

Eurohealth

RESEARCH • DEBATE • POLICY • NEWS

Volume 12 Number 2, 2006



Learning from
the past?
Choice in
health care

Health insurance reform in the Netherlands

Evolution of the Italian health care system

Alcohol in Europe: health, social and economic impact

Water contamination • Survey methods • Global health policy • Fertility in Russia
Protecting trial volunteers in France • Children's lifestyles in Europe

COMMENTARY

Learning from the past, preparing for the future

There are some who say that there are only seven truly original storylines. The same might be said of health system reforms; most are constantly revamped and recycled. Here, Walter Holland argues that we forget the past at our peril. Choice for instance, he contends, was for many years a major feature of the English NHS. He questions whether it is cost-effective to invest in a “minor correction to the problems of a health service market, to regain what existed in the past.” Marianna Fotaki in her response, agrees that the past is important, but should not be dwelt upon. Instead, there is a need to move beyond conventional health policy analysis to enhance understanding of how reform can work.

In our health policy section, Bartholomé and Maarse provide early thoughts on major recent reforms in the Dutch health insurance system. Giannoni meanwhile, draws on the past to outline challenges in safeguarding the core principles of universality and equity of access in the Italian NHS in the face of continuing fiscal and administrative decentralisation.

The impact on health across all policies is one theme of the current Finnish Presidency. It is nicely illustrated by public health articles here. Anderson and Baumberg conservatively estimate that the annual health, social and economic costs of alcohol in Europe are €125 billion or €650 per household. More than half these costs occur outside the health system and require multi-sector solutions. Leonardi focuses on the growing threat to the water supply because of contamination from industrial pollutants. He calls for solutions that consider both ecosystem protection and economic growth.

‘Snapshots’ written by European journalists are a new feature. Jean-Pierre Langellier, from *Le Monde*, highlights developments in clinical trial recruitment in France, while Kirill Anurov from *Novosti*, reports on measures announced by the Kremlin to address Russia’s dwindling birth rate. We will also cover global health issues in more depth in a series of articles brought together by John Wyn Owen. Here he sets the scene for this series and calls for a European Global Health Strategy. Again this is an area where Europe can have much to offer by learning from its past.

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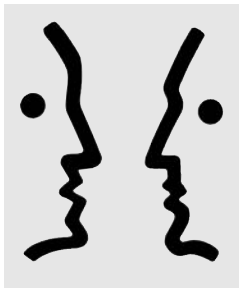
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Choice in health care: Old wine in new bottles?

Walter
Holland

Marianna Fotaki¹ discusses and describes methods whereby individuals can exercise

choice in health care provision. She states that this is a new measure and that before 1990, choice of specialist care “was needs-based and determined by the patient’s GP, with the exception of privately purchased services”. The government also believes that the introduction of choice polices in the UK is something new.²

These views ignore the past. The mantra of ‘choice’ in health services has become an icon and suggests that the practice and values of the supermarket reign.

Although there is an enormous increase in the availability of information on many issues, including medical care, few commentators, or policy analysts, have attempted to analyse either the consequences of choice in health service treatment, its possibilities or its limits. No one questions that, as a general proposition, being able to exercise choice is a ‘good thing’ – but few really examine the issue in depth. In health care nowadays, one mainly considers choice in which hospital or provider should be consulted or provide care. Few really appreciate the

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importance of choice by the patient in the treatment undergone or selected. It is worth understanding how the present system, and problems, have arisen.

Until about the middle of the 20th century physicians had few effective agents available that would influence the natural history of most conditions; digitalis and morphia were exceptions to this. The physician could make a diagnosis, predict a possible outcome, provide a palliative medicine, for example, cough suppressant or advise surgical intervention. The surgeon was able to provide a form of treat-

"The government believes that the introduction of choice is something new. This ignores the past."

ment that would ‘cure’ – for example, appendectomy for acute appendicitis, or ‘cutting for the stone’ to relieve renal colic. The advent of chemo-therapeutic and antibiotic agents completely altered the possibilities for the physician as well as the surgeon; anaesthetic advances increased surgical capacity to alleviate pain and cure. It is not my intention to provide a history of advances in medicine – but to consider how choice can, and has been exercised in medicine.

Choice before the NHS

Before the NHS was introduced in 1948, the employed population received general practitioner (GP) care from their Panel Doctor, who was paid for this by National Insurance. The rest of the population, including the wives and children

of the insured worker, had to pay for GP care. The insured could choose their Panel Doctor from a list, the others, of course, could choose freely. Cronin, in *The Citadel*, gives, probably the best account of medical care in the 1930s.³

There were two types of hospital at this time. About half were Local Authority (LA) hospitals (previously the Work Houses) and half Voluntary Hospitals and charitable foundations. In the middle of the 19th century the BMA, (or its equivalent representing general practice) had come to an agreement with the Voluntary Hospitals that they would only see patients in their out-patients department, if referred by a GP. LA hospitals rarely had out-patient departments. Thus arose the UK practice that a patient could only see a specialist if referred by a GP. There were, of course, casualty departments in the Voluntary Hospitals (which were mainly in urban areas). These were used in emergencies and to avoid payment for a GP.

The consultants (specialists) in Voluntary Hospitals, in contrast to those in LA hospitals, were not paid a salary. They received a token ‘retainer’ of, at most, £50 per annum. The consultants in voluntary hospitals were usually considered (by themselves) of a higher grade than those in LA hospitals. All Teaching Hospitals were Voluntary Hospitals. The consultants in the Voluntary Hospitals depended for their income on referrals of patients by a GP. Thus they took care to develop friendly relations with their students, most of whom would become GPs, and on whom they would depend for income. Thus a series of friendly relationships were established and this is what largely influenced the referral pattern to hospital.

Post 1948

In 1948, with the introduction of the NHS, all doctors were paid and thus the

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dependence of consultants on GPs vanished. The habits of old, in the referral of patients from general practice to hospital-based care persisted, to some extent. One of the most important consequences, following the introduction of the NHS, was the spread of specialist services to the country as a whole by the creation of District General Hospitals.

GPs, in their role as primary contact, not only had to diagnose and treat minor illnesses, but also refer patients for further treatment or diagnosis to specialist care. There are many studies of the referral to hospital by GPs, for example, a study by Morrell and his colleagues.⁴ They had complete freedom of choice of hospital care. In general, most chose a nearby institution, but not necessarily. For example in a study of the population of North Lambeth,⁵ 62% used the local St. Thomas' group, while 14% used four other local hospitals: Westminster, Guy's, King's College and the South London Hospital for Women and Children. The remaining 24% used another 93 hospitals. In a study⁶ in a more rural area, Farnham-Frimley, 66.5% of referrals were to the local Farnham group, 14% to other south west Metropolitan hospitals, 9% to the Oxford Group and 11% to other hospitals. The major concern, at that time, was that the Teaching Hospitals were 'cherry picking' the 'interesting' patients; this concern was subsequently shown to be unwarranted.^{7,8}

The recent past

In recent years the relationship between a doctor and patient has changed. There is now far more communication and discussion so that a patient has become involved in the choice of treatment. This entails a great deal of effort by both sides. The relationship is, however, still unbalanced. The doctor usually has the benefit of professional knowledge, crucial in the provision of advice on treatment and referral. The doctor also often has knowledge of the competence and quality of the specialists to whom referral is made.

Patients have always been involved in the choice of referral (as well as in the choice of treatment). Observational, qualitative studies in Lambeth of the interaction between the GP and patient indicated that the patient was far more likely to be definite about which surgeon they wished to be operated by; local folklore was a potent source of knowledge. They

were far more likely to abide by the GP's advice on which physician to go to. It was not until the introduction of the health service reforms in the 1990s that freedom of choice of specialist became constrained. Now, with our government's emphasis on choice, this will continue to be restricted – there may be a choice between provider institutions but GPs and patients will not be able to choose the individual consultant surgeon or physician. Although there may be some differences in the cleanliness of institution, or time taken to be seen, the variation in the quality of individual consultants and their team is likely to be more important in the care that the individual patient receives.

Patient choice, in England, has only been considered as a new concept since the introduction of the 'market reforms'. It is not clear that the political emphasis on choice has been examined critically. There is some variation in referral patterns between individual GPs and in different parts of the country. Furthermore, there is some variation in requests for referral between individuals coming from different social/ethnic groups. Although choice, in abstract, is to be welcomed, exercising choice of place of advice, investigation or intervention is often constrained by cultural, social, geographic, or quality factors.

Choice restricted to an institution may mean that individuals go to modern looking buildings with poor services, or may be constrained by distance, for example, in a Norfolk village the choice may be between Norwich (15 kilometres), King's Lynn (65 kilometres) or Bury St. Edmunds (95 kilometres). It is unfortunate that politicians have seized on this issue without adequate consideration of what it actually can contribute to the improvement of the quality and quantity of health services. Providing computer programmes for GPs is relatively easy – and it is obviously a relatively cheap trick. But whether it provides a cost-effective solution to health service improvements is doubtful. It is only a minor correction to the problems of a health service market, to regain what existed in the past.

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Marianna
Fotaki

Walter Holland mistakenly argues that in my paper 'Patient Choice and

Empowerment – what does it take to make it real?'¹ I present patient choice as a new policy objective. In fact, I discuss the evidence on what, in my view, was an unsuccessful attempt at introducing greater patient choice as part of the quasi market reforms in the UK in the early 1990s, to demonstrate the exact opposite. One of my key arguments, which Walter echoes in his argument, is that these quasi-market reforms, instead of improving actually reduced patient choice. One of a number of reasons for this was the reduction in the number of specialist providers that GPs would refer patients on to because of the limiting effect of cross-boundary flows via Extra-Contractual Referrals.²

I also argued, that by looking at similar experience from quasi-markets in the UK and various public competition models that were phased into several counties in Sweden in the early 1990s, we realise that the lessons of these reforms have been only superficially, if at all, taken account of in the current policy approach in England. Like Walter, I also make the case that the present patient choice debate

is more about rhetorical pronouncements and presumptions about the needs of service user rather than about substance. This is because the concept of choice is expected to fulfil several mutually conflicting policy goals of equity or universality.³ As one recent scoping review indicated, it is uncertain whether choice and competition can improve either efficiency or quality of service provision for the majority of those using the NHS.⁴

The real question then is what are the reasons for this policy recycling and 're-invention', despite its rather limited success in the recent past in the UK and elsewhere? Some analysts have concluded that more market-type reforms are needed for choice to produce its expected benefits⁵ while others have proposed that the shift to 'choice' reflects the changing values of increasingly business minded and individualistic constituencies.^{6,7} Regardless of his interesting historical review of the use of patient choice, Walter in his article here does not, however, offer any plausible answer to this question by arguing that current reforms "are only a minor correction to the problems of the health service market, to regain what existed in the past".

Neither nostalgic nor euphoric analyses will enhance our understanding of how policy works and what are the drivers behind policy makers' decisions. Multi-disciplinary theoretical frameworks and non-conventional insights from disciplines other than political science and economics might perhaps be needed to illuminate these dynamics. This is a pressing issue, as irrespective of whether patient choice policy succeeds or fails, it will have a lasting impact on how health care will be provided and who will mostly benefit from the changes still to come.

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Walter
Holland

There is a difference in comprehension between Marianna Fotaki and me. In her

original article she states "individual patient choice is currently being launched as a new and ground breaking idea in the English NHS" – certainly she describes a number of caveats in the market-oriented system of the 1990s but fails to put these policies into perspective as to what went on before.

It is difficult for a practitioner to argue with theoreticians, we can only quote anecdotal evidence or evidence from empirical surveys designed for other purposes. It is crucial for academic workers in health policy to have some knowledge of what happens in practice – reality is often far from theory, and most of us who have actually delivered a service are aware how centrally imposed policies can and are subverted.

As Marianna states far too little research has been done on how health policies are devised, implemented or evaluated. As one who, in the past, was involved in the development of some health policies, I am well aware of the possible contributions of theory, research, practice and personal beliefs in policy formulation. Thus I do not consider that analysis of "frameworks or insights" will be of great value – nor do I consider offering solutions – I believe it is far more important to state clear objectives for health policy development in terms of desired outcomes and then evaluate what achievements have been made – and modify them as necessary.

Marianna
Fotaki

It is always a daunting task for an academic who is also a former practitioner (medical

and senior policy adviser) to demonstrate the fence on which s/he sits. A social psychologist and an influential teacher of management change Kurt Lewin, said that there is nothing so challenging as a practical problem. He also said that there is nothing so practical as a good theory.¹ The divide in the social sciences between theory and practice is in my view artificial. The applicability and capacity of both to make the world more comprehensible and meaningful is their *raison d'être*. I have argued for this integration of theory and evidence from a wide range of social disciplines, not only economics and political science, but also for example, from the perspective of clinical psychology and management theory. Often prevailing policy analyses take insufficient account of these other factors that shape policy, nor do they consider how they impact on health care organisations and users of services alike.

My aim was not either, to make a case for, or against, the introduction of individual choice into publicly financed and provided health care systems. It was rather to offer a critique of the ways that complex and diffuse concepts such as choice are translated into rhetorical policy pronouncements, despite the existing evidence of their limited success as demonstrated in the market oriented reforms of the 1990s, and without taking into account complexities involved in policy implementation. Despite Walter's arguments to the contrary, I think I have made it clear that current patient choice policy is being 're-discovered' and 'invented' afresh as if it operates in an a-historical vacuum.

What I think unites practitioners turned academics like myself, is their desire to bring together disparate bodies of literature to make sense of their experience, and to improve the understanding of how policies operate in reality, rather than how they should work according to normative assumptions or any preconceptions.

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A new programme to boost fertility in Russia

Kirill Anurov

Russia's population has been on the decline for over a decade, now decreasing at a rate of 700,000 per annum.¹ Having peaked in 1992, at 148.7 million, it has now fallen to just over 142 million.² If the current trend is not successfully reversed, some analysts predict that there may be only 1% of the global population (100 million people) scattered across the world's largest country by 2050.³ Inward migration flows have so far helped to prevent the figures from plummeting; however, fertility and mortality are the core issues, as reiterated by the Kremlin's recently announced plan attempting to restore the population to its pre-1990s level.

This decline in the Russian population can be attributed to many factors: a low fertility rate (1.3 per 1,000) where only 3% of families have at least three children; a reduction in the health of newly born children (in 2004, 40% of newborns had health problems);⁴ and the increasing rate of premature mortality. Average life expectancy among men is now just 59 years.

The government is aware of the situation, and has been considering how to address this challenge for several years. This, in particular, has been in the context of pension reform, since the Russian population like that in most other European countries is ageing. The situation is now perceived as a national threat. President Vladimir Putin in his annual address to the nation in May 2006 acknowledged in respect of the declining population that "we have raised this issue on many occasions but have for the most part done very little to address it."¹

Subsequently, at the June session of the National Security Council it was agreed

that a step-by-step ten year programme must be drafted and included into the state budget no later than September 2006. Opening the session of the Security Council, President Putin remarked, "in fact, we are standing now at a critical point... In the last 13 years the number of deaths has exceeded births by 11.2 million. If nothing is done about it, by the end of the century the population will have halved".⁴

So far, numerous ideas have been floated along the corridors of the Presidential and government offices; however, it is not yet what shape the new programme will take. The rise of health problems on one hand, including cardiovascular and circulatory diseases, cancer, alcoholism, the epidemic of HIV/AIDS, and TB (still not fully under control) as well as the threats to health on the other, such as the prevailing low quality of life and thus fewer incentives to have children, and road traffic accidents which claim between 35,000–40,000 lives per year, to name but a few, have been key concerns for society. These will also have some influence on the programme.

A national programme for demographic change

What is clear however is that this first ten year national programme on demographic change, proposed by the Kremlin, is expected to come into operation in 2007. While it will probably include more funds to support better health care and streamline migration policy, the novelty lies in the direct approach it is likely to take to boost the 'image of the family' as well as increasing the fertility rate. The proposed programme will provide direct economic incentives intended to persuade Russians to have more children. These include:

- Receipt of a maternity bond or 'basic maternity capital' of at least £5,000. The money will be paid to mothers having a second child, born after 1

January 2007. Payments will be made from 2010 onwards. This bond can be used towards the costs of mortgage payments, tuition fees or invested in pension schemes.

- Increased monthly childcare allowance for the first child (up to £30) and the second-born (up to £60)
- Guaranteed 40% of usual salary for a period of up to 18 months if mothers take time off work
- Increased cash certificates for pregnant women (varying between £40 and £140)
- Partial subsidy of the cost of school meals: 20% for the first child, 50% for the second and 70% for the third.

In addition, as promised by the First Deputy Prime Minister, Dmitry Medvedev, other measures include more effective preventive measures against heart and infectious diseases, better training for emergency physicians, and the creation of a working group on migration control.

Potential impact of programme

The question remains as to whether this policy to increase the birth rate will in fact be enough to reverse the steady population decline. However despite the potential benefits that the new policy may provide, there are already concerns. The most pressing issue is how effective the cash incentive will be, and how this may affect society.

At present, high prices for oil are providing an unanticipated windfall for the state, but if the oil price falls, the burden of increased expenditure for these cash payments may be too much for the government. If sufficient funds are accumulated by the time the policy takes effect (as cash payments will only be made from 2010), then some increase in the birth rate might be expected. Poorer families may appreciate the cash benefit

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at first, but will a focus largely on one-off payment be sufficient to maintain higher fertility rates in the future?

In general, Russians have the same attitudes as seen elsewhere in Europe, desiring no more than one or two children. The new policy may encourage some parents to have a second child earlier than planned, before the period in which the maternity bond can be claimed ends (if the government's promise does indeed last until 2010). It is doubtful however if this incentive scheme will convince them to have further children. One can hardly expect that within the lifespan of the new programme that the fertility rate would increase from the current level of 1.3 to beyond the replacement rate of 2.1. In practice this is likely to mean a short term surge in births, after which the trend in births may revert back to its current rate.⁵

The other major point to consider is that a one-off financial incentive of £5,000 may not be enough to change the quality of life for a family. This sum may provide an insufficient level of compensation for

some parents to become more confident in planning their lives and the future of their children. Moreover, by knowing that more money will be distributed to each family, producers and the retail industry may raise prices for consumers.

For now, migration might remain the only potentially successful instrument of demographic policy, but again, this also deserves a fresh look by the government. It has been observed that migrants do not necessarily assimilate completely into the melting pot of society, but rather can evolve into independent communities, which seem reluctant to fully integrate within the country. In any attempt to change attitudes towards family planning in Russia, attention will also need to be placed on providing guarantees to improve quality of life. These might include raising the quality of health care and ensuring access to affordable housing.

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Protecting trial volunteers: New regulations on biomedical research in France

Jean-Pierre Langellier

France has adopted the most protective regulations in Europe for volunteers taking part in biomedical research, including clinical drugs trials. Strict rules following legislation passed in August 2004 will come into force before the end of August 2006.

For almost 20 years, France has led the way in this field. In 1988, an innovative law, *loi Huriet*, set out procedures governing biomedical research and the protection of volunteers.¹ For example, anyone participating in a clinical trial had to sign a consent form after being told

about any risks involved, and what known side-effects might occur. All trials were required to seek the advice of an ethics committee. These strict rules were also the inspiration for a European Directive, adopted in 2001.²

The new law reinforces protection for volunteers and improves the organisation of clinical trials in two ways. First, ethical committees will now not only have to provide advice, but also explicitly approve trial protocols. Similarly, approval is also required from health and safety agencies. Previously, the absence of an official response from these bodies could be interpreted as an implicit green light to go ahead. Now, no research can be conducted without the explicit autho-

risation of these bodies. In practice, there are about 40 ethics committees, known as *Comité de protection des personnes* (CPP). Their members are researchers, doctors, pharmacists, nurses, psychologists, experts in law and bioethics, and patient association representatives. The number of committees will be reduced and their role will be more 'professional'.

Even more important is the second innovation. The new legislation will not be limited to drug trials. It will be implemented in all fields covered by biomedical research: physiology, genetics, psychology, surgery, cosmetic testing and the storage of biological materials such as organs, tissues, labile blood products, and gene and cell therapy products. France is

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the only country in the EU which has transposed in an extensive way the European Directive, in accordance with its *loi Huriet*, which was already implemented in all fields of biomedical research.

The diversity and the complexity of this transposition explain why France had been slow in preparing the new legal system texts. "Now, our country is up to date, with regard to drug trials. And it is still ahead in Europe for biomedical research on the whole", explains Chantal Belorgey, from the AFSSPS (*Agence Française de Sécurité Sanitaire des Produits de Santé*), the body ultimately responsible for regulating and authorising clinical drug trials.³

Payments to volunteers

The new regulations contain two other safeguards concerning another controversial issue: money. The overwhelming majority of volunteers taking part in the trials enrol because of the fees that they can receive. These payments are the norm, but are not a necessity. According to the law, these payments cannot exceed a maximum ceiling of €4,500 in any one year. The aim is simply to compensate volunteers for the time they take out of their lives to participate in trials, rather than being seen to offer any inducement.

This concern is shared by some experts in the UK, where there is no ceiling on these payments. This issue has come to prominence following a case in March 2006 when six healthy men suffered multiple organ failure during a clinical drug trial run in an independent research unit at a hospital in north-west London. As

Ray Noble, a UK medical ethicist said, "people who are designing these trials have to make sure they do not offer so much money that young people simply ignore the boxes about their medical conditions in their consent forms in order to make sure they get the thousands of pounds they need to pay off their student loans".

It is precisely to prevent this sort of behaviour that the new French law has set in place a national computerised database which registers all volunteers, the dates and duration of any trials they participate in, and the amount of compensation received. So it is simple to double check that a potential trial participant has not already received the maximum level of payment from previous trials in any one year. Indeed, any volunteers must wait several months before participating in another study.

Regulating this issue should be relatively easy as there are approximately only ten private centres allowed in France to run Phase 1 drug trials in humans. These trials are used to demonstrate safety, and involve a small number of healthy volunteers. By contrast, Phase 2 tests can involve several hundred individuals, while the large scale trials run during Phase 3 of a drug evaluation typically involve tens of thousands of people.

Most trial volunteers in France are students, with flexible working hours, and in need of money. In 2005, around 10,000 volunteers took part in 225 Phase 1 drug trials. 35 side-effects have been officially registered, of which only five were considered to be serious. None of these incidents has had any long term conse-

quences. This is why in France, like in the UK, such trials are seen as crucial in the development of new drugs, and merit taking limited risks for the good of the wider population.

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Health insurance reform in the Netherlands

Yvette Bartholomé and Hans Maarse

Introduction

On 1 January 2006, a major reform of the Dutch health insurance system came into effect. The former system, a combination of a statutory sickness fund scheme for the majority of the population and private health insurance for the rest, was replaced with a single universal scheme. The aims of the reform were to make the health system more efficient, to improve the quality of health care and to make it more consumer-driven, while at the same time keeping it accessible to everyone. The ongoing reform is comprehensive because it affects not only health insurance but also the purchasing and delivery of health care; however, it is the new health insurance legislation that currently attracts the most attention. This article presents a brief analysis of the reform's historical background and its key elements, goals and preliminary effects.

Historical background

The new health insurance system is the most recent stage in a long process of reform. Prior to 2006, 63% of the population were covered by the statutory health insurance scheme operated by sickness funds and 37% were covered by private health insurance. The latter were mainly individuals with an income above a government-set income ceiling.*

There have always been voices calling for an end to the dual structure of health insurance and to replace it with a mandatory single scheme covering the entire

population. It has been argued that a mandatory single scheme would not only resolve various boundary problems between the statutory health insurance scheme and private health insurance but also, and more importantly, increase solidarity in health insurance. For instance in 1974, the Deputy Minister of Health Hendriks argued in favour of a single public scheme, but this proposal was never translated into a concrete bill. The introduction of a single scheme was also a cornerstone of the so-called Dekker report published in 1987.¹ However, the Dekker Committee (named after its chairman, a former Chief Executive Officer of the Philips Company) devised an additional proposal, the introduction of regulated market competition. In the view of this Committee, market competition was necessary to curb the rapid growth of health care expenditure.

A subsequent Deputy Minister of Health, Hans Simons, took the Dekker report as the basis for his plans to re-model health insurance in the Netherlands. However, his reform proposals did not survive in the political process and a variety of stakeholders expressed concerns. Employers were worried about the costs of a new system, employees feared its effects upon their income, insurers were afraid of government intervention in their field and there were general doubts about whether regulated competition would be feasible in health care.^{2,3}

In the 1990s, health insurance reform was politically taboo, yet many incremental changes were introduced that, taken together, significantly changed the health insurance landscape. Examples include the introduction of a nominal fee (not income-related) in addition to income-

related contributions to statutory health insurance, the abolition of the obligation for sickness funds to contract with all individual providers (collective contracting) and the further development of the risk equalisation scheme. These changes paved the way for a more radical market-based reform of statutory health insurance.

In 2000, the government came up with a new proposal to enact legislation for a mandatory single health insurance scheme based on the concept of regulated (or managed) competition. After some years of political debate, the government that took office in 2003 managed to mobilise a parliamentary majority for a fundamental reconstruction of health insurance by 2006. In many respects the reform of the present Minister of Health, Hans Hoogervorst, builds on the earlier proposals of the Dekker Committee, combining the idea of a single mandatory scheme and regulated market competition. At the same time, the current reform is more radical than the Dekker plan.

Once again the reform was politically contested and dissenting voices (doctors, patient groups and employers) argued that health care was not compatible with market competition. However, many health insurers and provider organisations developed a pro-market attitude and called for a drastic reform after years of increasing government interference in health care.

Key elements of the new system

The extension of market competition is one of the key features of the new health insurance system. Health insurers, which may operate on a for-profit basis, are

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* This dual system of public and private coverage applied to primary and acute care. There was and still is a separate universal scheme covering long-term care (AWBZ). The AWBZ scheme has not been significantly affected by the current reforms although there are plans to make changes to it in 2007.

required to compete on premiums, types of health plan and service levels. Consumers are free to choose any health insurer and type of health plan (for example, with or without deductibles, with or without preferred provider networks) and are able to change to an alternative insurer or plan once a year. All legal residents of the Netherlands are obliged to purchase a basic health plan, but are free to purchase a complementary voluntary plan covering additional health services such as physiotherapy, dental care for adults, psychotherapy and various forms of preventive care (there is an enormous variety of complementary plans). The basic insurance package covering essential health care is defined by the government and is more or less the same as the package of the former statutory health insurance scheme. However, health insurers have some freedom to decide, for instance, which providers to contract, what types of care to cover and whether or not to offer benefits in kind or reimburse subscribers. Thus, the new health insurance legislation allows for some differentiation among health plans in order to give consumers choice. Since the new system has been in place, 92% of purchased plans have been those without deductibles.⁴

Another element of the new system concerns premium-setting. The new system retains the nominal fee, so insurers must set a single flat rate premium for each type of health plan they offer. They are forbidden to vary premiums with age, sex or specific health risks. The government pays the premium for those under eighteen. Low-income groups receive an income-related government subsidy (a 'health care allowance') to purchase a health plan. Furthermore, each employed person pays a contribution of 6.5% of his/her income (up to an income ceiling of €30,000 per year). Employers do not pay any contributions. For the self-employed, retired persons and some other specific categories the contribution rate is set at 4.4%.

A further element of the health insurance reform relates to what the government terms 'public constraints'. Several of these constraints have already been mentioned. The new system is mandatory and covers the entire population. Pivotal in the new legislation is that health insurers must accept every applicant (open enrolment). They are not permitted to deny access to applicants with pre-existing medical conditions or to charge

them a higher premium. The ban on risk selection by insurers can only be enforced when insurers have no financial incentive to select risks. Therefore, a risk equalisation scheme has been developed to avoid risk selection by insurers and to facilitate fair competition. Insurers receive risk-adjusted capitation payments from a risk equalisation fund adjusted for age, sex, pharmaceutical consumption and major diagnostic groups. The risk equalisation fund pools income-related contributions and government contributions for those under eighteen.

A final element of the new health insurance scheme concerns its private character, as the government has presented it as an arrangement under private law. The relationship between insurer and subscriber is construed as a private one-year relationship that the subscriber may renew or terminate each year. The relationship cannot be terminated unilaterally by the insurer unless a subscriber does not meet his/her legal obligations in which case the subscriber may lose insurance coverage and become an uninsured person.

Policy goals of the new legislation

The Dutch government expects that the new insurance system will lead to more efficient, innovative and consumer-driven health care. Market competition is expected to encourage health insurers to negotiate favourable contracts with providers. For this purpose, insurers are granted more power in negotiating with provider organisations. They are no longer obliged to contract all providers and may use the instrument of competitive bidding. The idea is that insurers will negotiate on the basis of price and volume as well as on the basis of quality of care, for instance in terms of waiting times, other service levels and even clinical quality. Quality of care will be particularly important for them to keep and attract customers. Moreover, insurers are given the freedom to decide where care covered by the basic plan will be provided and by whom. For instance, they can decide that certain medical problems such as diabetes be treated by a specialised nurse instead of a doctor.

In order to help consumers to make informed choices when selecting an insurer or health care provider, considerable energy is now being spent on the construction of web sites and other facilities that provide comparative information about health plans and provider

performance (i.e. waiting times and patient satisfaction). The introduction of market competition is being accompanied by a rapidly expanding information industry in which not only the government but also a growing number of private agencies participate.

Efficiency gains are also expected from increasing individual responsibility. The new system grants consumers a larger freedom of choice and the government hopes they will vote with their feet if insurers fail to live up to their expectations.⁵ More individual responsibility, however, also implies greater financial responsibility. The nominal premium rate has significantly risen. It now averages €1,050 compared to €320 in 2005 and the income-related contribution has been lowered. Due to intense competition among insurers, the range of variation between nominal premiums has been limited this year, but this may change in future.

Low-income groups are compensated for the increased nominal premium by an income-related government subsidy. The government assumes that high nominal premiums are necessary to make people more cost-conscious. The government has also introduced a no-claim bonus system in which people who do not use health care or spend less than €255 a year receive a no-claims bonus refund at the end of the year. People with chronic illnesses will not be able to benefit from the no-claims bonus system. Furthermore those on low incomes are also likely to be the most vulnerable to cuts in the basic package, because they may face financial problems in purchasing complementary voluntary health insurance covering, for example, dental care, which was largely removed from the basic package in 2004.

As mentioned earlier, the preservation of risk and income solidarity can be regarded as a cornerstone of the new legislation. Health insurers must accept all applicants and premiums cannot vary based on individual characteristics. However, this regulation only applies to the basic health insurance scheme and not to complementary voluntary health insurance. In the future, health insurers may use the latter as a new instrument for risk selection (an insurer can do this by denying an applicant access to a complementary plan to discourage him/her from purchasing a basic health plan). The low-income groups health insurance subsidy system also aims to preserve income solidarity.

The key question, however, is how these arrangements will work in practice, particularly in the long-run? To what extent will market competition be compatible with solidarity arrangements? Markets tend to call for variation by differentiated packages and price-setting to enhance consumer choice. Health insurers and provider organisations may call for less restrictive government regulation to create more room for 'private solutions'. One scenario therefore is that market competition will eventually lead to a redefinition of the solidarity arrangements. It is not simply a neutral policy instrument to achieve better the goals of health care policy but will impact upon how these goals are stated. Market competition is not only the outcome of a neo-liberal model of health care policy-making but also reinforces that model.⁶

Preliminary results

So far the implementation of the new health insurance scheme has caused fewer problems than some had originally feared. First, since the new legislation has come into effect, many more people than expected have changed insurer. According to the latest data available, about 18% of the insured have switched from one insurer to another.⁷ While some insurers have grown significantly larger, one insurer has lost almost a quarter of its subscribers. Changing insurers has also caused a huge amount of administrative work.

Second, further consolidation in the health insurance market is expected if insurers are to survive and build up bargaining power in negotiations with providers. Two mergers were announced in May 2006 and each covers about 25% of the Dutch population.

Third, the new system creates administrative problems for providers. Many general practitioners have experienced difficulty in obtaining reimbursement as insured people who changed insurer may not yet be traceable.

Fourth, the government has had to concede that the new legislation may have unfair distributive effects for some groups of people and is looking for ways to compensate them (albeit reluctantly).

Most people who have changed insurer did so in order to benefit from a group (rather than individual) contract. At the moment, about 50% of the population is insured through group contracts.⁸ Insurers are allowed to offer a maximum

premium discount of 10% for group contracts, but in order to prevent risk selection the discount offered must be based on the number of participants, not on the type of group. Group contracts existed in the previous system but were limited to corporate groups purchasing private health insurance for their employees.

The new legislation permits the forming of all kinds of groups. The groups that have formed so far can be roughly divided into three types: corporate groups of employers on behalf of employees, consumer groups and patient groups.

Corporate groups are the largest category, accounting for about 85% of all group contracts.⁸ Although the corporations sign the insurance contract, employees are not obliged to register with the health plan chosen by the corporation, so they maintain their choice.

Consumer groups involve what might be called occasional alliances between people who have nothing in common except their need to purchase health insurance. For instance, they may be formed by commercial agents and middlemen or through the internet.

Patient groups are specific consumer groups formed by patients' associations.

Beyond receiving reduced premiums, groups can also choose a plan that is optimally geared to their specific needs. The latter possibility in particular has provided the incentive for patients' associations to form groups, but it remains to be seen how attractive the arrangement will be for insurers and patients with chronic illnesses. There are already signs that health insurers are not interested in signing a contract with patient groups, which cause a predictable loss to them. Another interesting observation is that it has been estimated that €70 million has been spent on advertising.⁸

Conclusion

The new reforms affect all parts of the health system including relationships between patients and providers and health insurers and providers. Yet it is clear that so far the health insurance reform has been the most visible and probably the most contested part of the ongoing transformation process.

The reform is expected to have two main implications. First, the position of consumers/patients has been significantly strengthened by giving them more

choice. Second, the position of health insurers as the agent of their subscribers has changed such that they have to negotiate contracts with health care providers. Thus, the reform aims to rebalance the relationship between health insurers and providers.

In spite of preliminary results (of which the high proportion of people changing insurer is the most remarkable and unexpected), it is too early to determine whether or not the reform has been a success. Success would imply that the competitive changes enhance value and efficiency in purchasing health care. This is the real test of the reform. Another reason for caution is that many legislative steps remain to be taken. What happened in January was indeed a 'big bang' but it was only the first step.

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Universality and decentralisation: The evolution of the Italian health care system

Margherita Giannoni

In Italy the publicly financed national health service, *Servizio Sanitario Nazionale* (SSN), provides universal and comprehensive coverage for the entire population, funded largely through taxation. Despite its high ranking in recent comparisons of international health care system performance,¹ today the system is facing several challenges, the most important of which is to ensure geographical equity in access to health care across the country. This reflects one of the key features of Italian history; the persistence of a marked regional (north-south) divide, favouring the richest northern and central regions.

The evolution of the system over time has been characterised firstly, by periodic attempts at reform to cope with increasingly strict budget constraints at both national and EU level, and secondly by a pronounced ongoing decentralisation process that began in the last decade. As a consequence, one of the main challenges today is the need to balance financial constraints with the original SSN principles of universality and solidarity, within a context of increasing regional autonomy. This article provides an overview of some of the main features of the Italian health care system and discusses some challenges to be faced in the light of continuing decentralisation.

Health status

Table 1 (overleaf) provides some indicators of health status and the health system across the country. Life expectancy in 2003 was two years above the OECD average, while infant mortality has dramatically improved, being 4.3 deaths per 1,000 live births in 2003, more than three

times lower than that seen in 1980 when the SSN was established.² The population is ageing; in 2004 the dependency ratio between older people and the working population was 50.6 and the proportion of older people (aged 65 plus) compared to younger people (aged under 14) was 137.7%.³ It has also been estimated that the ageing index, that is the ratio between the population under 20 and over 65 to the working age population, will more than double by 2050 and that future increases in public health care expenditure will be increasingly due to the growth of long-term care expenditure.⁴

Overview of the health care system

Organisation

The SSN is organised on three different levels: national, regional, and local. The responsibility for achieving overall objectives and safeguarding the fundamental principles of the system lies at the national level. Twenty regions or, more precisely, twenty-one, as one region, Trentino Alto Adige, is divided into two autonomous provinces (Trento and Bolzano), are responsible for the administration of services and the provision of care to the population. A basket of services to be provided uniformly across the country, known as the '*Livelli Essenziali di Assistenza*' – (Essential Levels of Care – LEAs) is set nationally and covers all medical care considered to be necessary, appropriate, and cost-effective.

Within regions each resident is enrolled with the local health authority – *Azienda Sanitarie Locali* (ASL) – in their municipality. Although there is significant variation across regions, in general ASLs plan, organise and guarantee comprehensive care through a network of public or accredited private institutions, including independently managed public sector hospitals. In addition to contracting services to major hospitals, the ASLs also may run small local hospitals. Primary

care is provided publicly at local level by general practitioners (GPs) who refer patients to specialist care and hospitals. GPs are independent self employed professionals paid on a capitation basis. Patients are free to choose between public or private providers for many health care services. An increasing share of services is supplied by accredited private providers. Satisfaction levels with the health care services are lower than the EU average and variable across the country, although trust in the SSN is quite high.⁵

Individuals can also buy private health insurance and/or receive treatment at private hospitals or consult private specialists at their own expense. Approximately 15% of the population have some type of complementary or supplemental private health insurance. User charges are one of the main drivers of private financing in the health system. They were introduced for publicly funded services as a tool for cost-containment in the 1990s and have been reformed several times. Their use varies across regions. Co-payments may apply to specialist care as well as to some diagnostic and laboratory tests, depending on the type of service, the income, age and health condition of patients. Co-payments are also levied on drugs in some regions, particularly those with centre-right local administrations; some centre-left administrations in contrast have abolished such charges.⁶

Expenditure

In 2003 Italy spent US\$PPP (Purchasing Power Parity) 2,258 per capita on health. Total expenditure on health was 8.4% of Gross Domestic Product (GDP), similar to that of the UK (8.0%) but less than Greece (9.9%), France (10.1%), and Germany (11.1%). Publicly funded health care expenditure accounts for over three quarters (75.1%) of total expenditure, above the OECD average (+3.4%) but lower than that of most northern

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Table 1: Health and health care system indicators

		North	Central	South	All Italy
Life expectancy at birth	Males	76.75	77.38	76.69	76.86
	Females	82.74	82.80	82.09	82.56
Population increase rate per 1,000 inhabitants		-1.68	-1.79	1.02	-0.74
Mortality rate per 1,000 inhabitants		10.80	10.79	9.08	10.18
Percentage of population affected by one or more chronic diseases		76.75	75.4	74.05	75.2
Health care expenditure as a percentage of GDP	Public	5.19	6.05	8.52	6.20
	Private	1.80	1.76	1.95	1.83
	Total	6.99	7.81	10.47	8.03
Public health care expenditure	Current euros (millions)	36,448	16,538	27,614	80,600
Per capita public health care expenditure	Current euros	1,405	1,496	1,340	1,399
Private health care expenditure of households (% of total health expenditure)		25.7	22.6	18.6	22.8
Inpatient admission rates per 1,000 population	Total	142.61	146.87	151.18	146.50
	Public hospitals	121.04	124.86	121.56	121.96
	Private hospitals	21.57	22.02	29.62	24.54
Hospital beds per 1,000 population	Public	3.46	3.28	2.85	3.21
	Private	0.84	1.24	0.94	0.96
Doctors in hospitals per 1,000 population	Public	1.78	2.07	1.70	1.81
	Private	0.30	0.38	0.28	0.31
GPs per 10,000 population (2002)	Public	8.03	8.84	8.09	8.21
Paediatricians per 10,000 population (2002)	Public	8.59	10.00	8.81	8.93
Total unemployment rate		3.78	6.49	17.74	8.68
Poverty incidence*		5.30	5.70	21.30	10.60
Poverty gap**		19.10	18.21	22.80	21.44
Individuals very satisfied with health care services (per 100 inpatients) (2001)	Medical care	45.60	34.90	23.10	34.50
	Nursing care	46.20	33.00	22.70	34.10
	Cleanliness	38.90	22.00	17.30	26.80

Note: North = Piemonte, Valle d'Aosta, Lombardia, Trentino-Alto Adige, Veneto, Friuli-Venezia Giulia, Liguria, and Emilia-Romagna; Central = Toscana, Umbria, Marche, Lazio; South = Abruzzo, Molise, Campania, Puglia, Basilicata, Calabria, Sicilia, and Sardegna.

Source: All information from Istat.³ This includes Indicatori socio-sanitari regionali (regional health and social indicators), 2006, Struttura e attivita' Istituti di cura (health system structure and activities), 2006 and Conti Regionali (regional accounts), 2005.

* The poverty incidence is the ratio of poor households/people to total number of households/people (per 100).

** The poverty gap ratio is the average difference between the consumption expenditure of poor households/people and the national consumption expenditure (poverty line) expressed as a percentage.

All data for 2003 unless otherwise indicated .

European countries. In recent years public health expenditure has however been rising, reaching 6.5% of GDP in 2004.² There are also significant regional variations in expenditure: per capita total health care expenditure is higher in northern and central Italy than in the south, whereas the public funded share of health care expenditure is higher in the south. Containment of public expenditure continues to be a major issue, given the existence of a large public deficit, which Italy as a Eurozone country must control.

Inequalities in health and utilisation of services

The Italian system is characterised by strong inequalities at the regional level. Economic growth has never been uniform and the gap favouring the richer northern and central regions has never been filled. Regional socioeconomic disparities have caused wide inter-regional differences in the quality and efficiency of health care services across the country, especially in the south where a higher proportion of low income families live (See Table 1).⁷ This might explain why satisfaction levels for hospital services in 2001 were twice as great in the north compared with the south. Moreover, most regions register pro-rich significant income-related inequalities in access to specialist services and diagnostic care, for example, for cancer care.⁸

Health care system reforms: towards decentralisation

Decentralisation and cost containment have characterised the evolution of the Italian NHS in recent years. Following the introduction of the SSN, a national health fund was created. The total budget has been determined annually by central government with funds subsequently distributed to the regions. It has been mainly financed from general taxation, including contributions by both employers and employees as well as a health tax levied on the self-employed. The regions regularly have claimed that the overall level of funding they receive from central government is insufficient to cover population need.

During the 1980s, the separation of the revenue raising responsibilities of the state from the expenditure responsibilities of the regions resulted in regional deficits. There was little incentive to avoid excess spending, as regions in deficit were periodically bailed out.⁹ The

high level of expenditure on health in the 1990s, at a time of large public deficits, prompted the first attempts at reform. There was the need to fight the corrosive politicisation of management, as well as bureaucracy and corruption, all of which had contributed to blame being levelled at the welfare state for the growing public debt.¹⁰ Starting with the 1992 Health Care Act no. 502, reforms were designed to increase the autonomy of the regions in both the financing and delivery of health care, creating an internal market, along the lines of reforms introduced in England.

Under this 1992 reform, the national health fund continued to be distributed to the regions using a capitation formula. It also allowed for retrospective compensation for in-patient transfers between regions. What changed, however, was the capping of budgets centrally for the first time. Health care services provided by the SSN would now be dependent on this budget.

A system of Diagnosis Related Group charges was also introduced during the mid 1990s for hospital reimbursement. Regions became directly responsible for planning how to spend funds on health care: appointing ASLs and hospital managers, with increasing freedom to manage their own budgets.⁵ To promote the concept of the internal market, hospitals also became independent providers of services, directly managing their own budgets.

At the central level, a set of cost containment policies was introduced, including wage freezes and budget cuts for drugs, staff and equipment, as well as more user charges. The effect was that the rate of growth per capita for public health care expenditure was reduced from around 2.0% a year during 1980–91 to less than 0.5% in 1992–95. However, this was offset by a 22.9% increase in private expenditure. The spending pattern of the regions remained highly diverse with increased variation around the national average, a widening north-south gap and increasing regional budget deficits.

After several technocratic governments dedicated to pursuing the objective of economic stability, in 1996 a new centre-left government introduced two major reforms affecting health care. The first introduced fiscal federalism, coupled with the approval of constitutional law no. 3/2001 that modified the Fifth Title of the Constitution. This marked the

beginning of a devolution process, still ongoing today, aimed at increasing the legal and administrative powers of the regional authorities. As a result of this reform, the SSN is financed through national and regional taxes, the latter becoming the primary source of funding.

The second major reform occurred in 1999. This aimed at reaffirming the original goals of universality, comprehensiveness and public funding, in the context of less external pressure over macroeconomic stability, and the ongoing process of decentralisation.⁵ In an attempt to overcome the trade-off between these SSN core targets, alongside the risk of increasing regional divergence, basic packages of care (LEAs) were introduced. The regions now have the responsibility for guaranteeing the provision of LEAs.

Impact of reform

This reform process has profoundly altered the organisational structure of the SSN. Competition between the public and the private sector was replaced by partnership; with changing roles and responsibilities between the regions and the ASLs. Much more power and responsibility now rests with the ASLs; only major or specialist hospitals remain autonomous at the local level.

Districts were created in order to introduce cooperation between local hospitals and other local services; competition was regulated using a new system of accredited providers.¹⁰ The role of doctors was redefined, introducing the principle of an 'exclusive relationship', forcing doctors for the first time in Italy to choose between working in the public or private sectors.¹⁰ Reforms have also tried to promote more clinical governance and evidence-based medicine.^{5,11} However, not all have been planned reforms have been implemented, particularly at the regional level. For instance, Lombardia chose not to apply the partnership and integration approach envisaged by the new reforms, but instead introduced total separation between purchasers and providers.⁵

The centre-right coalition which governed from 2001 until April 2006 also attempted to dismantle many provisions of the reform, such as those regulating doctors and managers in the public sector. They wished to increase opportunities for private sector involvement in the health care system at all levels, particularly in financing, through private health insurance. They also were under pressure

for more regional devolution from the *Lega Nord* (Northern League) Party – a member of the coalition government, that has since its creation in 1991, advocated even greater autonomy for the northern part of Italy.

In practice, priority was given to cutting taxes. Several issues, such as reducing waiting lists and long-term care management, remain unresolved. In the continuing context of an economic crisis, with expenditure running faster than GDP, annual budget increases from national taxation have been set at a rate below economic growth. The burden of financing health care expenditure has increasingly fallen to the regions. The ability of the regions to raise their own revenue through taxation remains highly variable: the northern regions raise 67% of their finances through local taxes compared with just 34% in southern regions. This is a major problem in the absence of clear and shared rules for fiscal equalisation.¹²

Despite recent reforms, as time passes, protecting the core objectives of the SSN becomes ever more challenging. Regions are diverse, for example, having their own funding rules, cost-containment and access policies, public-private mix and user charges. As a result of devolution and fiscal federalism the role of the regions has changed. They no longer simply regulate local providers, but often intervene more directly in order to contain expenditure, for example by purchasing services, thus reducing autonomy at the local level.¹³

Many regions, most notably in the south, are now fighting against the growth of deficits in health care spending. Legislation in 2005 foresaw compulsory increases in regional taxation for those regions not able to reduce deficits that presently total €4.3 billion. The impact of these regional deficits and related cost-containment policies on health care provision and health outcomes has not been systematically assessed. Long waiting lists are perceived by the general public as being the main problem of the NHS, followed by low quality of services, insufficient provision of services for chronic diseases and poor long-term care for older people and those with disabilities.¹⁴

Poor quality might also mean that patients are willing to move to other regions for better quality of care; there may be a further increased role for the private sector. Certainly systematic

migration of patients from the southern to northern and central regions can be seen, further aggravating inequalities in access to health care as well as disparities in regional public accounts. It seems that for many regions the introduction of fiscal federalism has not been as successful in terms of increasing efficiency and accountability as expected; malpractice and corruption problems have again emerged in some regions.

Conclusions

Keeping control of public expenditure remains a priority for a new government that has inherited a deficit-GDP ratio well above the EU Stability Pact maximum of 3%. The risk is that, once again, health care will become secondary to economic stability. Decentralisation is continuing, although further constitutional reform, strongly supported by the *Lega Nord*, was rejected in a recent referendum. The future seems uncertain and legislators are now likely to go back to the drawing board for ways to try and promote more stability in a country that has had 61 governments since 1945.

If current trends towards decentralisation continue, despite the referendum no vote, one possible scenario may well be twenty-one divergent health care systems. In principle of course, within each local system, there may be room to improve efficiency and accountability, but reconciling this with preserving core SSN principles including equity of access, could become even more challenging. Increasing regional disparities in the way in which health care is financed, in policy making capacity and accountability, coupled with greater autonomy on how services are delivered, suggest an urgent need at a national level for a clear definition of rules governing the application of the principle of solidarity. There is also a need for better defined, and more effective, policy instruments and rules to guarantee the uniform provision of publicly financed health care services across the regions.

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Water contamination: A question of sustainability

Giovanni Leonardi

Is water contamination a problem? A real story

In 1995, I was asked to contribute to an effort by the public health authorities in Hungary to assess the direct health effects of arsenic in ground water. For years they had known that many of their water sources contained a concentration of inorganic arsenic above the recommended level set by the World Health Organization. Town planners and engineers had however designed interventions to reduce the arsenic concentration to comply with this guidance. By the time of my involvement this had been achieved, but in response to more recent information on the cancer risk attributed to low levels of arsenic, the international health community agreed to reduce their recommendation on the permitted levels of arsenic in drinking water from 50 to 10 microgrammes per litre.

The Hungarian authorities then had to consider whether to invest in further costly interventions to comply with this new guidance. The direct observation of cancer risk in relation to the ingestion of arsenic appeared to be an attractive proposition, as it would have allowed local confirmation of something derived from evidence obtained in other parts of the world. In this way, the rationale for any further water intervention could be supported.

I was happy to contribute to this effort, but many questions presented themselves to me as I was trying to put together background material for this issue. Why had it become a problem for Hungary?

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What was the likely public health impact of ignoring the issue? What sort of engineering and social interventions had been chosen in the past, and what were being considered at the time? What type of public health investigation could generate sufficient evidence to contribute to improving the quality of the drinking water supply?

These issues were also identified in areas of Romania and Slovakia, but what were the differences and similarities? In attempting to find answers to these questions, a proposal for an epidemiological study was developed. In the following years, I came to appreciate that many of the aspects of the complex task of providing safe water for drinking were similar in Hungary to those seen elsewhere in the world. Moreover, any successful solution to water contamination has to be part of an overall plan for human development. Some of these issues are outlined below.

Threats to water quality

Human activities, for example agriculture, energy production by oil, coal or gas, mining and metallurgy, the chemical industry, textile processes, electronics and many others produce a large number of chemicals. These often exceed the environment's capacity for assimilation, and result in an accumulation of waste and discharge that pollute our water. Health and environmental protection agencies, both governmental and non-governmental, have documented acute incidents associated with the release of chemicals into water. Surveillance of these incidents is motivated by the desire to avoid any adverse health consequences that may follow by taking early action, one example being the National

Chemical Incident Surveillance system that reports quarterly in England and Wales.¹

Monitoring of emissions aims to document progress in reducing and controlling ongoing releases into the environment. 'Pollutant release and transfer registers' can be cost-effective in encouraging improvements in environmental performance and in providing public access to information on releases of pollutants and off-site transfers of pollutants and waste. They can also be used for tracking trends and demonstrating progress in pollution reduction. This experience has motivated the establishment of various registers, including the European Pollutant Emission Register.²

The vigilance of public agencies has contained rather than prevented the contamination of water. In the last century, the development of new methods for agriculture, including the use of fertilisers to foster crop growth, was achieved at the cost of polluting many surface water systems. Contamination from nitrates can lead to methaemoglobinaemia, which can affect vulnerable individuals severely. The use of pesticides in agricultural and managed urban landscapes has also been extensive, but the principal impacts on health have been documented in workers rather than in residents' drinking water. Other categories of chemicals that are released to water include:³

- Household cleaning chemicals, personal care products, medicines, petroleum products, and solvents.
- Human excreta that contain pharmaceuticals and their by-products.
- Chemicals from commercial premises/light industry (for example,

NOTE: Please note that the views and opinions presented in this paper are those of the author and do not necessarily represent the views of the United Kingdom Health Protection Agency.

degreasing solvents, ink, dyes, petroleum, paints and paint solvents, dry-cleaning solvents, metal plating chemicals, acids) used in everyday business operations.

— Industrial discharges containing a vast spectrum of both organic and inorganic substances.

In virtually all cases, industries have discharged chemically polluted waste water into a water source during periods of high water flow when dilution can mask any observable change, or keep it within legally accepted limits. Moreover, thousands of new chemicals are produced and released every year, and their toxicity is seldom evaluated. These chemicals are often long lasting, and when information on toxicity is known, it may not be released to public agencies.

Evidence from animal experiments on toxicity is not always reassuring; judgments in court cases may suggest in fact that toxicity is possible. One example of this, for instance, can be seen in the United States where there was a high profile out of court settlement in response to a legal case suggesting that there were detrimental health effects from being exposed to perfluorooctanate acid (PFOA), a fluoride compound used in the manufacturing of polytetrafluoroethylene (often referred to by the brand name Teflon). Subsequently the US Environmental Protection Agency created a scientific review panel to study the health and environmental effects of PFOA.⁴

Lead in old water distribution pipes is present in old homes, and represents about 20% of the background exposure to lead in the general population. Even at levels lower than previously thought, exposure to lead is associated with decreased intelligence and behavioural problems in infants and children.⁵ Another source of pollution are the hundred plus potentially toxic disinfection by-products formed when chlorine or bromine are added to water as a disinfectant. The most common are trihalomethanes and haloacetic acids. There is some epidemiological evidence associating exposure to these chemicals with cancer of the bladder and colon, as well as reproductive outcomes.^{6,7} There is also a relationship between waste disposal practices and water quality. Direct effects of unregulated substances, as well as indirect effects of the release of substances

such as detergent phosphate, leading to potentially hazardous deposits of algae, have been described.⁸

Water contamination or provision in sufficient quantity, what is the question?

Threats to water availability have been recognised for some time. These include population growth, economic development with its attendant increase in consumption and climate change leading to changes in the pattern of rainfall and droughts. The balance between growing population demand and water supplies has been narrowing severely in many places around the world.⁹ Chemical contamination of water resources may render them unsuitable for drinking, or mean that they need expensive treatments. In effect, contamination can lead to specific water resources being excluded from the available supply, resulting in an additional threat to water security. Production pressures that lead to dramatic changes in water distribution systems, may also lead to the emergence of contamination problems, such as around the Aral Sea in Central Asia.

Therefore, water contamination and its barely recognised effects on human and ecosystem health, is just one angle of the overall question of sustainable water management. The real issue that needs to be considered when examining what strategies and policies may alleviate the consequences of water contamination, is the challenge posed by the scarcity of water relative to human pressures from growing populations, and the associated use of water for the production of food, goods and to absorb waste.

False solutions: ground water and sea water

Surface water, contained in rivers and lakes, has been the main source of drinking water for much of the history of mankind. Biological threats from pathogens, as well as chemical threats from nitrates and pesticides have progressively limited sources of fresh surface water considered of sufficient quality for drinking. In the belief that ground water, contained in porous rocks and accessible for extraction through wells, represented a safe alternative, 'ground water mining' has become increasingly common.¹⁰ There is no doubt that when surface water is heavily contaminated with microbiological material from human waste, ground water can represent a

cleaner alternative, but is ground water necessarily a safe option?

There are problems with geological and human-driven elements hazardous in ground water. Arsenic, fluoride, and manganese can be naturally present in some sources of ground water. Arsenic can cause cancer at relatively low concentrations in water, as well as probable perinatal effects such as congenital anomalies.¹¹ Fluoride can lead to 'skeletal fluorosis' in which the bone structure is changed and ligaments calcify. Manganese may have effects on the reproductive system.

Pollutants from waste also have affected an increasing proportion of the available aquifers (the underground layers of porous rock from which water can be drawn); the rate of clean up can be so slow that their water is effectively no longer available. Regardless of the direct hazards from substances in ground water, it also remains an inescapable fact that such sources of water are a non-renewable resource, only available for a few decades at the current rate of extraction.

Desalination, the process of removing salt and other minerals from water, is an alternative but desperate measure, as it is very costly, both in terms of technology and the energy required. In addition, there are potential health hazards to consider, monitor and treat, when compared to fresh water, for example algae and endocrine disrupting chemicals. In general, because desalination is applied to non-typical source waters, and often uses non-typical technologies, existing WHO guidelines may not fully cover the unique factors that can be encountered during its production and distribution.

Imperfect solutions: standards for drinking water

There are severe limitations in the current regulatory system for health protection based on standards: standards do limit the amount of contaminants released, but at the same time they legalise their distribution in the environment. Standards also differ for treatment of waste water and drinking water, however the reality is that drinking water is becoming more and more similar to waste water. To an extent, it already is waste water. Surface water has been rendered unusable as it is often unfit for drinking, and unfit for many other uses. The trend appears to be increasing. Extracting fresh water from rocks or the sea is accompanied by

considerable disadvantages. What else could be done?

An innovative proposal is to stop using standards for drinking water and require that water companies use (at a cost) all available technology to remove all contaminants from water at a treatment plant for water intended for drinking.³ This may appeal superficially, as it would certainly reduce the exposure of human beings to a vast range of chemical substances, whether or not there is any evidence that they are hazardous. However, even if accepted by industry and consumers, this proposal would sanction the separation between drinking water and water for other uses, allowing dramatic increases in the amount and distribution of potentially hazardous chemicals in the environment. Given the various routes that water pollutants can take to reach us, and the many possible indirect consequences on human health and ecosystems, this course of action seems unwise. The proposal does however highlight the need for radically new approaches.

Are there real solutions?

The taste of clear, fresh, sweet water will be forgotten, and sustainable use of water for food and goods production will not be achieved, unless there is a fundamental change in approach. The availability of clean water has reached the political agenda: the United Nations General Assembly, on 23 December 2003, proclaimed the years 2005 to 2015 as the International Decade for Action: 'Water for Life'. In Europe, governments signed the Water and Health Protocol in 1999, a tool to develop a system whereby effective reduction and elimination of discharges and emission of substances judged to be hazardous to human health and water ecosystems is practiced.¹² But what can policy statements do to improve the situation? Very little, unless increasing awareness of the scale of the problem leads us to accept that water contamination is too costly and dangerous, and must be avoided.

The costs of avoiding contamination are being examined against the costs of allowing it to continue. When the Environment Agency for England and Wales examined the cost to water treatment plants and communities of allowing a chemical spill to be washed down the drain, it concluded that it would be cheaper to pay to provide all fire engines in the country with a 'grab pack' which

contains clay mats to block drains, putty to seal pipes, absorbent material to soak up spills, and booms to contain contaminated fire water and other materials.¹³ Each Fire and Rescue Service has also been part funded for an Environment Protection Unit with specialist equipment including pumps, large containment pools, drain blocking equipment and overpack drums. The roll out of this approach was completed across England and Wales in 2005. This turns the traditional thinking on its head, from 'dilution of pollution' to containment.

If a new agreement between agencies providing public services can achieve real progress towards the reduction of water pollution following acute incidents, a similar approach might be applied to the avoidance of ongoing releases through normal activities mostly outside the health sector, for example, agriculture, households, and industry. Integrated assessment of health gain from non-health service interventions requires coordination of health sector and non-health sector actors. Health agencies could provide intelligence on patterns of health impact.

When estimating public health burden, one should be mindful of a tenet of modern epidemiology of chronic disease: one of several causes is still a cause. Ignoring this principle limits the value of estimates of public health burden. Health agencies could act as catalysts, motivating non-health sector agencies to consider all costs linked with the discharge of substances in water. They could also contribute to defining appropriate and acceptable interventions, such as incentives to contain discharges as well as generally developing sustainable practices in relation to water quality and quantity.

One example of working arrangements in this area is the establishment of environmentally preferable purchasing guidelines to reduce resource use and cut air and water emissions in the US.¹⁴ These activities need the cooperation of health and non-health agencies and therefore represent an institutional challenge that might be overcome with increased awareness and support of intellectual advances in the field of integrated assessment.¹⁵

The reduction of discharges to water (any water), and discharges to land systems linked to water (all), should be seen as a new standard of efficiency for the water and other industries. This reduction in

discharges will be increasingly possible through better understanding of economic impact, analysed across the life cycle. These, and other factors, that highlight several aspects of water contamination should be included in health impact assessments. Integrated water resources management, advocated by the European inter-ministerial Water and Health Protocol of 1999, is likely to be realised more easily on the basis of such understanding.

Ecological thinking has proposed initiatives such as Zero Emissions Research and Initiatives (ZERI) that attempt to apply integrated assessment at a level above that of a single human activity. They then achieve a zero waste target by identifying the output of a particular activity as an input of another activity. By combining waste reduction with economic growth, and economic and ecosystem thinking in terms of cycles rather than linear production lines, such pioneering initiatives show that it is feasible to transform the way in which we think about the emission of hazardous substances into our water supply. In essence, these proposals suggest that the existence of the concept of waste is an obstacle to the preservation of clean water. Health agencies need to make this conceptual jump to achieve sustainable water management and maintain public health.

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Alcohol in Europe: Health, social and economic impact

Peter Anderson and Ben Baumberg

At the time when the European Commission has been preparing its own strategy on alcohol to cover the full range of activity that takes place at a European level,¹ it also called for an analysis of the health, social and economic impact of alcohol in Europe. The report, *Alcohol in Europe*,² published by the Commission at the beginning of June 2006, views alcohol policy as “serving the interests of public health and social well-being through its impact on health and social determinants”, itself embedded in a public health framework, a process to “mobilise local, state, national and international resources to ensure the conditions in which people can be healthy”. The main findings of the report are reproduced here.

“the total cost of alcohol to EU society in 2003 was estimated to be €125 billion”

Alcohol and the economy of Europe

Europe plays a central role in the global alcohol market, acting as the source of a quarter of the world's alcohol, and over half of the world's wine production. Although the majority of EU alcohol trade is between EU countries, the trade in alcohol contributes around €9 billion to the goods account balance for the EU as a whole.

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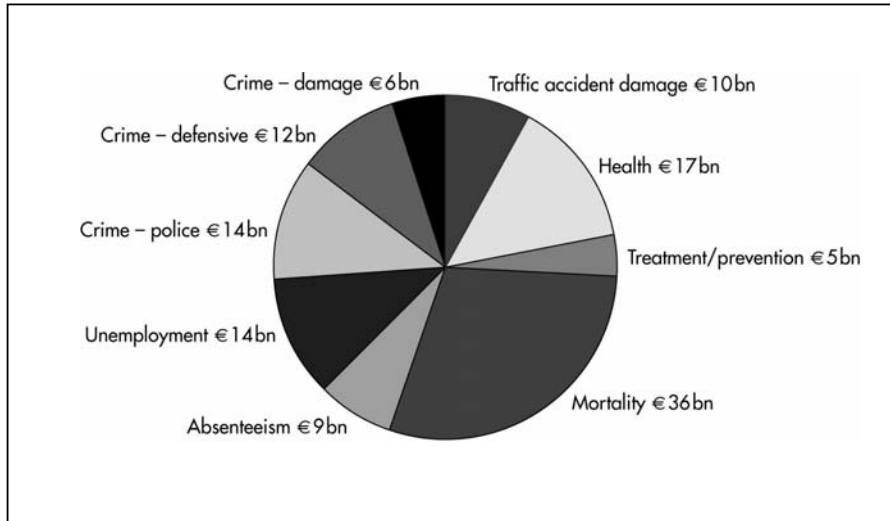
The economic role of the alcoholic drinks industry is also considerable in many European countries. Alcohol excise duties in the older EU-15 countries amounted to €25 billion in 2001, excluding sales taxes and other taxes paid within the supply chain – although €1.5 billion is given back to the supply chain through the Common Agricultural Policy. Due to the relative inelasticity of the demand for alcohol, the average tax rates are a much better predictor of a government's tax revenue than the level of alcohol consumption in a country.

Alcohol is also associated with a number of jobs, including over three-quarters of a million in drinks production (mainly wine). Further jobs are also related to alcohol elsewhere in the supply chain, for example, in pubs or shops. However, the size of the industry is not a good guide to the economic impact of alcohol policies – for example, trends in alcohol consumption show no crude correlation with trends in the number of jobs in associated areas such as hotels, restaurants and bars, suggesting that the effect of changes in consumption may be relatively weak.

Based on a review of existing studies, the total tangible cost of alcohol to EU society in 2003 was estimated to be €125 billion as illustrated in Figure 1. This is equivalent to €650 per household per year. If a value was placed on alcohol-related pain, suffering and life itself, then these costs would be much higher still.

The use of alcohol in Europe

The EU is the heaviest drinking region of the world, although the eleven litres of pure alcohol drunk per adult each year is still a substantial fall from a peak of fifteen litres in the mid-1970s. The last forty years has also seen a harmonisation in consumption levels, with rises in central and northern Europe between 1960 and 1980, met by a consistent fall in southern Europe. Most Europeans drink

Figure 1: Social Cost of Alcohol to Europe

Source: Anderson P, Baumberg B, 2006.²

alcohol, but fifty-five million adults (15%) abstain; taking this and unrecorded consumption into account, the consumption per drinker reaches fifteen litres per year.

Drinking to drunkenness varies across Europe, with fewer southern Europeans than others reporting getting drunk each month. This difference is reduced when 'binge-drinking', a measure of drinking beyond a certain number of drinks in a single occasion, is instead investigated, suggesting that there are systematic differences in people's willingness to report being intoxicated. Summing up across the older EU-15 countries, adults report getting drunk five times per year on average but binge-drink (5+ drinks on a single occasion) seventeen times. This is equivalent to 40 million EU-15 citizens 'drinking too much' monthly and 100 million (one in three) binge-drinking at least once per month.

While 266 million adults drink alcohol up to 20 grammes (g) (two drinks for women) or 40g (four drinks for men) per day, over 58 million adults (15%) consume above this level, with 20 million of these (6%) drinking over 40g (women) or 60g (six drinks for men) per day. Some 23 million Europeans (5% of men, 1% of women) are dependent on alcohol in any one year.

Nearly all 15–16 year old students (over 90%) have drunk alcohol at some point in their life, on average beginning to drink at 12.5 years of age, and getting drunk for the first time at 14 years old.

The average amount drunk on a single occasion by 15–16 year olds is over 60g (six drinks) of alcohol. Over one in eight (13%) of 15–16 year olds have been drunk more than twenty times in their life, and more than one in six (18%) have 'binged' (5+ drinks on a single occasion) three or more times in the last month. Most countries show a rise in binge drinking for boys between 1995 or 1999 and 2003, and nearly all countries show this for girls.

The impact of alcohol on individuals

Harms done by someone else's drinking range from social nuisances, such as being kept awake at night, through more serious consequences such as marital harm, child abuse, crime, violence and homicide. Generally the higher the level of alcohol consumption, the more serious is the crime or injury.

Apart from being a drug of dependence, alcohol is a cause of some sixty different types of diseases and conditions, including injuries, mental and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, lung diseases, skeletal and muscular diseases, reproductive disorders and pre-natal harm, including an increased risk of prematurity and low birth weight. For most conditions, alcohol increases the risk in a dose dependent manner, with the higher the alcohol consumption, the greater the risk. The frequency and volume of episodic heavy drinking are of particular importance for increasing the risk of injuries and certain

cardiovascular diseases (coronary heart disease and stroke).

A small dose of alcohol consumption reduces the risk of coronary heart disease, although the exact size of the reduction in risk and the level of alcohol consumption at which the greatest reduction occurs are still debated. Better quality studies that account for other influences find less of a reduced risk than poorer quality studies and find that the reduced risk occurs at a lower level of alcohol consumption. Most of the reduction in risk can be achieved by an average of 10g of alcohol (one drink) every other day. Beyond 20g of alcohol (two drinks) a day – the level of alcohol consumption with the lowest risk – the risk of coronary heart disease increases. In very old age, the reduction in risk is less. It is alcohol that mainly reduces the risk of heart disease rather than any specific beverage type.

The impact of alcohol on Europe

Looking from a social perspective, seven million adults reported being in fights when drinking over the past year, with the economic cost of alcohol-attributable crime estimated to be €32 billion in the EU in 2003. Based on our review of national costing studies, lost productivity due to alcohol-attributable absenteeism and unemployment has been estimated to cost €23 billion in 2003.

Looking from a health perspective, alcohol is responsible for 12% of male and 2% of female premature death and disability, after accounting for health benefits. This makes alcohol the third highest of twenty-six risk factors for ill-health in the EU, ahead of overweight/obesity and behind only tobacco and high blood pressure.

This health impact includes 17,000 deaths per year due to road traffic accidents (one in three of all road traffic fatalities), 27,000 accidental deaths, 2,000 homicides (four in ten of all murders and manslaughters), 10,000 suicides (one-sixth of all suicides), 45,000 deaths from liver cirrhosis, 50,000 cancer deaths, of which 11,000 are female breast cancer deaths, and 17,000 deaths due to neuropsychiatric conditions as well as 200,000 episodes of depression. Young people shoulder a disproportionate amount of this burden, with over 10% of youth female mortality and around 25% of youth male mortality being due to alcohol.

Between countries, alcohol plays a considerable role in the lowered life expectancy in the EU-10 compared to the EU-15, with the alcohol-attributable gap in crude death rates estimated at 90 (men) and 60 (women) per 100,000 population. Within countries, many of the conditions underlying health inequalities are associated with alcohol, although the exact condition may vary (for example, cirrhosis in France, violent deaths in Finland).

Many of the harms caused by alcohol are borne by people other than the drinker, including 60,000 underweight births, 16% of cases of child abuse and neglect, and seven million children living in families adversely affected by alcohol. Moreover, 10,000 deaths in drink-driving accidents occur to people other than the drink-driver.

Natural experiments and time-series analyses show that the health burden from alcohol is related to changes in consumption. These changes reflect the behaviour of the heaviest drinkers more than lighter drinkers (given that for example, the top 10% of drinkers account for one-third to one-half of total consumption in most countries), but also tap into the wider tendency for populations to change their levels of consumption collectively.

The impact of alcohol policy options

The drinking-driving policies that are highly effective include random breath testing, lowered blood alcohol concentration (BAC) levels, license suspension, and lower BAC levels for young drivers. The limited evidence does not find an impact from designated driver and safe drive programmes. Alcohol locks* can be effective as a preventive measure, but as a measure with drink driving offenders, they only work as long as they are fitted to a vehicle.

The impact of policies that support education, communication, training and public awareness is low. Although the reach of school-based educational programmes can be high because of the availability of captive audiences in schools, the population impact of these programmes is small due to their current limited, or lack of, effectiveness. On the other hand, mass

media programmes have a particular role to play in reinforcing community awareness of the problems created by alcohol use and also in preparing the ground for specific interventions.

There is very strong evidence for the effectiveness of policies that regulate the alcohol market in reducing the harm done by alcohol. Alcohol taxes are particularly important in targeting young people and the harms done by alcohol in all countries. If alcohol taxes were used to raise the price of alcohol in the EU-15 by 10%, over 9,000 deaths would be prevented during the following year and approximately €13 billion of additional excise duty revenues would also be gained. The evidence shows that if opening hours for the sale of alcohol are extended, then more violent harm results.

"if taxes were used to raise the price in the EU-15 by 10%, over 9,000 deaths would be prevented in the following year"

Restricting the volume and content of commercial communications of alcohol products is likely to reduce harm. Advertisements have a particular impact in promoting a more positive attitude to drinking amongst young people. Self-regulation of commercial communications by the beverage alcohol industry does not have a good track record for being effective.

There is growing evidence for the impact of strategies that alter the drinking context in reducing the harm done by alcohol. However, these strategies are primarily applicable to drinking in bars and restaurants, and their effectiveness relies on adequate enforcement. Passing a minimum drinking age law, for instance, will have little effect if it is not backed up with a credible threat to remove the licenses of outlets that repeatedly sell to

the under-aged. Such strategies are also more effective when backed up by community based prevention programmes. There is extensive evidence for the impact of brief advice, particularly in primary care settings, in reducing harmful alcohol consumption.

European and global alcohol policy

The ability of countries to implement effective alcohol policy is greatly affected by the trade law of the European Union (EU). Most of the cases relating to alcohol stem from the 'national treatment' rule on taxation, which means that states are forbidden from discriminating – either directly or indirectly – in favour of domestic goods against those from elsewhere in the EU. In contrast, the increasingly influential European Court of Justice (ECJ) has unambiguously supported advertising bans in Catalonia and France, accepting that "it is in fact undeniable that advertising acts as an encouragement to consumption".³

Standardised excise duties are a long-standing goal of the EU in order to reduce market distortions, where large differences in tax rates between nearby countries lead to large amounts of shopping abroad. This leads to lost revenue for the high-tax government, as well as creating pressure to lower taxation rates, as has occurred in some of the Nordic countries. The production of alcoholic drinks in the form of wine receives €1.5 billion worth of support each year through the Common Agricultural Policy (CAP). The economic and political importance of these subsidies, and in particular, the problems of wine producers, makes it hard to progress from a public health perspective.

Member State alcohol policy

Every country in the EU has a number of laws and other policies that set alcohol apart from other goods traded in its territory, often for reasons of public health. When the different policy areas are combined into a single scale, the overall strictness of alcohol policy ranges from 5.5 (Greece) to 17.7 (Norway) out of a possible maximum of 20, with an average of 10.8 (See Figure 2). This picture of alcohol policy is very different from the one visible fifty years ago, with the overall levels of policy now much closer together, largely due to the increased level of policy in many countries, particularly in the area of drink-driving where all countries have a legal limit. Marketing

* If fitted to a car, a driver would have to provide a breath sample to this device. If alcohol detected is above a certain maximum level, then the car will not start. The device can also be used to monitor a driver during their journey.

Figure 2: A scale of alcohol policy across the countries of Europe (the higher the score, the more comprehensive the policy).



Source: Anderson P, Baumberg B, 2006.²

controls, minimum ages to buy alcohol, and public policy structures to deliver alcohol policy are also much more common in 2005 than in 1950.

Recommendations

The full report makes eighteen general recommendations to support alcohol policy, followed by thirty-four specific alcohol policy recommendations. Key recommendations to support alcohol policy include:

– An alcoholic beverage could be

defined as any beverage with more than 0.5% alcohol by volume.

- A European Alcohol Monitoring Centre (EAMC) should be established and financed.
- Action plans on alcohol with clear objectives, strategies and targets should be formulated and implemented.
- Studies should be undertaken to determine how comity* of countries in relation to alcohol policy can be strengthened.

In terms of specific alcohol policy five key recommendations can also be outlined:

- A maximum blood alcohol concentration limit of 0.5g per litre should be introduced throughout Europe; countries with existing lower levels should not increase them.
- Media campaigns should be used to inform and raise awareness among citizens on implementation of policy initiatives.
- Containers of alcoholic products should carry warnings describing the harmful effects of alcohol when driving or operating machinery, and during pregnancy.
- Minimum tax rates for all alcoholic beverages should be increased in line with inflation, and should be at least proportional to the alcoholic content of all beverages that contain alcohol.
- Adequate policing and enforcement of alcohol sales and licensing laws should be implemented.
- Resources should be made available to ensure the widespread availability and accessibility of identification and advice programmes for hazardous and harmful alcohol consumption and alcohol dependence.

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* Comity is a term used in international law to describe an informal principle that nations will extend certain courtesies to other nations, particularly by recognising the validity and effect of their executive, legislative, and judicial acts. Part of the presumption of comity is that other nations will reciprocate the courtesy shown to them.

Children's lifestyles in Europe

Corinna Sorenson

Childhood is a critical stage in the development of lifestyle habits, such as dietary practices, physical activity, tobacco and alcohol use. These can positively and negatively affect health and prosperity throughout the lifespan. In fact, many experiences and exposures in childhood can have profound long-term implications on disease, disability and quality of life. Moreover, good physical and mental health in childhood influence the ability of young people to successfully navigate the challenges posed during the transition to adulthood.

The lifestyles of children have progressively changed over the last two decades as a result of a myriad of social, cultural and environmental factors. The emergence of electronic media (for example, television and internet), availability of convenience and fast foods, increased dependence on automotive travel, and changing parental roles and family dynamics are just a few of the developments that have an impact on the lifestyles of children. Although many of these transformations in the modern milieu have resulted in new opportunities and enhanced conveniences, such changes also come with risks and challenges to optimal physical, social and mental development.

Four lifestyle behaviours in particular, have influenced the health and development of modern youth. These are the focus of this article and include: the use of television and other media; tobacco consumption; increased physical sedation; and poor dietary habits. While most of these behaviours have significantly contributed to the burgeoning rise in childhood obesity, they also affect the onset of non-communicable disease such

as type II diabetes, and can stunt physical growth, educational achievement and mental health.

Television and other media

The emergence of a multimedia culture has transformed the daily lives of children and young people. In society today, the electronic media are thoroughly integrated into the fabric of life, with television, movies, videos, video games and computers central to both work and play. Increasingly, such media are assuming an integral role in children's leisure, educational and social activities across both private and public spheres. Furthermore, the influence of media is reaching children at a younger age than ever before, as evidenced by the rapidly growing markets for early childhood television programming, computer software for the under fives, and infant-oriented video series. Access to, and use of, electronic media among European youth is widespread. According to the World Health Organization,¹ more than 25% of young people watch television for more than four hours on weekdays, and even more at the weekend.

The effects of electronic media on children have garnered increased attention, as consumption continues to rise and new information and entertainment technologies infiltrate ever more the daily lives of children and their families. The use of certain types of media (for example, educational programming) may stimulate learning, improve motor skills, and offer educational opportunities not otherwise available to certain populations. They also have the potential to displace physical activities, encourage poor dietary habits, facilitate psychological problems (for example, aggression), and hinder educational achievement and cognitive development. Specifically, a high con-

sumption of all media can increase a child's exposure to violent characters and imagery via television or electronic games, as well as food marketing initiatives that focus on unhealthy foods and snacks, and forms of entertainment and social activity that do not involve physical activity or intellectual engagement.

Tobacco use

Tobacco use continues to be the largest single cause of disease and death in the EU, killing over 650,000 people every year.² Although the vast majority of tobacco-related disability and death occurs in middle-aged and older adults, smoking behaviour is most commonly established in childhood and adolescence. In fact, the vast majority of smokers begin using tobacco products well in advance of their eighteenth birthday.³ Young smokers may find it particularly difficult to quit in adulthood, increasing the risk for tobacco-related health problems in later life. It has been estimated that, unless current trends change, 30–40% of the approximate 2.3 billion children and teenagers worldwide will become smokers in early adult life and beyond. This could result in the death of some 250 million children and young people over a lifetime of tobacco use.⁴

Tobacco use in childhood has both short and long-term health effects. In the short-term, smoking can lead to reduced lung function, addiction to nicotine, increased asthmatic problems, coughing, shortness of breath, and an increased susceptibility to respiratory illness.^{3,5} Moreover, smoking is suspected to be a gateway to other types of risk behaviours, such as illicit drug and alcohol use, antisocial and violent actions (for example, fighting), and unprotected sex.³ The long-term health consequences of youth smoking include the onset of various

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cancers, reduced lung function, heart disease, and stroke later in adulthood.^{3,6} However, studies have shown that early signs of these conditions can also be found in adolescents who smoke.³

Physical activity and dietary habits

Proper fitness and eating habits in childhood offer a range of benefits during childhood, including healthy growth and development, maintenance of energy balance, weight control and psychological well-being. Moreover, an active lifestyle and good nutrition in childhood can protect against the development of non-communicable disease throughout the lifespan.

“the majority of children do not get enough physical activity, nor do they eat enough healthy, nutrient-dense foods”

Modern life has modified the social and physical environment in ways that can hinder physical activity and healthy dietary habits. These include the daily use of motorised transport, lack of open “green” spaces, changes to school physical education programmes, access to more sedentary activities (for example, television use), decline of the shared family meal, pervasive food advertising, and the use of vending machines selling unhealthy snacks in schools and colleges. Consequently, the majority of children across Europe do not get enough physical activity, nor do they eat enough healthy, nutrient-dense foods in their daily lives.

Current guidelines for young people recommend at least one hour of moderate physical activity per day, and further activities to improve muscular strength, flexibility and bone health two or more days per week.⁷ According to the Health Behaviour in School-aged Children survey,* young people in Europe only undertake one hour or more of moderate physical activity for an average of 3.86

days per week.⁹ In terms of nutrition, only about one-third of the young consume fruit and vegetables each day, while soft drinks and sweets often comprise a significant proportion of diets. In Malta, Scotland and the Netherlands, for instance, more than 40% of young people consume such foods on a daily basis.⁸

A lack of physical activity and good nutrition has contributed to the increasing prevalence of childhood obesity, which is rapidly reaching epidemic level in many European countries and closely approaching prevalence rates seen in the United States.⁹ According to the International Obesity Task Force (IOTF), more than 14 million children in the EU are overweight or obese.¹⁰ This trend is of increasing concern, especially considering that between 50–75% of children will remain as such throughout adulthood.⁹ The resulting short and long-term physical, emotional and social consequences are vast, including increased risk for many chronic conditions (for example, diabetes, hypertension), asthma, sleep disorders, psychological problems (for example, depression, body dissatisfaction) and social discrimination.

Policy Implications

As many lifestyle patterns originate in childhood, the potential for achieving the highest standards of health and well-being in Europe, by assuming a life-course perspective on relevant policy initiatives, is considerable. The alarming ascendance in obesity highlights the need for improved action and policy coordination, at both national and European levels, to address those childhood lifestyle behaviours that deleteriously affect short and long-term health and development.

A number of efforts are underway in Europe to improve the dietary habits, physical fitness and general health and development of children. Such initiatives range from EU-wide programmes and policies on childhood obesity and smoking, to country-specific legislation that restricts food advertising and marketing aimed at the young. Examples of specific actions include: the WHO Action Plan

for Food and Nutrition Policy, a School Transport Bill in England to encourage pupils to walk and cycle to school, and regulatory schemes in the Nordic countries to restrict television advertising targeted at the under twelves.

However, the scope for additional policy intervention is vast. Reflecting on available evidence regarding healthy lifestyle development in children, some potential areas for further action include:

- Multi-sector policies, involving urban planning, schools, transport, media and other government entities, to promote physical activity throughout Europe.
- Support by schools, governments and relevant health authorities for improved access to healthy food choices in the school environment (for example, cafeterias, vending machines) and nutrition education for all pupils. In addition, it may be beneficial for schools to offer media literacy education to provide children with an informed and critical understanding of the media.
- Research focusing on the effectiveness of policy interventions and models of policy coordination on nutrition, physical activity and obesity; dynamics of new media platforms (for example, internet, video games) and promotional vehicles on child development; long-term outcomes of patterns of media use in early childhood on various health and development outcomes; and the impact of physical activity on obesity and associated co-morbidities.
- Involvement and engagement of youth in the conception, development and implementation of tobacco control programmes and policies.
- Improved data and surveillance systems to monitor risk factors and associated outcomes of obesity and to evaluate the effectiveness of related policies and programmes.
- Increased funding for access to educational programmes provided through public television or other media.

Good public policies are central to the promotion, protection and enhancement of health and development. A comprehensive, multi-sectoral approach is necessary for the creation of an environment that empowers and encourages children,

* The Health Behaviour in School-aged Children (HBSC) survey covers the physical, emotional and psychological aspects of health, and the influences of the family, school and peers on young people aged eleven, thirteen and fifteen in 35 countries and regions in the WHO European Region and North America.

families and communities to adopt healthy lifestyles across the lifespan.

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Europe in the world and global health

John Wyn Owen

This is an introduction and sets the scene for a series of articles that will appear over the next 18 months in Eurohealth. They will review global health from a European perspective and its place in foreign policy, development, trade, environment and global governance.

Together the articles will form the consideration that a European Global Health Strategy and a European Partnership for Global Health are imperative as an integral part of a vision of a resilient Europe and its new global diplomacy, reflecting interconnectedness and future global challenges.

Partnerships for health to unlock Europe's futures

In a globalising world problems and solutions reach across national borders in a growing number of fields, linking economic opportunity and growth, as well as development and human security. Political stability or instability further shape the nature of international alignments while leaving them in an unprecedented state of flux. Traditional models of leadership are no longer as effective, as illustrated by disputes within the World Trade Organisation, disagreements concerning the Kyoto Protocol and the UN discord over Iraq. There is a need for new forms of leadership; governments alone cannot form a sustainable society from their own recourses.

It takes partnerships and civic engagement to create a dynamic society. Mr Javier Solana, EU High Representative for the Common Foreign and Security Policy and President of the Madariaga Foundation, has stressed the importance of developing partnerships to unlock Europe's role and voice in the global

future, recognising that its history and diversity confer a potential to become a bridge between civilisations and cultures. This will not be realised automatically, it requires organisation and concerted action.

Robert Schumann observed that Europe will not be made all at once. It will be built through concrete achievements which create a de facto solidarity. The development of a coherent and visible European Global Health Strategy would not only be in our own self interest, but also an exemplar of an effective European approach to external relations. It would be a way of promoting shared values, both within and outside our borders, towards sustainable development and a commitment to human rights including health.

Globalisation and health

Lee and Collin¹ define global health as an "issue when the determinants circumvent, undermine or are oblivious to the territorial boundaries of states and thus beyond the capacity of individual countries to address through domestic institutions" and are a reflection of "spatial, temporal and cognitive changes", in short, "globalisation". The EU Commissioner for External Relations, Benita Ferrero-Waldner,² claims that the debate about the EU boils down to one word "globalisation". Further she goes on to claim that the biggest Member

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States are too small to handle the “challenges of climate change, fighting pandemics, alleviating poverty, or stabilising neighbouring states and that the only effective approach is to work together to negotiate globalisation terms and consolidate a rule based order of the future”. The Commissioner quoted UK Prime Minister, Tony Blair, saying that “the world is more interdependent than ever. Nations are obliged to cooperate. If the EU did not exist we would have to invent it.”

To face today’s challenges, and those that lie ahead, the capacity to project ‘soft’ power will be increasingly important. Health as a bridge between internal and external policy development in Europe and as a key element of human security, extends beyond state security and ‘hard power’, the traditional features of foreign policy. It can play a key part in a ‘Europe in the World’ building ‘Prosperity, Security and Solidarity’.³ There is also a dark side to globalisation which requires action on hard security issues. Action against the proliferation of weapons of mass destruction, terrorism and organised crime, as well as the implementation of health protection measures are crucial.

Europe is already playing a leading role in world affairs, providing a sensible and responsible approach to globalisation but, as has been stressed by Benita Ferrero-Waldner, there is a need for “a stronger EU foreign policy”. This introduction and subsequent papers will explore the positioning of health as an exemplar of a new EU foreign policy “in a world where there is no such place as abroad”.⁴ Fidler claims that the increased prominence of health in foreign policy “signals a profound change in national and international governance. The position of health has become an independent marker of good governance.”⁵

Challenges

The global health challenges for both poor and advanced economies are well documented. These include global health inequalities; legal and illegal migration; the poaching of health professionals; traditional infectious and newly emerging diseases that do not recognise borders, such as SARS and avian flu; the spread of chronic diseases previously only found in wealthier societies; and the often neglected area of mental health. While we have been successful in eradicating diseases such as smallpox we have created poten-

tially threatening biological weapons.

Europe is well experienced with conflicts, natural disasters, and diseases transmissible from animals to man – planning for a flu pandemic is increasingly in the news. The enormous increase in trade in food across borders may enable the transmission of intentional or unintentional contamination and lead to serious outbreaks of disease. The increase in travel means that pathogens are transferred with great speed from one location to another locally, regionally or even globally. Food insecurity continues to be a major issue and malnutrition makes worse existing vulnerabilities and acts as a persistent drain on productivity. Conflict and civil unrest increase vulnerability to health risks, while violence adds to preventable morbidity and premature death. The instability associated with poverty and poor health accelerates both state or institutional failure and the proliferation of violence. Social problems of homelessness, crime and substance abuse also affect health, particularly that of children and young people.

“only 10% of research funds are spent on the 90% of health problems concentrated in the poorer countries of the world”

European responses

One recognition of Europe’s contribution to Global Health was signalled by former European Commissioner for Health and Consumer Protection, David Byrne, in his valedictory address at the European Health Forum in Gastein in October 2004, ‘Global Health ,Global Healing’. There is already a European Health Strategy, as well as a European Centre for Disease Control in Stockholm with a global remit of health protection on behalf of all Member States. European health industries are in a powerful position, particularly the pharmaceutical industry in their negotiations on intellectual property and vaccine patents. The public health implications of such negotiations are enormous.

The European health insurance industry, health care services, universities and

financial institutions with all their capacity, competence and capabilities are in a position to exert a major influence on global health care. European philanthropy is increasingly working together to promote global health through global giving and promoting policy debate. Furthermore, European Foundations’ convening power and their trans-Atlantic links and networks across civic society in Europe makes them important partners.

Europe’s health care systems are experienced but public health experts can play a more central role in global, European and national debates on policy development. There is also scope for further coordination of the work of multiple actors. This can already be seen in number of countries such as the UK where the Department of Health and the Foreign Office have been exploring health and foreign policy and a UK Partnership for Global Health is in place.⁶ Another example is the case of Switzerland where the Federal Government have produced a draft health and foreign policy.

European strategic issues

Health, security and foreign policy

Health has raised its profile in foreign policy, but there continues to be a need for an assessment of current thinking in Europe about new security challenges, such as fragile or failing states, what health can do for foreign policy, and what foreign policy can do for health.

Health interests have already played a key role in conflict prevention and in post conflict situations, but there is more work to be done in promoting peace studies,⁷ developing the place of health in security policy, including the role of the military in humanitarian assistance, the role of health in European military doctrine, and rebuilding post conflict societies to ensure the creation of long term stability within countries and regions.

Health and sustainable development

The relationship between health, climate and the environment are under researched given the challenges to society of shifts in demographics, increased urbanisation and the need for safe clean water. There are opportunities for further collaborations between non-governmental organisation, intergovernmental organisations and governments. European foundations could assist,

playing an important convening role.

These foundations, in partnership with other sectors, have a long tradition of supporting learning by investing in the sciences and humanities. A European innovation which could compliment the development of new health interventions, drugs, vaccines and better nutrition would be to use existing knowledge to strengthen the health care systems globally that deliver health interventions and thus reduce the gap between knowing and doing. European foundations might consider establishing national libraries of health as a part of the emerging national academies of science in a number of developing countries.

Health and trade

There is also a need to support efforts to clarify policy options between global health and economic interests. The potential impact of economic policies on the determinants of European health, and Europe on the health of others globally, through trade and intellectual property in particular, are matters for further analysis; recognising that 'good health is good economics'. The economic consequences of SARS for the global economy have been variously estimated as between €60–100 billion, while avian flu is a prominent reminder of the economic consequences of health emergencies. Many international financiers are now asking what other public health emergencies will have macro economic consequences.

European pharmaceutical companies, universities and research centres are major sources of research and development; yet only 10% of research funds are spent on the 90% of health problems concentrated in the poorer countries of the world. Further efforts to develop health systems in these poor economies are threatened by the flow of qualified personnel to European (and other) countries. This continues to be an area for urgent action by Member States. Again, philanthropic bodies in Europe could play an important part in convening meetings of interested parties, including Member States, the Commission and WHO.

Health and governance

The recent appreciation of the importance of global health by governments and philanthropists has revolutionised the scene with money, tools and creative ideas, but narrowing the gap between

aspirations and actions remains a challenge. The revolution has done some good, but according to the American Association for the Advancement of Science, the missing piece is the architecture for global health and the proper arrangements for health governance.⁸

Summary and global challenge

In summary, the challenge for European countries, as well as for the European Union and European Commission, is to make globalisation work and to use health to foster better forms of globalisation. Implicit in the idea of making globalisation work is the contention that it is not working at the moment. Some may argue that this is not the case; global life expectancy continues to rise, the global economy expands, and scientific innovation and discovery proceed at seemingly exponential rates unlocking the keys to increased health, wealth and happiness. However, we are aware, as never before, of the downside of increasing interconnectedness; while large parts of the globe experience the positive story of globalisation, millions are cut off from it. Little research is directed towards the major health problems that affect most of the world's population.

“Health could be a bridge to peace that has a role in conflict prevention and in rebuilding society in post conflict situations.”

These failings must be addressed, not just for reasons of common humanity, but for the fundamental reason that the negative externalities of economic globalisation may, in time, threaten its very foundations. Health therefore has a central role to play in meeting the challenges of making globalisation work. The danger is that we will have health as a private good, health as exclusive and hierarchical, health as only the preserve of the rich and health as a matter only of national or European security.

The challenge is not just about technology, neither is it just about supply and demand or getting markets right, although both will play a role. What is

important, as these series of articles will try and demonstrate, is the importance of extending the appreciation of health issues amongst policy makers and bringing diverse members of the policy community, including European foundations, together to discuss global challenges. Through consultation and engagement they can develop a European Global Health Strategy and establish a European Partnership for Global Health that, as weapons were the currency of the cold war, health could be one of the currencies to make globalisation work. Health could be a bridge to peace that has a role in conflict prevention and in rebuilding society in post conflict situations.

This is a matter not just for politicians, although they must play their part. This fundamentally is a challenge to our ability to act together at all levels affected by these issues: the places we live; political communities and nations; across different countries of Europe and in institutions of global governance. By mobilising key actors we can begin to fulfil the promise of the benefits of global health for 'Prosperity, Security and Solidarity'.

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Are non-respondents ill?

The relationship between survey participation and health

Ineke Stoop

Why is non-response a problem?

According to the 1987 Dutch Amenities and Services Utilisation (AVO) survey,* the physical condition of men aged 85 years and older was substantially better than that of men in a younger age bracket (80–84 years).¹ This remarkable result can be put down to the design of the survey. As in most social surveys, the sample was drawn from the non-institutionalised population. Assuming that older men who suffer from physical disabilities are more likely to be living in residential care, the health of those remaining in the community will compare favourably with that of younger men who are more likely to be living alone; hence this counter-intuitive outcome.

The health of the community dwelling population can also have an impact on their survey participation. Target respondents who are in hospital or seriously ill cannot be contacted. Target respondents who suffer from physical disabilities or mental health problems will not always be able to cooperate in a general survey. For instance people with visual impairments cannot easily respond to written questionnaires, those with hearing difficulties may not be able to hear spoken questions, and people living with cognitive problems, such as dementia, may not understand questions.** Target respondents who have a bad cold or headache may not look forward to a lengthy interview and thus refuse to cooperate. Conversely, those who are feeling a little unwell may be more likely to be at home. They may welcome the distraction of an interview and jump at the chance to dis-

cuss at length their ailments and complaints with a sympathetic interviewer. In both cases non-response bias may occur, resulting in either too low or too high an estimate of health problems. Cohen and Duffy, for instance, found that the “prevalence of common sources of ill-health in the over 75s is likely to be underestimated, even by a carefully conducted health survey, but among the ‘young elderly’ such prevalence estimates are unlikely to be severely biased if a reasonably high response rate is achieved”.²

Quality programme and non-response study

Response rates to the Dutch AVO survey fell from 60–70% in the 1980s to 43% in 1991, raising serious concerns about the quality of the data and the possible differences between respondents and non-respondents. An intensive data quality programme resulted in a substantial improvement in response rates (69% in 1995, and between 60% and 65% in 1999 and 2003), combined with a detailed record keeping of the response process. This monitoring, based on detailed records of the fieldwork, including information on the timing of household visits, outcomes of contacts and information on the interaction with householders, made it possible to evaluate the differences between ‘easy’ respondents (easy to contact and easy to persuade), those who

were hard to contact, and those who were initially reluctant to cooperate but who subsequently participated (the converted refusals). In addition, in 2000 a follow-up survey was conducted among a sample of the most adamant refusers in the 1999 study. The persistent refusers who finally cooperated in the follow-up survey could be compared with the converted refusers in the regular study. Previous publications indicate how the results of this follow-up study make it possible to assess whether the enrolment of converting refusals helps to minimise non-response bias and to what extent non-response bias remains in a survey with reasonably high response rates.^{3,4}

Enhancing response rates

The target households in the AVO were sent an advance letter on behalf of the Social and Cultural Planning Office outlining the purpose and contents of the survey. They were approached in person by experienced interviewers trained in achieving high response rates. In the AVO, almost all target households were contacted. This high contact rate was obtained by making up to twelve visits to previously non-contacted households over a five-month fieldwork period, including evening and Saturday house calls and additional telephone calls to those not at home. This large number of contact attempts ensured that both those

* The AVO is a face-to-face survey of a net sample of 6,000–6,500 households, commissioned by the Social and Cultural Planning Office (SCP) of the Netherlands, and conducted every four years. The survey comprises a household interview with a responsible adult and a drop-off self-completion questionnaire for every member of the household aged six years and older.

** Surveys can be adapted to include these groups, and special surveys can be conducted among people with learning and physical disabilities. In general social surveys, such as the AVO, these special measures are rarely taken. Most survey interviews in the Netherlands are only conducted in Dutch, so a very small minority of the population, such as recent migrants, may also not be able to participate.

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Table 1: Initial response at first contact and final outcome for all contacted sample households (%)

	Response at first contact	Final outcome
Interview	37.0	66.1
Appointment	14.3	–
Broken off/incomplete	5.3	5.7
Not able, ill	1.7	0.6
Not able, busy	2.2	0.3
Not able, language problems	0.1	0.1
Not able, other reasons	3.8	2.0
Refusal	35.5	25.2
N (=100%)	9,261	9,261

individuals who were rarely at home and those who were away for long periods could be contacted. The percentage of target respondents who said they were not able to cooperate because they were ill was slightly higher during the day than during the evening. Rather than reflecting poor labour morale in the Netherlands, this is likely to reflect the presence of other, healthy household members during evening hours.

Table 1 reports the initial responses to first contact with interviewers as well as the final outcomes for each household. Initially, 35.5% refused to cooperate. More than two-thirds of those who initially refused to cooperate were re-approached. 37% of the initial refusers ultimately agreed to participate. This led to a substantial increase in the response rate. The number of those who initially refused who were re-approached, and of

these those who then decided to participate after all are remarkably high. Similar findings have been seen elsewhere, as in the European Social Survey.⁵ This shows that perseverance pays, and that respect for respondents can be combined with asking them to cooperate after a previous refusal.

At the first contact, 1.7% of those individuals who opened the door said that they were too ill to be interviewed. Half of these individuals ultimately did cooperate. The net effect of re-approaching those who were ill was therefore much smaller than that of converting refusals; although of course those who cannot participate because of illness are a specific group.

Final refusers

In a follow-up survey of a small sample of adamant refusers, a response rate of

more than 70% was obtained. A comparison between respondents and non-respondents to this follow-up survey gave no reason to assume that these groups differed. The high level of response in the the follow-up survey can be attributed to a number of factors:

- A less burdensome survey design: shorter questionnaire, one person only, multi-mode;
- Highly motivated, well-trained and well-paid interviewers;
- Good support for interviewers from fieldwork organisations (training, support desk and special newsletter);
- A wide range of incentives for respondents (monetary, the prestige of participating in a survey reported in a major national newspaper, direct involvement of a high calibre management survey organisation and sponsor).

These adamant refusers differed in a number of aspects from the participants in the regular survey. In the latter group, for instance, single men were under-represented; it was therefore to be expected that they would be over-represented among refusers. They included both more of the younger (16–34) and older (55 plus) age groups. They were also slightly less active on a wide range of issues, participation in sport, in religious activity or in computer ownership. Those individuals who refused to participate who did own a computer, however, used it more often to access the internet, as well as for chatting and playing games. Cultural participation also had a particular relationship with response behaviour. Those who were hard to contact participated in more cultural activities than those who were more often at home. Those who initially refused partook more in classical cultural activities (classical music concerts, opera, theatre) whereas the final refusers participated more in popular cultural events (cinema, pop music concerts, clubbing). These differences suggest that converted refusers are not necessarily the best proxy for final refusers.

Health and response behaviour

The outcomes of the survey presented in Figure 1 show that hard to contact respondents are generally healthier than the other response groups; this has also been reported by Lynn and Clarke.⁶ In their UK based study, respondents in hard-to-contact households were

Figure 1: Health status by response group

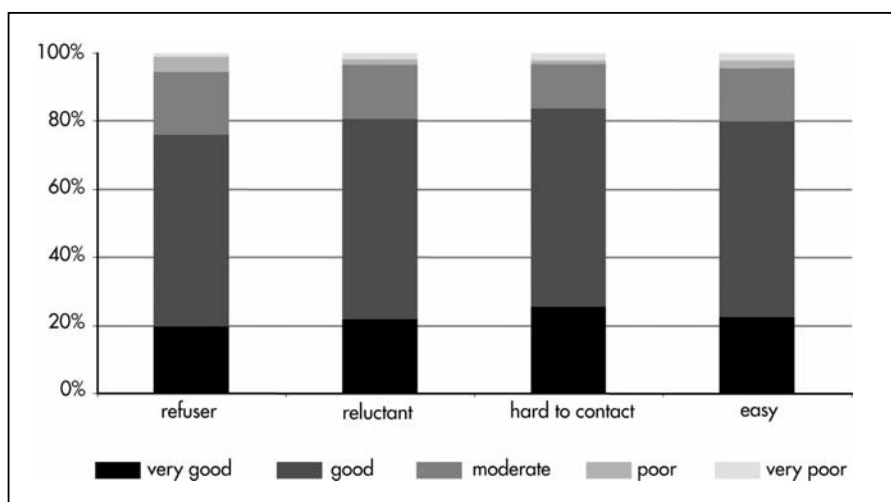
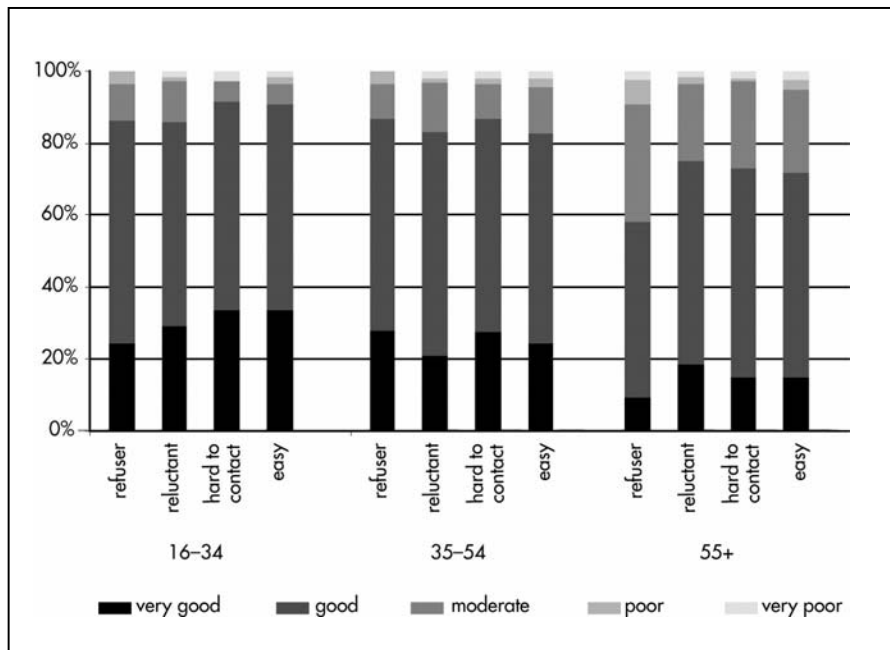


Figure 2: Health status by age and response group

younger, more likely to be employed, more often heavy smokers and drinkers, but still more healthy. This latter characteristic may be related to their age and employment status. The respondents in the Dutch survey who showed some initial reluctance (the converted refusals) did not differ from this pattern with respect to health. The final refusers who participated in the follow-up survey were, however, slightly less healthy than the respondents in the regular survey.

After correcting for socio-demographic characteristics, however, these health differences disappear, or show a less consistent pattern. Figure 2 shows that final refusers in the 16-34 and 55 plus age groups are less healthy than participants in the regular survey. Individuals in the 35-54 years age group were, however, at least as healthy as regular respondents. These differences are not significant.

Improving health surveys

What do these results teach us with respect to health surveys? First (and outside the scope of the non-response study presented above) they show that excluding people living in institutional care facilities from health surveys may give a biased view of the health of older people. Second, it appears that quite adequate response rates can be obtained by increasing the contact rate and persuading those who initially refuse to participate. This is important, because a high contact rate may improve the balance of the survey. More contact attempts will

increase the probability of contacting healthy, employed, busy people. Allowing sufficient time for fieldwork will make it possible to get in touch with those individuals who are not at home for a long periods, for instance because they are in hospital. This will also make it possible to re-approach those who were temporarily not able to cooperate because of illness. The results here suggest that the majority of this group may be willing to participate at a later point in time.

These results do not indicate that initial refusers are more or less healthy than willing participants. The health status of final refusers differed, but these differences are partly due to differences in age and sex. What is clear, however, from this

study is that non-contact and refusal may lead to different types of non-response bias: those who are hard to contact are likely to be more healthy than the easy to contact, whereas those who refuse may be more often older people who are less healthy than the participants. Only by closely monitoring the response process and by collecting supplementary information on final refusals can these factors be brought to light.

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Patient mobility in the European Union: Learning from experience

To what extent should patient mobility be of concern to European policy-makers?

The book is freely available on-line at www.euro.who.int/Document/E88697.pdf

This new book, edited by Magdalene Rosenmøller, Martin McKee and Rita Baeten, supported by the Sixth Framework Programme for Research, and published by the European Observatory on Health Systems and Policies, is an attempt to inform this debate. It seeks to understand how the opportunities offered by the EU, for instance on sharing capacity in border regions, or on ensuring access to specialist services, can be maximised.

A series of case studies illustrate different issues and how local health systems have responded. These include cross border care arrangements between Slovenia, Austria and Italy as well as between Estonia, Finland and Latvia. Arrangements on the island of Ireland are also discussed. Meeting the needs of new long term residents in Spain, tourists in the Veneto region of Italy and the development of contractual agreements and other forms of cooperation between several EU countries also feature.

Mythbusters

Myth: We can eliminate errors in health care by getting rid of the 'bad apples'

People expect that when they go to hospital, they will come out in better health. However, a minority of patients will suffer what are known as 'adverse events' or poor outcomes related to their care rather than their disease. Sometimes adverse events are the result of human error – from rolls of gauze left inside patients to hospital equipment improperly sterilised. One particularly tragic adverse event occurred in March 2004, when two Calgary patients died after being given potassium chloride rather than sodium chloride.¹

When an error does occur, a common response is to 'name, blame, and shame' – the person who made the mistake will be singled out, possibly sued or fired, and everyone feels an uneasy comfort – after all, the problem person has been dealt with.

While this is a common response, it does not make our hospitals any safer. Though there are some 'bad apples', most health care professionals do not make mistakes because they're negligent or careless. Rather, research shows that larger systemic problems are the cause of most mistakes, such as staff who are tired and not thinking clearly, equipment that is hard to read and control, or different medications that have similar names and packaging.²⁻⁶

The cost of medical errors

In 2004, the first large-scale study of adverse events in Canadian hospitals found that 7.5% of adult hospital admissions for surgery or medical care are associated with an adverse event – that is about 185,000 events a year. And almost 70,000 (36.9%) of these could likely be prevented.⁷ A second study found that nearly one-quarter of adult

Canadians reported having an adverse event happen to them or a family member in hospital or community care.⁸

Though it is cold comfort, Canada's numbers are in line with data from Australia, New Zealand, and England, which found adverse event rates of between 10.8 and 16.6%, with similar or slightly higher proportions of preventable errors as in Canada.^{7,9-11} In the United States, the Institute of Medicine estimates that between 44,000 and 98,000 Americans die annually because of system errors,¹² and the adverse event rate is estimated at between 2.9% and 3.7%. However, different methodologies and definitions make it difficult to compare results directly, and the American studies did not calculate preventability.

These studies tell us that people working in health care systems around the world – with different types of funding, organisation, and delivery – are making mistakes, often the same mistakes, refuting the myth of 'a few bad apples'.

Why we make mistakes

Errors are not isolated problems, but have underlying systemic causes.⁸ Research has long shown that working in complex, stressful environments like hospitals makes everyone prone to mistakes. Despite the demand for 'multi-tasking', the human brain is not capable of keeping more than a few pieces of information straight at any one time.²⁻⁴ Thus there is a risk of information overload when health care professionals must monitor many pieces of equipment in surgery or fill several medication orders in a short time.²⁻⁶

This is made worse when they are tired and overworked, or when there isn't enough staff.²⁻⁶ Physical aspects of health care today also contribute to mistakes; for example, handwritten prescriptions are often difficult to read, especially when medications have similar names.

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 September, 2004. © CHSRF, 2004.

How to fix the problem

An effective strategy is to change policies and procedures to make it more difficult for people to make mistakes and easier to recognise and recover from those that will occur.^{2-5,7,9,11-16} There are some simple ways to do this, such as bar codes on medications, patient-specific electronic health records, computerised ordering of medical tests, and standard treatment guidelines.⁸ Just using a computerised prescription system can cut medication errors by nearly 20%.^{17,18}

Some improvements have already been made. It used to be common for anaesthetists to accidentally connect oxygen lines to nitrous oxide tanks until the fittings were changed to make it physically impossible to do so.¹⁹ Following the deaths in Calgary, the health region moved its potassium chloride supply, and it changed its supplier to ensure the package is different from sodium chloride.¹

In the long run, it is probably more important, but perhaps more difficult, to address the 'culture of silence' around system mistakes. Many health care professionals say that, while patient safety is a high priority in their workplaces, they believe they would be treated negatively if they reported errors.⁸ However, it appears that this alone will not solve the problem; New Zealand, with its no-fault patient compensation system, still experiences a significant number of adverse events.^{8,9}

While they can lead to tragic outcomes, mistakes should be seen as learning opportunities, so another patient does not suffer the same error.^{2-5,7,9,12-16} And this is indeed what most patients, families, and health care professionals want.⁸

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MATTERS OF THE HEART AND MIND: RISK-RISK TRADE-OFFS IN EATING FISH CONTAINING METHYLMERCURY

Joshua T Cohen

“...we hope that this analysis demonstrates both the value and the feasibility of quantitatively evaluating the benefits and countervailing risks of this, and other, public health interventions.”

In 2004, the US Food and Drug Administration (FDA) and the US Environmental Protection Agency (EPA) issued an advisory about the risks of methylmercury in fish and shellfish. Methylmercury is a neurotoxin that can cause developmental delays when young or unborn children are exposed. The advisory therefore targeted parents of young children, pregnant women, women who may become pregnant, and nursing mothers.

On the other hand, fish are an excellent nutrition source, rich in omega-3 fatty acids. The omega-3 fatty acids are thought to reduce the risk of coronary heart disease and stroke, and may also be good for the neurodevelopment of young and unborn children. The FDA and EPA advisory therefore had to walk a fine line.

The advisory states that fish are an important part of a healthy diet, and that the advisory is not aimed at the large majority of the population for whom mercury poses little health risk. For those targeted by the advisory the message is nuanced:

1. Avoid those types of fish with high mercury concentrations (shark, swordfish, king mackerel, and tilefish);
2. Eat no more than one meal a week of fish with moderate mercury levels, such as albacore tuna;
3. Eat no more than two meals a week of fish with low mercury concentrations (for example, shrimp, canned light tuna, salmon, pollock, and catfish); and
4. Check local advisories about the safety of non-commercially caught fish.

The consequences of the 2004 advisory, however, remain an open question. First, because mercury poses a risk to the cognitive development of young and unborn children but omega-3 fatty acids can help cognitive development, does the recommended shift in maternal fish consumption help or hurt children?

Second, could unintended shifts in fish consumption among other members of the population lead to substantial increases in stroke and coronary heart disease? More generally, how should decision makers evaluate this and other

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The Harvard Center for Risk Analysis recently conducted two projects evaluating public-health interventions to address methylmercury exposure.

This article describes a project by Joshua Cohen and colleagues that estimates the net impact of the 2004 FDA/EPA advisory warning women of childbearing age about mercury in fish. Cohen *et al.* take the amount of mercury in the environment as given and evaluate the net effects of the 2004 advisory on public health, including both the cognitive benefits of lower mercury exposure and the forgone nutritional benefits from reduced fish consumption.

Earlier work, conducted by HCRA Director James K Hammitt and graduate student Glenn Rice, quantified the monetary value of health improvements associated with reducing mercury emissions from coal-fired power plants in the US. This took population fish consumption patterns as given and evaluated the impact of reducing the amount of mercury released to the environment.

public-health interventions that may involve trade-offs?

Evaluating these trade-offs in the context of the 2004 fish advisory depends on quantifying the impact of the advisory on fish-consumption patterns, estimating the extent to which the resulting changes in consumption affect nutrient intake and contaminant exposure, and quantifying the relationship between changes in these intakes and the resulting health effects. Finally, the different types of health effects must be aggregated to determine the net impact.

To study these questions, the Harvard Center for Risk Analysis (HCRA) was awarded a grant by the National Food Processors Association Research Foundation and the Fisheries Scholarship Fund. HCRA convened a scientific panel chaired by Steven Teutsch (now at Merck & Co, Inc., and formerly with the Centers for Disease Control and Prevention). Other panel members were David Bellinger (Department of Neurology, Children's Hospital, Boston), William Connor (Division of Endocrinology, Diabetes and Clinical Nutrition, Oregon Health Sciences University), Penny Kris-Etherton (Department of Nutritional Sciences, Pennsylvania State University), Robert Lawrence (Department of Health Policy and Management, Bloomberg School of Public Health, Johns Hopkins University), David Savitz (Department of Epidemiology, School of Public Health, University of North Carolina), and Bennett Shaywitz (Department of Pediatrics and Neurology, Yale University). Harvard scientific staff included Colleen Bouzan, Joshua Cohen, Ariane König, and principal investigator George Gray.

This Risk in Perspective summarises the full report, which has been peer reviewed and appears in the *American Journal of Preventive Medicine* 2005;29(4):325-334.

The impact of fish advisories on fish consumption

Estimating the impact of advisories on fish consumption patterns is difficult because relevant studies are limited. One study reported that following the release of a similar fish advisory by the federal government in 2001, pregnant women in eastern Massachusetts decreased their fish consumption by 17%. Beyond this study, the evidence is fragmentary. Although no study in the scientific literature reports

the impact of advisories on consumption among the broader population, it is not difficult to imagine that disturbing headlines, such as those below, may lead some individuals to avoid fish:

- EPA says mercury taints fish across US. (*New York Times* 25 August 2004);
- Study finds mercury levels in fish exceed US standards. (*New York Times* 4 August 2004);
- Proposal would require warnings about mercury dangers in fish restaurants, markets would be forced to post trilingual signs (*San Francisco Chronicle* 4 October 2005).

Rather than estimating exactly how the 2004 advisory affects consumption, we consider three representative scenarios. Our 'optimistic' scenario assumes that only women of childbearing age change their consumption in response to the advisory, and that they do so by shifting consumption from the typical mix of fish for US consumers to a mix that replaces fish high in mercury with fish low in mercury. This scenario is optimistic because it assumes women reduce mercury exposure while essentially preserving the omega-3 fatty acid health benefits.

Our 'middle' scenario also assumes that only women of childbearing age react to the advisory. In this case, however, we assume they reduce their consumption of fish by 17% without changing the mix of fish consumed. Unlike the optimistic scenario, this scenario envisions a loss of some neurological development benefits to unborn children because of decreased maternal intake of omega-3 fatty acids.

Our 'pessimistic' scenario assumes that all adult members of the population reduce their fish consumption by 17%. In this case, all adults lose some protection against coronary heart disease and stroke.

In addition to these scenarios, we examined how an increase in fish consumption would affect public health.

The impact of fish consumption on omega-3 fatty acid intake and mercury exposure

We use data on omega-3 fatty acid concentrations in fish, together with a model developed by the FDA, to quantify the impact of the shifts in fish consumption envisioned in our three scenarios on

omega-3 fatty acid intake and mercury exposure.

Health effects due to shifts in fish consumption, omega-3 fatty acid intake and mercury Exposure

Quantifying the health effects associated with shifts in fish consumption, omega-3 fatty acid intake, and mercury exposure has proven to be the most challenging aspect of the project. For mercury, typical risk assessments conducted by the federal government are not helpful because they identify a safe level of mercury exposure (referred to as the 'reference dose'), rather than quantifying the incremental risk associated with changes in exposure. Although we could translate changes in fish consumption into changes in the proportion of individuals above and below the reference dose, we could not determine the impact of such shifts on measurable outcomes, such as cognitive ability as measured by IQ.

The second problem is the sheer number of potential health effects to consider. For example, in addition to aiding cognitive development in children and reducing the risk of coronary heart disease and stroke in adults, omega-3 fatty acids may also protect against Alzheimer's disease, depression, and low birth weight. In addition to compromising cognitive development, mercury may affect coronary health, harm the immune system, and adversely affect the kidneys. The HCRA panel reviewed the scientific literature and identified those effects judged both reasonably plausible given the available scientific evidence and likely to be substantial relative to the other health effects under consideration.

A related problem concerns other contaminants in fish. For example, some fish have elevated concentrations of organic chemicals, such as polychlorinated biphenyls (PCBs), which may cause cancer. However, because we judged their impact to be small when compared to other health effects included in our analysis, the effects of these compounds are not included.

Ultimately, our analysis includes four health effects:

1. The impact of mercury exposure during pregnancy on cognitive development, as measured by IQ.
2. The impact of omega-3 fatty acids on cognitive development, also measured in terms of IQ.

3. The net impact of fish consumption (i.e., the effects of both omega-3 fatty acids and mercury) on coronary heart disease mortality.
4. The net impact of fish consumption on stroke incidence and mortality.

Aggregating different types of health effects

Integrating the fish consumption scenarios, their modelled impact on fish consumption, mercury exposure and omega-3 fatty acid intake, and the estimated impact of these shifts on the health outcomes yields projected changes in population mortality (due to stroke and coronary heart disease), non-fatal stroke incidence, and IQ. In order to aggregate these impacts, we convert them to a common metric: the quality-adjusted life year (QALY). QALYs provide a method to account for changes in both mortality and morbidity. One QALY is defined as a year of life in perfect health, while death is assigned a value of zero QALYs. A year of life in less-than-perfect health has a value between zero and one QALY. The QALY has a well-defined theoretical foundation and has been used extensively in the scientific literature to evaluate the costs, risks, and benefits of many hundreds of health interventions.

Results

Our analysis shows, not surprisingly, that the impact of the 2004 advisory depends heavily on how it affects fish-consumption patterns. Table 1 summarises our findings for the US population in terms of ‘natural units’ – i.e., changes in annual mortality (due to coronary heart disease and stroke), annual non-fatal stroke incidence, and total IQ (i.e., the sum of the gains and losses in IQ among all four million babies born in the US each year).

Under our optimistic scenario (women of childbearing age shift to low mercury fish, but do not change total fish consumption, as effectively recommended by the 2004 advisory), there is a gain of more than 400,000 IQ points among newborn babies each year. There are slight increases in mortality and non-fatal strokes, but these are small because women of childbearing age are at low risk of these effects. To help put these numbers into perspective, it is useful to think of them on an individual basis. The cognitive-development benefit averages 0.1 IQ points per newborn baby and the increase

in individual annual mortality risk is less than one in 1 million for women between the ages of 35 and 44.

Under our middle scenario (women of childbearing age decrease fish consumption by 17%), the positive effects of omega-3 fatty acids on cognitive development are reduced and the net gain in IQ drops to 92,000 points per year for all newborn babies in the US (approximately 0.02 points per child). The mortality and non-fatal stroke risks remain small.

Our pessimistic scenario (all adults decrease fish consumption by 17%) results in the same cognitive-development benefits to newborn babies because this scenario is identical to our middle scenario for women of childbearing age. The decrease in fish consumption among other members of the adult population, with much higher baseline risks for coronary heart disease and stroke, results in

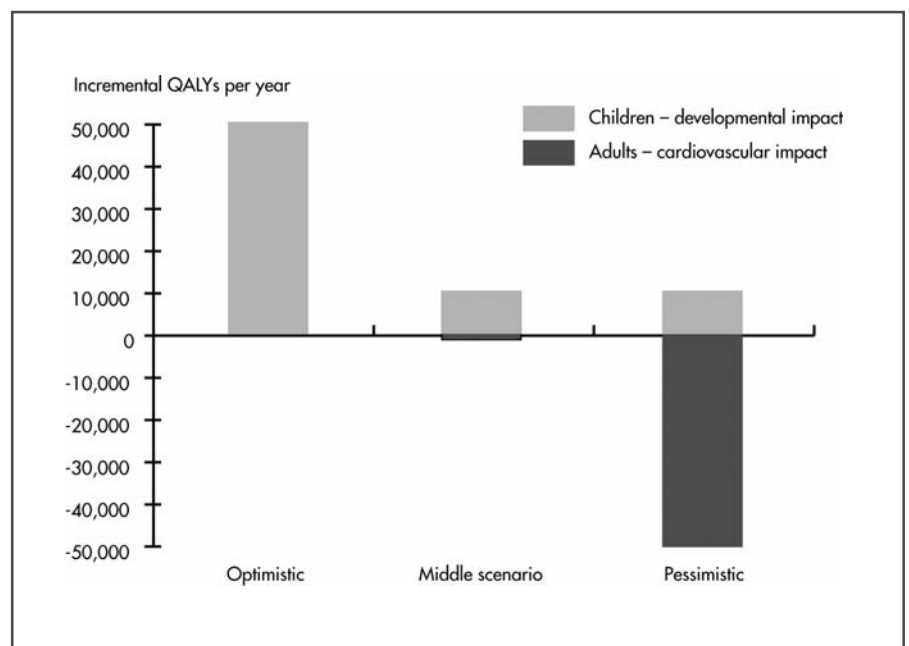
approximately 8,000 additional deaths and 1,500 non-fatal strokes each year. On an individual basis, the risks differ by age group because of differences in baseline risks. For example, we estimate that the 17% decrease in fish consumption would increase annual mortality risk by approximately 3 per 100,000 for males aged between 55 and 64, by 8 per 100,000 for males aged 65 to 74, and by 28 per 100,000 for males aged 75 to 84.

Converting IQ points, fatalities, and non-fatal strokes into QALYs makes it possible to aggregate these outcomes and determine if the overall impact on public health is positive or negative. Figure 1 shows that, under our optimistic scenario, the cognitive-development gains among newborns are the dominant factor and that population well-being improves. Under the middle scenario, cognitive development remains the dominant factor, although the countervailing loss

Table 1: Impacts by health effects

Health effect	Scenario		
	Optimistic	Middle	Pessimistic
Cognitive development (net IQ points gained)	410,000	92,000	92,000
CHD and stroke mortality (additional annual fatalities)	14	71	7,900
Non-fatal stroke incidence (additional annual cases)	14	68	1,500

Figure 1: Impacts aggregated over health effects



due to lower omega-3 intake contributes to reducing this gain by a factor of five. Under our pessimistic scenario, the cognitive impact for newborns remains beneficial but is dominated (in QALY terms) by the increased cardiovascular impact among adults.

Finally, we found that an increase in fish consumption would decrease both stroke and coronary heart disease risk. In the case of coronary heart disease, our evaluation of the epidemiologic data suggests substantial benefits are associated with consumption of at least some fish (for example, one meal per week), rather than no fish.

Uncertainty

Our evaluation includes an extensive analysis to identify assumptions that have a substantial impact on our findings. We review several here. First, our estimate of the impact of mercury on cognitive development is more pessimistic (i.e., we believe mercury is more harmful) than the estimate developed for US EPA in 2005 in their evaluation of proposed rules for coal burning power plants (the 'Clear Skies' Initiative). Using an assumption closer to that of the EPA reduces the net benefits projected under our optimistic scenario by a factor of three. Under our middle scenario, the net effect of the advisory becomes negative.

Second, our evaluation of the epidemiologic literature leads us to conclude that people who consume a small amount of fish gain a great deal of protection against coronary heart disease compared with people who eat no fish (defined as less than one meal per month). We assume that increasing fish consumption even more affords further incremental protection against coronary heart disease, though in our analysis most of the benefit occurs with a single fish meal per week.

If we drop the first assumption (that there is a substantial benefit associated with eating at least some fish), our projected losses for the pessimistic scenario decrease from 41,000 to 23,000 QALYs annually. If we instead retain that first assumption but drop our second assumption (that further fish consumption confers additional benefits), then projected losses for the pessimistic scenario decrease to 6,600 QALYs annually.

Finally, it is useful to explore the extent to which our findings depend on the scenarios we define. For example, the net

loss projected for the pessimistic scenario is driven in large part by the 17% drop in fish consumption among adults who are not women of childbearing age and the resulting increase in mortality from coronary heart disease and stroke. Even if the assumed decrease in fish consumption among this group is as small as 4%, however, the adverse impact outweighs the residual cognitive development benefits resulting from decreased fish consumption among women of child-bearing age.

Conclusions

The scientific literature on the adverse effects of mercury and the benefits of omega-3 fatty acids is extensive. Yet this literature alone is not sufficient for decision makers to evaluate potential interventions to address exposure to mercury in fish. The analysis described here is an effort to synthesise the available information to determine under what conditions the 2004 advisory might improve public health.

Our optimistic scenario approximates net health effects if the public correctly understands and complies with the 2004 advisory. Net health effects for this scenario are positive and large, suggesting that the advisory as promulgated by FDA/EPA appropriately balances health benefits and risks.

However, using plausible assumptions about how people might react to the 2004 advisory, we find that the net impact on public health could be negative. For that reason, it is critical that additional information be gathered on how people are actually reacting to the 2004 advisory. Actual patterns of fish consumption in the general population as well as for sub-populations of concern (such as women of child-bearing age and pregnant women) ultimately will determine whether the net health effects of the 2004 advisory are positive or negative.

We note that our analysis does not address all trade-offs associated with changes in fish consumption (including, for example, ecological implications and the nutritional characteristics of food people might eat in place of fish). Nonetheless, we hope that this analysis demonstrates both the value and the feasibility of quantitatively evaluating the benefits and countervailing risks of this, and other, public health interventions.

Decision makers must typically rely on

incomplete data and imperfect science. We addressed this challenge in part by convening a panel of experts to guide and advise us. The panel helped us identify important health effects, make suitable assumptions, estimate the dose-response relationships, and combine these relationships to arrive at an aggregate estimate of risk. We also endeavoured to make our analysis as transparent as possible so that people can understand which assumptions most strongly influence our findings.

Even so, we acknowledge that the science underpinning our analysis is uncertain. Waiting for the science to resolve definitively these areas of uncertainty is not an option, however. Mercury exposure continues and decision makers must determine an appropriate course of action now. We believe that the analysis described here offers an approach to identify a reasonable course of action with present knowledge, and also identifies the key questions that must be answered to improve the confidence in our findings. As better information is developed, the analysis should be refined and, if necessary, interventions such as the 2004 advisory can be modified accordingly.

RECOMMENDED READING

Cohen JT, Connor WE, Kris-Etherton PM, Lawrence RS, Savitz DA, Teutsch SM, Gray GM. A quantitative risk-benefit analysis of changes in population fish consumption. *American Journal of Preventive Medicine* 2005;29(4):325-34.

Graham JD and Wiener JB. *Risk versus Risk: Trade-offs in Protecting Health and the Environment*. Cambridge, MA: Harvard University Press, 1995.

National Research Council. *Toxicological Effects of Methylmercury*. Washington, DC: National Academy Press, 2000.

Evidence-based health care



Delivering better health care

What can go wrong when you are implementing evidence-based practice? Some lessons from the development process

*Michael
Dunning,
Editor, ImpAct*

Considerable effort has been devoted in the last ten years to questions about clinical behaviour and changing clinical practice. Extensive research and development programmes have been funded. All of the latter have involved projects tackling specific clinical conditions and working from the basis of robust evidence of clinical effectiveness. These efforts have had a number of labels over the years – moving through from medical (and clinical) audit, to clinical effectiveness and now to clinical governance. While the labels change the concern remains to improve the quality of care for patients. Despite all this effort, definitive answers remain elusive although some practical lessons are emerging.

The first paper in this series starts from the premise that development work might tell us what we should do. But it will also, if people are scrupulously honest and open, help us learn what we should not do, perhaps the more important lessons from the work. After a note about context, eleven traps to avoid are described.

Where did we start?

In the early 1990s, as interest in evidence-based practice grew a few of us were starting to ask questions about speeding up the process of change. Could we find ways to implement proven clinical practices and thus bring the benefits to patients more quickly? The focus would be on organisational development - designed to secure the implementation of evidence for a specific clinical condition across populations. This seemed to have attractions and could complement efforts to promote evidence-based practice within the clinical community. It would represent a management approach to service improvement.

Discussions across the (then) Oxford region argued that one of the measures of success of

health authorities as commissioners of health care should be: Are they commissioning the right things? This prompted the creation of one of the first major development programmes in this field: Getting Research into Practice (GRiP). Henry McQuay and I created the GRiP project in Oxford in 1993. Four health authorities in the region worked with us to tackle a range of clinical issues. GRiP demonstrated that change was possible and identified a series of steps that people might follow. Other development programmes followed, including:

In the North West, with the NHS Executive Research and Development Directorate and working through Research Liaison Groups.

In London, again with NHS Executive Research and Development in a regional programme to mirror a national Research and Development programme focused on methods to promote the implementation of research findings in the NHS.

At the King's Fund with the Promoting Action on Clinical Effectiveness (PACE) Programme.

More recently in the West Midlands, with Linda Dunn from the Partnership for Developing Quality, we created a short training session to get over key messages about managing change. The aim was to help participants understand the overall process – rather than the individual activities, i.e. to create a manageable picture of the task overall. Later papers in this series will build on that work.

These initiatives recognised that answers to all the questions about changing clinical practice are not available. Andy Oxman's work in the early 1990s reminded us that there are no magic bullets (to implement change) but that a multi-faceted approach (using a set of linked interventions) was more likely to be successful. The trick was to make the best use of what is already known and believe that change was possible – although it might be difficult. The challenge was to bring together the knowledge from research with the practical experience to develop a practical model for general use. The unknown was not an excuse

Bandolier is an independent monthly journal about evidence-based health care, written by Oxford scientists.

Articles can be accessed at www.jr2.ox.ac.uk/bandolier

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Eleven traps to avoid

Spending too much time looking for evidence

Creating glossy guidelines

Assembling the wrong team

Expecting people to give up their time for you

Assuming that everyone will re-act the same

Ignoring the impact on services

Keeping people in the dark

Leaving patients out of discussions

Assuming that staff will turn up to training sessions

Forgetting to provide stickers for patient records

Making the same mistake twice

for not trying.

A clearer picture about how to do this type of work is emerging – even though some important questions remain. It was most recently summarised in an effectiveness bulletin produced by the Centre for Reviews and Dissemination at York University in 1999.

The work of dedicated research groups, such as those involved in the Cochrane Collaboration (Effective Practice and the Organisation of Care – EPOC) remains important.

The following notes are based on observations of many local projects but out of respect to those involved, do not point the finger to where things went wrong. The eleven traps are:

1. Spending too much time looking for evidence

The immediate reaction of many people when they first get involved in an implementation project is to set out to find the evidence – that is commission and/or undertake their own searches. They often say “we need to find the most up to date evidence”. But this is fraught with problems. It ignores the fact that the evidence is common across the NHS: it's not a local issue. Beware also of clinicians who

have their own approach to evidence – they know what they like (this could be papers by colleagues from medical school or from colleagues they have met at professional conferences!) but this may not be evidence within current understanding.

Many people devote too much time and effort looking for the right evidence. It may be increasingly easy to find papers through internet searches of Medline etc but interpreting them is another story. Defining evidence is a serious business. It requires skill to find and review research papers. It is not something to be undertaken lightly. A better starting point is a review produced by a reputable source.

Experience has shown that it is wise to focus implementation initiatives on clinical topics where the evidence is robust and generally non-controversial.

2. Creating glossy guidelines

Once the team has agreed a focus for their work and assembled the relevant evidence discussion will turn to views about how the service should look in the future. What are the key elements and decision points in the new service? Views will emerge about whether the aim is to create a guideline, a protocol, a pathway etc. It can be fun designing flow charts and guidelines – but glossy presentation may not impress clinicians. In fact it might irritate them.

The challenge is to persuade clinicians about the value of the evidence so decide whether a guideline may or indeed may not help that process. It is easy to write down what others should do, but it is much harder to persuade them to do it. Conserve your energy for activities, such as training and education sessions, that will make a real difference.

Remember that the evidence base is evolving and will change over time. Don't waste energy and effort on creating something elaborate that may be soon out of date.

3. Assembling the wrong team

Most people prefer to work with people they know and like – but have they the right skills and contacts? You will need people who can contribute to the clinical discussions, people who can handle the training aspects and people who can influence the deployment of resources. There is a danger of believing that only people with a clinical background can

contribute.

Whatever topic you tackle it will have an impact on the level of service – such as diagnostic services or the supply of particular drugs or dressings. All organisations have strict timetables for resource allocation processes so make sure that people are involved in your team that can help you through that maze. Fitting in to the budget setting timetable is important.

Think carefully about the skills and experiences you will need. Make sure that you include managers and those who can influence resource allocations. Don't leave them out. Remember they need time to change budgets.

4. Expecting people to give up their time for you

People who set up and lead implementation projects are inevitably enthusiastic. They are prepared to make sacrifices to create space in their diary for the work. But all people in the organisation will not feel the same. “Why should I give up my time for you?” is a question you will have to be ready to answer. It cannot be avoided if you are to assemble the range of skills and experience you will need to make the work a success.

Experience has shown that senior commitment to initiatives is a prerequisite of success. It can free up time in people's busy schedules and legitimise their contribution.

Bear in mind that everyone will not share your enthusiasm for the extra work. Time spent early in the process to get the commitment of senior managers is well spent.

5. Assuming that everyone will react the same

Most people are aware of the work of Rogers when they talk about innovation and change. The language of innovators and laggards will be familiar. But people often fail to take this into account when they are planning their project. They expect everyone to react to their messages the same. They do not consider the context within which they will be working and the implications of whether some clinicians they hope to influence will be receptive or hostile.

Time taken to assess the likely reaction to your initiative is time well spent: create a contextual analysis. Determine where to start – with clinicians at the cooperative

end of the scale. Starting with difficult people will wear you out before you start. Throughout this process avoid language that labels people as difficult. Those you think may be difficult may turn out to be some of your strongest allies.

It is wise to start with clinicians that are likely to be sympathetic to your cause. Early success will give you confidence and results to help you persuade more resistant colleagues.

6. Ignoring the impact on services

It's easy to get locked into a mindset that sees the only challenge is to change clinical behaviour: a belief that it is about information and education. Many people channel most of their energy into this aspect of their work. They lose sight of the need to change service levels – such as access to diagnostic services. It can often take as long to achieve these changes as those in clinical behaviour.

A link with planning and budgeting timetables and the engagement of the appropriate managers in the discussions will be important (see above). Careful assessment of the scale and pace of change will ensure that progress on the two aspects of the work keeps in step. Don't let one aspect of the work outpace the other.

There is no point in persuading clinicians to change their practice if the service cannot cope with additional demand. Make sure any difficult resource issues are tackled early in your project.

7. Keeping people in the dark

Everyone in the NHS is busy. The amount of information flowing about the service continues to grow. Diaries are perpetually full and offices are overflowing with paper. Try to ensure that your initiative is not buried under this mountain. You have to keep the attention of those you seek to influence. Too many people think that once they have engaged people they will retain their interest: this is a fallacy. They will not be holding their breath to hear from you.

Communications is an issue you overlook at your peril. Draw up a schedule that helps the team be clear about how their message gets to different groups. Remember the choice of messenger is essential: will people believe and trust them? Steps need to be taken to ensure the consistency of the message. Make the

best use of existing communications systems and avoid the need to create new meetings and paperwork.

Don't prompt the question "Is that project still going?" Make sure that those affected by your work get enough – and not too much – information to keep them in touch with your progress and what it means for them.

8. Leaving patients out of discussions

People have a sense that they should involve patients, somehow, in their efforts but many are still unsure how to do this. So they put it off. They overlook the positive impact patients can have on their efforts and that patients can contribute. They have a false sense that they need a representative patient(s).

Patients can be strong advocates for change. Moreover they are no longer shy about demanding effective care from clinicians. A variety of mechanisms (such as focus groups and patient panels) have been shown to be effective in gaining an understanding about what patients think about the changes proposed.

Don't put off involving patients because you are not sure how to involve them. They will want the same as you – effective practice locally.

9. Assuming that staff will turn up to training sessions

Time and space will have to be found to enable busy clinicians to learn about the initiative and what it will mean for them. Allow time to discuss the evidence and its impact on current practice. Prepare carefully for these sessions: plan the presentation of evidence and the structure of the sessions and find ways to engage participants in discussion. Research shows that a talking heads approach with lectures but little or no time for discussions is not likely to work.

Don't overlook the need to ensure that clinical staff can get away from their commitments. Can staff attend your training sessions? Don't assume the answer is yes. Have you checked rotas with their clinical managers? If workshop sessions prove difficult a series of individual tutorial for individual clinicians may be the best way forward.

Progress will depend critically on the extent to which you are able to get the message over to busy clinicians. It will grind to a halt if effective education and training is not organised for clinical staff.

10. Forgetting to provide stickers for patient records

In the heat of a short-term project it is easy to lose sight of the longer-term goal: to ensure that improvement in the quality of care endures. The problems beyond the project may slide off the agenda. A smooth transition from a project to routine practice should be the objective.

Research has demonstrated that simple steps like creating reminder systems as part of a patient record can sustain change. Similarly make sure that someone takes responsibility for maintaining the supply of new material (such as referral forms and or leaflets for patients). Finally, staff turnover is perpetual in the NHS: there is little stability. Make sure that on-going induction training for new staff continues to promote the changes.

Don't let your efforts become just another dead project where the improvements you achieve are eroded over time. Put arrangements in place to sustain the changes in the long-term.

11. Making the same mistake twice

Creating a project can be exciting and rewarding. It should be approached as a learning opportunity for the team and the organisation. All too often it is possible to see in retrospect what was done but not how it was done. That experience is often soon forgotten.

Build time for reflections into the agenda for project meetings. An opportunity to look back over the work so far and note those things that went well and those that didn't. From the outset encourage honesty and emphasise that mistakes hidden are learning opportunities missed. Look for ways to help other local colleagues learn from your endeavours – can they learn from your mistakes?

Encourage honesty and a willingness to discuss failure: it is unrealistic to expect to be right all the time.

Conclusion

Managing a local implementation project can be rewarding and educational. Things will go wrong, opportunities will be missed and mistakes will be made. Don't most of us learn more from things that we get wrong rather than those things we get right? Everything will not go smoothly, but learning from others can help speed up the process. The lessons from others that informed this paper are intended for this purpose.

NEW PUBLICATIONS

Eurohealth aims to provide information on new publications that may be of interest to readers. Contact Sherry Merkur s.m.merkur@lse.ac.uk if you wish to submit a publication for potential inclusion in a future issue.

Policy for older persons in the perspective of an ageing population

Ministry of Health, Welfare and Sport,
The Hague, Netherlands, 2006



Freely available online at:
www.minvws.nl/images/fo-policy-olderpersons_tcm11-84830.pdf

53 pages

Published in early 2006, this publication emphasises the importance that the Dutch government places on a life-course policy. With this policy, they aim to address the broad social consequences of an ageing population beyond pensions, housing and care needs, and towards a pro-active ageing policy that invests in young people, education and encouraging innovation in order to strengthen the economic base to support an ageing population.

The report begins by setting the scene in 2030, where 25% of the total population of the Netherlands will be over 65. The changing definition of 'old age', beyond the generally accepted criterion of age 65, is examined from the perspective of an increasingly ageing society. The ageing society is also analysed in detail, with particular reference to the cohesion in various policy areas and related social tasks. Policy in the long-term must focus on enhancing participation and individual responsibility, creating a balance among the contributions

made by different generations and promoting social cohesion. It does not argue for a radical change of policy direction instead it argues that existing policy is the basis for the long term agenda.

A number of areas where important future choices need to be made are outlined. These include looking at the challenges of unhealthy lifestyles, promoting social inclusion through increased participation in local communities by older people, addressing the issue of a declining working age population with its impact on solidarity across generations, a need for adequate housing and access to both formal and informal care. It also details the government's role in terms of coordinating and communicating the response to this issue.

Contents: Introduction; Growing old is changing; The setting for an ageing population; Main aspects of a future policy for older persons; Basic values in more practical terms; Coordination and communication; Annexes.

Drug information for consumers and patients: A review of the research

Ulla Närhi, National Agency for Medicines, Helsinki, Finland, 2006



Freely available online at:
www.nam.fi/uploads/julkaisut/laakkeet/Drug_information_pdf.pdf

ISBN 952- 5099-91-1

38 pages

This publication summarises recent research on the dissemination of information on drugs. The report states that patients and consumers want more information about drugs, and that patients need drug information in order to be able to participate in decision-making about their treatment. Moreover, consumers need information that enables them to choose about when to self-treat symptoms and when to seek advice from a doctor.

This report suggests that patients most commonly want information on adverse effects of medicines, followed by information on their efficacy, duration and cost. The most common sources of drug information are physicians and pharmacists, followed by nurses, relatives and friends. Consumers find it difficult to recognise drug regulatory authorities as a source of drug information. While pharmaceutical companies produce large quantities of information, the line between advertising and information can be volatile.

A number of recommendations are made. These include ensuring that information on pharmaceuticals is valid and understandable. Written information can decrease the

amount of misunderstanding, and package information leaflets are often used as a resource. However, patients may not understand fully understand this information. The number of consumers and patients searching for drug information on the internet is increasing in Europe, with around 50% of Europeans now having access, but the quality of information is variable and it may be difficult to discover and recognise valid sources of information.

The report also focuses on sources and tools of drug information and future challenges. It predicts that new technological innovations will provide new opportunities for disseminating information, but conventional tools (i.e. leaflets, booklets) will still be of value. Moreover, more drug information appropriate to the needs of special groups, i.e. for elderly people and disabled people, should be available.

Contents: Foreword; Introduction; Drug information – from paternalism to partnership; What kind of drug information is required?; Sources of drug information; Methods of drug information; Special needs for drug information; Future challenges; Conclusions; References.



Finnish Presidency of the EU

www.eu2006.fi

News and information on the Finnish Presidency of the European Union.

Health-EU Portal

http://ec.europa.eu/health-eu/index_en.htm

In May, the European Commission launched the Health-EU Portal to provide European citizens, health professionals, policy makers and stakeholders, with easy access to comprehensive information on public health initiatives and programmes at EU level. Information is provided on 47 health-related topics under the following headings: my health, my lifestyle, my environment, health problems, care for me, and health in the EU. The Portal also aims to provide simple, clear and scientifically sound information about measures to protect health and prevent diseases and to convey that citizens share responsibility for improving their health. The Health-EU Portal is a multilingual portal with content available in all 20 EU official languages. Information on external sites is often available in English and if possible, other languages are provided.

Ireland and Northern Ireland's Population Health Observatory

www.inispho.org/index.asp

INISPHO produces and disseminates health intelligence and works to strengthen the research and information infrastructure on the island of Ireland. It works closely with others involved in the production of health intelligence and its translation into evidence-based policy and practice. It also supports the Department of Health and Children (Ireland), the Department of Health, Social Services and Public Safety (Northern Ireland), and other health related authorities, such as Health Information and Quality Authority, Health Service Executive and the health and personal social services agencies in Ireland and Northern Ireland. The INISPHO web site provides descriptions of its projects, publications available for download, access to the Population Health Intelligence System (PHIS Online), details of news and events as well as links to relevant institutions and other observatories.

The Sax Institute

www.saxinstitute.org.au

Based in New South Wales, Australia, the Sax Institute works to build partnerships between researchers and health policy and service delivery agencies for better health. Of particular interest on its web site is the description of linking policy and research through the Getting Research into Policy and Practice (GRIPP) Program. This program encourages more research focussed on the issues of concern to policy-makers, improved access to research findings, and increased exchange and discussion between policy-makers and researchers. Also available are corporate publications and other reports; details of research support, which is designed to strengthen researcher expertise; and research assets such as systems, cohorts, registers, skills banks and other resources that can be used by policy makers, service providers and researchers.

Open Society Mental Health Initiative (MHI)

www.osmhi.org

MHI aims to ensure that people with mental disabilities are able to live as equal citizens in the community and to participate in society with full respect for their human rights. MHI has recently launched a new web site that highlights best practices in community-based care for mental disability, and includes a comprehensive resource directory that provides information on mental health, intellectual disability, deinstitutionalisation and community living, and human rights. The web site is available in English and provides international instruments, publications for download, links to relevant organisations and disability and human rights-related news.

Finnish Institute of Occupational Health (FIOH)

www.ttl.fi/internet/english

FIOH is a research and specialist organisation in the field of occupational health and safety. It works to promote the work ability, functional capacity and health of the working population in Finland. The institute has centres of expertise focussing on good practices and competence; human factors; work environment development and more. FIOH produces, compiles and disseminates research-based information on the interaction between work and health and promotes the practical application of this information. The web site is available in English, Finnish and Swedish and provides thematic pages on a variety of topics, such as ageing and work, chemical safety, and ergonomics. There is also a news section, publications and newsletters are available for download and details of training and advisory services.

EUROPEAN MONITOR

**WHO General Assembly:
Global Health Agenda adopted**

From 22 to 27 May in Geneva, the 59th World Health Assembly brought together delegations from all 192 Member States. The event was overshadowed by the death at the age of 61 of WHO Director General, Dr Lee Jong-Wook.

The Assembly adopted a ten-year framework outlining the strategic direction for health partners across the globe. This included a situation analysis of the state of global health and seven priority areas for action – ‘the Global Health Agenda’. These include building global health security, promoting universal coverage for HIV/AIDS treatment, addressing the determinants of health, and strengthening health systems. WHO will use the Global Health Agenda as the basis for engaging with partners to address the critical gaps in improving population health, in particular that of poorer people.

The Assembly also adopted a resolution urging the remaining polio-endemic countries to intensify immunisation campaigns in the final push to interrupt transmission of the polio virus. The resolution also called on all countries to respond rapidly to imported poliovirus, and on WHO to provide technical advice on planning for a post-eradication world. Dr Anders Nordström, Acting Director-General of WHO, in his closing address to the Assembly remarked that Dr Lee had been determined to see polio eradicated and that completing this task would be a fitting dedication to all that he stood for.

In response to the worldwide shortage of health workers, the Health Assembly adopted a resolution on the rapid scaling up of the health workforce. The Global Health Workforce Alliance was also launched

during the Health Assembly to tackle the worldwide shortage of nurses, doctors, midwives and other health workers. Vice President of the Assembly, Professor Paulo Ivo Garrido, Minister of Health of the Republic of Mozambique, in his address to the delegates stated that this “shortage is most severe in the poorest countries, especially in sub-Saharan Africa, where health workers are most needed. Human resources are fundamental for the strengthening of health systems.”

Full coverage of the World Health Assembly can be found at www.who.int/features/2006/wba59/en/index.html

WHO General Assembly: Prince of Wales calls for integration of complementary and orthodox approaches to medicine

In his keynote address to the Assembly, His Royal Highness the Prince of Wales, focused on the theme of integration between medical and complementary approaches to health. The Prince said that “orthodox practice can learn from complementary medicine, the West can learn from the East and new from old traditions. For the past twenty-four years I have argued that patients should be able to gain the benefit of the “best of both worlds” – complementary and orthodox – as part of an integrated approach to healing. Many of today’s complementary therapies are rooted in ancient traditions that intuitively understood the need to maintain balance and harmony with our minds, bodies and the natural world.” He urged delegates to “look at the possibility, over the next five years say, of developing integrated plans for future health and care, perhaps beginning with a pilot or feasibility study...it would be a plan that would integrate medical services with individual and community approaches to health and self-care; a plan that might build upon current examples of integrated health and care, which

exist everywhere.”

The full text of the Prince’s speech is available at www.who.int/mediacentre/events/2006/wba59/hrh/en/index.html

**New WHO publication:
10 health questions about the new EU neighbours**

This new publication, looking at the essential features of health and health systems in the enlarged EU’s new neighbours, was launched in Brussels on 22 June by the WHO and the United Nations Regional Information Centre. Written by Albená Arnaudova, each chapter provides a concise overview of key health indicators in one of the countries, comparing them to three averages for the EU-25, EU-15 and EU-10. Each chapter also summarises the key features of the country’s health system and describes the results of more than a decade of health system reform. This book is not intended to be an in-depth study, but rather an easy guide to the knowledge available and an accurate entry point to understanding health in the EU’s 12 new neighbours

Speakers at the launch, including Marc Danzon, Regional Director of WHO Europe, Nata Menabde, Deputy Regional Director of WHO Europe, and Joseph Figueras, Director of the European Observatory on Health Systems and Policies, stressed that health inequalities are not a monopoly of poor countries. They highlighted the strong correlation between the quality of health systems in countries, the different phases of economic transformation that countries are in, and health status. For those countries that have, or are acceding to the EU, this process has been a real engine for change with respect to strengthening health systems.

The publication is available at www.who.dk/eprise/main/WHO/InformationSources/Publications/Catalogue/20060301_2

Press releases and other suggested information for future inclusion can be e-mailed to the editor David McDaid d.mcdaid@lse.ac.uk

Health under the Finnish Presidency

The Finnish EU presidency's overall objective in health policy is to promote the principle of 'Health in All Policies', given that health status is largely determined by factors outside the domain of health care. A high level expert conference on the topic will take place from 20 to 21 September. A book is expected to be published by the end of August as a background material for this conference.

Topics that will be covered in plenary sessions and workshops include health inequalities, nutrition and physical activity, alcohol policies, and mental health. Council conclusions on the issue are expected by 30 November. Other EU legislative proposals to be dealt with later this year include reform of legislation on medical devices, as well as a proposal for a Directive on advanced therapies, including gene and cell therapy and human tissue engineering.

More information on the Health in All Policies conference is available at www.eu2006.fi/calendar/vko38/en_GB/1129710020770/?calYear=2006&calMonth=8

EU Employment, Social Policy, Health and Consumer Affairs Council Meeting

The Employment and Social Policy, Health and Consumer Affairs Council met in Luxembourg on 1 and 2 June. The Council endorsed a statement on common values and principles for EU health systems. This followed agreement reached on 29 May to exclude health services from the Service Directive, and also was in recognition of the need following a series of European Court of Justice judgements to clarify the interaction between the EC Treaty provisions, particularly on the free movement of services, and the health services provided by national health systems.

The Council noted that health systems are a central part of Europe's high levels of social protection and make a major contribution to social cohesion and social justice. They also emphasised the overarching values of universality, access to good quality care, equity and solidarity and invited the European Commission to ensure that common values and principles contained in the statement are respected when drafting specific proposals concerning health services.

In particular, the Council noted that

there will continue to be much diversity in health systems across Europe and, in particular, decisions about the basket of health care to which citizens are entitled and the mechanisms used to finance and deliver that health care. The extent to which it is appropriate to rely on market mechanisms and competitive pressures to manage health systems must be taken in the national context. They noted that while there is much to be learnt from different experiences in using market mechanisms, it is up to individual member states to determine which specific interventions to use.

Ministers also adopted a series of conclusions recognising the need for health promotion by addressing the underlying determinants of health. The Council adopted conclusions on the promotion of healthy lifestyles and prevention of diabetes type II, on women's health and on the common values and principles in EU health systems.

In its conclusions, the Council stressed the importance of raising awareness, not only amongst the general public, but also among care professionals, that gender is a key determinant of health. The Council recognised that although women live generally longer, they suffer a greater burden of unhealthy life years. They also recognised the importance of addressing inequalities that may exist within and between Member States, by tackling social and economic health determinants.

They noted that cardiovascular disease is a major cause of death and of reduced quality of life for women, despite still being perceived as predominantly male disease in some Member States; the rise in smoking among females in some Member States is causing a substantially increased risk of lung cancer and cardiovascular diseases; and that depression is predicted in some Member States to be the major burden of disease for women by 2020. The Council also noted that a new report on the health status of women across the enlarged European Union is needed.

Ministers also approved a draft regulation establishing a European Institute for Gender Equality. The Institute will give technical support to the Community institutions and Member States for collection, analysis and dissemination of data/statistics and the development of methodological tools for integrating gender equality policies.

In respect of diabetes, ministers also

acknowledged that health promotion requires an integrated approach and needs to be comprehensive, multi-sectoral, multi-disciplinary and based on the best available research and evidence. The Council thereby invited Member States and the European Commission to do more to prevent diabetes and promote healthy lifestyles.

Ministers also discussed the EU sustainable development strategy (SDS), recalling that the social dimension of the SDS must be strengthened, by ensuring close cooperation with the existing processes under the open method of coordination (OMC) in social protection and social inclusion and the revised Lisbon Strategy. It was noted at this occasion that the OMC (in particular the exchange of good practices and use of indicators for monitoring developments) provided an adequate framework for integrating social inclusion into the SDS as one of its essential elements.

The Council Conclusions including the full statement on common values and principles are available at www.consilium.europa.eu/ueDocs/cms_Data/docs/pressdata/en/lisa/89830.pdf

Improving children's medicines: EU reaches final agreement

Following a proposal from the Commission in September 2004, the European Parliament and the Council on 1 June reached a final agreement on a regulation for children's medicines. Currently, more than 50% of the medicines used to treat children in Europe have not been tested and authorised for their use. Doctors therefore have had a limited choice of medicines for sick children. The new regulation on children's medicines will improve the health of Europe's children by increasing the availability of fully researched, developed and authorised medicines specifically for use in children.

The key measures include a requirement, at the time of marketing authorisation applications, for data on the use of the medicine in children resulting from an agreed paediatric investigation plan; a system of waivers from the requirement for medicines unlikely to benefit children; and a system of deferrals of the timing of the requirement to ensure medicines are tested in children only when it is safe to do so as to prevent the requirements delaying the authorisation

of medicines for adults.

One incentive to comply with the new requirement will be a *de facto* six month patent extension. For orphan medicines, this incentive will take the form of an additional two years of market exclusivity added to the existing ten years awarded under the EU orphan regulation. There will also be a new type of marketing authorisation, the Paediatric Use Marketing Authorisation (PUMA), which allows ten-years of data protection for innovation (new studies) on off-patent products.

Support measures include a commitment to EU funding into studies on off-patent medicines for children (the so-called 'MICE Programme'); the establishment of an expert committee, the Paediatric Committee within the European Medicines Agency (EMA); and measures to increase the robustness of pharmacovigilance for medicines for children.

Maria Rauch-Kallat, Austrian Minister for Health and then holder of the Council Presidency, said that the agreement "paves the way for the greatest possible safety in treatment of children with pharmaceuticals in the future." Commission Vice President, Günter Verheugen, added that "this regulation will improve the health of children by ensuring innovation in the development of medicines for their use."

Further information available at <http://ec.europa.eu/enterprise/pharmaceuticals/paediatrics/index.htm>

EU legislation: 'smokers need not apply'

On 4 August, the *Financial Times* reported that the European Commission was of the view that EU anti-discrimination legislation does not cover smokers. This came in a written reply to UK MEP, Catherine Stihler, on whether a job advertisement stating that "smokers need not apply" breached European law.

Quoted in the *FT*, Vladimir Spidla, the Commissioner for Employment and Equal Opportunities, said that "EU anti-discrimination law prohibits discrimination on the grounds of racial or ethnic origin, disability, age, sexual orientation, religion or belief in employment and other fields. A job advertisement saying that 'smokers need not apply' would not seem to fall under any of the above mentioned prohibited grounds". Speaking on

5 August, Commission spokeswoman, Katharina Von Schurbein, confirmed that "it is not a violation within the anti-discrimination rules on a European level for an employer to put into an advertisement "smokers need not apply".

This arose as a result of concerns raised about such a job advertisement placed by Irish e-commerce firm Dotcom Directories. Speaking on 5 August on *BBC Radio Five Live*, Phillip Tobin, director of the company, stated that there was good evidence that smokers were more prone to being sick and absent from work.

There has been a mixed reaction to the EU's position, with both pro and anti smoking groups being critical. Ian Willmore, a spokesman for UK based anti-smoking group, Ash, believes refusing to employ smokers is "thoroughly bad public policy" and said that "our advice to employers would be not to do that unless there is a clear occupational reason why smoking is not possible". Simon Clark, director of pro-smoking campaign group Forest, speaking to the *FT* said "we know employers discriminate on all sorts of grounds, from being too fat to the wrong colour hair. But for it to be so overt is depressing and shows that smokers are fair game."

The *Financial Times* article can be accessed at www.ft.com/cms/s/0f887cde-23df-11db-ae89-0000779e2340.html

EC and World Bank collaborate on Avian and Human Influenza Facility

Meeting in Vienna, the European Commission and the World Bank agreed to a new avian flu trust fund arrangement under which the Commission will contribute €46 million to a new multi-donor financing mechanism administered by the Bank, called the Avian and Human Influenza (AHI) Facility.

The Commission contribution will finance grants for countries in Central Asia, East and South Asia, Eastern Europe and the Mediterranean, to increase human influenza pandemic preparedness, as well as preventing, or progressively controlling, avian influenza within these regions. At the global level, the AHI Facility will help countries to prepare and implement integrated country action plans. The objective is to reduce the social and economic impact of avian influenza and to minimise the

possibility of a human flu pandemic in developing countries with insufficient domestic resources and capacity to combat the disease.

This commitment by the European Commission represents more than 80% of the total commitment to date by donors to the Facility. James Adams, Vice President for Operations and Country Services at the World Bank, expressed his appreciation that "the Commission has once again taken the lead, as it has in so many other important social development areas, to help in the preparation of country-based plans designed to protect vulnerable populations against this real threat". Koos Richelle, Director-General of the European Commission's Europe Aid Cooperation Office said that "by working together with the Bank and other donors I believe that we can maximise the impact of EC funds on an issue that is of vital importance to developing countries."

More information at www.worldbank.org/avianflu

EU agrees on funding for stem cell research

EU research ministers gathered in Brussels to discuss the highly sensitive issue of EU funding of research involving human stem cells. Several Member States had voiced their opposition, but after assurances that no funding will be granted to research activities which destroy human embryos, EU Ministers agreed that EU funding for embryonic stem cell research can continue under the current case-by-case practice. Research into human cloning will be prohibited. No activity will be funded that is forbidden in all Member States and research projects will only be considered for funding from Member States where the research is legal.

Five countries voted against the decision – Austria, Lithuania, Malta, Poland and Slovakia. Germany which had initially led the coalition of countries opposed funding, together with Italy and Slovenia agreed to back the compromise position.

Much opposition to embryonic stem cell research has come from religious groups who remain unhappy with the compromise reached. Responding to the decision, the Commission of the [Catholic] Bishop's Conference of the European

Community (COMECE) stated that they were “perplexed by the contradiction between this decision which is an attack on human dignity at the beginning of life and the objective of the European Union to promote therapies aiming to save human life.” They also argue that the decision contradicts the Charter of Fundamental Rights of the EU which states in Article 1 that “human dignity is inviolable and must be respected and protected.”

In contrast, EuropaBio, the European Association for Bioindustries, has welcomed the agreement, saying that “continuing the funding of embryonic stem cells research at European level is a positive signal for European biotech research, which may one day offer hope for patients suffering from diseases like Parkinson’s and Alzheimer’s.”

The agreement paves the way for a second reading of Seventh Framework Research Programme by the European Parliament this autumn, and potential adoption by the new year, although this may be delayed by disagreements in the Parliament.

More information at www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/intm/90654.pdf

US and EU regulators boost cooperation on pharmaceuticals

At the recent EU-US summit in Vienna on 21 June, agreement was reached over further cooperation in the area of pharmaceutical development and research. The US Food and Drug Administration (FDA) and the European Medicines Agency (EMA) plan to intensify cooperation in the next year, with particular focus on vaccines (including preparedness for influenza pandemic), medicines for children; orphan medicines, oncology, pharmacogenomics and counterfeit medicines. They also plan to hold a workshop in 2007 on better regulation of medicinal products through transatlantic dialogue.

As part of the recently intensified confidentiality arrangements between EMA, the FDA and the European Commission, the EU and the US regulatory authorities have also agreed on a new procedure for sharing information on the use of genomics and pharmacogenomic tests in global drug development. This process helps ensure that regulatory authorities are familiar with issues arising

from the integration of pharmacogenomics in drug development and that industry has an opportunity to hear scientific perspectives from the FDA and EMA.

More on the EU-US summit’s conclusions can be found at www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/EN/declarations/90179.pdf

New report on employment in social care in Europe

The European Foundation for Living and Working Conditions has published a new report looking at the state of employment in social care in eleven EU Member States, as well as two acceding countries. The report looks at a range of innovative approaches adopted, aimed at increasing the supply of qualified workers who can meet the growing demand for care services. This is of particular importance given the ageing of the EU population and increasing demand for care services in the European Union.

There is also a growing concern about the supply of suitably qualified care workers; low pay, low status, and high rates of turnover and burnout make it difficult to attract workers to the care sector and to keep them in their jobs.

The report highlights a number of policy strategies that could be developed to address this issue, such as improving the public image of care work, raising the qualification profile of care workers, increasing salary levels, attracting more qualified migrants to the profession, achieving a better age and gender balance, and improving overall working conditions for care workers.

It is hoped that by documenting good practice, it offers a range of practical responses to one of Europe’s most pressing dilemmas.

The report can be freely downloaded at www.eurofound.eu.int/pub-docs/2005/125/en/1/ef05125en.pdf

EU summit on tackling health inequalities in Europe: workshop reports available

Under the UK Presidency, a summit *Tackling Health Inequalities: Governing for Health*, held in London in October 2005, brought together decision makers from all EU member states, with representatives of the European Commission,

WHO and other international agencies such as OECD. In addition to the plenary sessions, the programme included twelve workshops, including three policy development groups and three fringe meetings. The reports from these workshops have now been published. Topics covered include: impact on regions and cities; information and research; tobacco, nutrition and alcohol; improving consumer engagement; the role of public health associations; inequalities in ethnicity and health; health impact assessment; and sustainable development in health.

One workshop, chaired by Eric Ziglio, from the WHO Centre for Investment and Development, Venice, looked at policies and practice within Member States for tackling health inequalities. This was discussed in the context of the European Commission’s work, including the new Expert Working Group on Social Determinants of Health Inequalities, the public health programme and the research framework. The need for effective synergy with other European efforts such as the programme managed by WHO Regional Office for Europe’s European Office for Investment for Health and Development and the WHO’s newly established Commission on Social Determinants of Health were also explored.

Proposals for action coming out of this workshop included a recognition that Member States should do more to develop cross-government and cross-sectoral policies to reduce health inequalities and provide leadership. Actions need to tackle social and economic determinants of health, as well as the avoidable health risks for individuals, and to engage different sectors who may have an impact on health inequalities. This might include tackling low income and poverty, education, unhealthy living conditions, working conditions and unemployment, and health care access, as well as lifestyle factors.

There remains a need to intensify efforts to collect evidence of effective strategies, policies and practice to tackle health inequalities. It is important that information collected on effective action is shared and disseminated between Member States. It was also acknowledged that the European Commission might play a role in facilitating and increasing the opportunities for Member States to share information on effective policies, strategies

and best practice on what works, to learn from existing networks and centres of excellence, and in supporting European countries to establish effective programmes and policies, particularly through the new Expert Working Group

Summaries of all workshops and lunchtime fringe meetings are available at www.db.gov.uk/assetRoot/04/13/50/12/04135012.pdf

EUROPEAN COURT NEWS

Commission refers Germany to the European Court of Justice on tobacco advertising

On 28 June the European Commission decided to refer Germany to the European Court of Justice (ECJ) for non-transposition of the Tobacco Advertising Directive 2003/33/EC. The Court referral follows a letter of formal notice sent in October 2005 and a reasoned opinion sent in February 2006. The referral to the ECJ is the next step in the infringement procedure.

European Health and Consumer Protection Commissioner Markos Kyprianou said "tobacco advertising and sponsorship glamorises tobacco and incites children and young adults to start smoking. I am determined to hold all Member States to account for their implementation of this key piece of EU legislation, and if this means referring the matter to the Court, so be it."

The Tobacco Advertising Directive 2003/33/EC bans tobacco advertising in printed media, on radio and over the internet. It also prohibits tobacco sponsorship of cross-border events or activities, such as Formula One races. It applies only to advertising and sponsorship with a cross-border dimension. Advertising in cinemas and on billboards or using merchandising (for example, ashtrays or umbrellas) therefore falls outside its scope, although these can still be banned under national law – a path chosen by several EU Member States.

Tobacco advertising on television has been banned in the EU since the early 1990s, and is governed by the TV Without Frontiers Directive. The Tobacco Advertising Directive should have been transposed into national legislation by 31 July 2005.

The Commission also sent a reasoned

opinion for non-transposition to Luxembourg on 7 February 2006. On 4 April, Luxembourg replied that the government had changed its policy in terms of tobacco control and that it had thus withdrawn its support for Germany's application for the annulment of the Directive before the ECJ. It also announced its intention to transpose the Tobacco Advertising Directive by July 2006.

For further information, on the Tobacco Directive see http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/tobacco_en.htm

ECJ ruling in favour of patient receiving treatment abroad

The European Court of Justice has said that the English NHS could not refuse to refund costs if patients wait longer than doctors advise, even if targets were met. This ECJ ruling was triggered by the case of Yvonne Watts, aged 75, of Bedford, England who paid £3,800 for a hip operation in France.

Mrs Watts went to the English High Court in 2003 to challenge the NHS's refusal to allow her to go abroad for treatment, paid for by the NHS. Her doctor had previously recognised that her hip problems caused her pain and incapacitated her. She proceeded to travel to France for the operation, and then sought compensation from her Primary Care Trust to refund the cost of treatment.

The judge agreed that Bedford Primary Care Trust was wrong in using the waiting list target instead of clinical need to assess when patients should have their operation. However, the Department of Health appealed against the principle that patients facing undue delay are entitled to go to other EU Member States for medical treatment, paid for by the NHS.

The case was referred to the ECJ, which has historically ruled that European health insurers should pay for patients to have health care in a neighbouring country if there is "undue delay" in their treatment at home. However, this case concerned whether an NHS system is also covered by the undue delay principle. Other governments submitted arguments on both sides of the case because the implication of the ruling affects all Member States.

In May 2006, the ECJ ruled that under Article 49 of the European Convention of Human Rights, Mrs Watts was entitled to reimbursement for surgery, because Member States cannot prevent nationals of other EU states from receiving services. However, the judges said the principle held good only if the delay "appears to exceed an acceptable time". The Department of Health is appealing against the ruling, arguing that because the NHS is a "free" service it is not bound by EU law governing the right of citizens to buy services where they wish.

For more details of the judgement see <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:62004J0372:EN:HTML>

COUNTRY NEWS

Baltic States

This report provides an overview of current developments in mental health care policy in all three Baltic countries, Estonia, Latvia and Lithuania and provides recommendations on how to move towards more community-based services and away from institution based care. It was developed by the Latvian Centre for Human Rights and its partner organisations, the Vilnius office of the Global Initiative for Psychiatry, the Mental Disability Advocacy Centre, and the Estonian Patient Advocacy Association, as part of a European Commission funded project, 'Monitoring Human Rights and Prevention of Torture in Closed Institutions: Prisons, Police Cells and Mental Health Care Institutions in Baltic Countries.'

The report argues that in all three countries people with mental health problems still lack access to community-based services and their human rights are ignored. Policy and legislation have, however, moved forward more rapidly in Lithuania and Estonia than in Latvia. It also highlights a lack of well-functioning independent inspection bodies and independent human rights monitoring mechanisms. There is a need for greater cross-sectoral collaboration and also for more involvement of service user groups in the policy making process. Guardianship legislation is also in need of reform.

Specific recommendations for all three countries are made. These include a

request that Latvia ratify the Council of Europe Convention on Human Rights and Biomedicine and the Optional Protocol X of the collective complaint mechanism of the European Social Charter.

The report is available in English at www.humanrights.org.lv/upload_file/Publikacija/HRinMHbaltics_ENG.pdf

HIV/AIDS in Germany still increasing

The number of newly diagnosed cases of HIV infection in Germany rose in 2005 by 13% (from 2,210 new cases in 2004 to 2,490 in 2005) according to the half-yearly HIV/AIDS report just published in the Epidemiological Bulletin of the Robert Koch Institute. In the first six months of 2005 the increase was 20% greater than in the same period in the previous year.

The number of new HIV diagnoses, calculated at 3.02 per 100,000 inhabitants, continues to increase; in the year 2001, only 1.75 new diagnoses were registered per 100,000 inhabitants. However, following a period of declining protective behaviour, there has been an increase in the use of condoms among sexually active people, according to the latest representative survey Public Awareness of AIDS in 2005 conducted by the Federal Centre for Health Education. The number of condoms sold has also increased.

"This is a spur to further prevention work," said Ulla Schmidt, Germany's Federal Minister of Health, "since AIDS remains, despite good treatment possibilities, an incurable, fatal illness. Only education and prevention can provide protection." With its strategy for combating HIV/AIDS issued on 13 July 2005, the Federal Government launched a new initiative aimed at expanding cooperation in Germany, Europe and worldwide. The principal fields of activity in this initiative are education and prevention, social inclusion and anti-discrimination, and research support.

Recent surveys conducted by the Federal Ministry for Health indicate that AIDS education measures continue to reach the overwhelming majority of the population. Extensive coverage last year of the rise in new cases of HIV possibly provided people with a new incentive to protect themselves better. Those under 45 years of age who live alone continue to exercise a high level of protection. Condoms are also being increasingly used, once again,

at the start of a new relationship. Whereas the proportion of people in this group using condoms was 70% in the year 2004, it rose last year to 75%. The steepest increase in the number of newly diagnosed HIV infections in recent years has been among men who have sex with men (MSM); last year the increase was from 1,078 cases (2004) to 1,237 (2005). The number of newly diagnosed HIV infections has also increased among those subject to heterosexual transmission risk – from 276 in the previous year to 344 in 2005. Proportionally the increase among this group is actually greater than that of the MSM group.

More information in German at www.bzga.de

German court rules that patients must be fully informed of specific risks

The German Federal Court – *Bundesgerichtshof*, (BGH) has recently, in the so called "Robodoc" judgment, ruled that patients always must be informed expressly and clearly on the risks of new medical treatment methods. According to the BGH, the application of new procedures is indispensable for medical development. However, such new procedures may only be applied to patients if they are clearly informed that the new method may involve unknown risks. The patient must be in a position to weigh up the traditional treatment with its known risks, and the new method with unknown risks.

In this judgment, the BGH dismissed the lawsuit of a patient for €30,000 damages. The claimant was operated on at a clinic in Frankfurt using a new computer driven milling procedure. During the surgical procedure, which lasted five and a half hours, a nerve track was damaged. The BGH ruled that the information given by the consulting physician to the patient had been insufficient. Nevertheless, the adverse event experienced was one also associated with traditional surgical techniques. The patient had been informed of the general risk of damage to the nerve track prior to surgery.

German coalition government reaches agreement on health care reform

On 4 July the government reached agreement on a plan for health care reform. Structural measures will be taken to increase cost efficiency and improve transparency. The financial effects of the

plan are not expected to have an immediate impact, but premiums paid into the statutory health insurance system will rise by 0.25% for both employees and employers from January 2007. In future, an increasing share of funding for child health care services will come from general taxation. €1.5 billion will be allocated to child health from 2008, doubling to €3 billion in 2009. This will come from the existing budget, rather than from any increase in income tax originally mooted by the Christian Democrats.

Chancellor Angela Merkel presenting the plan said that "never before has a government opened up the way for such dramatic structural change in the health care system with the aim of encouraging more competition." She went on to say that this is the first government ever to propose a tax-based approach to financing health care costs.

The Chancellor has made health reform a major priority, with the aim of introducing more competition into a system that is increasingly under strain because of a low birth rate, ageing population, heavy bureaucracy and increasing medical costs. The rules have been revised for health insurance providers to promote competition. Health insurance providers will be able to negotiate contracts with individual physicians. Private insurers will also have to open up their schemes to all individuals so as to promote greater competition. There will also be more freedom for insurers, pharmaceutical companies, distributors, and pharmacists to negotiate better prices for medicines.

More information on the reforms are available at www.bundesregierung.de/nm_6562/Content/EN/Artikel/2006/07/2006-07-04-gesundheitsreform-auf-den-weg-gebracht__en.html

Human rights and mental health in the Cyprus: Workplace health promotion seminar takes place

A seminar on workplace health promotion, organised by the Department of Labour Inspection, took place on 25 May in Nicosia with the aim of discussing the future development of workplace health promotion in Cyprus. There were almost fifty participants including health and safety officers from companies, representatives from the Departments of Labour Inspection and Social Insurance, the Ministry of Health, and the Cyprus National Institute for the Environment

and Public Health.

Welcoming the participants, Minister of Labour and Social Insurance, Mr Christos Taliadoros, stressed the importance of the concept of workplace health promotion. Among the speakers was Dr Uwe Brandenburg, Head of Ergonomics, at Volkswagen AG who highlighted health practices in the company. There were also presentations of good practice relevant to workplace health promotion in Cyprus, including those by Christina Vasila from the Employers and Industrialists Federation of Cyprus, Theodoros Makrigiannis from the Cyprus Telecommunication's Authority, Dr Elpidoforos Sotiriades from the Cyprus Institute on the Environment and Public Health and Mr Mimis Theodotou from the Cyprus Union of Bank Employees.

All participants agreed that the support of all stakeholders is needed in order to enhance workplace health promotion activities in Cyprus. The Department of Labour Inspection is now preparing an action plan in order to gain the support of all stakeholders and determine subsequent steps towards the implementation of good health promotion practices in the workplace.

More information at www.enwhp.org/news/news-show.php?news=245

Spanish government establishes Observatory for the Prevention of Smoking

On 28 July the Spanish Council of Ministers approved a proposal from the Minister of Health and Consumer Affairs, Elena Salgado, for the establishment of an Observatory for the Prevention of Smoking. This had previously been trailed in Article 16 of the health law against smoking.

This Observatory, which will be the responsibility of the Ministry of Health and Consumer Affairs, will be a focal point at the national level in the struggle against nicotine addiction. Initiatives, activities and research will be channelled to the development of prevention and support mechanisms to reduce the prevalence of smoking in the country.

For this reason, the observatory is structured in such a way as to facilitate communication and co-ordination between all agencies working on this

task. Under the authority of the Director General for Public Health at the Ministry, the Observatory will bring together members of the General Administration of the State, representatives of the Autonomous Communities, municipal councils, scientific groups, non-governmental organisations and consumer and service users groups.

Functions of the Observatory will include monitoring the implementation of the new law on the prevention of smoking, as well as looking at implementation of measures undertaken by the Autonomous Communities. Other key tasks include the collation and dissemination of information on effective interventions to help reduce smoking; making recommendations on priority actions; and helping to co-ordinate the implementation of such actions across different agencies and stakeholder groups. The Observatory may also commission research and will collaborate with other international groups working in the field of tobacco control. It will also produce an annual report on progress across Spain.

More information (in Spanish only) at www.msc.es/en/gabinetePrensa/notaPrensa/desarrolloNotaPrensa.jsp?id=649

Netherlands: Social Support Act approved by Parliament

On 27 June, the Upper House of the Dutch Parliament approved, without amendment, the proposed Social Support Act (Wet maatschappelijke ondersteuning). This will come into effect on 1 January 2007.

The objective of the Act is to enable everyone in the Netherlands to play a full part in society. Under its provisions local authorities will be required to assist those who require additional support in their day-to-day lives, such as domiciliary care, modifications to their accommodation or aids such as a wheelchair.

Support will also be given to volunteers and carers who actively contribute to the neighbourhood or society in general, as well as to those individuals who promote social involvement in the community. Another feature of the Act is the provision of pre-emptive support (in areas such as childrearing and efforts to counter social isolation), intended to reduce the need for more drastic forms of assistance at a later date.

The Netherlands already has a number of statutes to promote social participation. They include the Services for the Disabled Act (WVG), the Social Welfare Act and certain sections of the Exceptional Medical Expenses Act (AWBZ). From next year, the relevant provisions will be brought together within the Social Support Act. Implementation of the Act will be the responsibility of local authorities, since they are best placed to assess and address the requirements of local residents.

More information at www.minvws.nl/en/nieuwsberichten/dmo/2006/social-support-act-passed-by-upper-house.asp

Ireland: New drug pricing and supply agreement announced

The Tánaiste (Deputy Prime Minister) and Minister for Health and Children, Mary Harney, announced on 6 July the conclusion of negotiations between the Irish Pharmaceutical Healthcare Association (IPHA) and the Health Service Executive on an important new agreement setting out the pricing and supply of medicines for the Irish health service.

This agreement will lead to a reduction in the price of existing drugs and medicines coming off patent, and will also mean that a wider basket of countries, including some traditionally lower priced countries such as Spain, will be used to determine pricing for new drugs coming onto the market. There will also be two price reviews for new medicines during the lifetime of the agreement, which runs to 2010.

It is expected to achieve savings of the order of €300 million across the various primary care drug schemes, and in the cost of drugs to hospitals, through off-patent price cuts of 35% for drugs with substitutable alternatives. The discount will be introduced in two phases with the first 20% being introduced in March 2007, followed by a second reduction of 15% after another 22 months.

The agreement also means that for the first time, reimbursement of new drugs coming onto the Irish market can now be informed by pharmacoeconomic assessment, in line with other EU countries. Patients would not however be denied reimbursement for any drugs if their need was determined on clinical grounds.

Announcing the agreement the Tánaiste said: "This agreement will have a major longer term benefit through putting in place more rigorous and cost effective processes for evaluating drug prices. The savings achieved as a result of this agreement will be used to improve the overall level and quality of health services provided to patients."

More information at www.dohc.ie/press/releases/2006/20060706b.html

England: Reorganisation of Strategic Health Authorities

From 1 July 2006, new Strategic Health Authorities (SHAs) have begun operation in England. This process began in July 2005, when the government asked the SHAs to consider potential reconfiguration in a way that would deliver significant reductions in management and administrative costs. The reconfiguration proposals were subject to a patient-led local consultation, and then reviewed by an external panel. Following their advice, Minister for Health in England, Patricia Hewitt, agreed to the reorganisation of SHAs in England.

The number of SHAs has been reduced from 28 to 10 with the aim of ensuring that the NHS is structurally able to deliver the next stage of health reforms. The NHS has stated that fewer, more strategic organisations will deliver stronger commissioning functions, leading to improved services for patients and streamlined back office functions affording better value for money for the taxpayer. It expects that the SHAs will be better placed to oversee and support the development of more strategic Primary Care Trusts and the move towards more NHS Foundation Trusts.

SHAs were originally introduced in 2002 to replace the former Health Authorities and took on a strategic role in improving local health services, while making sure local NHS organisations were performing well.

A map of reorganised SHAs is available at www.dh.gov.uk/assetRoot/04/13/37/60/04133760.pdf

Report on progress with the NHS IT programme in England

A report by the National Audit Office (NAO) in June 2006 has warned that key

parts of the National Programme for IT in the NHS are falling behind schedule. The system is designed to link every GP surgery and hospital in England and provide online records for up to 50 million patients. Other elements include electronically accessible x-rays, transmission of prescriptions and booking of outpatient appointments. The programme was launched in 2002, and was planned to cost £6.2 billion and run for ten years.

According to the NAO report, the success of the programme is ultimately reliant on the performance of the IT suppliers contracted to provide the technology. In highlighting the key challenges facing the project, the report says the following are necessary for success: "ensuring that the IT suppliers continue to deliver systems that meet the needs of the NHS, and to agreed timescales without further slippage"; "ensuring that NHS organisations can and do fully play their part in implementing the programme's systems"; and "winning the support of NHS staff and the public in making the best use of the systems to improve services." Furthermore, the report states that while it was too early to tell if the programme provides value for money, significant challenges remain if it is to be completed.

Furthermore, beyond the complexity of implementing large computer programmes in the public sector, the NHS IT Programme is the biggest of its kind anywhere in the world. The NAO estimates the gross cost of the Programme will be £12.4 billion to 2013–2014. It acknowledges however, that while the pilot NHS Care Records Service will not be in place until late 2006 (almost two years late) and other milestones have been deferred, there has been substantial progress in other aspects of the programme.

The NAO report is available at www.nao.org.uk/publications/nao_report/s/05-06/05061173.pdf

Northern Ireland: new CMO appointed

Dr Michael McBride was appointed as the new Chief Medical Officer (CMO) for Northern Ireland in July. Previously Dr McBride was Medical Director at the Royal Hospitals in Belfast and takes over from Dr Henrietta Campbell who retired in January. Commenting on his appointment he said that "it is important that health services are not delivered in

isolation and as Chief Medical Officer I will continue to work with patients to ensure that they receive the highest quality of care and to keep key issues – such as patient safety – high on the health service agenda... There are particular challenges facing us over the coming months, such as the roll-out of the smoking ban and the implementation of the suicide prevention strategy, but I intend to provide the necessary professional leadership to make these a success."

Concern over foreign medical students in Denmark

Concerns have been expressed in Denmark about the high number of foreign students at medical school who subsequently return to their own countries to practice medicine, despite the shortage of doctors in Denmark. Swedes and Norwegians have been the subject of particular attention as they have made up approximately 12% of all medical students in the country.

The Danish Minister of Science, Helge Sander (V) has called this situation "unacceptable". Speaking to the Danish newspaper *Berlingske Tidende*, Nina Kerrig, chairwomen of the City of Copenhagen Health Committee, said that "it is a grotesque situation that we are training people for the Swedish health system at the same time as we are forced to import doctors from countries such as Poland and Germany to help offset the shortage of manpower in Denmark. Nordic and European cooperation are good things but we have to make sure that the system works for sick Danes too." She has proposed that doctors trained in Denmark should be contracted to work in the country for a certain number of years after graduation.

In response to these concerns, the Swedish government has stated that it is willing to discuss the issue; the issue will be even more pressing as in the coming year nearly one quarter of all medical students in Denmark will be Swedish nationals. Quoted by the Nordic Council website, Willie Birksten, press secretary for the Swedish Minister of Education, Leif Pagrotsky, stated that he "fully understands that the Danish government considers this situation to be a problem and Helge Sander is more than welcome to approach us again to discuss the situation. However, he must naturally also take the case to the EU".

News in Brief

Health and safety at work campaign launched

On 30 June, the European Agency for Safety and Health at Work launched 'The Healthy Workplace Initiative' to provide both employers and employees with information about how to improve their business environment by becoming healthier and more productive. A series of thirty-six seminars will take place throughout twelve participating countries – the ten new Member States, as well as Bulgaria and Romania.

http://agency.osha.eu.int/press_room/HWI_Launch_2006-06-30

Improved air quality saves thousands of lives

In a report entitled *Air quality and ancillary benefits of climate change policies*, the European Environment Agency indicate that stringent EU climate change policies (aimed at limiting temperature increases to 2° above pre-industrial levels) could improve Europe's air quality, cut premature deaths by 20,000 per annum as a result of lower concentrations of ground level ozone and fine particulates and save €10 billion each year in air pollution control costs by 2030.

The report is available at http://reports.eea.europa.eu/technical_report_2006_4/en

Tobacco use declining in EU

On May 31, 'World No Tobacco Day', the European Commission released the results of its latest Eurobarometer survey on tobacco use. According to this survey the number of smokers in the EU declined from 33% in 2002 to 27% in 2005. In addition, 80% of respondents were in favour of banning smoking in public places. The Commission intends to put forward in late-2006 a Green Paper on smoke free environments, with a view to the impact on human health of passive smoking. The consultation will aim to establish the best way forward in tackling environmental tobacco smoke and will address the scope of smoke-free environments as well as different policy options

More information at http://ec.europa.eu/comm/health/ph_publication/eurobarometers_en.htm

Taxes and pricing could combat obesity

A new report by Clifford Goodman and Ayadola Anise, from the Lewin Group, Falls Church, Virginia, USA, and written for the WHO Health Evidence Network looked at the evidence on the effectiveness of policy-related economic instruments in reducing the consumption of unhealthy foods and increasing that of healthy foods. Indirect evidence from studies of tax and price policies applied to tobacco and alcohol products in many countries provides persuasive evidence of their impact on decreasing consumption of those products. These policy interventions may serve as models for similar approaches to lowering consumption of highly saturated fats or other energy-dense foods. However, critical differences among these interventions may limit their generalisability to food consumption.

The report can be accessed at www.euro.who.int/HEN/Syntheses/obesity/20060712_1

IVF can contribute to increasing fertility rates in Europe

Results of a RAND Europe study, released at the European Society for Human Reproduction & Embryology suggest that assisted reproductive technology (ART), such as in-vitro fertilisation (IVF), could help governments combat the problem of ageing populations if incorporated into population policies. The study suggests that if the number of ART cycles per million women in the UK were increased to levels similar to those in Denmark, the total fertility rate would increase by 0.04 children per woman. While this impact appears small, it is comparable to that of other policies used to influence fertility, such as increasing European state-supported child benefits. The study authors warn however that while the impact of ART on fertility rates could be positive, its contribution could be wiped out if women choose to postpone childbirth based on the prospect of successful ART treatment. Infertility rates rise dramatically among women over 35.

The study is available at www.rand.org/pubs/documented_briefings/DB507

Green Paper on drug use

On the International Day against Drug Abuse and Illicit Trafficking, 26 June, the European Commission published a Green Paper on the role of civil society in drug policy. The aim of the consultation is to explore how best to involve civil society in the fight against drug abuse and to help the Commission develop a comprehensive EU policy against drugs, reducing both demand and supply. The deadline for contributions is 30 September.

The Green Paper is available at http://ec.europa.eu/justice_home/news/consulting_public/news_consulting_public_en.htm

14th Cochrane Colloquium, Dublin

The fourteenth Cochrane Colloquium, will take place in central Dublin from 23-26 October. Themes of plenary sessions include a focus on the accessibility of Cochrane reviews, including new ways to summarise the findings of individual reviews and ways to bring together the findings of a collection of Cochrane reviews into a new 'umbrella' review. There will also be three separate presentations on new content for systematic reviews, including economic information, qualitative information, and the Human Genome Epidemiology Network, which will be working on systematic reviews of, among other things, gene-disease associations. The closing session will include presentations and discussion of evidence based policy making at the global level, including the World Health Organization's International Clinical Trials Registry Platform and the use of evidence in the development of guidelines and policy within the WHO.

More information at <http://colloquium.info>

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