', the Health Systems Action Network was created to facilitate the sharing of knowledge towards better health systems by enhancing the creation and flow of credible information, and strengthening coordination and collaboration. Interviews with leaders in global health are posted, where they share their views on the challenges developing countries face to increase access to critical health interventions in the context of weak and dysfunctional health systems. The website contains reports and resources, information on global health initiatives and partnerships, details of conferences and links to websites of organisations concerned about health systems.

International Health Economics Association (iHEA)

<http://healthconomics.org>

The International Health Economics Association was formed to increase communication among health economists, foster a higher standard of debate in the application of economics to health and health care systems, and assist young researchers at the start of their careers. The website is available in English and makes available information on its members and how to join the association, training courses in health economics, job postings and upcoming conferences. Details are also provided of recently published books on related topics, calls for abstracts/papers, a weekly newsletter as well as links to the websites of national health economics organisations, such as the American Society of Health Economists (ASHE).

The International Network of Agencies for Health Technology Assessment (INAHTA)

www.inahta.org

The mission of INAHTA is to provide a forum for the identification and pursuit of interests common to health technology assessment agencies. Established in 1993, INAHTA has grown to 43 member agencies from 21 countries. The network's objectives are to accelerate exchange and collaboration among agencies, to promote information sharing and comparison, and to prevent duplication of activities. The website details INAHTA's on-going activities, such as meetings, conferences, project launches and publications as well as information about health technology assessment, news items and publications for download including newsletters, briefs, joint projects and synthesis reports. These documents can be searched by keyword, date, disease category and language, which include English, French and Spanish.

National Public Health Institute, Finland (KTL)

www.ktl.fi

Under the Finnish Ministry of Social Affairs and Health, KTL serves to monitor the health of the population and the factors influencing it, to develop tools to promote public health, and to distribute information to decision-makers, actors and citizens. KTL's expertise includes public health monitoring and promotion, education and training, facilitating international collaboration, laboratory research and dissemination on various topics such as environmental health, infectious diseases, mental health and others. Available in English, Finnish and Swedish, the website provides publications and articles for download, details of its scientific departments, a list of meetings and conferences, and Kansanterveys, the KTL bulletin which is circulated to health care professionals and the media.

Europe for Patients (e4p)

www.iese.edu/en/events/Projects/Health/Home/Home.asp

Supported by the European Research programme, Europe for Patients is a project about the benefits and challenges of patient mobility in Europe. The project's objective is to contribute scientific evidence that will enable policy-makers to take concerted and coordinated action towards enhanced mobility in Europe. It involves a multidisciplinary team of European experts that have extensive experience in the subject drawing on legal, health policy and health services research perspectives. Research is being carried out both on Europe-wide initiatives and through in-depth case studies. The website provides news on the EU patient mobility process, details of events, the project partners as well as supplying documents for download and links to related websites.

Harvard Center for Risk Analysis (HCRA)

www.hcra.harvard.edu/index.html

Launched in 1989, HCRA endeavours to promote public health by using decision sciences to take a broad view and empowers informed public responses to health, safety and environmental challenges by identifying policies that will achieve the greatest benefits with the most efficient use of limited resources. This is achieved by applying analytic methods and comparing various risk management or health intervention strategies. Their research programmes include, economic evaluation of medical technologies, environmental science, and food safety and agriculture. The website is available in English and provides news on the centre's activities, details of research programmes, publications for download, and courses as well as being equipped with a search engine.

NEW PUBLICATIONS

Eurohealth aims to provide information on new publications that may be of interest to readers. Contact David McDaid d.mcdaid@lse.ac.uk if you wish to submit a publication for potential inclusion in a future issue.

Creating a healthy workplace

Faculty of Public Health and Faculty of Occupational Medicine, London, 2006



ISBN 1-900273-21-7

37 pages

Freely available on line at:

www.fph.org.uk/policy_communication/downloads/publications/reports/healthy_workplaces_report_2006.pdf

Written by the Occupational Health Working Group of the Faculty of Public Health and the Faculty of Occupational Medicine, this guide is aimed at providing practical ideas to support employers and occupational safety and health professionals improve health and well being in the workplace.

A multitude of legislation and advice has been aimed at employers to create a healthy work environment for their employees. The working group have pooled their expertise and written this book and the accompanying 4-page practical guide (that can be downloaded or ordered from the Faculty of Public Health website at <http://www.fph.org.uk>), which provide a persuasive argument as to why healthy workplaces make good business sense.

The report begins by stressing the cost of ill health to an organisation. In the UK, sickness absence costs employers around £12.2 billion each year, up to 16% of the annual salary bill. The most commonly reported causes of sickness absence from work are stress-related conditions and

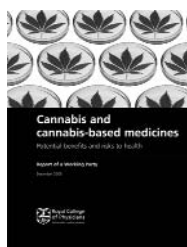
musculoskeletal disorders. Smoking-related illness results in a loss of an estimated 34 million workdays annually in England and Wales.

The report lists many benefits of a healthy workplace, including improved productivity and performance, reduced absenteeism and other costs associated with ill health, and better employee morale and staff retention. Each health-related topic has its own chapter that identifies what is known, what an employer must do, and easy steps an employer can take. Also, special groups are recognised, such as pregnant women and shift workers, and case studies are used to illustrate good practices by well-recognised employers. Furthermore, practical help can be found from the list of resources.

Contents: Introduction; Creating a safe and healthy workplace; Recruitment, retention and rehabilitation; Mental wellbeing and minimising stress; Musculoskeletal disorders; Tobacco smoke and smoking cessation; Alcohol and other substance misuse; Physical activity; Healthy eating

Cannabis and cannabis-based medicines: Potential benefits and risks to health

Royal College of Physicians, London, December 2005



ISBN 1-86016-254-1

44 pages. Soft cover

£12.00 UK, £14.00 Overseas

Technical supplements freely available online: www.rcplondon.ac.uk/pubs/books/cannabis/

Written by a Working Party, this report takes an objective and careful look at the evidence on cannabis-based medicines. Their ability to treat conditions such as chronic pain and multiple sclerosis is examined. Each potential use is considered in light of the pharmacological effect of cannabinoids, their efficacy in comparison with other medicines, and the results of clinical trials. The efficacy in treating a range of other conditions is also assessed, along with their overall safety, including the possible link between cannabis and psychosis.

Professor Martin Wilkins, Chair of the working party and Professor of Clinical Pharmacology at Imperial College London, said: "Cannabis-based medicines are an active area of research and may offer new treatments for the symptoms of multiple sclerosis, pain, cardiovascular disease and osteoporosis. It is appropriate that these medicines are examined and developed through carefully controlled

clinical trials, in line with the regulations governing the approval of new drugs."

The report strongly discourages smoking cannabis as this may carry similar risks to the lungs as smoking tobacco. The working party recommends that clinical trials to address the therapeutic value of cannabinoids should be based on alternative methods of administration. The report provides an informative guide in a contentious area of medicine and can be useful for general practitioners, hospital doctors, psychiatrists and patients. There is also an information section for patients.

Contents: Chemistry and pharmacology of cannabinoids; Cannabinoids and the treatment of multiple sclerosis; Cannabinoids as a treatment for chronic pain; Cannabinoids, appetite regulation and body weight; Other potential medicinal uses of cannabinoids and cannabis-based medicines; Safety of cannabis and cannabinoids; Appendix: Patient information

EUROPEAN MONITOR

New WHO report on tuberculosis

23 March saw the launch of a new WHO report, *Global Tuberculosis Control – Surveillance, Planning, Financing*. According to the report, the tuberculosis (TB) epidemic in the WHO European Region, which peaked in 2001, is now declining. Nevertheless, multidrug-resistant TB and HIV co-infection continue seriously to hamper work to control the disease and the TB emergency in the eastern half of the Region continues.

According to the report, more than 400,000 cases were reported in the WHO European Region in 2004, with 80% in just 16 countries: those in the Commonwealth of Independent States (CIS), the Baltic states and Romania. TB also was responsible for an estimated 69,000 deaths in the Region in 2004.

The rates of multidrug-resistant TB in the countries of central and eastern Europe and the CIS are estimated to be among the highest in the world. Of the 20 countries with the highest rates of multidrug resistance among previously treated cases, 14 are in the WHO European Region. The Region also reports the highest rate of treatment failure (7%) and the second-highest rate of death as a treatment outcome (6%).

In western Europe, increased immigration from countries with high TB prevalence has resulted in cases in immigrants outnumbering those for the indigenous population. According to the WHO, despite greater commitment and increased funding, current prevention and treatment efforts need to be strengthened to improve cure rates, bring multidrug resistance under control and also address the challenge of TB-HIV co-infection.

Acknowledging that substantial funds have been committed expand TB programmes in

countries in the WHO European Region, the WHO state that several countries in eastern Europe and central Asia have not yet translated their political commitment to fighting TB into sustained national funding. While poverty may be an important obstacle in some countries, low domestic funding for TB programmes reflects a lack of real commitment.

Speaking at the launch of the report, Dr Marc Danzon, WHO Regional Director for Europe, called for a higher political commitment to the implementation of the DOTS approach. Dr Risards Zaleskis, WHO Regional Adviser for Tuberculosis Control, stressed the importance of a Europe wide approach to tackle TB. “Effective TB control is not limited to the borders of individual countries. The multidrug-resistant TB situation, the potential for TB outbreaks in the increasing pool of HIV-infected people and the high rates of TB in many countries in the WHO European Region must be addressed as a regional emergency.”

The WHO European Regional Office will hold a ministerial forum in Copenhagen, Denmark in October 2006 for ministers of health, justice, finance and foreign affairs from the 52 Member States in the Region, in order to boost political and financial commitments to improve TB control.

The forum is organised in close collaboration with the Finnish Presidency to the European Union, the Stop TB partnership, the Royal Netherlands Tuberculosis Association (KNCV), the International Federation of Red Cross and Red Crescent Societies (IFRC), the Finnish Lung Health Association (FILHA), the United States Agency for International Development (USAID) and other partners.

The WHO report can be accessed at www.who.int/tb/publications/global_report/2006/download_centre/en/index.html

Further information on the ministerial forum is available at www.euro.who.int/tuberculosis/forum/20060308_1

Review of road safety action programme

The European Commission has recently adopted a communication on the mid-term review of the European Road Safety Action Programme. The programme review aims to stimulate more responsible behaviour by road users, make vehicles safer and improve the road infrastructure.

The Transport White Paper adopted in 2001 proposed a target of halving the number of road fatalities by 2010 (from 50,000 to 25,000). Some categories of road users or population groups are particularly at risk: young people between 15 and 24 year of age (10,000 fatalities/year), pedestrians (7,000 fatalities), motor-cyclists and moped users (6,000 fatalities), and cyclists (1,800 fatalities).

Dangerous behaviour of many road users is the principal cause of avoidable mortality. Excessive speed accounts for 15,000 deaths per annum and the consumption of alcohol/drugs and fatigue a further 10,000 deaths. The failure to wear seat belts or protective helmets is the reason for a further 7,000 needless deaths every year. Injury prevention is one of the key health themes of the Austrian presidency and it will host a conference on accidents and injuries in June.

Further information at http://europa.eu.int/comm/transport/road/roadsafety/index_en.htm

Tobacco advertising: EC takes action against two non-compliant EU Member States

On 1 February the European Commission sent “reasoned opinions” to Germany and Luxembourg for failing to transpose into national law Directive 2003/33/EC of 26 May 2003 on the advertising and sponsorship of tobacco products. More

specifically the Directive bans tobacco advertising in the print media, on radio and over the internet. It also prohibits tobacco sponsorship of cross-border events or activities.

The Directive was passed by the European Parliament and Council in 2003 and was due for transposition into national legislation by 31 July 2005. It applies only to advertising and sponsorship with a cross-border dimension.

These two countries had already received a "letter of formal notice" in October 2005. They now have two months to comply, otherwise the Commission will resort to the European Court of Justice (ECJ) to declare that they have failed to fulfil their obligation to transpose EU legislation. In the event that they still do not comply with the judgement of the Court, the ECJ can impose fines following a proposal from the European Commission.

"The Commission must ensure that EU law is upheld," said European Health and Consumer Protection Commissioner Markos Kyprianou. "I am determined to enforce this piece of legislation, which is essential in the fight against smoking. I am sure that all governments realise that glamorising smoking through fancy advertising can have devastating effects, in particular on young people. So I strongly urge non-compliant countries to come back into line and help us defend European citizens' health."

The Commission is also investigating the situation in countries where transposition has not been made correctly.

More information is available at http://europa.eu.int/comm/health/ph_determinants/life_style/Tobacco/tobacco_en.htm

Eurobarometer on medical errors published

One of the goals of the European Commission is to improve the safety of care for patients in all EU Member States through the sharing of information and expertise.

As part of this remit, the Directorate-General of Health and Consumer Protection undertook a Eurobarometer survey on citizens' perceptions and experiences of medical errors in the 25 Member States, Acceding and Candidate countries and in the Turkish Cypriot

Community. The subsequent impact on trust in health care professionals and hospital treatment was also recorded. This, according to the Commission, was the first time that the issue of medical errors had been studied at an EU level in any systematic fashion.

It was clear from the survey that perceptions and experiences of medical errors vary notably between countries, but that in all countries, bar Finland, medical errors are perceived to be a prominent problem.

European citizens appeared to be well aware of the existence of medical errors; 78% indicated that they have at least sometimes read or heard about them. In all countries polled, at least half of the respondents belonged to this group. This awareness was not widely based on concrete experiences; less than 1 in 5 respondents indicated having either personally or within their family encountered a medical error in a hospital.

Half of all respondents in the survey believed that a medical error would be likely to occur in their country. Most seemed to believe that it was the responsibility of the health care system to ensure the quality of treatment, although a substantial share also recognised the role to be played by patients in avoiding medical errors.

Some difference in the level of concern over medical errors was also observed in population sub-groups, including women, those with a low level of education, the unemployed and the retired. Unsurprisingly concern was also higher in those individuals who had personally experienced misconduct within their health care system.

The report can be downloaded at www.europa.eu.int/comm/health/ph_information/documents/eb_64_en.pdf

EU acts to combat resistance to antibiotics

A new scientific network, supported by the EU's Research Framework Programme, will tackle the increasing problem of resistance to antibiotics when dealing with lower respiratory tract infections, such as bronchitis or pneumonia. This Network of Excellence, known as GRACE (Genomics to Combat Resistance against Antibiotics in Community-acquired LRTI in Europe), will pool European expertise and excellence in this field to

increase knowledge, ensure the practical application of any research findings, develop new diagnostic tests and improve education and training.

The network brings together 17 academic groups, from nine EU Member States. Respiratory tract infections affect millions of people every year, particularly the very young and the elderly and entail a major cost to European society.

European Science and Research Commissioner, Janez Potočnik, welcomed this new research network, saying "We know that there is growing concern among the public about rising rates of antibiotic resistance to illnesses that affect many of us every year. GRACE is a good example of research tackling the issues that matter to people. By pooling our excellence at European level, we have a much better chance of finding answers more quickly."

Antibiotic resistance and antibiotic use vary widely within and between European countries, but there is general agreement that the over-prescription of antibiotics to tackle illnesses such as bronchitis and pneumonia is contributing to the rise of resistance to these medicines in the organisms that cause these diseases. To take the example of acute bronchitis, this illness affects over 16 million people per year, and 70% to 90% of them are prescribed antibiotics for it.

Over three million cases of community-acquired pneumonia (CAP) should be expected annually in the EU and assuming that about 20% of cases of CAP are hospitalised, this means over 500,000 hospitalisations per year in the EU. Mortality rates in hospitalised patients with a CAP range between 5 to 15%.

The European Respiratory Society recently reported that clinically relevant acute exacerbations of chronic obstructive pulmonary disease (COPD) now affect 4–6% of adults in Europe. By 2020, COPD will be the third most common cause of death and will account for over 6 million deaths per year in Europe.

Acute exacerbations of COPD are a common cause of hospital admission resulting in major health care expenditure and are a major determinant of quality of life in COPD patients. The course of an exacerbation is several weeks and it can take up to six weeks

until the patient is in a stable condition again. The mortality rate in patients with an exacerbation admitted to hospital stay is about 8%, increasing to around 23% after one year of follow-up. Yearly expenditures for treatment of exacerbations of COPD in British primary care were estimated at €52 million (1994 prices).

Herman Goossens, GRACE's coordinator and Professor at the University of Antwerp, Belgium, and also at Leiden, the Netherlands, says that over-prescription of antibiotics to tackle illnesses such as bronchitis and pneumonia is contributing to the rise of resistance to these antibiotics. Antibiotic resistance and antibiotic use vary widely both within and between European Countries. The available scientific evidence cannot support this variation in antibiotic practice. In the absence of clear guidelines on antibiotic use based on robust science, it is left to doctors to make decisions on their own.

So the GRACE Network will seek to provide better information for doctors and patients about antibiotic use. It will link scientific research centres of excellence and primary care networks throughout Europe, including internationally recognised leaders in fields such as basic medical sciences including genomics, applied laboratory sciences, primary health care including general practice, hospital medical practice, epidemiology, communication sciences, information technology, health economics, modelling and professional training and development.

The network will not only coordinate research, but will also address the best possible use of results, through the involvement of small and medium-sized companies that can help to develop bedside diagnostic tools. It will also address the need to provide proper information and training for healthcare professionals through both web-based teaching and practical courses. Looking further into the future, GRACE may be in a position to address many other future research issues and conduct clinical trials such as epidemiological studies on influenza and other emerging infectious diseases, studying rapid diagnostic testing, as well as evaluating new antibiotics, antivirals, and vaccines. This could potentially lead to a virtual "European Lower Respiratory Tract Infection Research Centre".

The network will receive €11.5 million from the EU's Research Framework Programme and will run until at least 2011.

More information is available at www.GRACE-LRTI.org

Commission launches multimedia initiative

On 2 February, European Health and Consumer Protection Commissioner Markos Kyprianou launched the "European Health Information Platform" or "Health in Europe" project. This health information system is co-financed with €1.4 million from the EU Public Health Programme, and managed by the European Broadcasting Union (EBU). It is a multimedia initiative which aims to create a network of public broadcasters and other media across Europe, and foster the exchange of reports, including television documentaries, radio broadcasts and press and internet articles on health issues.

"There is a need for better and more widespread information about health issues in Europe", said Commission Kyprianou. "This partnership of TV and radio networks across Europe through the European Broadcasting Union will help keep citizens, and in particular patients and health professionals, informed on public health issues with a European dimension."

Health in Europe is based on an ongoing exchange of reports on health and medicine produced by TV broadcasters for their theme magazines. Reports are offered free of rights to participating organisations. The project also includes a series of TV and radio documentaries produced by a consortium of public service broadcasters around Europe, animations for publication on websites of participating organisations and a network of professionals working on health magazines.

All information will be available on the project website, where participants in the project will also exchange information. European broadcasters and associated media will be encouraged to create their own health magazines; to include health themes in existing consumer, youth and – for instance – breakfast magazines; to report on breaking health stories in their current affairs and news programmes, and to do so across 'old' and 'new' media

Project participants

The project already involves the main public service broadcasters in ten European Countries: ARD (Germany), CT (Czech Republic), France2 (France), RTBF (Belgium), YLE (Finland), TVP (Poland), ERT (Greece), RAI (Italy), ORF (Austria), Radio Prague (Czech Republic), Radio Netherlands, Radio France International. All the other members of the EBU are invited to join.

TVE (Spain), RTE (Ireland), RTP (Portugal), DR (Denmark), SVT (Sweden), LRT (Lithuania), RTM (Morocco), TV channel 'Russia', AVRO (Netherlands), MTV (Hungary), RTVS-LO (Slovenia), HRT (Croatia) and a number of public service radio stations have already expressed a strong interest.

Details of the project are available on the Commission public health website: http://europa.eu.int/comm/health/ph_projects/2004/action1/action1_2004_11_en.htm

Expert group to promote inclusion of ethnic minorities in the EU

On 13 February in Brussels, the first meeting of a high-level group of experts analysing the social inclusion of ethnic minorities in the EU took place. The group, established by the European Commission under its strategy for tackling discrimination, comprises ten eminent personalities from business, local politics, civil society, the academic world and the media, headed by former President of the German Parliament, Rita Süßmuth.

The group will focus on issues such as good practices in the integration of disadvantaged ethnic groups in the labour markets and on the promotion of pragmatic, workable concepts in this area. In its work, the group will draw on a new study launched by the Commission as well as on the experiences from existing EU programmes, such as the Community initiative EQUAL. It will report back before the end of 2007 with policy recommendations on how the EU can approach the problems of social and labour market exclusion for disadvantaged minorities. Of particular concern is the difficult situation faced by the Roma throughout Europe – in terms of employment, health, education, housing, and other areas.

Opening the meeting Vladimír Špidla, EU Commissioner for Employment,

Social Affairs and Equal Opportunities, emphasised the importance of social exclusion stating that “The EU’s ethnic diversity increased with its 2004 enlargement, while in 2005 violence in France’s poorer suburbs again highlighted the problem of social exclusion among communities of immigrant origin in some Member States”.

Further information on the European Commission’s framework strategy for tackling discrimination is available at http://europa.eu.int/comm/employment_social/fundamental_rights/pdf/ey07/com07_en.pdf

OECD countries agree guidelines for licensing of genetic interventions

OECD member countries have adopted a set of *Guidelines for the Licensing of Genetic Interventions* used in healthcare, in a move designed to help people benefit more widely from advances in genetics while making research and innovation faster and more efficient.

The Guidelines respond to some of the concerns of governments, patient groups and industry that patenting of genetic inventions and restrictive licensing of their use is reducing access to the benefits of the technology and discouraging new research. By setting out principles and best practices for businesses, researchers and health systems that enter into license agreements for genetic inventions, the Guidelines aim to encourage broad licensing and timely dissemination of biotechnological innovation.

The guidelines were developed by a broad group of experts from diverse backgrounds and were subject to wide public consultation prior to adoption. Though they are not legally binding, they represent an important political and moral commitment on the part of OECD countries. Governments have agreed to report back in four years time on progress in their diffusion and implementation.

The full text of the Guidelines and additional information is available on the OECD website at: www.oecd.org/sti/biotechnology/licensing

EUROPEAN COURT NEWS

ECJ opinion on Supplementary Protection Certificates (Case C-431/04)

An advocate general of the European Court of Justice (ECJ) has given an opinion that a combination product, which contains an active substance and an excipient (an inert substance that acts as a diluent or vehicle for a drug) that enhances the substance’s effectiveness could qualify for a Supplementary Protection Certificate (SPC). This opinion disagreed with the German Patent Court decision that decided not to grant an SPC for a combination product, because under the EU SPC Regulation (No. 1768/92) it understood that both of the product’s main constituents had to be active substances, each having its own therapeutic effect.

The question was put to the ECJ by the German Court with regards to a ruling on the product Gliadel, which is used in the treatment of malignant brain tumours. In 2001, the German Patent and Trademark Office rejected MIT’s application for an SPC because the combination of Carmustine and Polifeprosan was not a “combination of active ingredients” due to the fact that Polifeprosan was not an active ingredient under the SPC Regulation.

The German Court sought clarification as to whether a “combination of active ingredients of a medicinal product” should include a combination of two substances where one is pharmacologically active but the other is required for that substance’s efficacy. France and the UK had already taken this interpretation and awarded Gliadel SPCs.

The interpretation of the ECJ is in line with the aim of the SPC Regulation that aims to improve public health by rewarding therapeutic developments. Furthermore, the advocate general stated that if products such as Gliadel, which was the result of extensive and costly research, were denied SPCs it may discourage pharmaceutical companies from investing in developing such innovative products.

EU Court of First Instance case on Tenuate Retard

The German pharmaceutical company Artegodan GmbH is seeking damages for the illegal removal of its anti-obesity

medicine following an ECJ ruling that the product’s removal from the market was illegal. Artegodan is now seeking damages in the region of €1.5 million and wants the Commission to compensate for all future damages that will be incurred as a result of marketing expenses that are needed to re-establish the product’s market position.

Artegodan considers that the removal of this product from the market infringed on its basic right to carry on its business. The company, Artegodan GmbH, was the market authorisation holder in Germany for a slimming pill called Tenuate Retard. Due to public health issues associated with the product and after a review of the product in accordance with article 15a of Council Directive 75/319/EEC, in March 2000 the European Commission ruled that all marketing authorisations for amfepramone-containing products must be revoked. Thus Artegodan was required to take Tenuate Retard off the market. The company challenged this decision in the EU Court of First Instance and the Court found in favour of the pharmaceutical company in November 2002. In July 2003, the decision was upheld by the ECJ, despite an appeal by the Commission.

AVIAN FLU UPDATE

US FDA proposal to prohibit use of antiviral drugs in poultry

The US Food and Drug Administration (FDA) intends to prohibit the ‘extralabel’ use in poultry of two classes of approved human antiviral drugs that are used in the treatment of influenza. Acting FDA Commissioner, Dr Andrew von Eschenbach, commenting on the proposal said that this “action is a preventive measure designed to protect the public health”.

Specifically, the order will prohibit the extralabel use (the actual use or intended use of a drug in an animal in a manner that is not in accordance with the approved labelling) by vets of anti-influenza adamantane (amantadine and rimantadine) and neuraminidase inhibitor (oseltamivir and zanamivir) drugs in chickens, turkeys, and ducks.

Currently, no drugs have been approved for the treatment or prevention of

influenza A in animals. However, two classes of antiviral drugs are approved in the United States for the treatment or prevention of influenza A in humans. Under the Animal Medicinal Drug Use Clarification Act of 1994 (AMDUCA) veterinarians can legally prescribe these human antiviral drugs to protect animals from influenza.

The FDA can, however, prohibit certain extralabel use in animals if such use presents a risk to the public health. Concerns have been raised by a number of public health organisations, including the US Food and Agriculture Organisation, and the World Animal Health Organisation, that the extralabel use of these drugs in poultry could lead to the emergence of resistant strains of type A influenza. The FDA has indicated that it may add other animal species to the prohibited list as new data becomes available. The proposal is now open to comment. The order of prohibition is due to become effective June 20, 2006, unless the FDA revokes or modifies the order, or extends the consultation period.

Further information on the final rule may be obtained by contacting Kim Young at kim.young@fda.hhs.gov

Vaccination plans for poultry in the Netherlands and France

In contrast to the FDA ruling, in February 2006, the Standing Committee on the Food Chain and Animal Health backed Commission proposals to allow France and the Netherlands to carry out targeted preventive vaccination campaigns on poultry, as a precautionary measure against highly pathogenic avian influenza. The vaccination programmes are authorised only for specific birds in specified regions, and will be subject to rigorous surveillance and control requirements.

The Netherlands plan applies to poultry kept as a hobby and to free-range laying hens throughout the whole country. The vaccination will be provided on a voluntary basis, as an alternative to the requirement that these birds be kept indoors.

In France approximately 900,000 ducks and geese which can not easily be put indoors and separated from wild birds in the departments of Landes, Loire-Atlantique and Vendée will be vaccinated.

The European Commission are currently preparing a discussion paper setting out the pros and cons for vaccinating poultry.

A work in progress version of this document is available at http://europa.eu.int/comm/food/animal/diseases/controlmeasures/avian/discussion_paper.pdf

MEPs call for better communication and more research on avian flu

At a meeting on 25 January between the European Parliament's Committee on the Environment, Public Health and Food Safety and Health and Consumer Protection Commissioner, Markos Kyprianou, MEPs called for better communication and more research on avian flu.

Environment Committee, Chairman Karl-Heinz Florenz, stated that the public lacks clear information on how they can actually catch the disease and what safeguards are in place to protect the EU.

MEPs were very keen to hear what measures are being taken at national level to contain any outbreak of the virus and to perform real-time analysis. The Commissioner said "the EU is still the best prepared region in the world but there is still a lot to do, we can't allow complacency." He urged Member States to improve information exchange and keep alert.

He agreed with committee members that research is very important, which is why of the €100 million the European Commission is pledging to support the fight against avian influenza outside the EU, €20 million is committed to research projects.

To those MEPs who asked exactly how the disease could be contracted, and the danger this presents to EU citizens, Mr Kyprianou said that well-cooked meat does not contain the disease and in any case, in the EU, sick birds do not reach the market so "the combination of the two makes it safe." He said that many of the problems had arisen from the handling of raw meat, blood and sick animals. Noting that in one Turkish case, someone preparing the meal became sick but those eating the meal did not fall ill, "If people are educated to follow personal hygiene rules...to wash their hands" risks would be reduced he said.

COUNTRY NEWS

Dutch cabinet approves plan for new institute of pharmaceutical research

On 28 March, the Dutch cabinet approved a plan to establish a new institute for pharmaceutical research. This new institute is intended to be a centre in which industry, hospitals and universities will work together. It is expected that by combining their knowledge, they will be able to achieve better results in the development of new medicines.

According to a press release following the cabinet meeting, the new institute will be in a good position to help stimulate foreign companies to commission more research in Dutch universities. €130 million will be made available by the government over a four-year period. This will be matched by contributions from industry, universities and hospitals.

England to ban smoking from mid-2007

In England, smoking will be banned in all pubs, restaurants, offices and public transport from the summer of 2007. The total ban will include all enclosed public spaces, although private homes, residential care homes, hospitals, prisons and hotel bedrooms would be exempt.

In the original proposal, pubs and clubs that did not serve food and private members' clubs were to be excluded from the ban, but MPs overwhelmingly voted for a complete ban by a margin of 200 votes. Premises that ignore the ban will face a fine of up to £2,500 (€3,650).

Speaking to the BBC, shadow health minister, Andrew Lansley, welcomed the result as "a very important step" and Liberal Democrat health spokesman Steve Webb called the ban "good news for the health and safety of people who work in public places". Cancer Research UK said it was the biggest step forward in public health for half a century.

Elsewhere in the United Kingdom, a total smoking ban came into force on 26 March 2006 in Scotland, while a ban will be introduced in Northern Ireland in April 2007. In May 2005, the Welsh Assembly voted in support of a full ban on smoking, and the Welsh health minister has indicated that he hopes the ban will be implemented in advance of that in England.

An opinion poll conducted by the BBC

in 2004, showed that a ban was favoured by more than two-thirds of respondents. As a result of the ban in England, the government predicts an estimated 600,000 people will give up smoking.

Opponents, including the smokers' rights group Forest and the Tobacco Manufacturers' Association say the ban is an infringement of civil liberties. The former has voiced concerns that people will move onto the street to smoke and that more patio heaters will be installed, which will lead to increased greenhouse gas emissions. Furthermore, if people decide to smoke more at home, there is concern that children will be more exposed to second-hand smoke.

The WHO reports that tobacco is the leading preventable cause of death in the world, with an estimated 4.9 million deaths per year. If current smoking patterns continue, the toll will nearly double by 2020.

The UK now joins a growing number of countries and regions around the world that have already implemented smoking restrictions. Since 1998, several US states and cities including California and New York have restricted smoking in public places. In January 2004, the Netherlands banned smoking in many public places, while Norway imposed a national ban in restaurants, bars and cafes in June 2004.

Partial or total smoking bans in enclosed public places have been implemented in 2004/5 in Ireland, Italy, Malta and Sweden. In Spain, tobacco use fell by 12% in the month after a ban on smoking in public (apart from bars) was implemented in January 2006. Studies in Canada, the US and Australia report that smoke-free bylaws do not adversely affect restaurant and bar sales.

England: Cancer patient wins legal battle for Herceptin

A breast cancer patient should have access to the drug Herceptin (trastuzumab) on the NHS according to a landmark ruling in April by the Court of Appeal in England. The decision overturns an earlier ruling in the High Court when Mr Justice Bean indicated that the refusal of Swindon Primary Care Trust (PCT) to pay for Ann Marie Rogers to use the drug was lawful. Since March 2002, Herceptin has been licensed in the UK for use in women with advanced breast cancer, but in Mrs Rogers' case her cancer was in the early stage.

Herceptin targets the HER2 protein, which can fuel the growth of breast tumours. Around 20–30% of breast cancers are HER2 positive. The manufacturer Roche has applied to the European Medicines Agency for a license for Herceptin to be used in early stage breast cancer, and claims that the drug can halve the risk of the HER2 form of cancer returning.

The Appeal Court ruling does not force local NHS bodies to fund the drug, but it said that it was "irrational to treat one patient but not another". They ruled that the focus should be "what a doctor felt was right for their patient." The three Court of Appeal judges said the ruling would not "open the floodgates" as only women who met the clinical criteria for Herceptin would qualify for the drug. It is estimated that around 5,000 women in England could now benefit, costing the NHS around £100m a year.

The NHS funding process for early stage treatment with Herceptin has been criticised as another example of the "post-code lottery". In England, some health authorities have opted to pay for all eligible applicants, but others have adopted a policy of only funding the drug in "exceptional cases". This had been in line with NHS guidelines.

Previously the high court ruled that the policy adopted by Swindon PCT of funding only early stage treatment in "exceptional cases" was not unlawful because it was not "arbitrary or irrational". Nor was it a breach of article 2 of the European Convention on Human Rights - the right to life, because it was not denying an individual health care that the state had undertaken to make available to the public.

Last year, two women threatened to take their PCTs to court, but both trusts backed down and agreed to supply the drug. The situation is not confined to England alone. In Wales, local health boards have agreed to provide Herceptin to early stage breast cancer patients from March 2006 when prescribed by their clinician subject to agreed parameters. The decision follows the high profile protest of Jayne Sullivan, a cancer patient who staged a week long vigil inside the Welsh Assembly.

The Minister for Health in England, Patricia Hewitt, had previously said that health managers must not use cost as an excuse not to fund the drug, and that

decisions must be taken on a case-by-case basis. Jan Stubbings, chief executive of Swindon PCT, said that they now accept "when considering this case and exceptional circumstances we should have taken costs into account to make our decision more rational. Following this new judgment we will now revisit our policy taking into consideration the points made by the court. In the meantime, it has been agreed that we will continue to provide Herceptin for Mrs Rogers."

Christine Fogg, Joint Chief Executive of the charity Breast Cancer Care, welcomed the ruling saying that "we hope today's judgment will provide greater clarity for patients and primary care trusts ahead of a final licensing decision later in the year. This drug has the potential to benefit many people with early stage breast cancer. Yet we hear daily from patients confused and worried about their possible access to it. Clinicians should be able to feel confident that they can prescribe the treatment their patients could benefit from, wherever and whenever they need it."

The government has promised that once Herceptin is licensed for use by patients with early stage breast cancer, the National Institute for Health and Clinical Excellence will fast-track its appraisal in England to see if the drug is cost-effective.

Further information at

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Cancer/fs/en>

German Federal Administrative Court rules that the state must not inhibit potential treatment success

A recently published Court decision, taken on 19 May 2005, ruled that the German Institute for Medicinal Products and Medical Devices (BfArM) must not generally prevent the use of cannabis in the treatment of patients. The Federal Administrative Court in Leipzig decided that according to the German Act on Narcotics, BfArM can authorise the treatment of patients with cannabis provided that it serves a scientific purpose or is a matter of public concern (Ref.3 C 17/04).

According to the Court, the State violates the basic right for bodily integrity if it hinders a cure for a patient or the alleviation of a disease. The BfArM had

previously assumed that this was not a matter of public concern. However, according to the Federal Administrative Court decision, this official practice is contrary to a previous decision of the German Constitutional Court of January 2000, according to which medical supply is a “matter of public concern”, which in individual cases may justify a self-treatment involving restricted narcotics.

This case involved a 56 year-old lawyer suffering from multiple sclerosis who had been declined a request to use cannabis by BfArM. The Court has now obliged the BfArM to reconsider the claimant’s request according to its own jurisdiction and the jurisdiction of the German Constitutional Court. Nevertheless, according to the Court, such an authorisation to use cannabis issued by the BfArM does not enable physicians to prescribe cannabis. Physicians, however, may accompany and medically advise a patient who uses cannabis as a form of self-treatment.

Ireland: Report on “truly shocking” practice in Drogheda hospital published

A report by Judge Maureen Harding Clarke into peripartum hysterectomy practices at Our Lady of Lourdes Hospital, Drogheda, was published in February. The report was commissioned following the decision of the Irish Medical Council to remove Dr Michael Neary from the Register of Medical Practitioners after finding him guilty of professional misconduct.

The Inquiry examined how the rate of peripartum hysterectomy performed at the Lourdes Hospital in Drogheda over a 25 year period compared with that found in other hospitals in the State. It also looked at how existing monitoring and reporting systems functioned.

The report concluded that the rate of 188 peripartum hysterectomies during the 25 year period was ‘truly shocking’. The rate of caesarean hysterectomies at the hospital were 1 per 37 caesarean sections, compared with 1 per 300 to 1 per 254 elsewhere. No concerns were raised with the Health Board about this until 1998; moreover an unidentified person or persons had undertaken a deliberate, careful and systematic removal of key historical records, together with master cards and patient charts.

The report concluded that the isolation of the unit played a role in the lack of awareness about what constituted good practice and went on to say that any isolated institution which fails to have in place a process of outcome review by peers and benchmark comparators could produce a similar outcome to that which occurred in the Lourdes Hospital.

Responding to the Report, the Tainiste and Minister for Health Mary Harney said “this is a damning report and it is clear from the findings that many lessons need to be learned and changes made to ensure that such events do not happen again in Irish hospitals. The findings and recommendations are being examined in detail by my Department which will consult with the Health Service Executive and the various professional regulatory bodies. The recommendations in the report will act as a significant catalyst in the reform agenda. They confirm the appropriateness of the actions being taken in relation to the preparation of the new Medical Practitioners Bill, the reform of the current consultant contract and the changes in management systems within hospitals.”

The report can be viewed at www.dohc.ie/publications/lourdes.html

Spain: Report reveals persistent discrimination of people with HIV/AIDS

The Ministry of Health and Consumer Affairs in Madrid, has launched a study which reveals that discrimination against people with HIV/AIDS persists in the country.

The research, supported by the Foundation for the Investigation and Prevention of AIDS in Spain (FIPSE), was undertaken at the Carlos III University in Madrid in collaboration with the Spanish Red Cross and various non governmental organisations. It was based on a protocol developed by the Joint United Nations Programme on HIV/AIDS to identify all types of discrimination against people with HIV/AIDS. It is the first time that this specific question has been asked in Spain, and is among the first few studies of this type to be carried out worldwide.

One of the gravest consequences of HIV/AIDS is the discrimination that individuals face within society. This can have an impact on all aspects of daily life and fundamental human rights. This can

be compounded by other forms of discrimination, for instance because of race or sexual orientation. This discrimination can also have a negative impact on the effectiveness of the public health measures to minimise the risk of HIV.

The government have now called on all Spanish citizens to take action against discrimination. A recent survey produced by the National Institute of Statistics in collaboration with the National Plan for Health, reported that one in three Spaniards still will not work or study alongside a person infected with HIV.

The current study sought to identify discriminatory practices in many sectors including health care, employment, criminal justice, housing and education, as well as identify examples of good practice and make recommendations on anti-discrimination measures. A wide ranging review of legislation, rules and internal procedures for both public and private organisations was undertaken. In addition interviews were conducted with members of the public.

The review found that Spanish legislation was not a cause of discrimination, although isolated examples of discrimination were found in rules and internal procedures governing some organisations. There was however much evidence of discrimination in everyday life: for instance the unjustified isolation of people with HIV/AIDS because of ignorance on how the virus is transmitted.

Another example of discrimination is the difficulty that individuals have in obtaining insurance or bank loans. Moreover, while companies are adamant that discrimination in the workplace is not possible, during the interview process an individual may be asked about their health status including whether or not they have HIV.

The Ministry of Health and Consumer Affairs is committed to eradicating the sources of discrimination identified in the report. This will need to be done in partnership with other government departments. Funding will also be transferred in 2006 to the Autonomous Communities to help deal with this issue. Dealing with stigma and discrimination has now also become an identified priority areas for grants to non-governmental bodies.

The government will look at how the

rules and regulations for organisations might be strengthened. It will also see whether measures might be taken to deal with the misperception of the general public that people with HIV/AIDS should be treated as if they have a highly contagious illness. Spain is also active internationally, being one of two Member States (the other is Germany) that are participating in a working group preparing the first European report on human rights and HIV/AIDS.

The full report is available (in Spanish) at www.fipse.es/Informe%20discriminacion.pdf

Sweden: television and child health

Children in Sweden watch slightly less than 10,000 hours of television during their childhood. This is approximately the same amount of time as they spend in compulsory schooling. It is therefore of great importance to analyse what effects television viewing can have on children's health and adjustment. Hence the Swedish National Institute of Public Health has undertaken a systematic review looking at the effect of television consumption on children's health and behaviour. Written by Ann Margret Rydell and Sven Bremberg, the review shows that too much television viewing has clear negative effects, even when controlling for socioeconomic conditions.

Studies analysing the effects of television viewing on child health were identified in five databases indexing scientific literature and 39 publications meeting all inclusion criteria were found. The analyses indicated associations between high television consumption and aggression in children and the incidence of externalised behaviour problems.

In seven out of ten experimental studies increased aggression was noted among children a short time after visual exposure to violence, and in seven out of ten longitudinal studies an increase in the incidence of behaviour problems was seen among children who watched television often after controls were made for confounders. High television consumption would seem to be able to explain 2–4 % of the variation in the population of aggression and of externalised behaviour problems.

The analyses also indicate an association between high television consumption and excess weight among children. One

of two experimental studies indicated a decrease in the incidence of being overweight when television viewing was reduced. In five out of eight longitudinal studies, there was an increased incidence of excess weight observed in children who frequently watched television. High television consumption would seem to explain about 1% of the variation in excess weight in the population.

The study notes that while effects between 1–4 % are of negligible significance for the individual, from a public health perspective these effects are significant since practically all children watch television. The links between high television consumption, regardless of content, and the incidence of mental health problems and school achievement were inconclusive. Children's school achievement seems to be positively affected by watching programmes with an informative content and negatively affected by entertainment programmes.

The authors conclude that it is desirable that parents and teachers discuss the associations reported in the report and consider developing guidelines on both the amount of time that children spend in front of the television and the programmes that they should watch.

The full report can be freely downloaded at www.fhi.se/upload/ar2006/Rapporter/r20062Televisionconsumption0602.pdf

Spain: Creation of new registry for biological tissues

In February 2006, the Council of Ministers adopted a Royal Decree on requirements relating to the import and export of biological tissues. A voluntary registry - the Registry of Importers and Exporters of Biological Tissues - has been established. This will now allow the continued import or export of biological tissues without a specific individual permit being required.

Importers and exporters of biological tissues can now join the voluntary registry so long as they engage in import or export once per quarter. Registration is valid for five years and documentation must be renewed when there is a change in the type of biological tissue used.

By joining the registry, importers will no longer be obliged to present a certificate of origin to the local health authorities, and exporters will automatically

obtain a certificate that details the type of product and time period during which it may be used for medical procedures. They can continue to use the express authorisation procedure for each import or export that they arrange

The Royal Decree defines biological tissues as any human material or any other substance used in diagnosis or research on human beings, including infectious substances. The registry does not cover health care products, products for in-vitro diagnosis, cosmetics, embryos, umbilical cord blood, organs for transplants or raw materials required for the manufacture of medicines. This registry has been created in response to the continued increase in the import and export of biological tissues in Spain and their significance for research, analysis and diagnosis.

The full text of the decree (in Spanish) is available at www.agpd.es/upload/Canal_Documentacion/legislacion/Normativa_Estatal_Conexa/Real%20Decreto%2065-2006.pdf

Italy: Competition Authority recommends review of regulations on the sale of medicines

In February 2006, the Italian Competition Authority recommended a review of the regulations on the sale of pharmaceuticals in Italy due to their distorting effects on competition.

The Authority deems that a specific law (Article 8, Law 362/1991) presents an obstacle to competition and constitutes an unnecessary and disproportionate instrument to the objective of health protection. According to this law, there is some conflict between activities related to the production, distribution and provision of scientific information on medicines and the ownership of a pharmacy.

The Authority wishes to eliminate current rules that only allow qualified pharmacists through partnership companies (società di persone), and limited liability cooperatives (which managed pharmacies before 1991) to own private pharmacies. Also, they hope that the elimination of this conflict would lead to improvements in the market for pharmaceuticals, including improved economies of scale, the reduction of distribution costs and the greater application of discounts, which could lead to a reduction in some pharmaceutical prices for consumers.

The Authority believes that the abolition of such limitations would allow new players to operate in the pharmaceutical market and eliminate an “unjustified” monopolistic position. But they agree that health protection should be maintained by requiring that a qualified pharmacist should dispense medicines and a registered pharmacist should be the director of a pharmacy.

The Authority is also urging the Italian Government to modify the rules on the ownership of pharmacies, particularly in the light of recent EC action asking Italy to review the regulations on the incompatibility between wholesaling and retailing activities for medications and the ownership of private pharmacies.

More information available at www.agcm.it/eng/index.htm

Czech Republic: Plans for extra funding may lead to increased health insurance contributions

In January, speaking on Czech television, the Czech Minister for Health stated his intention to increase funding for health care within four years from 7% to 9% of GDP. According to the Health Policy Institute in Bratislava, Slovakia, this would bring an extra 203 billion Czech crowns into the health system.

One consequence, however, may be that health insurance contributions would have to increase from 13.5% to 19.4%. This, the Health Policy Institute argue, may have a major destabilising effect on the public finances and may directly threaten the creation of jobs and national competitiveness. The Institute also argue that increased funding will lead to better performance of the health care system as it would lead to an increase in physician salaries.

The full article and further information can be accessed at www.hpi.sk/attachments/IntoBalance_02-2006_EN.pdf

Czech Republic: Civil society organisations throughout Europe urge government follow-up of report on coercive sterilisation

None of the measures proposed in the groundbreaking report by the Czech Public Defender of Rights (Ombudsman) on coercive sterilisation practices have been implemented, months after its publication in December 2005.

Following the publication of the English

translation of the report, the civil society organisations: The European Roma Rights Centre (ERRC), The League of Human Rights, Life Together and the European Association for the Defence of Human Rights (AEDH) have urged the Government of the Czech Republic to act without delay to implement the proposed measures.

Moreover, in light of the historic resolution on the Roma passed by the European Parliament in April of last year, these organisations also call for debate at a European level, in order to raise awareness of the issues of informed consent and coercive sterilisation of Romani women.

The report, *Final Statement of the Public Defender of Rights in the Matter of Sterilisation Performed in Contravention of the Law and Proposed Remedial Measures*, is the result of more than a year of research by the Ombudsman and his staff, on the basis of complaints brought by women coercively sterilised by Czech doctors. The overwhelming majority of the victims are Romani.

During the course of his research, the Ombudsman filed a number of criminal complaints in connection with cases brought to his attention. The report concluded that “The Public Defender of Rights believes that the problem of sexual sterilisation carried out in the Czech Republic, either with improper motivation or illegally, exists, and that Czech society stands before the task of coming to terms with this fact.”

The report brings detailed recommendations to Czech law- and policy-makers, as well as to other stakeholders, aimed at bringing about systemic changes in this area, as well as bringing just remedy to the victims. Among other recommendations, a compensation mechanism is proposed for certain categories of victims. The Czech government has not as yet stated how it intends to respond to the report.

Civil society organisations have called on the government to issue a public apology to the victims of this practice. Furthermore, they call for the Czech Legislature to act without delay to adopt the legislative changes necessary to establish the criteria for informed consent, in the context of sterilisation set out in the recommendations of the Ombudsman.

A compensation mechanism should be established as well as a fund to assist victims in bringing claims under the compensation mechanism or, where relevant, before courts of law, such that all victims of coercive sterilisation practices have access to justice. Such a fund should be able to: (i) provide compensatory damages to victims, in such cases where the mechanism established pursuant to the Ombudsman Report may not be able to; (ii) support the work of advocates in bringing claims to court; (iii) where relevant, ensure payment of court fees and other relevant costs arising in the course of establishing coercive sterilisation claims before courts of law and/or other instances.

The organisations also called on the Czech Ministry of Foreign Affairs to raise with the Slovak Government the issue of compensation for persons who are currently Czech citizens but who were coercively sterilised in the Slovak Republic.

The full text of the Ombudsman’s report is available at: www.ochrance.cz/en/dokumenty/dokument.php?doc=400

Comparison of the top 100 most costly drugs in Slovakia and the Czech Republic

The expenditure by health insurance companies on drugs between July 2004 and June 2005 were used to compile a list of the top 100 mostly costly drugs in the two countries.

Prices and fees used in both countries as of 1 January 2006 were used. In total, the 100 most costly drugs accounted for 50.9% of the costs of insurance companies spent on drugs in Slovakia. According to study author, Angelika Szalayova, a board member of the Health Policy Institute in Bratislava, 42% of these drugs are more favourable from the viewpoint of the insurance company in Slovakia, while the prices of 62% of these drugs were lower in Slovakia compared with the Czech Republic.

For antibiotics, which are rarely fully covered in Slovakia unlike the Czech Republic, both prices and co-payments are much lower, in some cases by as much as one half. For drugs where no generic alternative was available, up to 82% had a higher co-payment in Slovakia than in the Czech Republic. The opposite was the case where

generics were available; only 41% had a higher co-payment in Slovakia.

If co-payments for individual groups were set at the lower of current levels of payments for the Standard Drug Dose in both countries then the Slovak system would reduce its costs by SK (Slovakian Crowns) 1.4 billion per annum (11.2% of costs to insurance companies for the top 100 drugs). Equally in the Czech Republic this could lead to savings of SK 1.2 billion.

More information on the report can be found at www.hpi.sk/attachments/IntoBalance_02-2006_EN.pdf

Albania: World Bank to support modernisation of health system

On 14 March the World Bank approved a credit of US\$15.4 million to Albania to help finance the Health System Modernisation Project in Albania. The project will help the government improve both physical and financial access to health services with an emphasis on the poor and those in rural and remote areas. The total cost of the Project is estimated at US\$19.1 million and will be co-financed by the Government of Japan (US\$1.6 million) and the Government of Albania (US\$2.1 million).

The quality of health care in Albania is low compared with other countries in south east Europe, particularly at the primary care level. Physical and human resources in the health sector need to be aligned with the population's health needs. Productivity in this sector is low and the efficiency of resource use can be improved.

The public sector contribution to health care is small, so low-income groups are not well protected and are easily thrown into poverty as a result of out-of-pocket spending. Further, there is large contribution evasion in the health insurance, which decreases the number of those who benefit from the coverage.

The Health System Modernisation Project aims to tackle all these deficiencies by introducing fundamental and systemic changes in the way health care is financed, delivered, and organised. These changes will require a gradual introduction, careful preparation and capacity building of health care providers, Health Insurance Institute, and Ministry of Health to ensure that they are ready to assume their increased

responsibilities.

The project includes the following components: (i) strengthening health sector stewardship, financing, and purchasing; (ii) improving primary health care service delivery; and (iii) strengthening hospital governance and management. It will build on the work done by other development partners, including USAID, WHO and SDC, and will involve those partners in project implementation.

By the time the project is completed, it is expected that at least 70% of the population will be enrolled with a primary health care provider as their source of health care, and hospitals will perform better, using new governance approaches. The Health System Modernisation Project has a maturity of 20 years, including a ten-year grace period. Since Albania joined the World Bank in 1991, Bank commitments to the country total approximately US\$808 million for 58 operations.

For more information about the World Bank's work in Albania see www.worldbank.org.al

Wales: Report published on NHS finances

Short term financial pressures are preventing the NHS in Wales from resolving longer-standing deficits and the situation is likely to get worse this financial year, the Auditor General for Wales, Jeremy Colman claims in a new report published in April.

Is the NHS in Wales Managing Within its Available Resources? found that NHS trusts, local health boards and Health Commission Wales met their financial targets during 2004/2005, but a number had received additional funding – cumulatively some £82 million at the end of that year – with some £55 million repayable by 2009. Most NHS trusts were forecasting that they would not break even in 2005/2006 and were expecting to be some £26 million over-spent by the end of the financial year.

The report concludes that if the underlying reasons for the financial difficulties are not managed successfully then the situation will get worse for the NHS in 2006/2007. This is because some trusts and local health boards will have to start making repayments which will place an additional pressure on organisations with underlying deficits.

Among his recommendations, the Auditor General called for an all-Wales analysis of the quality and effectiveness of NHS performance and financial management. Commenting on the report, he said “while the exercise of financial control has improved, there is a worrying downward trend in the financial position of the NHS in Wales. Recovery plans must be realistic with effective reporting procedures. It must be quite clear where responsibilities for action lie and who is accountable for delivery. Most of all, the underlying reasons for the deficit must be addressed.”

The report can be accessed at www.wales.nhs.uk/documents/NHS_finances_english.pdf

Austria: First European Conference on Injury Prevention and Safety Promotion

Injuries are one of the leading causes of death and permanent disability in Europe. The risk of death and severe injury is particularly high in such diverse settings as in the home, at school, on the road, at the workplace and in the local community. Furthermore, the burden of injury is unequally distributed across the region. Within countries there are also marked differences, with economically and socially vulnerable groups being at greater risk.

However, there are effective measures to reduce the risk of serious injuries and to lower the high costs to society. This conference, which takes place in Vienna from 25 to 27 June under the auspices of the Austrian presidency, will be the starting point for the implementation of the EU strategy “Measures for a Safe Europe” and the current recommendations of the European Regional Assembly of the World Health Organization on the prevention of injuries.

Its main objectives include making the injury issue visible both on the European public health and consumer protection agenda, as well as in related policy domains, by profiling the impact of injuries on society and the substantial benefits to be gained through their reduction. Evidence on good practice and successful safety promotion programmes will also be highlighted.

More information available at www.eurosafe.eu.com/csi/eurosafe.nsf/events

News in Brief

What is the evidence that school health promotion improves health or prevents disease?

A new report from the Health Evidence Network, written by Sarah Stewart-Brown from the University of Warwick, UK, shows that health promotion in schools can improve children's health and well-being. Among the most effective programmes are those that promote mental health, healthy eating and physical activity. Programmes to prevent substance abuse have not been shown to be effective and may be better addressed in a more holistic programme that promotes mental health. Programmes on preventing suicide can reduce suicide potential, but potential harmful effects in young males should be considered. However, there is a lack of evidence on all the elements that contribute to an effective health promotion programme, or to the health promoting schools approach as a whole. A holistic evaluation of programmes in local settings is needed.

The review can be downloaded at www.who.dk/HEN/Syntheses/health-promotion_schools/20060224_7

In the driver's seat?

A new publication from the European Observatory on Health Systems and Policies, edited by Richard Saltman, Ana Rico and Wienke Boerma, examines reforms in primary care across Europe. It also looks at their impacts on the broader coordination mechanisms within European health care systems and provides suggestions for effective strategies for future improvement in health care system reform.

Further information and on-line access to the book can be found at www.euro.who.int/observatory/Publications/20060117_1

Report on unhealthy food marketing to children

An ongoing investigation by the UK Consumers Association magazine *Which?* reports that techniques used to market foods high in sugar, salt and fat to children are increasingly sophisticated. More than 40 different marketing methods used to encourage

children to eat unhealthy foods, ranging from product placement in films to text (or SMS) marketing.

More at www.which.net/campaigns/food/kidsfood/060131childcatchers_rep.pdf

Ireland: On-line access to public health information

As an all-island body committed to tackling inequalities in health, at an event in Armagh in January the Institute of Public Health in Ireland launched an online version of two key public health information resources on the island. The online version brings together tables of information published annually by the Chief Medical Officer and the four Health Board Directors of Public Health in Northern Ireland, and tables of information produced annually by the Department of Health and Children in the Republic of Ireland. The tables are also included in the Population Health Intelligence System (PHIS Online) website being developed by the Institute. They contain a wide range of public health information such as rates of mortality, fertility, congenital abnormalities, and population growth in Northern Ireland and the Republic of Ireland.

More information at www.publichealth.ie/ or www.inispbo.org/

Growing threat of counterfeit medicines

Counterfeit medicines pose an ever-greater threat to public health in Europe today. In an effort to adequately measure the scope of the phenomenon and reduce the inherent risks, the Council of Europe has commissioned a survey on issues related to this particularly disquieting form of fraud. The many issues the report covers include the current and estimated market and trade matters; the status of pharmaceutical regulation; national and international cooperation between authorities, the industry and wholesalers; detection systems and procedures; the adequacy of legal, judicial and administrative systems and professional training in the matter. It also sets out to define counterfeit medicine and pharmaceutical crime.

More at <http://book.coe.int/EN/index.php?PAGEID=15&lang=EN&idactu=150>

The international brokering of health care professionals

The global health care profession employs an estimated 100 million people, but is not attracting enough new recruits in both developed and developing countries alike. So fierce is the competition to secure scarce health care professionals, that private recruitment agencies stage promotional events and aggressive recruitment campaigns in supplying countries. A recent International Labour Organization study examines these shortages of health care professionals and the role played by private recruitment agencies in the flows of international migration.

More at www.ilo.org/public/english/bureau/inf/features/06/nurses.htm

ENMESH Conference 2006

ENMESH is a network of active researchers in the field of mental health service research and evaluation. It was established in 1991 and aims to promote the development of study designs, research instruments, and outcome indicators (including cost measurements). The 7th ENMESH conference will take place in Lund, Sweden from 9–11 June 2006. Themes of the conference include: mental illness; occupation and rehabilitation; attitudes towards mental illness and issues of comorbidity; and the implementation of evidence based services.

More information available at http://portal.omv.lu.se/Portal/forskning/research_areas/04_area/0401_area/conferences/enmesh2006

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