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Tobacco use in South East Europe

**The free market and
health**

**TB and AIDS
control in Russia:
Closing the
knowing-doing gap**

**Moving beyond the
rhetoric of citizen
involvement**

**Restructuring
provider institutions:
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**Learning needs in
health and social
care in England**



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C O M M E N T

Lighting up public health policy

The European Commission, led by Commissioner Byrne, has been at the forefront of positive anti-tobacco actions, while Ireland has become the first country in the EU to introduce a comprehensive ban on smoking in the workplace. Despite these positive developments, the challenge to be met remains daunting especially in most of the countries of the former Yugoslavia, Albania, Bulgaria and Romania. As outlined in this issue by Ivana Bozicevic, Anna Gilmore and Tom Novotny, the public health threat from tobacco will, if current patterns prevail, worsen with major cost implications for health systems and for the well-being of society in general.

One key issue to tackle is smuggling in the region. Until this is curbed, measures such as increased taxation are unlikely to be effective. Corruption, organised crime, and poor coordination between criminal justice and health agencies compound this problem. Greater emphasis should be placed on preventing a wide range of serious health problems by reducing tobacco consumption. Despite the significant economic and health benefits to be gained, such long-term preventative actions, without significant political and public support, are unlikely to figure highly on a list of national health priorities. For this to change awareness of the dangers of tobacco need to increase. This though can only happen with broad political consensus and public support, stimulated by contributions from a strong public health lobby and non-governmental organisations. The example from Ireland, where historically smoking had been a major part of Irish life is evidence that dramatic change can take place.

All these countries have undergone rapid economic reform, while many have endured the tragedy of conflict in the last decade. Greater stability now provides an opportunity to improve public health, but much needs to be done to begin stubbing out cigarettes and lighting up effective anti tobacco policies. Only Bulgaria has signed the WHO Framework Convention on Tobacco Control, and remains the only country to develop a national action plan for tobacco. Experience in the EU can provide both positive examples of a way forward and also serve to identify some of the obstacles that need to be overcome.

David McDaid
Editor

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Tobacco use, a major public health issue in south-east Europe



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South-east Europe (SEE), including the countries of Albania, Bosnia and Herzegovina (B&H), Bulgaria, Croatia, the Former Yugoslav Republic of Macedonia, Romania, and Serbia and Montenegro, is Europe's poorest region. It has undergone enormous changes in the last 15 years with the demise of communism, conflicts among the countries of former-Yugoslavia, and economic deterioration. This considerably weakened the public health infrastructure, and thus, particularly in war areas, attention focused on providing care for the wounded and displaced and on controlling communicable diseases. With increasing stability, attention must now address the major preventable health problems facing the region. As a recent comprehensive review of tobacco control issues in SEE demonstrates,¹ SEE health authorities must prioritise tobacco as a public health issue. This paper, based on the above report, summarises the key issues for tobacco and health in SEE and makes recommendations for action.

The limitations of current data

A barrier to understanding the magnitude of the tobacco problem is the paucity of accurate health and lifestyle data. For example, although regular youth smoking surveys are now conducted in most countries of the region as part of an international collaboration, no SEE country performs routine behavioural surveys of adult tobacco use. Only market-based cigarette consumption data are regularly collected across the region, although their accuracy is limited by widespread cigarette smuggling.

There are also major concerns with the accuracy of data on the health impact of

tobacco use. This concern relates in part to the scarcity of vital statistics, demographic, and health care data, but also to other systemic problems. For example, age-specific lung cancer death rates for the former-Yugoslav countries vary markedly from year to year and death rates from bronchitis, emphysema, and asthma in Romania increased almost three-fold after 1998 compared with the period 1995 to 1998. Chronic disease mortality rates do not generally fluctuate so widely over time. Therefore, in SEE, such data must be treated with caution

Smoking prevalence and tobacco consumption

The available youth smoking data, based largely on surveys of 15-year olds, suggest that smoking among boys ranges from 22% in the Former Yugoslav Republic of Macedonia to 53% in Bosnia and Herzegovina, similar to rates seen in European Union countries. Among girls, the range is from 10% in Romania to 47% in Bosnia and Herzegovina (below and above EU rates, respectively). Trends over time, available only for Croatia, show that the prevalence increased between 1995 and 1999 from 27% to 31% among boys and from 18% to 25% among girls.

Adult prevalence data have been collected from various specially commissioned surveys that differ widely in methodology, thereby limiting between-country comparisons. The available data nevertheless indicate that rates are lowest in Romania and highest in the countries of the former-Yugoslavia. Very high rates of smoking are seen among men (49% in Bosnia and Herzegovina, 46% in Serbia), while rates in women peak at approximately 30% in Bosnia & Herzegovina and Serbia. In the Former Yugoslav Republic of Macedonia, an estimated 40% of male and 32% of female physicians smoke, suggesting that rates in the general population may be even higher.

Historical data suggest that while smoking in men in SEE is a well-established addic-

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tion, smoking among women is relatively new but steadily increasing.¹ This finding is supported by data from Albania and Bulgaria, which show higher rates among younger compared with older women and a positive (albeit non-significant) relationship with education, a pattern traditionally seen early in the tobacco epidemic.^{2,3} Moreover, in Albania the majority of female smokers reported that they had only been smoking for the last five years. Higher smoking rates in urban areas are also seen among women in Albania, Bulgaria, and Serbia,¹ suggesting that smoking is initiated more in cities, where advertising is likely to be more intense. Similar findings of higher rates among women in cities compared to rural areas and among younger compared with older women have been seen in the former Soviet Union (FSU).⁴

Cigarette consumption data, although of questionable accuracy, also suggest that consumption is increasing and that the rates in SEE are very high; 5% higher on average than in central and eastern Europe and 35.2% higher than in the EU.

Disease burden from tobacco use

Estimates of the health impact of smoking show that smoking is the leading cause of mortality and disability among men in SEE and the fourth leading cause among women.⁵ The smoking-attributable proportions of death among men aged 35–69 in 1995 were 30.3% in Bulgaria, 32.4% in Romania, and 42.2% in the countries of the former Yugoslavia. Among women, the proportions were 7.7%, 5.3%, and 10.3% respectively.⁶ In both genders, smoking attributable deaths have increased considerably over time and as female smoking rates continue to increase, so will female mortality from tobacco.

Despite concerns about its accuracy, lung cancer mortality data also indicate the high toll of tobacco use, most notably in Bosnia and Herzegovina, Croatia, and Serbia and Montenegro. The International Agency for Research on Cancer's data for 2000 indicates that countries of this region have some of the highest age-standardised male lung cancer incidence and mortality rates in Europe. The highest lung cancer incidence rates were seen in Hungary (95.5/100,000), followed by Croatia (82.5/100,000), Bosnia and Herzegovina (81.2/100,000), and Serbia and Montenegro (80.9/100,000).¹ In Albania, Bosnia and Herzegovina, Croatia, Serbia and Montenegro, female lung cancer incidence rates are now also higher than the western European average.

The tobacco industry

The countries of south-east Europe both grow and manufacture tobacco, and the tobacco industry, until recently dominated by state-owned monopolies, has traditionally been economically and politically influential. The collapse of communism and the opening of these markets to imports and private investment has led to the growing presence of transnational tobacco company (TTC) and other smaller but locally influential companies. These changes are of concern for public health, as increased tobacco market competition reduces prices, increases advertising (which was unknown in the communist era), and thus increases consumption.⁷

The TTCs already dominate the Romanian market. In the 1990s, Philip Morris, British American Tobacco (BAT), and RJ Reynolds (now part of Japan Tobacco International) all established factories in this nation. In 2003, Philip Morris also acquired the largest Serbian tobacco company, and BAT a smaller plant.¹ In the former Yugoslav Republic of Macedonia, the German manufacturer Reemtsma (now part of Imperial Tobacco) acquired one of three cigarette factories, and BAT and Philip Morris have expressed interest in the other two, which have been due for privatisation for several years. In Bosnia and Herzegovina, Japan Tobacco International acquired a 60% interest in the Mostar factory, and a subsidiary of Reemtsma entered a cooperative effort with the Banja Luka plant.

The private tobacco company Rovinj supplies almost all the legitimate domestic market in Croatia, and it has growing export markets in Bosnia and Herzegovina and in Serbia and Montenegro. BAT has acquired the smaller Croatian tobacco company Zadar, and in 2003 moved its regional office from Budapest to Zagreb. It is now negotiating the acquisition of Rovinj.¹ BAT's investments in Serbia and Croatia have occurred despite considerable criticism from European Union customs officials on BAT's alleged support of smuggling in the region.⁸

Many TTCs have expressed an interest in the failed privatisation of Bulgartabac, the Bulgarian state monopoly, which has been a major regional cigarette producer with large export markets in Eastern Europe. Albania is the only country in SEE without direct TTC presence, although manufacturing there has virtually ceased due to the enormous smuggling problem.

“Health authorities in south-east Europe must prioritise tobacco as a public health issue”

“Tobacco smuggling is a major issue”

Smuggling of tobacco products

Tobacco smuggling is a major issue in SEE, with contraband cigarettes easily and cheaply available. Given that price is a major determinant of tobacco use, smuggling is a major barrier to effective tobacco control and deprives SEE governments of much needed income.

Officially recorded cigarette imports in SEE are considerably lower than official exports from the supplying countries.¹ It is estimated that up to 25% of total cigarette consumption in Croatia and Romania is unreported smuggled cigarettes. This figure is 38% in Bulgaria, 36.5% in Serbia and Montenegro, 40% in the former Yugoslav Republic of Macedonia, 47% in Bosnia and Herzegovina, and an estimated 80% in Albania.⁹ Thus, smuggling is lowest in the country where the TTCs have the largest presence and official market share (Romania) and highest in Albania where they are absent. Given the evidence of the tobacco industry's complicity in smuggling this is unlikely to be a coincidence.^{10,11}

Cigarette smuggling benefits TTCs in a number of ways. It stimulates consumption through the sale of cheap cigarettes, while the industry profits regardless of whether cigarettes are legal or illegal. It enables the TTCs to enter markets that would otherwise be closed to them, and it undermines local tobacco companies, making them easier and cheaper to acquire.

The smuggling problem in SEE is further facilitated by the possible direct involvement of government officials;^{11,12} widespread corruption and organised crime; limited coordination between criminal justice and health agencies; limited regulatory, police, and judicial systems; weak border controls; and inadequate tobacco taxation policies. Without an improved rule of law and recognition by political leaders that the economies of their countries suffer from such laxity in the enforcement of trade and price policies, tobacco use will continue to cause increasing economic and human hardship throughout SEE.

Tobacco control

All the SEE countries now have inter-sectoral coordinating committees on tobacco. However, the extent to which government departments other than the ministries of health (finance, education, and internal affairs for example) are involved is inadequate. Moreover, only Bulgaria has developed a national action plan for tobacco. Civil society groups, which elsewhere play

a vital role in tobacco control, are relatively new to the region, and often excluded from mainstream policy formulation or from meaningful leadership in tobacco control.

Although some SEE countries have quite strong tobacco control legislation on record, it is too often inadequately enforced. All countries have a complete ban on tobacco advertising on national television and radio, but many allow other forms of advertising or weakly enforce existing restrictions. Billboard advertising has been completely banned in Bulgaria, Croatia, the Former Yugoslav Republic of Macedonia, and Serbia and Montenegro, but the industry uses advertisements identical to banned cigarette advertisements with no cigarette seen in the display. Indirect tobacco advertising through brand stretching and sponsorship of events by the tobacco industry is completely banned only in Bulgaria, Bosnia and Herzegovina and Croatia, but again enforcement is a major issue.

Excise taxes are generally low, rates on the most popular domestic brands range from 33% in Romania to 49% in Croatia, compared with the 57% EU minimum. Thus, even legally traded cigarettes are cheap, and in almost all countries the most popular domestic brand costs less per pack than a kilo of apples and less than or the same as a loaf of bread.

Greater restrictions on smoking in public places and worksites and better enforcement of existing smoke-free legislation are needed, in addition, in many countries, to improved product labelling and regulation. Access to smoking cessation services is limited. Nicotine replacement therapies are not available in Albania, nor are cessation clinics in the Former Yugoslav Republic of Macedonia, Serbia and Montenegro and Albania. Although cessation clinics operate elsewhere, they are usually privately run and not covered by health insurance, thereby limiting accessibility.

Conclusions

These findings emphasise that tobacco is already a major threat to public health in SEE and that if current patterns prevail, its impact will worsen, with major cost implications for health systems and for the well-being of society in general. Urgent and comprehensive actions to curb tobacco use are therefore needed. This will require concerted action by governments in the region, to whom we make the following recommendations:

- Comprehensive national programmes on

preventing and reducing tobacco use should be developed as a public health priority and involve a wide range of government departments and non-governmental organisations (NGOs).

- Dissemination of information about the dangers of both active and passive smoking should be strengthened.
- Tobacco taxes should increase and consideration be given to allocating at least 1% of the revenue raised to fund tobacco control activities.
- Countries without comprehensive bans on direct and indirect tobacco advertising should enact them. Countries with such bans should ensure their enforcement.
- All countries should work towards ensuring smoke-free environments in public facilities and in the workplace.
- Action against smuggling must be prioritised.
- Access to smoking cessation services should be widened, ideally by making such services part of a basic health insurance package.
- Health professionals should play a more active role in tobacco control by urging their governments to recognise its importance and providing smoking cessation services. Medical undergraduate and post-graduate curricula should improve their coverage of smoking-related issues.
- Health professionals in SEE need to quit smoking before their advice will be taken seriously. Hospitals and clinics that are not already smoke-free should become so, and medical staff should be offered access to smoking cessation services.
- The development of new NGOs and support for existing NGOs with expertise in tobacco control and public health advocacy is essential.
- Data collection systems must be improved to provide regular and accurate data on tobacco consumption, smoking prevalence, knowledge and attitudes about smoking and accurate mortality and morbidity data. This will require, inter-alia, national surveys of

smoking prevalence, national household surveys which can estimate expenditure on, and consumption of, legally and illegally purchased cigarettes and improved health data collection systems. Questions on smoking habits should be added to death certificates.

- Health impact assessments should be performed before further tobacco industry privatisation so that the potential negative impacts of privatisation can be identified and mitigated.
- The countries of SEE should be encouraged to sign and ratify the WHO Framework Convention on Tobacco Control.

“Tobacco control legislation is too often inadequately enforced”

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Moving beyond the rhetoric of citizen involvement: Strategies for enablement



Andrew G H
Thompson

“The lack of citizen involvement in health care decision making points to the existence of barriers”

Health and health care policies* in many European nations are these days replete with normative statements about the desirability and indeed necessity of citizen involvement, albeit at various levels of detail and sophistication. Inclusiveness would also seem to be a central tenet of modern views of quality management, in which citizens arguably have a primary stake. On one reading, the UK could perhaps be seen to be in the vanguard of this initiative, as successive governments since 1979 have striven to emphasise the need to break the dependency on State and professional paternalism. It is also clear that a problem of democratic legitimacy due to falling voter turnout, particularly true in the UK, is refocussing attention on direct participatory action by citizens themselves.

Policy frameworks

Since 1997 the UK Government has committed itself to a modernisation agenda that emphasises social inclusion, stakeholder engagement and partnership working. These concepts have underpinned the reforms of the White Paper *The New NHS*¹ and *A First Class Service*,² which committed the NHS to develop and enhance patient and public involvement, to develop a strong public voice in health care decision-making, to explore new ways of securing public and expert involvement in such decisions, and, to promote close working with the public, patients and lay carers in a range of areas.

Policies for patient and public involvement exist in each of the constituent nations of Great Britain. Perhaps the strongest embodiment of this was in England in the Bristol Royal Infirmary Inquiry Report in 2001,³ which emphasised that “(T)he public

are entitled to expect that means exist for them to become involved in the planning, delivery and organisation of healthcare”. This echoes clearly the prevailing consensus around clinical governance, neatly summed up recently by the Chief Medical Officer for England:⁴

“Above all, though, clinical governance is about the culture of NHS organisations. A culture where openness and participation are encouraged...”

As Marinker reports from the meeting of the group of European experts in health targeting, however, it is recognised that “it [is] not enough simply to advocate ‘public involvement’...citizens must become ‘actively engaged’”.⁵ This normative exhortation demands answers to at least two questions: ‘Do citizens want to be involved?’ and ‘If so, why are they not already doing it?’. Evidence of the former certainly reveals that not all do want to be involved, for a variety of reasons, while for those who do, the desired levels can vary between people and for the same person at different times and in different contexts.⁶ If we are to achieve active engagement of the citizenry, or at least of the willing members of the general public, then we need a strategy or strategies that effectively resolve this policy implementation problem. This would help to fulfil not only the goals of health targeting, but also to move countries towards better health care quality, as outlined in the recent paper by Mattison in the last edition of *Eurohealth*.⁷

During 2000 and 2001 colleagues and I undertook research to delve deeper into these issues by exploring the perspectives of patients and citizens themselves. The investigation involved a total of 208

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* Whilst recognising the distinct and important nature of each, I shall henceforth use the term ‘policy’ as an abbreviated reference for health care policy, since this is the focus of this paper.

individuals in three phases of a deliberative nature in six different areas of England. This process began with a sample of 44 individual domiciliary interviews with people invited from GP lists. These were followed by 34 focus groups with 111 individual citizens (including the original interviewees) stratified by age, gender and presence/ absence of chronic disease, and a further 79 people from local voluntary groups. The concluding phase invited everyone from the previous phases, of whom 121 attended, to receive feedback and develop priorities in 12 workshops. The purpose was not to make statistical generalisations, but rather, using a qualitative design, to explore and interpret meanings and relationships in an in-depth way. The generality of these findings is limited by the extent to which different groups of people agreed to participate in the research, of which younger citizens and particularly young men were hardest to reach. The design attempted to ensure inclusion of a wide range of citizens, from those who could be termed 'activists' to those that neither participate nor have any obvious affiliation to any group at all.

Among the plethora of findings a number of issues stand out for immediate attention by policy-makers, as well as others that need development on a long term basis. These include the fundamental problems of access to the forums and debates about service planning, as well as the obvious fact that universal involvement cannot occur unless services themselves are attainable by all. Professional attitudes and related communication skills are crucial to encouraging and supporting involvement, as is the provision of desired and intelligible information to enable people to understand and perhaps take some form of control over their health and health care. Underpinning many of these issues is the need for services to commit sufficient resources to the involvement strategies, including adequate time for effective consultations. All of this becomes even more acute as changes are made under ever decreasing timescales.

Partners and terrains of decision-making

The concept of partnership working implies that there exists a common project to which each stakeholder is committed. The current obvious lack of citizen involvement in health care decision-making, at a time when policies are bending over backwards to declare their crucial role in it, points to the existence of barriers,

whether real or perceived. Nonetheless, the reality for many is of a project that is waiting to be put into practice.

The partners in this project, besides the citizens, will depend on the particular terrain of decision-making. For health care consultations, including treatments, this must include health care practitioners, while in the policy and planning forums the partners could include the whole range of policy makers, including politicians, civil servants, health care professionals, managers and maybe others, depending on the particular health care system. Thus, there is a need to consider the perceived barriers and ways of resolution of them from the various viewpoints if we are to make progress in this arena. My focus here will be on citizens, whether patients or not, whether affiliated to groups or individualistic.

Evidence of an active, if small, citizenry already exists, however, suggesting that some characteristics, or components, enable participation. Within each terrain of decision-making we can identify two broad sets of issues that are key to understanding how we can make involvement a reality for citizens. These concern the components of *personal capacity*, relating to skills, resources and confidence to access information and decision-making, and *organisational opportunities* that are the responsibility of the NHS to make available to the public.

Involvement at the service delivery level

Here we focus on the consultation between a patient and the health care practitioner. Improvements have been noted in terms of better communication, although opinions differ as to whether this is due to more open doctors or better informed and less deferential patients. There are four components that relate to patients themselves, in terms of their personal capacity to get involved, and four components at the organisational level with respect to the provision of opportunities (Table 1).

“Citizens and patients must be seen as primary stakeholders”

**Table 1
COMPONENTS OF INVOLVEMENT IN SERVICE DELIVERY**

Personal Capacity	Organisational Opportunity
Knowledge and education	Access and continuity
Confidence and assertiveness	Time and resources
Socio-demography	Professional communication and attitudes
Health and cognition	Information

“Increasing recognition of the expertise of patients may help change attitudes”

Common barriers at this level include, for example, the perceived inequalities between patient and health care professional in knowledge, education and skills and the related degree of confidence to participate in a consultation; the difficulties of being active when trying to cope with ill-health, particularly during acute episodes; and, the lack of time within consultations to do more than answer a few questions from the health care practitioner. Common enablers, on the other hand, include examples where membership of a voluntary group has developed knowledge, information and experience; and, the existence of more open and interactive health care professionals who have facilitated patients’ confidence and ability to make involvement a meaningful and rewarding experience.

Involvement in policy and planning

These components affect the ability of citizens, rather than patients specifically, to become involved in issues of policy and planning within the NHS. This time we can identify six that can be ascribed to issues of personal capacity, with four that concern the organisational opportunities afforded to citizens (Table 2). Despite a large degree of overlap with the components for consultations, some differences and additional components need to be taken into account. Time here becomes a component of personal capacity rather than organisational opportunity, as involvement here has to compete with other demands on citizens, unlike consultations where needs override other considerations.

At this level of involvement common barriers include the fact that very few in the population know anything about how the NHS operates, thus making involvement a difficult concept to initiate; formal and alien structures within which little support is given to understand the issues and related jargon; and, the pace of change in the NHS creating uncertainty and consequent confusion and frustration even for the informed

activists. Common enablers here once again include the experience, knowledge and support derived from membership of voluntary groups; proactive attempts by local health care organisations to invite a wide spectrum of people to participate; and, accessible information from innovatory sources such as the internet.

Next steps in policy implementation

These different components display a range of well-known issues which, when attended to positively and with resources, can enable citizens to get involved and maintain their commitment, but otherwise raise barriers. Members of the public usually recognise their own shortcomings, in terms of lack of education or confidence, as well as various attributes over which they have little, if any, control, such as their socio-demographic characteristics or health status. On the other hand there are some clear messages about what the NHS needs to do in its own organisations to ensure the involvement project is feasible and successful. On both counts there are actions which the NHS could take to increase citizen involvement, some of which involve extra, targeted resources, some are related to improved management of change and access to services, and some require improved professional training.

We have already noted the crucial importance of inclusiveness in developing and maintaining quality in health care. Patients and citizens more generally are the intended beneficiaries of health care systems and must therefore be seen as the primary stakeholders. This is crucial in order to understand the real needs of people from their own perspectives, as well as recognising that their support is essential to the maintenance of health care systems, whether democratically based on collective provision as in the UK, or within more fragmented market structures. There is increasing evidence of the value of public involvement in developing and sustaining quality health care, both at the consultation and planning levels. One of the largest issues that is raised by studies such as the one referred to here is a concern with equity and inclusiveness, which is a concern with all groups in society, many of whom are currently invisible to services or treated in a way that effectively discriminates against them. These groups are often the ones with most health care needs, such as those with mental health problems, learning disabilities, minority language users, etc. Making such groups more visible will

Table 2
COMPONENTS OF INVOLVEMENT IN POLICY AND PLANNING

Personal Capacity	Organisational Opportunity
Knowledge and education	Access and awareness
Confidence and assertiveness	Professional communication and attitudes
Socio-demography and health	Information
Time	Changes and timescales
Money	
Altruism	

help, but it will require a change in attitude and commensurate resources to effect real change. Increasing recognition of the expertise of patients and their potential role in the training of professionals may help to change attitudes and sensitise the NHS to the difficulties that many citizens have in becoming involved. Trust is key to an effective and meaningful involvement by citizens, reinforced by a demonstration that changes will occur for the better as a result.

There is a need for a strategic approach to the implementation of the policy intention of increasing citizen involvement either in consultations or in policy and planning of health services. The above list of components, while broad in scope, gives substance to how this might be addressed. Through involving the public in deliberating on how the project of involvement in health care might be achieved, as individuals or members of groups, we can discern a clear set of building blocks that need to be put in place as pillars for an effective outcome. These can be summarised in the following:

- Values and principles that guide effective and inclusive involvement, which prioritise equality, in terms of opportunity and anti-discrimination, and open access.
- Education and skills that enable citizens and NHS staff to make a contribution, through training and support, as well as public education.
- Communication between the NHS and citizens to create and sustain effective involvement, through information exchange, regular feedback, and relationships with professionals based on partnership and trust.

Moves are already taking place within the NHS to consider how it might engage with the general public to achieve healthy communities. A recent research programme between the King's Fund and the Universities of Liverpool, Salford and Lancaster⁸ involved NHS organisations in trying to isolate the main factors that prevented them from forming more effective and equal relationships with citizens. They identified five such factors:

- Community capacity to engage.
- Skills and competencies of staff.
- Professional service culture.
- Overall organisational ethos.
- Dynamics of local and national political systems.

There is clearly a common agenda between the perspectives of each of these stakeholder groups, albeit differing in focus and priority. If strategies can be forged between the two that take the fine words of the policy statements forward into an effective and meaningful culture of mutual involvement based on partnership and trust then the likelihood of healthy and satisfied communities might stand a chance of being achieved.

“Trust is key to effective and meaningful involvement of citizens”

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*Teresa Petrangolini
with Charlotte
Roffiaen and
Nancy Mattison*

*“citizens can take the
initiative and play a
positive role in quality
improvement”*

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Leading the way:

Italy's citizens work to shape health care

In the lead article in this series on quality, Mattison notes that ‘inclusiveness’ in health care quality processes and policies is a core condition for fostering successful and lasting quality improvement.¹ Involving the full range of interests can both help build trust and credibility and encourage a sense of ownership in progress toward quality. Historically, governments, insurers, and providers have set the agenda, with citizens or patients involved only indirectly. Today, however, as Thompson points out in this issue, many European countries have expressed official support for greater direct involvement of patients and citizens in health care policies and processes.² At the same time, he notes, practical barriers to effective participation exist that can be difficult to overcome.

Two Italian initiatives offer examples of what citizens and patients can do to increase effective involvement in health care quality processes and policy discussions. The first example is a programme called ‘Civic Audit’, which focuses on hospital quality improvement, and is organised by the Tribunal for Patients’ Rights (Tribunale per i diritti del malato). The second is the development of the recent

European Charter of Patients’ Rights, a process largely initiated by Italy’s Active Citizenship (Cittadinanzattiva) and led by its European extension, Active Citizenship Network. (See Box 1.)

The Civic Audit programme

Since the early 1990s, the Tribunal has been overseeing Civic Audit, which inspects service-related quality aspects of Italian hospitals. The audits are conducted by citizens who have been trained by the Tribunal specifically for this task. Teresa Petrangolini has been involved with the Tribunal since its inception in the early 1980s, and her perspectives on the programme are summarised below.

How did the Civic Audit programme begin?

As was true in many other countries at the time, concern about the quality of health care became an important theme in policy discussions in Italy in the late 1980s and early 1990s. A 1992 survey of the European Union Member States, sponsored by the European Commission, showed that Italy ranked second in dissatisfaction with the quality and effectiveness of health services.³

Box 1.

The Tribunal for the Rights of the Patients is an initiative that began in 1980 to protect the health and welfare rights of citizens and to help achieve a more humane and functional health service. The Tribunal is comprised of ordinary citizens, workers from the sector and professionals who provide their services on a voluntary basis. It involves local units throughout Italy and over 10,000 citizens working in hospitals and territorial services, a central structure to coordinate the network activities, promote the national initiatives and manage “PIT Salute” (an integrated project to protect rights). The Tribunal for Patients’ Rights is linked to the Chronically Ill Associations Coalition, which has around one hundred member Federations and Associations for patients suffering chronic diseases.

Active Citizenship, established in 1978, is committed to ensuring that the general public affirms and plays an active role in governing society. At operational level, this is effected via a commitment to ensure that rights set forth in law are implemented effectively. To ensure that individuals and organisations join forces to reach these goals, networks are emphasised. The main networks operating at the national level are the Tribunal for Patients’ Rights, the Chronically Ill Associations Coalition, the Citizens’ Advocates, the Justice for Rights Coordination, the School for Active Citizenship and a network of employees applying good practices in public services and public administration.

Active Citizenship Network officially began operation in December of 2001 as the European and international branch of the Italian citizens’ movement, Active Citizenship. Its mission is to promote and support the construction of a European citizenship as an ‘active citizenship’, that is, the exercise of powers and responsibilities by citizens in policy making.

That same year, the Tribunal took steps to illustrate the need for quality improvement in hospitals. It organised and trained groups of citizens, approximately 23,000 in all. Using a checklist and a questionnaire, these volunteers inspected 300 hospitals. The focus was on specific aspects of service quality; for example, the time it took for a nurse to respond to patients' calls or the frequency of cleaning services. The results formed the basis for a report on what was needed to improve the quality of service in hospitals.

Although the 1992 and 1993 Decrees reforming the Italian National Health Service attempted to address the process and service aspects of health care quality, the satisfaction rating did not improve. A Decree in late 1996 was intended to push the process forward. It identified 79 indicators in four areas: personalising and humanising care (for example, ability to book appointments by telephone, out-of-hours services by general practitioners); citizens' rights to information (for example, consumer relations offices, hospital attention to patient satisfaction); quality of 'hotel services' in hospitals; and disease prevention measures. These were intended to apply in all settings and at all levels of care, from preventive medicine and primary care, to secondary care, hospital care, nursing homes and rehabilitation facilities.

When has happened since then?

The Tribunal, the Active Citizenship Network and the Italian health authorities developed a certification process and a protocol for assessing the quality of services in Italian hospitals. The current Civic Audit programme began in 2000, financed by a grant from a private source. It is now a yearly exercise, still relying on trained volunteers to undertake the inspections.

What is included in the programme today?

Civic Audit is based on four activities. The first three are the same nationwide; the fourth varies to fit local concerns and conditions. These are:

1. Use of a checklist to record how well a hospital meets certain standards in delivering care.
2. An analysis of patients' complaints to the hospital.
3. An analysis of the hospital's own deliberations on service quality; for example, existing policy and quality control procedures.

4. An inspection that focuses on a problem specific to the locality or hospital; for example, waiting lists or mental health services.

The results are used to prepare local and national reports and are presented at a public conference. The local news media have been particularly interested in reporting the results; at the national level, the coverage has been less frequent and usually has focused on negative findings, which is not necessarily constructive.

How many hospitals are included in the Audit?

The process began in 2000 with ten hospitals and by the end of 2003, 40 had been audited. To date, audits have been conducted only in public hospitals; agreement has not yet been reached with private hospitals.

What impact has the programme had?

The programme demonstrates that citizens can take the initiative and play a positive role in quality improvement. It has been generally well received by the hospitals and several have made specific changes as a result of the Audit. These include structural changes such as a new oncology department, an internal cafeteria and facilities for the disabled. Organisational changes include two new centralised reservation units, a telephone reservation service and more convenient visiting hours.

The European Charter of Patients' Rights

The Active Citizenship Network (ACN) and the Tribunal for Patients Rights led the effort to develop the first Europe-wide charter of patients' rights by preparing the first draft and arranging a meeting in September 2002 of representatives of citizens' and patients' groups from Austria, Belgium, Denmark, Germany, Greece, Ireland, Italy, The Netherlands, Portugal, Spain and the United Kingdom. Teresa Petrangolini and Charlotte Roffiaen, Administrator of ACN, provided their perspectives.

Why did the ACN and the Tribunal initiate this effort?

We had first-hand experience in Italy of the need for a patients' right charter and produced the Italian National Charter of Patients' Rights in 1995. This is the only such national charter to date that has been developed entirely by patients and citizens. The key concern that led to the Charter

"cost containment measuresshould not be allowed to compromise a basic set of patients' rights"

Box 2**European Charter of Patients' Rights: Fourteen Rights of the Patient****1. Right to Preventive Measures**

Every individual has the right to a proper service in order to prevent illness.

2. Right of Access

Every individual has the right of access to the health services that his or her health needs require. The health services must guarantee equal access to everyone, without discriminating on the basis of financial resources, place of residence, type of illness or time of access to services.

3. Right to Information

Every individual has the right to access to all kind of information regarding their state of health, the health services and how to use them, and all that scientific research and technological innovation makes available.

4. Right to Consent

Every individual has the right of access to all information that might enable him or her to actively participate in the decisions regarding his or her health; this information is a prerequisite for any procedure and treatment, including the participation in scientific research.

5. Right to Free Choice

Each individual has the right to freely choose from among different treatment procedures and providers on the basis of adequate information.

6. Right to Privacy and Confidentiality

Every individual has the right to the confidentiality of personal information, including information regarding his or her state of health and potential diagnostic or therapeutic procedures, as well as the protection of his or her privacy during the performance of diagnostic exams, specialist visits, and medical/surgical treatments in general.

7. Right to Respect of Patients' Time

Each individual has the right to receive necessary treatment within a swift and predetermined period of time. This right applies at each phase of the treatment.

8. Right to the Observance of Quality Standards

Each individual has the right of access to high quality health services on the basis of the specification and observance of precise standards.

9. Right to Safety

Each individual has the right to be free from harm caused by the poor functioning of health services, medical malpractice and errors, and the right of access to health services and treatments that meet high safety standards.

10. Right to Innovation

Each individual has the right of access to innovative procedures, including diagnostic procedures, according to international standards and independently of economic or financial considerations.

11. Right to Avoid Unnecessary Suffering and Pain

Each individual has the right to avoid as much suffering and pain as possible, in each phase of his or her illness.

12. Right to Personalised Treatment

Each individual has the right to diagnostic or therapeutic programmes tailored as much as possible to his or her personal needs.

13. Right to Complain

Each individual has the right to complain whenever he or she has suffered a harm and the right to receive a response or other feedback.

14. Right to Compensation

Each individual has the right to receive sufficient compensation within a reasonably short time whenever he or she has suffered physical or moral and psychological harm caused by a health service treatment.

The full Charter and additional information are available on the web at www.activecitizenship.net/projects/europ_chart.htm

was the effect on health care of the cost containment measures being taken to allow Italy to enter the Eurozone. We believed that these should not be allowed to compromise a basic set of patients' rights that hold in every situation. As we looked around Europe and interacted with peers in other countries, it became clear that the situation in Italy was not unique. With the impending enlargement of the EU, it seemed the right time to begin to take action on a Europe-wide basis.

Other than the Italian Charter, what is the basis for the European Charter?

The draft has as its reference the EU Charter of Fundamental Human Rights (the Nice Charter) and other official international charters and declarations, particularly from the Council of Europe and the World Health Organisation. The European Charter of Patients' Rights, however, is the only such charter to date that has been drawn up by citizens rather than by governmental institutions.

What is included in the Charter?

The Charter⁴ is divided into four parts. The first is a statement of concern about the failure of health systems throughout Europe to take sufficient steps to respect and guarantee the rights of patients. The second part elaborates fourteen specific 'rights of the patient' (see Box 2). As stated in the preamble, these are 'fundamental rights and, as such, they must be recognised and respected independently of financial, economic or political constraints, taking the criteria of the appropriateness of care into consideration'. Importantly, the Charter also notes that citizens and patients not only have rights, but duties and responsibilities as well. The third section of the Charter details the rights of citizens and their associations to 'perform advocacy activities' and 'participate in policy-making in the area of health', while the fourth offers guidelines for implementing the Charter that range from access and information to financial and legislative support.

What has been the response to the Charter?

It has been received very well by organisations of patients and citizens of course, and also at conferences for the news media held in Italy and Brussels during the autumn of 2003. During Italy's term as President of the EU, the health ministry distributed the draft to all participants at an EU health

ministerial conference in September 2003. So far, however, the reception from other EU governments has been cool, if not negative. Countries due to join the EU in 2004 have been more positive, particularly Poland.

What are the plans for the Charter now?

The Charter still is very much a work in progress and it undoubtedly will be refined based on experience. The main project now, however, is to move toward the second phase, which is implementation. For this, a working group was set up to design the methodology for monitoring progress. It included sociologists and experts in health policy, protection of legal rights, and data collection and processing. A working document has been produced and will be finalised soon, with the advice and participation of citizens' and patients' groups.

We also are in the process of identifying one citizens' organisation in each of the 15 EU Member States to take the lead in monitoring. Monitoring schemes should be in place in early 2004 and later in the year each country will produce a written report. This will be based on hospital inspections using a list of indicators and interviews with health care experts. At the end of 2004, a composite report will be presented in Brussels.

Conclusions

In Italy, Civic Audit provides an excellent and remarkable example of how individual

citizens can become involved directly in processes that can help improve quality at the local level. The availability of an active network organisation, the Tribunal for Patients Rights, to recruit, train and guide patients has provided the means for lowering the barriers to individual participation. Plans for implementation of activities to monitor progress on the European Charter of Patients' Rights draw on this successful experience.

The situation that led to the creation of Civic Audit, however, casts a far less positive light on government attention to improving standards of care. In essence, Civic Audit's purpose today is to encourage hospitals to implement changes to satisfy indicators adopted in legislation as long as a decade ago. It is understandable, then, that the Italian-inspired European Charter of Patients' Rights emphasises that rights must be respected, not promised and then forgotten.

“The European Charter of Patients' Rights, is drawn up by citizens rather than government”

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5th European Conference on Health Economics

London School of Economics and Political Science

LSE Health and Social Care at the London School of Economics and Political Science is hosting the 5th European Conference on Health Economics. It will be opened by Professor Julian Le Grand at a reception on the evening of Wednesday, 8 September and will close with a reception at lunchtime on Saturday, 11 September 2004. Keynote speakers include Professor Bo Rothstein who will speak on the universal welfare state and Professor Richard Layard who will speak on happiness.

The conference will include presentations from all areas of health economics, including, but not limited to, financing and resource allocation, economic evaluation, econometrics in health economics, incentives in health care, equity in health and health care, outcomes evaluation, pharmaceutical economics, social care and mental health economics. One of the conference streams is organised by the European Health Policy Group (EHPG), a forum that encourages discussion between economists and political scientists, this will focus on regulation in health care.

The deadline for early bird registrations is 31st May.

8th-11th
September 2004

Further information on the conference, accommodation and a registration form can be downloaded from www.lse.ac.uk/collections/LSEHealthAndSocialCare/europeanConferenceOnHealthEconomics2004/



The application of free market theory to the health care market



Mark JC Nuijten

“evidence-based medicine will increase homogeneity, which implies products can compete on price”

Every government is eager to control the increase in expenditure by the implementation of central cost containment policies particularly relating to pharmaceuticals. For the most part, those measures have relied on budgeting or price controls, including negotiated prospective budgets for hospitals, centralised negotiated budgets for ambulatory physicians including drug prescriptions, and limitations on payments for particular medications. Because those traditional central cost containment measures were only partially successful, due to a lack of incentives, the health authorities in Europe started to establish incentives for efficient health care delivery. Although there is great variety between countries, there are two related trends: the implementation of market mechanisms and decentralisation of the health care decision-making process. The aim of those reforms is to control the increasing health care costs, which have become an important part of the collective burden of the economy. The objective of this paper is to assess those health care reforms from an economic perspective by applying the concept of free market theory.

Background

Decentralisation

Most European health care systems, except that of Germany, have been based on the so-called Beveridge model, a central system of care consisting of public institutions financed by state budgets. Local authorities and councils have recently obtained increasing authority to implement policies and a freedom to structure the local organisation of health care, for example in Italy and Sweden.^{1,2} While local health authorities in most countries usually receive funding from central health authorities based on a per capita basis, in Italy and Sweden they can supplement this funding with local taxation and health service charges, which may vary locally depending on local budgetary needs.

Market mechanisms

A growing number of countries have recently adopted some form of purchaser-provider split, although others have retained a more conventional budget setting structure. The basic idea is to create a demand side (purchasing agency) that is separate from the supply side (providers). The reforms split the system into purchasers and providers. For example, in the United Kingdom health authorities and general practitioner fundholders became purchasers, while the hospitals and directly managed units became the providers. General practitioner fundholders are now grouped into primary care groups, and are becoming primary care trusts (PCTs). PCTs control the whole budget (except for some specialist services); they provide primary care and purchase hospital care and other services including drugs. In Sweden and Italy similarly there are signals at the local level of such purchaser-provider splits being established by local health care councils.

Other related strategies

The decentralisation of the health care decision-making process and the implementation of market mechanisms resulted in various other related strategies.

Shift to primary care Throughout the 1980s and 1990s the trend has been away from hospital-based consultations and towards primary care. The function of the general practitioner has switched from a physician treating patients to a gatekeeper of the health care system, whose main responsibility is avoiding inappropriate optimal referring of patients to secondary care in order to save costs. Furthermore, health authorities have encouraged the development of practice networks and integrated care models integrating in-patient and out-patient care, as in Germany.

Clinical guidelines These outline the proper care of medical conditions and performance of clinical procedures. The intended goal of guidelines is to reduce inappropriate care and to improve patient outcomes. In addition, these guidelines are potential tools for reducing the costs of health care and for improving medical education.³

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Recent developments

Evidence-based medicine Traditionally, the art of medicine has consisted of physicians using their expert and largely tacit knowledge culled from years of experience to tailor diagnosis and therapy to the specific needs of individual patients. Today this perspective is clearly outdated, because the general agreement in contemporary debates on health care is that the practice of medicine should be evidence-based. However the clinical and health policy communities lack consensus about what types of evidence are relevant to decision making, how to properly evaluate and interpret various bits of evidence, and how to translate evidence into plans of action. For example evidence-based medicine may be used to validate and improve the existing clinical guidelines. A critical success factor for the implementation of evidence-based medicine is the availability of evidence-based data in large databases.

Information technology Although the use of information technology in health care still lags behind in Europe compared with the US, further and broader applications are expected. Information technology may be used for the development of administrative and clinical outcomes databases for collecting evidence-based data. Another application is the development of decision support tools for physicians, which may facilitate diagnosis and choice of treatment and increase adherence by physicians to clinical guidelines.

E-health This may be considered a special spin-off application of the innovation in information technology. Health care professionals and patients show a large demand for updated information, which is finetuned to their needs, especially for new innovative drugs. The internet may become a key success factor in the communication process by the pharmaceutical industry to pharmacists, physicians, hospitals, insurers and patients. For example patients now make significant demands for knowledge related to their disease. An example is the concept of the on-line community (OLC) or virtual community, which is a site on the Internet containing information about a specific topic for members of a specific target group. This can be a combination of any topic and target group.⁴

Drug genetic engineering Genetic screening will lead to a strategic change in future drug development programmes and marketing strategy. Genetic screening will allow the fine-tuning of a drug treatment to

a typical patient. Patients' genes will be screened and the choice of medication will be based on the findings of this genetic screening, as until now most treatment strategies consist of a broad empirical treatment. An analogue comparison may be the selection of antibiotic treatment, where initially blind broad empirical therapy is started without knowledge of the underlying cause (pathogen), while treatment of non-responders will be based on knowledge of the pathogen and the sensitivity pattern of the bacteria.

Current treatment strategies may be compared with broad empirical therapy based on probability of success, while new treatment after genetic screening may be compared with selection of antibiotic treatment based on an identified pathogen. An example is the use of anti-leukotrienes, which are thought to play a role in the pathogenesis of asthma. However, only a third of the patients will benefit from this drug, while it has no or only marginal effects in other patients. Genetic screening of patients will allow anti-leukotriene prescription only to the appropriate subpopulation, avoiding inappropriate treatment and associated costs in other patients.

One consequence is that the return on the investment in new drugs will decrease due to a reduction in market volume; on the other hand the higher effectiveness of the new drug in the target patients may justify a higher price. The application of Porter's strategy framework shows that the pharmaceutical industry may need to move from a 'differentiation' strategy to a 'focus' strategy.⁵ While differentiation is based on selling a unique and innovative product, which appeals to many price-insensitive buyers, a "focus" strategy only fulfils the need of particular buyers in a particular market segment. The resulting smaller market will lead to higher costs for delivering a product, for instance because of fewer economies of scale for research, development and marketing costs. In contrast, segmentation of the market and patient population will also lead to a demand for specific drugs for each segment, and consequently industry will become less dependent on blockbusters.

Application of free market theory to the health care market

Economic background

In a pure market economy supply and demand are determined by individual firms and consumers. In a free market demand

“genetic engineering technology may lead to less competition and higher prices”

“Co-payments fail to control patient demands in many countries because of complementary insurance”

and supply should be equivalent and it is the price of the commodity, which brings demand and supply into balance or equilibrium. The economic model of consumer behaviour assumes that the consumer attempts to use his/her income in order to obtain maximum well-being or utility (consumer as maximiser) by purchasing a range of goods and services, subject to available income. It assumes that consumers know how best to increase their own welfare and therefore which goods to choose. Information is readily available on their characteristics and these can be related to the individual's preferences.

In the health care market patients do not pay directly for treatment (moral hazard), and consequently the price of a health care service will not bring demand and supply into balance: patient demand will not be limited by price, while an increasing supply of health care services will not lead to lower prices, while providers even have financial incentives to increase the volume of health care services.

The third party, the health insurer, who is responsible for direct payment, may have some control over price, but to a much less extent on volume. Although a health insurance company can pass on the cost of this excess expenditure through increased contributions, this is spread between all those insured. The problem of patient moral hazard is compounded where providers are also given incentives to overtreat patients, through fee for service payment. In this case neither the patient nor the provider has an incentive to contain costs. To counter this problem the insurer may require the patient to share in the cost of treatment, for instance by a co-payment.

Principal among the conditions for market optimality is that there is a high degree of competition among suppliers. The traditional health care market is characterised by a number of features, which inhibit competition.

With free entry into the market if there is a profit to be made, new firms will enter and reduce profit to each firm to a minimum. In health care there are restrictions on new entrants in the form of control by professional associations, for example, on the number of doctors allowed to practise, which may be required to ensure that quality standards are met, but can also have the effect of inflating the prices that doctors may charge.

In a free market there are many firms and households, so that none can individually

affect price and all are price-takers. There should be a large number of similar, independent, and competing providers that are free to enter or exit the industry quickly. This ensures that the product is offered at the most competitive price to consumers. If the firm begins to make excess profits newer firms enter to increase quantity available and reduce price.

The economies of scale to be gained from being first into the industry may preclude any further entrants (because unit costs of production decrease as production volume increases) giving the larger firm a competitive advantage over the smaller. In some markets the size of the initial investment required for efficient production, means that new entrants are naturally restricted. In health care some economies of scale (size) and scope (range of services) exist in the provision of secondary care. Hospitals that offer a limited range of specialities (general medicine, and surgery, gynaecology, and paediatrics) must generate sufficient demand to keep a number of specialists in employment. Those that provide more extensive services, such as major trauma, require a wide range of support services as well as the presence of other specialities such as orthopaedic departments.

The scope for economies of scale is however, sometimes exaggerated and very large units may induce dis-economies of scale through an increasing managerial burden and travel costs for patients. Nevertheless, the economic and clinical requirements for a minimum hospital size mean that some areas, particularly those that are sparsely populated, will be unable to support more than one or two hospitals. This obviously places a limit on the competition occurring between units and may mean that the market mechanism is unable to function competitively. Another possibility is that providers collude in setting the price as in monopoly or oligopoly. Such behaviour is easier if just a small number of providers exist in a market.

Perfect knowledge of all market transactions is required for both firms and consumers, so that if a firm sets a price above that charged by other firms, consumers can react by purchasing from another firm. It is necessary for consumers to have, and be able to understand, information on prices and other attributes of the goods such as quality and effectiveness. If this is not the case the consumer may end up buying a product that does not give the capabilities that are required. In health care markets

consumers often do not know what type of care will generate greatest improvements in their health status and must rely on the providers to advise them.

Mobility of factors of production is required so that firms are able to obtain the necessary land, labour and capital in order to begin or alter production. Health care factors are usually less than fully mobile, so that markets adjust slowly to or are restricted from adjusting at all. For example, it takes a long time to train health workers, whose numbers may be controlled by some central body, such as the government or a trade union, and so producers, are unable to substitute factors at will as market conditions change. Therefore only cost containment of drug costs are perceived to result in short-term economic savings.

A high degree of homogeneity of the product being produced is required, so that the products can compete on price and be comparable with one another. More importantly, health care is a notoriously non-homogeneous product. Purchasers and patients cannot simply compare prices; they must also try to assess the appropriateness and quality of the intervention, which it is very hard to do, even for professionals.

The traditional health care market is also affected by the so-called 'externality' phenomena as in some markets the costs and benefits derived from producing and consuming a particular good are not restricted to those engaged in trading in that good. Known as an externality this may lead to an incomplete market for the good for instance the burden of pollution falls on society through taxation.

For some medical care a positive externality occurs, if the benefits of a particular procedure accrue to other individuals in addition to the patient who is treated. The clearest example is vaccination, which provides protection both for those immunised and for those with whom they come into contact. These positive externalities are found mostly in public health measures, which is why in most health care systems these goods are paid by the state. Because benefits accrue to society as well as the individual, the vaccination rate may be less than optimal if left purely to individual purchasing decisions.

Some health care goods also come in the category of 'public goods'. This is a specific term used by economists to denote goods, which are non-rival and non-excludable, that is, goods which you cannot stop peo-

ple from consuming and whose availability is not affected by the number of people consuming them: examples are clean air or national security. It costs the same to provide national defence whether one person or one million persons are benefiting from it (non-rival). An important consequence is the free-rider problem; each person will be not be willing to pay for something from which they cannot be excluded; however valuable the good, they will try to get other people to pay for a service from which they can in turn benefit for free.

Feasibility of a free market in health care

Now some of these requirements for a free market are examined in more detail, taking into consideration the most recent development in the health care environment.

Co-payment In the current free market, health care remains free at the point of delivery or is paid for indirectly through insurance premia. The objective of co-payment is to establish financial incentives for patient's demand control, which in many countries fail because of complementary insurance for co-payments. Although there is an increase in co-payment, private health insurance is taken out for those services that are not provided free of charge.

For example, in France, most citizens have complementary private insurance, which is paid both by the employee and the employer, at least in large companies. This complementary insurance covers a significant part of the patient co-payment left by the Sécurité Sociale. The consequence is that customers do not shop around for the lowest price, and consequently there is still little pressure on producers to keep prices down. Instead, they may compete with one another by providing more attractive services, which may in fact lead to price increases rather than decreases; this being referred to as non-price competition.

Symmetry of information The asymmetry of information between physicians and patients has become much smaller, because patients have become more knowledgeable than in the past by means of better education and media. The internet offers (for example, on-line patient communities) opportunities to further reduce this knowledge gap. However, the increasing complexity of medical diagnosis and available procedures make obtaining accurate knowledge difficult and the appropriateness of e-health information should be scrutinised. After all, if doctors have problems dealing with daily enormous flows of information, it may be questioned whether

“Decentralisation and use of market mechanisms will certainly increase the efficiency of health care markets”

“Some regulation will remain necessary to benefit from a free market without jeopardising equity”

patients will access appropriate information. Consequently most consumers may still rely on the doctor. Hence the patient's agent, the doctor, is able to influence the amount of health care consumed. In addition genetic engineering technology may further increase the information gap both for patients as well as physicians, versus providers of those products or related services.

Homogeneity of products The use of evidence-based medicine will increase the consensus in clinical decision making, increasing the degree of homogeneity and improving assessment of appropriateness and quality, for example by means of clinical guidelines. Consequently, higher homogeneity of the health care services implies that products can compete on price and be comparable with one another.

The use of evidence-based data may be fulfilled by use of targeted longitudinal observational databases, or patient registries, primarily designed to measure the impact of a particular disease or condition on clinical and patient-specific outcomes, and to document the outcomes associated with different treatments or settings of care. Increasing information technology (for example, databases) may contribute to collection of evidence-based data, and may facilitate implementation (for example, decision support tools for physicians) of more standardised treatment, from prescription guidelines to more comprehensive disease management programmes.

On the other hand, genetic engineering technology may lead to a substantial increase in heterogeneity in health care services: a broad empirical treatment will be replaced by specific treatment leading to market segmentation of indication areas. Within each market segment the small number of competing providers leads to less competition (oligopoly, monopoly), which may lead to higher prices. First, prices will increase when the competition decreases and second, market segmentation will reduce sales volume and economies of scale, consequently higher prices are required to remain profitable.

Absence of monopoly or oligopoly The decentralisation of the health care decision-making process, by broadening the role of health insurers from financial controllers to purchasers, increased competition by increasing the number of buyers from one central body to more potential buyers. There are two recent developments, which may inhibit the favourable consequences of

this competition. First, the increasing opportunities of administrative databases may lead to mergers between purchasers: The use of databases allows management at a larger scale (for example, larger number of patients) and may only be beneficial, when benefiting from economies of scale. As a consequence mergers may lead to an oligopoly inhibiting the intended efficiency of purchaser-provider split and higher premiums.

Perfect knowledge and moral hazard Currently, consumers do not pay directly for treatment, and all costs are spread between all those insured (moral hazard). The underlying rationale is that insurers cannot predict future medical risks of consumers. To some extent insurers can already ascertain risk by examining past medical history and current lifestyle, testing for relevant risk factors and adjusting for age, sex and race. A profit-making firm could earn more by attempting to obtain a high level of contribution from those in high-risk groups so that the premium is related to the expected benefits paid.

The use of genetic screening will disturb the current relationship between health insurers and patients, because it will increase adverse selection, which allows companies to identify high-risk individuals, which may lead to unacceptably high premiums for some individuals. Although perfect knowledge is a specific requirement in general free market theory, it inhibits a full free market in health care, which is based on current insurance schemes.

Conclusion

Summarising, we may conclude that the increase in decentralisation and use of market mechanisms will certainly increase the efficiency of health care markets. However, there are developments, which may inhibit a full free market, which include the feasibility of access to adequate information in a complex health care environment, and the possibilities for economies of scale due to information technology, which may lead to oligopoly. In addition genetic engineering will upset the current premium system, which is based on spreading risk over the population. Prior knowledge of disease information may lead to unbearable premiums. Hence some degree of central government regulation will remain necessary in order to benefit from a free market without jeopardising equity in health care.

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European health policies – moving towards markets in health?



Meri Koivusalo

“Regulatory proposals can provide indirect pressure for the harmonisation of health care systems”

The future of European national health systems is currently at a critical juncture. In the European Union, health issues tend to be discussed in non-health arenas while at the same time in many Member States health care systems face increasing pressures and demands in terms of universal access to services, cost-containment and the sustainability of health care financing. In this respect it is important to draw attention to five interlinked processes:

1. The impact of internal market regulations on the financial sustainability and functioning of national health care systems.
2. The negotiation process concerning the General Agreement on Trade in Services (GATS),
3. The European Commission’s Green Paper on Services of General Economic Interest.
4. How current processes within the health sector are geared towards accommodating patient mobility and the open-method coordination in health services.
5. How the proposed draft Constitutional Treaty may raise challenges for national health systems.

Internal market regulations

The impact of the internal market on health care systems has been raised in the context of European Court of Justice decisions and European policies towards health.^{1,2} The relevance of these decisions seems to be greater than the existing size of patient mobility or services in Europe and thus relates more to policy priorities and the legitimacy of imposing structural change.

There is little, if any, evidence that commercialisation of service provision leads to improved, lower cost and better quality health care systems for all citizens. However, more evidence exists of the problems and problematic incentives that

health service commercialisation brings in terms of cost-containment and equity considerations. Choice is typically linked to responsibility. Enabling choice in health care is costly and has broad-based implications for equity of access amongst those who are less able to choose.

These issues are already problematic within current European health care systems, making it unlikely that commercialisation will be part of a solution to cost-containment and ensuring equity in access to services. There is also a fundamental problem in priorities if in European Community policy the rights of service providers to establish services take precedence over European citizen’s rights of access to high quality health services according to need, independent of the ability to pay.

It is necessary to acknowledge the known information asymmetries and market failures in health care. It is also important to understand that quality of care in health has broader aspects than easily measurable issues of staff requirements, equipment levels and cleanliness. While it is unlikely that health systems will collapse due to one major regulatory move, it is much more likely that incremental changes and measures may culminate in vicious cycles and compromises in the longer-term, leading slowly to malfunctioning and decay. In this context the proposal for a directive on services in the internal market merits detailed analysis.³ The directive is clearly based on the assumption that health services are part of the broader internal market of services and thus need to be included in the regulatory framework. However, it is likely that this framework may become deeply problematic for European health care systems. Problematic issues extend from authorisation and country of origin principles to the restrictiveness of exceptions allowing little leeway for governments in regulation of services. In this context it is important to emphasise again that while the regulatory proposals may not directly imply harmonisation of health care systems, it is clear that they can provide indirect pressure towards this end and more importantly limit the

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ways in which Member States can ensure cost-containment, quality of services, cross-subsidisation and access to services within the scope of national health care systems. While European health care systems may not be harmonised into one similar system, they may each become commercialised in different ways.

The impact of GATS negotiation

Negotiations concerning the General Agreement on Trade in Services are continuing under the auspices of the World Trade Organisation. In the European Community trade policy is determined by the Article 133 Committee named after the relevant article in the EC Treaty. The Committee is technically a Working Group of the Council where European decisions are made on the basis of the trade and foreign policy expertise. Consultations, if they take place, occur at the national level and often within very short time frames. It is not evident to what extent European Union trade related views on necessity tests, subsidies and other aspects of domestic regulation may be serving the ends and needs of Member States or the regional and local entities accountable for service provision in practice. It would, for example, be problematic if European proposals on subsidies in the context of GATS would suggest obligatory use of competitive bidding in service contracts if these would otherwise be considered as potentially inappropriate subsidies to local providers.

It is known that many aspects of the GATS negotiations have both direct and indirect implications for European health care systems and their regulation. Legal analyses suggest that most European health care systems would not be covered by the current WTO exemption for public services and that GATS would have significant implications for health care systems.⁴⁻⁶ The European Community has taken a specific horizontal commitment on mode 3 in market access, however, it is not clear how this relates to other areas of the agreement and their impact on service provision. The flexibility in GATS rests in a government's ability to decide the level of commitment, but the general emphasis and context of the negotiations aims to promote the liberalisation of service provision and when commitments are made it is difficult to change them subsequently. As liberalisation of service provision is possible without GATS commitments this implies that it is wiser to take a cautionary approach within the GATS negotiations. The strong emphasis

of effectiveness in trade negotiations in promoting majority voting, with no exceptions in the context of commercial policies, thus needs to be challenged by requirements for caution and better understanding of the implications of negotiated commitments in all service sectors.

Green Paper on Services of General Economic Interest

It is important to draw attention to the Green Paper on Services of General Economic Interest as it proposes a definition for the scope and nature of these services.⁷ The Green Paper places services of general interest and those of general economic interest in separate categories. This is important as competition and internal market rules would not apply to the former, but only to the latter category. The problematic aspect for health, social and education services is that they are defined as being part of services of general economic interest. This means that the narrowest interpretation of exclusion would include only those services provided directly and without charge in the category of services of general interests and that all other provision would be subject to internal market rules and regulations in the context of the European Union.

The Green Paper also points out that the European Community has freely decided to undertake binding commitments in respect to certain services of general economic interest already open to competition within the internal market.⁷ This implies that this would also be likely with respect to other services that are also subject to internal market rules and regulations. While so far Member States have the right to schedule services and decide on scheduled services, it should be noted that when scheduled in the context of the GATS these services sectors are subject to requirements in relation to domestic regulation, including requirements about least trade restriction of government policies and regulatory measures. The issue is thus not so much about changing the aims of service provision or public policies, but rather of how and in what kind of a regulatory context this is done.

Patient mobility

In European health policy substantial attention has been drawn to the mobility of patients and the implications of European Court of Justice judgements for national health care systems. The aims of current efforts and the proposed mechanisms for

“Enabling choice in health care is costly and has broad implications for equity of access”

the open method of coordination are unclear. These activities run the risk of becoming more important in guiding European health care systems to adopt a more commercial framework of operation rather than ensuring that they can have the necessary scope and regulatory freedom to ensure their commitments on provision of health services for all of their citizens. In this light it is worrying that the proposed regulation on internal markets in services states that it is consistent with work on patient mobility.¹ Increasing cooperation and mutual learning between Member States is easy to support. However, if the mechanism of open method of coordination becomes a soft mechanism of governance and a means to adjust Member States health systems to fit with the requirements of an internal market and competitiveness within the European Union, this activity becomes problematic.

This is important also within the context of the forthcoming enlargement of the European Union, which will bring even more diversity of health systems and underlying values into the European Union. It is clear that action at the European level in terms of health will be required. However, there is a danger of merely increasing the European level competence without an increase in the capacity to ensure health policy and public interests at the European level. The danger of is that this will lead to a greater emphasis on the interests of industrial and interest group aims rather than the the interests of citizens; an outcome that is all too apparent in the context of pharmaceutical policies.

Draft Constitution

The proposed draft constitutional Treaty provides both threats and opportunities for European health systems. In this context it is necessary to emphasise that the actual details of the Treaty may not as yet have attracted sufficient attention, especially part III. Even though it would be unrealistic to assume that health would be a central objective of the EU, it is clear that a European social model can exist only if social and health policy priorities and commitments are considered to be of equal relevance with the free movement of goods, people, capital and services and the right of establishment. At the moment no such clear recognition exists in a Treaty that instead seems to enhance the economic aspects of the EU at the expense of social goals in the context of the 'hard' legal framework of aims and priority commitments.

In this context it is necessary to ensure that definitions of competence do not end up leaving Member States with residual powers where EU activities would in practice define competence. On the other hand, the draft constitutional Treaty is weak in terms of European competence in the area of public health, health promotion and in broad fields that would improve European level regulatory functions for health promotion (e.g. alcohol, tobacco policies) or help ensure high levels of health protection.

Commitments to EU citizens in terms of access to health services and the provision of care remain with Member States. This is to be expected, but it does not provide grounds for further changing a situation that is already problematic. There is thus a danger that current problems with respect to internal markets and health may become further enhanced through a new Treaty. In order to ensure that access to health services and social security are not compromised by commitments to fundamental freedoms, (free movement of goods, people, capital, services and freedom of establishment) and that public health issues receive higher priority within all policy areas, additions and changes would need to be proposed. In practice proposals to address the problem of internal markets and health services and other health-related matters have already taken place, having been put forward by Member States. The challenge is to ensure that they obtain sufficient priority in future rounds of negotiation.

The current negotiation process, in the context of the WTO, raises concern with respect to EU competence in the negotiation of international Treaties. This is particularly true in respect of EU competence and common commercial policies as stated in the draft Constitutional Treaty. In the current version of the constitution the only exclusion from majority voting in commercial policies is made for audiovisual services. In comparison to the Treaty of Nice, the current draft constitutional Treaty clearly expands EU competence in relation to commercial policies. Majority voting is promoted on the basis of increasing the effectiveness of trade negotiations and decision-making, yet there is often a trade-off between the more shortsighted efficiency aims and democratic processes and accountability. If the Member States, or in many cases their regional or local authorities, are held accountable for service provision, it is problematic to treat health, social and educational services simply as part of

“It is problematic to treat health, social and education services as part of the general EU approach to trade negotiations”

the general Community approach to trade negotiations. The Assembly of European Regions has drawn attention to this problem with respect to stipulations in commercial policy in the draft Constitutional

Treaty.⁸ If the stance on common commercial policies remains unchanged, there is a high risk that European Community trade policies will compromise the capacities of Member States to ensure the financial sustainability of their health systems and social rights of their citizens. European citizens have the right to expect that decisions concerning the organisation of their health systems and the delivery of health care will be made on the basis of health policy priorities and interests, rather than on the basis of equal treatment of service providers or the priorities of commercial actors.

European health policies have reached a critical juncture. It is clear that the profile of health and concerns over health systems capacities, resources and functions need to be raised at European level. It is not though clear whether this automatically means increasing EU competence over health. It is in the interests of European citizens to ensure that health and the sustainability of European health care systems are given a higher priority at a European level and that this is recognised both within the context of internal market, trade and competition policies, and within the further negotiation process for the draft Constitutional Treaty.

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European Network for Mental Health Service Evaluation (ENMESH)

Sixth International Conference

Inclusion and Mental Health in the New Europe

King's College, London, United Kingdom. September 3rd – 5th, 2004

There are 52 countries in the WHO Europe region, and certainly rather more than 52 health systems. Some health systems give considerable emphasis to the identification, treatment and alleviation of mental health needs; others remain worryingly neglected.

The last few years have seen unprecedented attention paid to the promotion of mental health, especially by international bodies like the WHO, the World Bank and the European Commission. Part of this global effort has been directed at the many people with mental health problems who find themselves socially and economically excluded, either because of stigma, difficulties in finding work, poverty, homelessness, victimisation, or unwarranted incarceration. The focus of many national and international initiatives is to improve the 'connections' between people with mental health problems and the wider society.

There will be a limited number of bursaries to enable those, including consumers and carers, who may need some financial support to be able to attend.

- The conference will address these issues within the 'New Europe' through four main themes:

User/Consumer Involvement

Keynote speakers:
Judi Chamberlin and Diana Rose

Mental Health Policy in the New Europe

Keynote speakers:
John Bowis and Benedetto Saraceno

The Mental Health of Vulnerable Groups

Keynote speakers:
Norman Sartorius and Costas Stefanis

Interventions that Work

Keynote speakers:
Karl Kuhn and Mario Maj

Further information on the conference and the registration form can be downloaded from the conference website www.enmesh2004.org

Tuberculosis and AIDS control in Russia: Closing the knowing-doing gap

*Olusoji Adeyi,
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*“The agreement marks a strategic shift in Russia’s approach to
TB and HIV/AIDS control on a large scale”*

Russia has a unique combination of characteristics that render decision-making in the health system more complex than in other parts of the world. On the one hand, it wields geopolitical clout through its membership of the Group of Eight highly industrialised countries (G-8) and its permanent membership on the United Nations Security Council. On the other hand, it suffers from a fast-growing epidemic of HIV/AIDS and a large burden of tuberculosis (TB), as seen in a number of poorer countries. In addition, there is a strong legacy of health care in the socialist model, which is often at odds with modern public health and contemporary moves to evidence-based medicine and disease control. These factors contributed to the tension between the need for large-scale implementation of evidence-based disease control and the traditional practices of doubtful effectiveness.

TB is a major health problem in most of the countries of the former Soviet Union. Russia is one of 22 countries with the highest TB burden in the world¹ and it is the only country that belongs to that group from the former socialist countries of Eastern Europe and Central Asia. This problem is being fuelled by a combination of factors, including poverty, ineffective approaches to diagnosis and treatment, a dysfunctional penitentiary system and a weak health system overall. In addition, prisons play a role as breeding grounds for infectious diseases.²⁻⁴ TB is also the most important opportunistic infection for people suffering from AIDS, and persons with latent TB are more likely to develop clinical

TB if they become infected with HIV. This increases the likelihood that the TB problem will grow in a context of rising HIV/AIDS prevalence. This significant TB problem in Russia exists despite the availability of effective approaches to diagnosis and treatment that are recognised by WHO and known to be cost-effective. For example, treatment of smear-positive TB, using the WHO recommendation of directly observed treatment, short course (DOTS), has by far the highest impact, with a cost-effectiveness ranging from US\$5 per disability-adjusted life year (DALY) gained to US\$40 per DALY gained.⁵ By the end of 2001, DOTS was being implemented in about 19 demonstration projects in Russia with a population coverage of a mere 12%.⁶

The Europe and Central Asia Region (ECA) is experiencing the world’s fastest-growing HIV/AIDS epidemic. Tackling this epidemic effectively requires political mobilisation, epidemiological and behavioural surveillance, effective prevention (with particular attention to high-risk core transmitters and bridge populations), care and treatment.⁷ Russia alone had over 200,000 officially registered HIV cases at the end of 2002, but the Russian Federal AIDS Centre estimated that there were at least one million HIV cases. Studies indicate high prevalence rates among injecting drug users.⁸ Russia shows the features of an epidemic that was initially concentrated among the high-risk, core transmitters, mostly the injecting drug users and commercial sex workers, and is now starting to spread into the bridge population, such as

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“The fear of change may prevent knowledge-based action”

the sex partners of the high-risk core transmitters. Without effective control, it is probable that the epidemic will spread from this bridge population into the general population. According to one source, cumulative new cases may range from 4 to 19 million by 2025.⁴ This has potentially drastic economic consequences for Russia. In May 2002, a study of the potential economic effects of an unchecked epidemic in Russia suggested that, in a plausible scenario, the Gross Domestic Product (GDP) could be as much as 4.15% lower by 2010 due to the spread of HIV/AIDS. The same study suggests that investment would decline by more than production and the quality-adjusted labour supply would decrease over time.⁹ Despite these dangers to health and the economy, efforts to control HIV/AIDS in Russia have remained weak and patchy, mostly limited to pilot efforts. In early 2001, discussions of a large-scale project to control TB and AIDS reached an impasse. Two years later, the Russian Government and the World Bank have reached an agreement on a country-wide implementation of effective TB and AIDS control strategies. We examine why Russia was so slow to act in the face of these problems and how the breakthrough was accomplished.

Methods and data sources

Drawing on materials that are readily available to us in the course of our work, we examine the issues, strategies and the political economy of changing the approaches to TB and AIDS control in Russia. Much of the information is unpublished, particularly on negotiations of the TB and AIDS programme.

Stuck in the pilot phase: why was it so difficult to scale up?

Russia's geopolitical clout and its traditional practices in the health sector complicate its efforts to control TB and HIV/AIDS. For both diseases, it is relatively easy for local and international agencies to secure approval for demonstration projects on a small scale in Russia. Unlike countrywide programmes, small-scale efforts neither threaten the established order nor require approval at the highest levels of government. Countrywide efforts that require changes in long-established approaches, in particular when it comes to altering the vertical disease control system, run into difficulties in closing the gap between what is known (or thought) to be effective and what is practiced. The fear of change may prevent knowledge-based action.¹⁰

Tuberculosis

While Russia embarked on a transition from the centrally planned Soviet economy to a more open society and a rather poorly regulated market economy, its TB control system remained the same, with institutional reluctance to change. Information on TB prevalence and treatment impact was classified during Soviet times. The approach to TB control was costly because it was overly reliant on mass screenings, often along professional groups by X-rays for diagnosis (so called fluoroscopy), lengthy hospitalisations for treatment and frequent use of surgery. The power of the Federal Government to enforce compliance with screening programmes that target non-symptomatic population groups has diminished, rendering these expensive programmes largely ineffective.

Nonetheless, the Soviet approach to TB control was held in high esteem by the Russian health establishment, partly because the TB burden in the late Soviet era was not the big problem that it became in the 1990s, according to official data.

An exception was the Ministry of Justice which, for years, had expressed a willingness to use internationally recognised guidelines to manage the huge TB problem among prisoners. This willingness became possible after the prison health service was transferred from the Ministry of Interior to the Ministry of Justice as part of overall judicial reform in Russia. However, while the Ministry of Justice ran a parallel system of TB control services, its desire for change could not be implemented without endorsement by the Ministry of Health. In addition, the incentives for financing the TB services favoured the maintenance of large TB hospitals and sanatoria because they were based on the number of beds. Such an input-driven system does not help to improve performance on the basis of outcomes. Furthermore, a generation of practitioners, distinguished in the Soviet era, resisted rapid change from the familiar system to the new one. As a result, promising approaches remained in the pilot phase, on a scale at which they could not be perceived to threaten the established order.

Russia also has an epidemic of multi-drug resistant TB (MDR-TB) caused by strains of the TB bacteria that are resistant to at least isoniazid and rifampicin, the two principal first-line drugs used in combination chemotherapy. MDR-TB results from poor management of drug-sensitive TB; it is a big problem that arises from a failure to

manage a smaller problem effectively. It is the result of one or more of multiple failures in the disease control or the broader health care system. These failures include first, the use of incorrect drugs or incorrect doses of the right drugs to treat TB often exacerbated by an erratic drug supply. Second, the discontinuation of treatment before the bacteria that causes TB have been killed off, which makes it possible for these bacteria to develop into stronger versions of the same bacteria. The breakdowns in the drug supply chain as well as the lack of a functioning reference laboratory network make it difficult for doctors, nurses and other health care workers to provide the right treatment and to achieve lasting results.

The penitentiary system contributes to a great deal to the spread of the epidemic and the rise of MDR-TB. Many of the preconditions for TB are prevalent in a prison environment: overcrowding, inadequate nutrition, lack of hygiene, and low quality health services. To make matters even worse there are perverse incentives for prisoners to get infected, which often results in preferential treatment, better food, and even early release. The Russian practice of large-scale amnesties for prisoners contributes to this problem as thousands of prisoners under treatment for TB are released every year during amnesties, and are at risk of discontinuing their treatment once out of prison. Civilian health authorities have no means to follow them up.

In cross-country comparisons, the MDR rate among previously untreated cases is inversely correlated with treatment success under short-course chemotherapy (SCC).¹¹ The straightforward conclusion is that high cure rates have prevented the emergence of resistance in countries that have made effective use of SCC. If few patients fail treatment, fewer still can develop resistance. High rates of resistance tend to be associated with low treatment success. In the Ivanovo Oblast (Region), Russia, the reported treatment success for patients carrying fully sensitive strains is 63%; with a cure rate this low, it is not surprising that 9% of new TB cases are MDR,¹² which is perceived as a growing hazard to human health worldwide.³

A large number of international organisations supported pilot projects at the operational level in Russia, often in technical collaboration with the WHO, which plays a key role in interagency coordination in Russia through a High-Level Working

Group (HLWG). The HLWG serves as a convenor of work programmes to update Russia's approaches to diagnosis and treatment in accordance with modern practices in agreement with WHO guidelines.¹³ However, even when a new approach to TB control is more effective than an established practice, its countrywide adaptation may be blocked if it does not originate from the 'establishment'.³ Although the European Region has the lowest DOTS coverage (17.3%) and the lowest DOTS case detection rate of the six WHO regions, this is no comfort to Russia, since most Western European countries have far more resources per capita to spend on health, and none of them has a TB burden as large as Russia's.

HIV/AIDS

There is a need for targeted, non-stigmatising prevention programmes¹⁴ on a larger scale than the current pilot projects. As sex workers may become a bridging population for further spread into the general population, an extension of the few projects and programmes that already provide appropriate HIV prevention education and health services to sex workers and their clients is urgently needed.¹⁵ The current approach of large-scale HIV testing is not linked to the planning, targeting, monitoring and evaluation of interventions. There is an institutional reluctance to undertake serological and behavioural surveillance (so-called second generation surveillance).^{16,17} There is also a reluctance to develop and implement non-punitive interventions among hard-to-reach populations.

The large-scale implementation of interventions to interrupt HIV transmission among high-risk groups has been hampered by legal and social constraints, despite evidence that such programmes produce reductions in risk behaviour in demonstration projects.¹⁸ The Russian context is such that it is easier to undertake general awareness campaigns and other politically safe interventions, such as the prevention of mother-to-child transmission, than to address the sources of rapid growth of the epidemic by targeting interventions to high-risk, core transmitters such as intravenous drug users (IDUs), commercial sex workers and their sex partners. The HIV/AIDS epidemic in Russia was initially concentrated in these population groups. However, the HIV/AIDS epidemic is now starting to spread into the bridge population (such as the sex partners of the high-risk core transmitters). Although precise

“institutional, policy and legal decisions required for scaling up are more challenging than the financial requirements”

“Agreement was facilitated by the removal, through negotiations, of multiple chokepoints in the decision-making process”

predictions are impossible, it is reasonable to expect that, without effective efforts to control the trend, the epidemic will likely spread from this bridge population into the general population. Interrupting HIV transmission among the high-risk core transmitters and the bridge populations is central to effective prevention of a generalised epidemic.

Togliatti city in the Samara Region of Russia presents an example of high prevalence rates of HIV among IDUs tested in 2001 (56%). 74% of these were unaware of their positive status. This high prevalence of HIV and a recent increase in HIV detected through routine tests since 2000 suggest that an explosive epidemic occurred among IDUs in Togliatti.⁸ In the face of currently inadequate HIV prevention coverage among IDUs, this has urgent implications for maximising the distribution of sterile injecting equipment and for enhancing sexual risk reduction practices. This situation appears to be typical of many high prevalence countries in the ECA region (Ukraine, Belarus) where the highest infection rates (in parallel to a large number of users of illicit drugs) can be found in mid-sized industrial towns with high youth unemployment.

In addition to concerns over injecting drug use, recent data indicate a potential for rapid heterosexual spread of HIV in Russia. For example, one third of all 14–20 year old respondents reported being sexually active during the past year. 75% of these respondents reported a friend or casual acquaintance as their current partner and 44% of them did not use a condom the last time they had sex. Among those who had sex in exchange for money or gifts, 35.6% of the 21–30 year olds and 43.5% of the 41–49 year olds had not used a condom.¹⁹ The increasing levels of prostitution and the common practice of unprotected casual sex favour the spread of HIV beyond the drug-user subpopulation. In the past five years, the sex work industry has expanded dramatically as a consequence of increasing unemployment, poverty, population mobility, family disruption and other factors associated with a transition to a market economy.

The agreed Tuberculosis and AIDS Control programme: what will it do?

In March 2003, the Russian Government confirmed a landmark agreement with the World Bank on a US\$286 million Tuberculosis and AIDS Control Project, of which US\$150 million would be financed

from the proceeds of a loan from the World Bank to be implemented over a five year period, with the remainder financed by the Government. The importance of the agreement is that it marks a strategic shift in Russia's approaches to TB and HIV/AIDS control on a large scale, and it will influence decisions on allocations of other resources being devoted to these efforts. It also makes Russia more attractive to additional financing from grant sources.

For TB control, the project will support the implementation of new policies, strategies and protocols that were developed by Russian officials in agreement with WHO. As of early March 2003, the new policies and guidelines were at advanced stages of clearances in the Russian system. Within that policy framework, the project will improve surveillance, monitoring, quality control and quality assurance, strengthen case detection and improve case management. For HIV/AIDS, the project will help to improve policies and strategies; support public information campaigns, strengthen surveillance and monitoring, improve laboratory service and blood safety, and deliver preventive interventions to defined groups, taking into account findings from serological and behavioural surveillance.

Key factors in reaching an agreement

The agreement was facilitated by the removal, through negotiations, of multiple chokepoints in the decision-making process. First, the leadership of the Russian health sector concluded that it was in the country's best interest to reach this decision. Estimates and projections of the epidemic suggested potentially serious problems if Russia opted for 'business as usual' through the traditional approaches to TB control and patchy efforts to control HIV/AIDS.⁹ Senior analysts in the Russian health sector were becoming concerned about the potential demographic impact of the epidemic. Decision makers began to view the epidemic in broader terms than a problem of marginalised groups alone, and the policy environment became more supportive of stronger efforts to control the epidemics.

Moreover efforts were made to address local concerns that externally derived protocols meant for low-income countries were being imposed on Russia. The country would develop its own protocols for TB control, but funding through the project would be contingent upon the protocol being reached in agreement with WHO, in

line with currently recognised international guidelines for diagnosis, surveillance, treatment, monitoring and evaluation.¹³ This made it possible to overcome institutional reluctance to change. In the mid-1990s, there was an implicit assumption by international experts that, faced with a fast-growing epidemic, Russia would automatically opt for the most effective interventions based on international guidelines and current knowledge or thinking. This was rational from a purely technocratic perspective, but misguided in terms of the political economy, since the Russian health establishment saw no need for change. The acronym DOTS was confusing to some people and unacceptable to others who regarded the approach as tailor-made for third-world countries but inappropriate for Russia. The feasible approach was a transition from the old system into a new one that would be specific to Russia while keeping international guidelines at its core.

Russia will not spend the loan proceeds to procure technical support from the WHO, the lead technical agency on TB control in Russia. This is a departure from earlier thinking by the World Bank's team and WHO officials who were close to the negotiations. WHO will find funds from other sources to finance its activities in technical support, training, quality assurance, monitoring and evaluation, including cohort analysis. This resolved one of the concerns of the Russian Ministry of Finance and also maintained a strong technical role for WHO in the agreed programme.

Regarding the procurement of second-line drugs, the method to be used will be acceptable to the Russian Government and the World Bank. Eligible methods include but are not limited to International Competitive Bidding (ICB). This resolved one of the biggest obstacles to an agreement. Powerful interest groups in Russia had expressed opposition to the procurement of drugs through one or more suppliers to be identified by the Green Light Committee, a subgroup of the international Working Group on DOTS-Plus for MDR-TB, which has its Secretariat at WHO. The Green Light Committee is essentially a quality assurance mechanism, which helps to ensure that countries meet technical criteria before they can have access to second-line drugs at preferential prices, obtained through WHO-supervised bulk procurement from pre-qualified suppliers. The intention is to prevent the inappropriate use of second-line drugs, which might lead to resistance to those drugs and the emer-

gence of super-drug resistant strains of the tubercle bacillus. In view of the public health importance of TB, the World Bank had taken extraordinary steps, including adjustments to its procurement guidelines, to enable Russia to procure second-line drugs at quality-assured and low prices. In 2001, the World Bank's team was surprised to discover that opposition was not coming from the international research-based pharmaceutical companies, but rather from the local Russian industry. They were concerned that a World Bank-financed project could disturb existing pharmaceutical supply and distribution mechanisms. Intensive dialogue with local industry representatives and officials in the Ministry of the Economy finally resolved this impasse. In parallel, the Bank agreed to support the local industry in achieving minimum standards of Good Manufacturing Practices (GMP) that are acceptable to the WHO. Compliance with GMP requirements would enable Russian suppliers to bid for contracts to be funded under projects financed by the World Bank. Finally, Russia agreed that the use of loan proceeds to purchase second-line drugs for treating MDR-TB would only be done upon compliance with technical guidelines on quality assurance, to be verified by WHO. Russia will use its own budget to procure from the domestic market quality-assured first-line drugs for TB control, with the option of using reserve funds from the loan if the budget proved insufficient.

As for AIDS control, approaches to epidemiological and behavioural surveillance of HIV will now be done using methods that were agreed with WHO and UNAIDS,¹⁵ an improvement upon the current practice of large numbers of tests without relevance to programme planning and monitoring. Efforts will be made to alleviate legislative barriers to large-scale programmes. Among other interventions, the prevention of new infections among injecting drug users will receive particular attention as part of the scaling up of targeted interventions among high-risk core transmitters. Bridge populations will be identified, with a view to developing and implementing interventions to prevent HIV transmission in those groups, and to preventing transmission from them to the general population. Further details are available from the authors on request.²⁰

A number of important risks remain. Most cannot be fully mitigated in advance, but they will need to be identified and resolved as work progresses. Interventions among

“Decision makers began to view these epidemics in broader terms than being a problem of marginalised groups alone”

“Efforts were made to address local concerns that external protocols were being imposed”

high-risk core transmitters and bridge populations may still face opposition among certain interest groups, given a perception that such interventions legitimise “bad” behaviour. The logistics of managing a country-wide programme across the vast expanse of Russia are very challenging. Supporting the implementation of this project will be a challenge for the World Bank in terms of resources required. However, now that Russia has chosen to tackle its TB and AIDS epidemics decisively, it is more likely to attract significant international grant assistance to make this programme succeed.

Conclusion

A deliberate convergence of local and international interests in disease control made possible the qualitative leap from pilot projects to a programme for the entire country. In a complex situation as in Russia, the institutional, policy and legal decisions required for scaling up are more challenging than the financial requirements. Meeting this challenge requires, in addition to financial resources, a combination of local leadership, strategic focus, flexibility of tactics and cooperation among international agencies.

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The role of the European Health Forum Gastein



Matthias Schuppe

“the Forum serves as a ‘university of ideas’ for European health policy development”

The European Health Forum Gastein (EHFG) was established in 1998 as a European health policy conference aiming to provide a discussion platform for various stakeholders in the field of public health and health care. Also known as the ‘Gastein Forum’, EHFG is organised by the International Forum Gastein (IFG), a non-profit and non-partisan association.

Founded in the early 1990s, IFG took up the tradition of inspired physicians such as Theophrastus Paracelsus and Christian Doppler, who played a decisive role in facilitating medical progress in the region of Salzburg (where Gastein is located). Aiming to support holistic medicine according to the logic of Paracelsus through national and international events, IFG reconsidered its focus when new challenges for health systems, in particular European integration, emerged.

Launched as a joint initiative of Prof Dr Günther Leiner, a socially committed physician, and then member of the Austrian Parliament and Mr Pdraig Flynn, then European Commissioner for Social Affairs and Employment, the EHFG has become a unique annual event. It acts as an interdisciplinary forum, bringing together experts, varied interest groups, politicians, decision-makers and the media to debate key health issues.

Having been launched with major financial support from the European Commission, subsequent events have grown with the continued and extended cooperation of Commission services, which besides having Directorate General (DG) for Health and Consumer Protection as a key partner also includes others DG’s: Enterprise, Information Society, Employment and Social Affairs, and Research. It is co-organised by the Austrian Ministry for Health and Women and the Austrian Broadcasting Corporation. The European Observatory on Health Care Systems, Salzburg Regional Government (Land Salzburg), the OECD,

World Bank, and the European Region Office of the World Health Organisation also support the event.

Integrating national, regional and European perspectives it facilitates the exchange of views and experience amongst key actors and experts not only in EU and accession countries, but from all 52 countries in the WHO European region. Far removed from the Brussels political ‘hothouse’ the Forum serves as a ‘university of ideas’ for European health policy development. The unique setting located in the Austrian Alps is used by the European Commission “to take soundings with the health policy community on the future direction of health-related policy at the European level.”¹

All stakeholders in the European health arena, advocates of citizen and patient concerns; politicians and public servants; representatives of business and industry; scientists; and members of the academic community have a level platform on which to discuss key health issues. Its main objective is to facilitate the establishment of a framework for advising and developing European health policy while recognising the importance of national and regional authorities and other decision-making bodies.

By focusing on key issues in the European health arena the Forum considers in particular strategic issues in the development and implementation of health policy at a Community level, as well as at the national and regional level. It evaluates future health challenges, current developments and their effects on society, and health systems and services, in particular the changing role of citizens and patients. In doing so the Forum considers opportunities for the integration of health policy across different policy areas and analyses the impact of European integration on health systems, in particular Common Market developments. Mutual learning and the exchange of national and regional experiences play an important role in this process.

Over the years the Forum has covered a wide variety of topics ranging from the health implications of the Common

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Agricultural Policy to eHealth. Under the motto of “Creating a better Future for Health Systems in Europe” it has so far addressed the main themes of ‘Health and Social Security’, ‘Information and Communication in Health’, ‘Integrating Health across Policies’, ‘Common Challenges for Health and Care’ and ‘Health and Wealth’.

The programme for 2004 is currently being considered. In addition to key developments at the EU level it will consider values, objectives and principles of health

policies in Europe, performance improvement and financial sustainability of health systems, the financing of innovation and health care, mental health and social inclusion, and the wider determinants of health.

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Health as a macro-economic growth factor

Matthias Schuppe

“health care is increasingly seen as growth promoting”

Making the economic case for health

Speaking at the Sixth European Health Forum Gastein EU Commissioner David Byrne noted that while the political argument on health at a European level is being won, the economic case has only begun to be addressed. Byrne asserted that “it is the economic case which is definitive... if we are to win the argument for greater European cooperation on the protection and promotion of health, we must speak to Finance Ministers on their terms and in their own language.”¹

Such an economic case needs to be made even more so, as the dominant policy in most European countries is one of cost-containment, spending cuts and cost-shifting since for “...finance ministers, the words ‘health’, ‘spending’ and ‘bottomless pit’ tend to go together.”¹ Indeed it is not only finance ministers, but also health policy makers who have jumped on the bandwagon and try to define an ‘optimal’ level of health expenditure (as a share of Gross Domestic Product (GDP)).

However taking a long-term historical perspective it does not seem so dismal to have witnessed our predominantly agrarian societies shift to an industrial base and further on to a service and knowledge economy over the centuries. Indeed as the service sector as a whole accounts for an increasing

share of GDP why should health services not grow as well?

Health expenditure as a welfare loss?

Conventional health economic wisdom would suggest health services should not grow. The contribution of health care to population health is limited and the level of health care expenditure is highly correlated with income, resulting in an income elasticity of demand of more than unity. In other words health is a ‘luxury’ good and the more money we have the more we will spend on health care, but the marginal productivity of these additional expenses will be almost nothing.

However there are a number of serious problems with this conventional knowledge. At the time the underlying research was conducted, between the 1960s, and the early 1980s, the contribution of health care to population health may indeed have been quite limited, and sometimes even counter-productive. However, as medical technology has progressed and health care become more evidence based, more conditions have become amenable to health interventions.² Furthermore, while there have been a number of international comparative studies corroborating the conventional view, there is also ample contradictory country level evidence pointing to the fact that income elasticity of demand for health care is less than unity. This means that health care may be a ‘necessity’ rather than a ‘luxury’. Last but not least there are some significant

Footnote: This article has been inspired by a presentation by Martin McKee at the 6th European Health Forum Gastein, October 2003.

methodological problems associated with this sort of comparative research.^{3,4}

Considering that the evidence base for current policy making is both outdated and shaky there may be a case to be made "... that intelligent investment in health, increases financial choice and feeds economic productivity."¹

The relationship between health and wealth

Ample evidence exists on the presence of a nexus between wealth and health. This correlation found both on an individual level in terms of the social determinants of health, as well as on a country level, is thought to reflect a causal link running from income to health. However the reverse causation leading from health to income (wealth) has thus far been the focus of much less attention.

The largest and most systematic effort to explore this relationship has been undertaken in the context of the WHO Commission on Macroeconomics and Health (CMH). Based on this analysis the Commission is calling for a massive investment in health to elevate developing countries out of poverty and help foster their development.

As the Commission's report primarily focused on low and middle-income countries, the relevance of its findings for Europe are limited even with respect to relatively 'poor' European countries. The primary disease burden in Europe involves non-communicable diseases, also entailing a different age profile of diseases with a disproportionately high adult mortality. In addition educational attainment levels, per capita income and health system infrastructure are generally much higher than in developing countries. Therefore the value of the CMH report in the European context lies "...mainly in the provision of the underlying rationale and evidence".⁵

The mechanisms, which could explain the relationship between health and wealth in developed countries, fall into three categories:⁶

Labour productivity: Healthier populations are physically more energetic, have better cognitive functioning and have lower absence from work due to illness, or illness of other family members.

Education: Healthy people who also live longer have a stronger incentive to invest in developing their skills as the benefits can be reaped over a longer period. In contrast

those with mental health problems in particular are more likely to experience an adverse impact on educational attainment.⁷

Investment in physical capital: Higher life expectancy will induce higher retirement savings, which in turn leads to more investment.

What is the evidence?

When calling for a new perspective on health as a productive force in economic prosperity Commissioner Byrne asserted that the new perspective needs to be based on agreed methodologies and hard data. Unfortunately these two prerequisites are largely absent at present.

At the micro-level cost-of-illness studies provide an accumulating body of evidence on the costs of specific conditions, and work productivity effects. However there still is an ongoing debate on how to value productivity losses due to absenteeism. Nevertheless current research has evolved further by investigating reduced work performance before and after absence from work⁸ thereby adding another piece to the puzzle. Indeed reduced work performance while at work may be an important if not dominant cause for lost productive time.⁹

The estimates of many of these studies are significant and may sometimes be convincing enough to warrant immediate action in their own right. Unfortunately micro-level evidence cannot that easily be translated to the macro-level. However there is also reason to believe that this micro-evidence may be understating relevant effects, as it does not take into account the impact illness has on other individuals and society as a whole. For instance the work productivity of an individual may also depend on the productivity of others.

At a macro-level the relevant concept is the health (capital) component of human capital. Surprisingly the potential influence health may have on human capital was hypothesised back in the early 1960s. However very little empirical attention has been devoted to this topic. Growth theory has primarily focused on education as the main component of human capital instead. However there are now results, which identify health (capital) as a key component of economic growth, sometimes attributing a more significant role to health capital than to education.^{10,11}

A study which served as the background for the CMH, has concluded that: "a one year improvement in life expectancy contributes to an increase of 4% in output."¹²

"health gain must be the focus of economic evaluations"

“Healthy people who also live longer have a strong incentive to invest in developing their skills”

Based on these results the authors concluded that increased expenditures on improving health might be justifiable purely on grounds of their impact on labour productivity. Furthermore the results may underestimate other positive effects, as life expectancy may also influence life cycle savings and capital accumulation, variables that have not been included in the model.¹³

Obviously the issue of an increasing life expectancy is a double-edged sword. From a strictly economic perspective an increasing part of the population which enjoys an ever-increasing ‘unproductive’ retirement period may become a drain on economic resources. An ageing population will be a drag to the economy if an increasing period of retirement is not offset by raising individual savings, or even worse has to be financed through pay-as-you-go public retirement systems.

Generally it appears that the positive impact of increases in longevity on per capita income due to higher savings appears to be large enough to offset the negative impact arising from a greater proportion of retirees.¹⁴ If health improvements not only increase longevity but also decrease morbidity resulting in an increasing active working life span these effects may cancel each other out. While there is evidence that the health of the elderly is increasing significantly¹⁵ the issue of extending active labour force participation beyond the current retirement age needs particular attention by policy makers. Then increases in the retirement age may indeed “be effective in promoting growth and sustaining high levels of health”.¹⁶

Lack of data and unclear methodology

As can be seen by a focus on life expectancy above, available measures at the macro-level are relatively crude. Gross domestic product usually is used as a key parameter. However non-market activities, which form an important element of social and care activities, are omitted from national accounts. There are also hardly any serious attempts to measure the ‘real output’ of investments in health or the health-care industry specifically. Basically there is little connection between health spending and health status improvements, or its economic value.

Medical care spending as used in most studies measures factor prices but neither real inputs nor outcomes. For instance Americans pay approximately 40% more

per capita for health care than Germans. However 15% fewer real health care resources are received by American patients.¹⁷ Which of these measures should be used to properly evaluate and compare systems? The same applies to output measures. The country ranking of the World Health Report 2000 was changed significantly when the concept of mortality amenable to health care was used as an outcome measure, which is arguably more closely related to health system performance than disability adjusted life expectancy.¹⁸

Serious problems are encountered when attempting to measure and account for changes over time. There are no attempts to account for improvements in life expectancy in current measures of living standards.¹⁹ The pre-occupation of economists with single-period models does also not take into consideration changes in technology. However not all blame should be laid upon economists. Basic statistical data required for these purposes are not available. In addition available data are rudimentary, and appear to overestimate cost increases.^{20,21}

For all these reasons we have to be aware that the debate on macro-economics and health and as noted by the Gastein Health Declaration 2003 (available from info@ehfg.org) “has been characterised by a lack of theoretical underpinning, a focus on what can be measured rather than what is important and the use of data of dubious validity. The amount a country spends on health care cannot easily be assessed by comparisons with others where patterns of health and costs and combinations of inputs vary. Instead health gain must be the focus of economic evaluations.”

According to Yale economist William Nordhaus we are currently “dramatically mismeasuring, and almost certainly underestimating the contribution of improvements in health care to economic welfare.”¹⁹

No easy task

The task of establishing a “new perspective on health as a productive force in economic prosperity” won’t be easy. In addition to the discussion here the challenge will also be to separate “genuine self-financing investment, ...from the escalation of current expenditure, which needs to be carefully managed if our social model is to remain sustainable.”¹

However it should be encouraging to

realise that as the body of evidence with regard to developed countries expands, health care is increasingly seen as growth promoting as well as welfare improving. Subsequently proposed 'cost-containment' policies need to be carefully scrutinised as they may result in welfare losses. Furthermore growth effects of health care spending need to be included in economic policy analysis, "since an exclusive focus on cutting current health costs...may have severe negative effects for long run growth performance."¹⁹

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“Agreed methodologies to measure the link between health and wealth are largely absent”

Learning needs in health and social care in England

The NHSU Learning Needs Observatory



*Christopher
Loughlan*

*“lifelong learning is
put at the very heart
of improved health
and social care”*

Scoping the field, critiquing major policy issues

The Government's ten-year strategy (NHS Plan) for the NHS aims to redesign care around the needs of patients and to transform the provision of health and social care.¹ The service is now two years into implementing the plan and current priorities are set out in *Improvement, Expansion and Reform: The Next Three Years, Priorities and Planning Framework, 2003–2006*.

The National Health Service University (NHSU) will make a key contribution to the fulfillment of the NHS Plan. NHSU launched its first programmes and learning services in November 2003. In the short term, it is developing learning programmes to meet the immediate and urgent needs of the NHS. Over time, it will design learning services and programmes to support team working and enable staff to work more effectively across traditional occupational, professional and organisational boundaries.²

A focus on patients will ensure the whole of NHSU is patient-centred, not only seeing patients as the ultimate customers and beneficiaries of a better NHS, but recognising that they must be involved in each stage of planning, from design through to delivery. The core purpose of the NHSU is to contribute to radical change and improvement in health and social care through the transformation of learning. NHSU will both encourage and enable staff to develop new skills, to achieve higher qualifications, and to build better careers through the health and social care 'skills escalator'. Most importantly, it will put lifelong learning at the very heart of improved health and social care, empowering staff to respond actively and effectively to the challenge of improving front-line services for the benefit of patients and clients, their families and the wider community.

NHSU Learning Needs Observatory

The vision of the Learning Needs Observatory (LNO) is to create and sustain a highly valued knowledge and evidence-based resource providing an up-to-date assessment of health and social care learning needs. The primary purpose of the LNO is to provide a corporate resource to the NHSU by identifying the priorities for learning that will shape the future curriculum provision and learner support services of the NHSU.

The LNO aims to be an authoritative source of knowledge and ideas informing and influencing the development of the strategic and business development of NHSU. It will do this through research and analysis of needs in relation to learning and learner support in the health and social care sectors, drawing as fully as possible on existing sources of information and analysis as well as undertaking original work. The LNO will also aim in time to create a centre of academic excellence in the practice of undertaking high quality analysis of learning needs and support services, with a particular focus on the health and social care domain. In this context the Observatory will share best practice in both method and evidence from needs analysis.

The LNO will increasingly be involved in the area of 'Health Futures'. This is an area of work that seeks to gain insights from analytical studies of potential changes in a range of factors over a more long term period (5,10 and 15 years) for example, public engagement in relation to their health, health care technology, work based learning, demographic patterns of employment and the concomitant effect these have on learning needs.

NHSU is a corporate university of the health and social care supporting, resourcing and promoting the educational needs and opportunities serving approximately 2.8 million staff. As a corporate university,

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its work is to help implement national policy in health and social care. Similarly its work must be to respond to the needs of its staff. To what extent do national driven learning needs correspond to those needs identified by an organisation and individuals? In common parlance, does a top down approach to learning needs engender the same learning needs as a bottom up approach? A second fundamental question arises from the fact that there will always be more needs identified that can be provided for. What are the processes for synthesising all these needs and crucially what criterion are enlisted to prioritise them?

This article sets out to explain the process of identifying and generating learning needs in health and social care at individual and organisational levels and looks at the way in which NHSU intends to meet this need through a curriculum and a range of support services. It offers comment on the science in the process of identifying and analysing learning needs in health and social care.

Background

Public health in the UK has contributed to a significant body of literature around health needs assessment. There is a growing body of literature on learning needs assessment. Learning needs assessment can be defined quite simply as ‘a systematic process to collect and analyse information on what a target group needs to learn’.³ In any exploration of learning needs it is important to set out types of need. Based on the work of Bradshaw⁴ on the grouping of needs in relation to health, Box 1 lists and explains four categories of learning needs. This is a useful typology as it sharply defines three target groups namely, the recipients of the educational interventions (staff), the provider or context of the educational intervention (employee organisation) and political context or systems in which this functions (commissioning and providers of services).

A further dimension of learning need is in relation to those that are *met*, for example, mandatory health and safety training, as well as *poorly met* needs i.e. learning needs that have been identified but poorly provided. The remaining category of *unmet* need relates to a need that has been identified but as yet has not been accommodated.

The pitfalls of using perceived (or felt) need as a sole criterion include unwillingness on the part of the individual to admit a weakness or an apparent lack of clinical skill;

some individuals may lack the necessary skills to communicate and or articulate their needs.³ Thus the absence of perceived need does not reflect the absence of need.

Though learning needs analysis is a crucial element of the educational process, extensive reliance on formal needs assessment could ‘render education an instrumental and narrow process rather than a creative and professional one’.⁵ For example, learning needs around health futures might always be squeezed out by the more pressing immediate learning needs.

Another layer of complexity with learning needs analysis concerns a philosophical dimension in assigning some form of prioritisation to different needs. Within a context of finite resources for education, how can a greater need be determined? For example, should a principal criterion be the benefit that could potentially be obtained by one individual judged against the potential benefit to another individual. In other words should greater priority, a greater assessed need, be attributed to the need for a young person trying to improve basic skills (longer term benefit) or to a more senior experienced and qualified person progressing specialised training linked to continuing professional development (shorter term benefit)? In the context of health needs it is the former i.e. the approach that favours overall greater benefit that takes precedence in formal needs assessment.⁶ Health needs assessment though has a robust body of literature and evidence on measures of benefit from intervention. Learning needs analysis requires a similar body of research and evidence.

Data collation and analysis

NHSU Learning Needs Observatory will collate and analyse data at national and regional levels. This will be undertaken as secondary research of the many excellent sources of employment and workforce data currently available at national level. Further primary research will be undertaken by the

Box 1

CLASSIFICATION OF LEARNING NEEDS

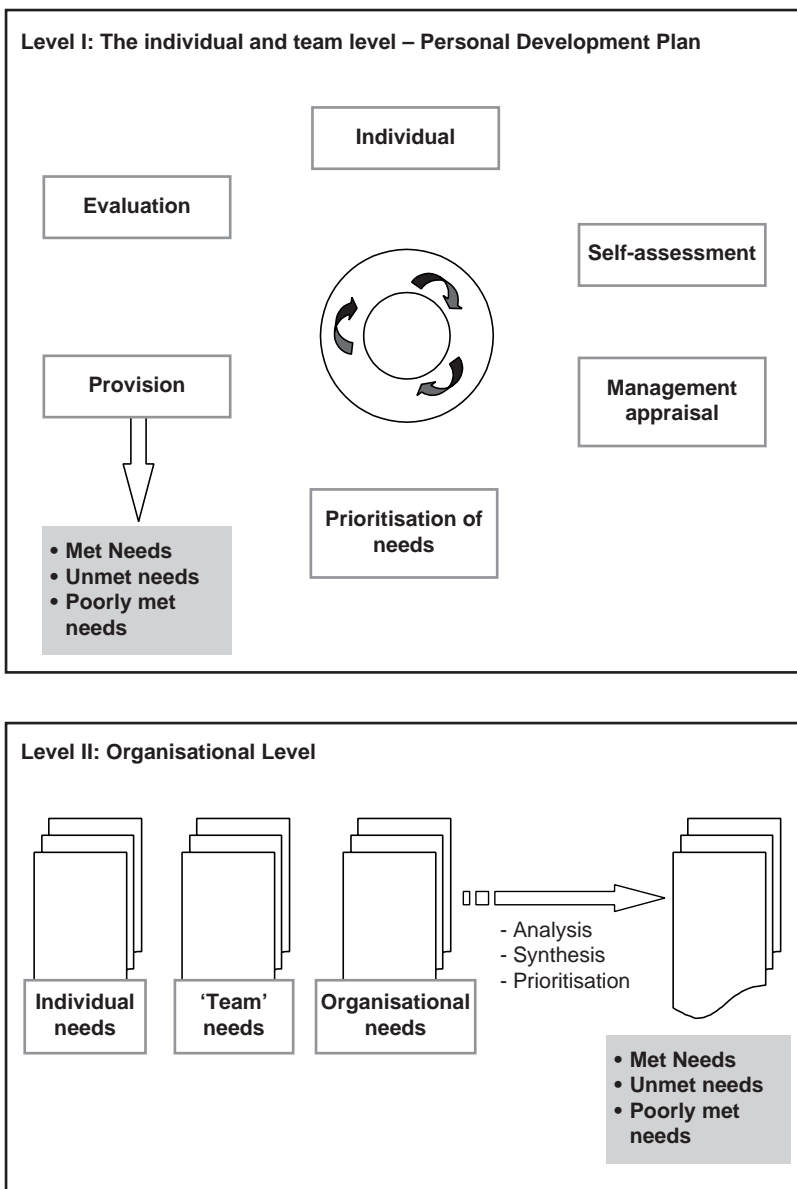
Felt need	An individual is aware of the need to undertake some form of structured learning
Expressed need	An individual makes known, seeks advice, looks for information about some form of structured learning
Normative need	A professional (e.g. a manager) identifies appropriate educational provision to meet the expressed need
Comparative need	Comparison between expressed and normative need

“Learning needs data will be part of the evidence base which informs decision making”

LNO and strategic partners (for example, Sector Skills Councils). At regional level, this will be undertaken primarily in partnership with regional bodies (for example, Regional Development Agencies). There remain however substantial challenges in learning needs analysis around the research process i.e. reliability and validity in addition to the more fundamental issue as to where needs analysis sits within the wider context of educational process and provision.

The Figures depict the NHSU LNO strategic planning cycle showing the processes and context in which learning needs can be identified at individual and organisational levels and the ways in which NHSU will use this data to inform programme and service provision. Each part of the cycle is now explained.

From Identification of learning needs to educational provision and support: NHSU LNO STRATEGIC PLANNING CYCLE



**Learning need: level I
The individual and 'team'**

The individual assesses her need through discussion and negotiation of a personal development plan with her manager. This is an opportunity to explore the 'unperceived' needs of the individual i.e. where learning needs are not known by that individual and which may in turn become 'prescribed' needs. This meeting of minds is an important process as it has a twofold function to both appraise the development needs of the individual and to ensure that, as far as possible, individual expressed needs resonate or correspond with team and departmental objectives. As to the science: the resulting educational interventions stem from a rich amalgam of insight, tacit knowledge, experience, understanding, funding allocation and perhaps an element of personal politics.

**Learning need: level II
The organisation**

In any organisation in health and social care there will be at least four categories of staff group needs: staff who treat and care for patients and users; support staff; managers; and the executive board. Each category will have distinct and specific learning needs. Health and social care organisations differ considerably in staff size from below fifty to over five thousand; organisations in the latter category will thus experience greater issues around analysis of learning needs of large numbers of staff who vary widely not so much in the *what* but in the *degree* of learning needs.

These organisations are mandated to carry out a wide range of tasks and functions and will therefore have learning needs around these well-defined functions. The learning needs may have their origin in an educational strategy that reflects the core aims and objectives of the organisation. The learning needs of an organisation will also be in response to the demands placed by strategic and commissioning bodies (performance management) and opportunistic in relation to funding opportunities and new provision.

As to the science: the resultant plethora of learning needs will be some form of synthesis of the rich diversity of met, unmet and poorly met provision. Prioritisation of the learning needs will stem from imperatives of clinical governance ('must do' elements), political insight and advantage, a history of provision, the culture of learning and the ability to attract new funding.

Learning need: level III NHSU and national policy level

The learning needs in health and social care are vast. A recent white paper⁷ sets out an England-wide strategy for improving the skills and productivity of the workforce. It aims to tackle what it calls 'deep and pervasive problems' that have resulted in the UK suffering from a significant productivity and skills deficit relative to its major competitors. It argues that improving workforce skills is crucial to developing a more competitive economy and an inclusive society, but insists that this will only happen if there is 'step change' on the part of government, employers and individuals. To achieve this, the government argues that the *needs* of employers will have to be placed 'centre stage'. The main aim is 'to ensure that employers have the right skills to support success in their businesses and organisations, and individuals have the skills they need to be both employable and personally fulfilled'. NHSU LNO's work is to promote and support this process.

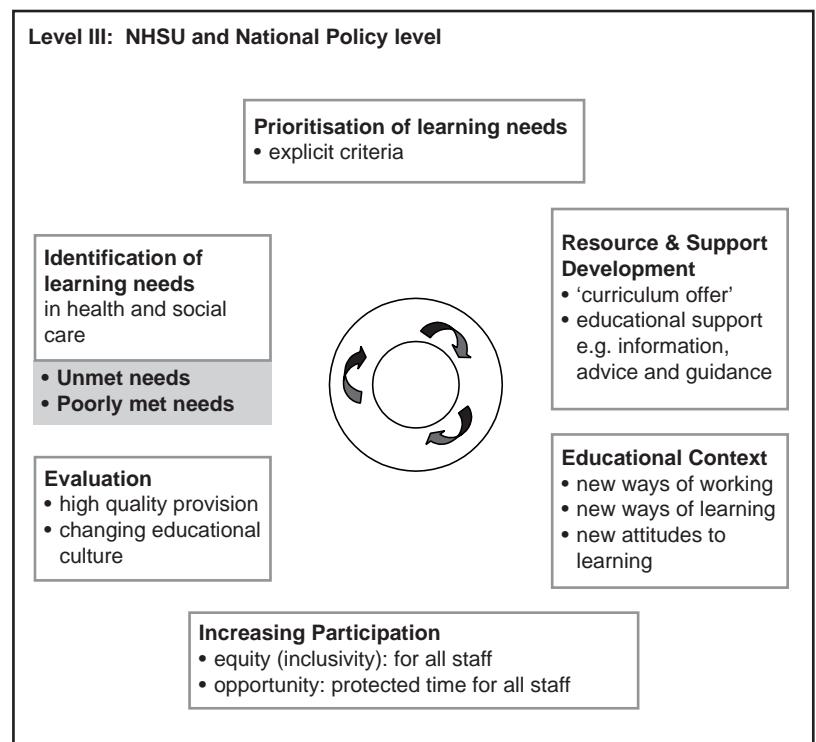
In the space of this brief article, two specific service provision areas have been chosen to demonstrate the breadth and scope of learning needs in health and social care: new services in child care and tackling the ever growing health associated problems around the steady rise in obesity.

Children's services

Many learning needs spring from the ways in which government responds to national inquiries. One particular case being that of the government response to the report of the inquiry into the death of Victoria Climbié (aged 8 years) who died as a result of appalling ill treatment at the hands of two individuals who were supposed to be caring for her. The corresponding Green Paper sets out a series of recommendations for consultation.⁸ One of the four main areas for improvement i.e. early intervention and effective protection is extremely important as one of the key findings of the inquiry report laid bare the poor management and quality of training of front line staff. Another specific recommendation highlighted the need to encourage professionals to work in multi-disciplinary teams based in and around schools and Children's Centres.

Obesity

The prevalence of obesity is rising to epidemic proportions at an alarming rate in both developed 'westernised' and less developed countries around the world. The



prevalence of obesity has increased by about 10–50% in the majority of European countries in the last ten years. Current prevalence data from individual national studies suggests that the range of obesity prevalence in European countries is from 10 to 20% for men, and 10 to 25% for women. The most dramatic increase has been in the UK where it has more than doubled since 1980. Tackling obesity in the UK will require long-term concerted and well coordinated action across all sectors of health and social care. Learning needs will span prevention through health education and promotion, treatment, rehabilitation and long-term maintenance. In general practice alone, three quarters of practice nurses and one third of general practitioner doctors reported the need for better training in the management of obese/overweight patients.⁹

Summary

The process of conducting learning needs analysis from a 'bottom up approach' i.e. at individual, team, organisation and regional levels is open to scrutiny as to the criteria on which needs are first synthesised and then prioritised. The degree of fit between a 'bottom up approach' and a 'top down' i.e. policy-driven approach remains open to debate.

Learning needs data will be part of an evidence base which informs the decision making process as to the allocation of finite resources. If it is to do with change – i.e. allocation or reallocation of finite resources

in health and social care, then transparent, structured processes are called for at organisational, regional and national levels.

There is no easy, quick-fix recipe for learning needs analysis. Different topics will require different approaches. These may involve a combination of qualitative and

quantitative research methods to collect original information, or adapting and transferring what is already known or available. As Ziman¹⁰ has pointed out, the scientific process cannot be divorced from the social context of carrying out research, that in many instances it reflects at best common sense and, embodies meaning and is understood by both fellow researchers and the beneficiaries of the research (staff within health and social care).

NHSU Learning Needs Observatory is involved in four major national initiatives. Firstly, it is establishing a joint management group with representation from a wide range of bodies in health, social care, education and research to oversee the development of the LNO and promote involvement from strategic partners. Second, it has set up three regional pilots in London, the West Midlands and the East of England to explore ways of making the best use of available resources at regional levels in learning needs data, frameworks for analysing data and determining models of best practice for roll out to the remaining six regions throughout England. Thirdly, the LNO is setting up an interactive website (see www.nhsu.nhs.uk) where practitioners and researchers can share ideas and literature on learning needs analysis. Finally, it is organising a symposium on *Health Futures* to be held in London in July 2004, which will not only explore this exciting dimension to learning needs, but also create a national learning network of researchers and practitioners that can support and promote such work.

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Raising your eyes:

leading learning for healthy communities of the future - an open space event

London, 19th and 20th July 2004

NHSU is organising an event aimed at policy and research executives and senior managers, which will look at the way that learning communities and learning cultures can contribute to health and social care of the future.

The symposium will address how organisations in the future can 'create positive learning environments for all'. It will critique and analyse organisational systems and processes for learning across a range of sectors including health, social care, education, commerce and the wider community.

The event itself will consist of small group work in which we ask, through a call of papers, for all participants to contribute to and help construct the format of the day (embodying an 'open space' philosophy). Central to the overall theme of new ways of learning is that NHSU wishes to ensure that the symposium serves as part of a wider process of constructing a learning community around health futures.

- Details of the call for presentations can be found by contacting any of the following:

NHSU website
www.nhsu.nhs.uk

Email
Chris.Loughlan@doh.gsi.gov.uk

Write
Health Futures Symposium
NHSU Learning Needs Observatory
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Restructuring provider institutions: The experience of Portugal



Vaida Bankauskaite

Increased efficiency in health care provision has been identified as one of the main reform objectives of the health care system in Portugal. In pursuit of this objective, Portugal has experimented with a variety of innovative managerial models for its health care institutions. This article reviews recent management developments in Portuguese hospitals and primary health care centres.

Hospitals

The Portuguese health care system has traditionally relied on hospitals for the provision of health care.¹ Over the last 30 years, there has been an attempt to modify this situation and as a result there has been a significant decrease in the number of hospitals, from 634 in 1970 to 205 in 1999, a reduction of 67%. Compared to other western European countries, Portugal has a relatively low number of hospital beds per capita, but the utilisation rate is at the European average, as measured by admission and occupancy rates. In 1999, Portugal had 205 hospitals, 110 public and 84 private (Table 1). Almost half of the private hospitals are owned by for-profit organisations. However, only 23% of the total bed stock is privately owned, since many private hospitals are small surgical clinics.

In an effort to achieve both efficiency and accountability, several successive

Portuguese governments have turned to innovative hospital management models. The first legislative step was taken in 1990, in the Law on the Fundamental Principles of Health, which stated that management of NHS institutions and services could be contracted out to the private sector. This act stipulated that these contracts could apply to an entire institution, i.e. hospital or health centre, to a particular service, or to any functionally autonomous aspect of a facility. Currently, most hospital services are provided according to an integrated model, that is, directly by the Portuguese NHS. However, for some time non-clinical services such as maintenance, security, catering, laundering and incineration have been outsourced to the private sector. Also, diagnostic and therapeutic services in the ambulatory sector are mainly provided by the private sector, through any willing provider contracts.

The first experiment with a new management model occurred in 1995 under a Socialist government, when Fernando Fonseca Hospital (also known as Amadora Sintra Hospital), located in the greater Lisbon region, was placed under the management of a private consortium. In 1998, a different model was applied to a hospital in San Sebastião, in the north. Like the experiment in Fernando Fonseca, the aim was not



Marikay McCabe

Table 1
NUMBERS OF HOSPITALS BY CATEGORY, 1970–1999

	1970	1980	1990	1996	1999
Total	634	493	257	221	205
Public (NHS)	171	394	145	122	110
Other public	19	2	17	10	11
Misericórdias*	284	8	–	–	–
Other private	160	89	95	89	84
For profit	–	–	44	40	40
Not for profit	–	–	51	49	44

* Misericórdias are independent non-profit institutions with a charitable background which can include links with the Church



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“In an effort to achieve efficiency and accountability successive governments have turned to innovative hospital management models”

so much a withdrawal of the state from the providing function, but rather the establishment of an entrepreneurial management scheme in a public hospital. The primary difference with the model employed in San Sebastião is that purchasing of goods and services, as well as personnel recruitment and management, are now governed by private sector corporate law, rather than public sector administrative law. The same legal status was conferred to the Matosinhos Local Health Unit in the north when it was created in 1999 and the Barlavento Hospital in the Algarve in 2001. The former is a unique facility that integrates hospital and health centre functions. Both the San Sebastião and Barlavento hospitals are publicly owned and managed, although the application of private law, particularly regarding staff management and purchasing, means that employees can be privately contracted. Moreover the acquisition of goods and services are not bound to bureaucratic public bids, but rather follow the rules that apply to private firms.

In parallel with these broad structural changes, there have also been attempts to introduce more efficient management measures inside the institutions. For example, in hospitals, Responsibility Centres were created to facilitate the delegation of responsibility to lower-level managers. Hospital services and management units were grouped together to better coordinate medical specialties, control costs and increase competition. Although legislation was enacted in 1999 to set up the framework for the establishment of Responsibility Centres in all NHS hospitals, this project has not been implemented to date on a national basis.

In August 2002, the new Conservative-led government passed legislation intended to expand this process of hospital sector reform. As outlined by health policy analyst Monica Oliveira, this reform measure created several new categories of hospitals.² A public enterprise model, commonly known as ‘hospital-companies’, is expected to be the dominant solution. Under this model, providers are placed under corporate law with equity shares but the state is the exclusive shareholder. A group of 34 medium-sized hospitals (between 150 and 600 beds), representing approximately 40% of all NHS hospitals, were selected for transformation into such public enterprises. In addition to greater flexibility and accountability in resource use, a major implication is the progressive change of NHS personnel status from salaried civil

servants to private employees working under negotiable contracts. An independent commission has been created to monitor the performance of the new public enterprise hospitals.

The Ministry of Health has reported good results following the first year of the introduction of these changes in hospital management. It has been estimated that production increased 9.4% for outpatient visits; 17.9% for day care; 20.8% for all types of surgery; 4.7% for inpatient admissions; 0.9% for inpatient days and 0.7% for emergencies.³ It has also been informally reported that global costs have decreased, though no official documentation has yet been released regarding the performance of this new hospital model.

It is foreseen that by 2006, ten new hospital projects will be launched under public-private partnerships, including the replacement of seven facilities and building of two new hospitals. A private consortium, to be selected by international competition, will be responsible for building and managing the new hospitals. One new hospital in Loures has already been opened in November 2003 under the public-private initiative. It has 550 beds and is located in an area that previously did not have accessible medical services.

Primary health care centres

Recent health care reforms in Portugal have also included changes in the management of primary health care centres. Primary health care (PHC) in the public sector is mostly delivered through publicly funded and managed health centres. Each covers an average of 28,000 people although some of them cover more than 100,000, and others fewer than 5,000. There are on average 80 health professionals per centre, although some have as many as 200 and others as few as one medical doctor. According to the World Health Organisation, the number of outpatient contacts per person in Portugal are among the lowest in Europe.⁴

A series of experimental projects in PHC management were implemented throughout the 1990s, and their positive results have been used to promote the adoption of GP performance-related pay on an experimental basis, new contracting practices, quality requirements and an information infrastructure. Another major reform that was proposed in 1999 but not actually implemented would have granted financial and administrative autonomy to health centres. It would have allowed Regional Health

Authorities to independently contract multi-professional teams, especially family health teams from the health centre, and hold them accountable for care provided.

A further primary health care reform was initiated after April 2002, the principles of which have recently received legislative approval. The new model concentrates the executive responsibility of a health care centre in one director, who does not have to be a general practitioner (GP) or other medical doctor. Under this scheme when the director is not a medical doctor, one is to be appointed to assume responsibility for the coordination of medical care. Most recently, a proposed reform is expected to introduce further changes to existing organisational and funding models of primary health care. The government has adopted new legislation regarding the organisation of health centres, including the possibility of being managed by professional cooperatives, the private for-profit sector, or the social non-profit sector. GPs' organisations as well as medical unions and associations have expressed strong opposition to this reform.

The health care reform agenda now emphasises the role of the private sector and defines the health care system in Portugal as a network of health care delivery services belonging to the public, private and social sectors. The current government has made private investment in state-owned health facilities one of its priorities. The objective is to improve NHS service levels while guaranteeing more value for money, by involving private entities in the public responsibility of building, maintaining and operating health facilities. From a financial point of view, the risk transfer from state to private operators removes the initial investment burden from the state, which currently is under severe financial constraints regarding new public sector expenditure.

Management/coordination between hospitals and health centres

Portugal has a gatekeeper system by which the GP/family doctor is meant to be the first point of contact. In reality, a large number of patients bypass the referral system and as a result there is a general problem of a lack of coordination between hospitals and health centres. Several reform initiatives have aimed to address this issue, however none have been fully implemented. For example, local health units were developed to link a hospital (or several hospitals) with a number of health centres based on geographical proximity, but

unfortunately they did not fulfil the aim of integrating, coordinating and facilitating continuity of care. Another reform measure enacted in May 1999, went further by introducing the concept of "local health systems". The primary difference with earlier measures is that these reforms were to include private institutions and local health councils in addition to the medical services provided within the NHS. The development of local health care systems were expected to lead to better interlinking between primary, secondary, public and private care. They attempted to address the problem of coordination by embracing a broader understanding of health care. In practice, however, there have been difficulties in introducing such changes to health care organisations. One exception is the integrated health care centre in Matosinhos, which includes hospital and related health centres.

Conclusion

The reform agenda of many European health care systems is intended to improve cost containment and efficiency. The health care reform agenda in Portugal bears an interesting resemblance to that of the Labour government in England, which is promoting greater use of the private sector on the supply side.⁵ Pursuing increased efficiency in the delivery of health services, it has supported two principal initiatives. Firstly it has utilised private sector finance and management expertise to finance, build, operate and manage NHS capital projects, particularly new hospitals. Secondly it has set up public-private partnerships, whereby the private sector provides services funded through the NHS. A similar reform process is underway in Norway.

Current reforms to the Portuguese health sector also target the structure and management of hospitals and health care centres. In the past, partial implementation and incomplete evaluation have limited Portuguese reform efforts. The current reform process may yet succeed in increasing the efficiency of health care institutions through the introduction of new management models. It is essential, however, to ensure the transparent and objective analysis of current policies so that adequate lessons can be drawn both from inside and outside Portugal.

We would like to thank Margarida Bentes, Economist and Hospital Administrator, for her assistance with this article.

"Public-private partnerships have been set up, with the NHS funded private sector services"

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Accessing health care: responding to diversity

Edited by Judith Healey and Martin McKee

Oxford University Press, 2004.

ISBN 0-19-851618-5

398 pages, hardback £49.50

While much has been written on the organisation, financing and performance of health care systems, much less has been written on how and to what extent they should explicitly take account of the needs of diverse, and perhaps marginalised, groups within society. All too often the way in which health care systems have been shaped has been driven by cultural values and norms, which may not promote equitable access to services and meet the needs of all elements within increasingly diverse societies. In their introduction the editors Judith Healey and Martin McKee argue that “as health care professionals, policy makers and citizens we often seem blind to the diversity around us. Judged by our actions we seem to imply that society mainly consists of middle class citizens of European descent.” This book brings together examples written by experts and stakeholders from a wide variety of backgrounds, and looks at how health care systems across the developed world have, or have not, met the challenge of diversity. Chapters present a range of different issues and experiences for different groups including those of minority and indigenous populations, the impoverished, the old and those in prison. The editors conclude the volume with a discussion of how each of the contributions identifies barriers to the access and use of health services, and the advantages and disadvantages of separate as opposed to collective services.

Contents: Different People, Different Services; Sex and Gender in Health Care and Health Policy; Services for Older People; Meeting the Needs of People with Disabilities; Health Care for Poor and Rich Alike; Access and Equity in Australian Rural Health Services; Captive Populations: Prison Health Care; New Citizens: East Germans in a United Germany; Overseas Citizens: Citoyens de France; Migrants: Universal Health Services in Sweden; Asylum Seekers and Refugees in the United Kingdom; Multicultural Health Care in Britain; Roma Health: Problems and Perception; ‘On Our Terms’: the Politics of Aboriginal Health in Australia; Maori in Aotearoa/New Zealand; The History and Politics of Health Care for Native Americans; The Value and Challenge of Separate Services: First Nation in Canada; Delivering Health Services in Diverse Societies.

Health

Mildred Blaxter

Polity, 2004.

ISBN 0-7456-3083-9

168 pages, paperback £14.99

In her introduction Mildred Blaxter states that “The meaning of health is neither simple nor unchanging. Ways of defining health have always influenced the practice of healers and the organisation of care, and continue to play a part in determining the social policies of nations” This concise and clear book provides an introduction to the different concepts that surround the meaning of health from a sociological perspective and looks at how these have developed over time within and across developed societies. Different conceptual models of the relationship between health and society including lay concepts of health are discussed, while other areas covered include the links between health and economic development, health inequalities and social capital. It concludes with consideration of how recent technological and scientific advances, such as improvements in screening and diagnosis, genetic testing, and the growth of the information society may influence and change fundamental definitions of health.

Contents: How is Health Defined? How is Health Constructed? How is Health Experienced? How is Health Enacted? How is Health Related to Social Systems? Where is the Concept of Health Going in the Contemporary World?

Social inequalities and the distribution of the common mental disorders

Edited by David Melzer, Tom Fryers, Rachel Jenkins

Psychology Press, 2003.

ISBN 1-8416-9385

256 pages, hardback £24.95

While much research has been undertaken to examine the links between social status and physical health status, much less is known about the links between mental health and socio-economic position. This book provides evidence from a detailed review of research on which has sought to identify some of these links.

Contents: Systematic Literature Review; Quantifying Associations Between Social Position and the Common Mental Disorders in Britain; Ethnicity and Common Mental Disorders. Bullet Points and Executive Summary.

**Chief Medical Officer
Wales**

www.cmo.wales.gov.uk

This site contains information about the work of the Chief Medical Officer for Wales, Dr Ruth Hall, and her office. It covers a wide range of public health, health promotion and health professional issues, providing up-to-date information and downloadable resources for a largely health professional audience. Among the many work areas covered are health impact assessment, immunisation, health gain targets, healthy eating, physical activity, smoking, sexual health and workplace health promotion. The site also features a number of specialist areas such as dentistry and pharmacy. There is a large section on the Welsh Assembly Government's Inequalities in Health Fund, a press release archive for journalists, a publications section and an extensive collection of external links. The site also includes the web pages of the Welsh Assembly Government's Health Promotion Library. The site is available in English and Welsh.

Portal on health-related governmental bodies and agencies in France (Le Portail des Agences Sanitaires)

www.sante.fr

This portal provides brief descriptive information and links to the Ministry of Health and other official health agencies including AFSSAPS – French Drug and Medical Products Agency (*Agence française de sécurité sanitaire des produits de santé*), the ANAES – National Health Evaluation and Accreditation Agency (*Agence nationale d'accréditation et d'évaluation en santé*), the EFS – French Blood Agency (*Etablissement français du sang*), InVS – the National Institute for Public Health Surveillance (*Institut de veille sanitaire*), and the French Food Safety Bureau (*Agence française de sécurité sanitaire des aliments*). The portal also provides one-stop access to press releases from all of these agencies, an opportunity to join various mailing lists and links to a wide variety of French health resources. The site is available in French only.

Health Economics Research Programme at the University of Oslo – HERO

www.hero.uio.no/eng.html

HERO is a research programme concentrating on research in health economics at the University of Oslo, Norway's oldest and largest university. HERO has its foundation in economics, but emphasises the need for cross-disciplinary cooperation to ensure the relevance of research to the needs of the health care sector. The programme's staff includes researchers in social sciences, mainly economics, and researchers from the medical profession. The programme has three research units which cover a wide range of fields, The Department of Health Management and Health Economics, The Frisch Centre, and The Department of Economics at the University of Oslo. The programme affords opportunities for economists, doctors, and political scientists to cooperate in projects in health economics in Norway. The site provides information on current projects and data sets of interest to health economists and on-line access to a working paper series. The website is available in Norwegian and English.

The Joseph Rowntree Foundation

www.jrf.org.uk

The Joseph Rowntree Foundation is one of the largest independent social policy research and development charities in the UK. It supports a wide programme of research and development projects in housing, social and long term care and social policy. The Foundation does not carry out the research in-house, but works in partnership with a wide variety of academic and other institutions to achieve its aims. The website provides information on current work in progress, a bookshop and information on current grant programmes. Four page research summaries (Findings) are also available on-line.

The Social Care Institute of Excellence

www.scie.org.uk

The Social Care Institute for Excellence gathers and publicises knowledge about how to make social care services better across England and Wales. SCIE is an independent organisation, launched in October 2001, and has around 30 permanent staff and a board of 12 trustees who guide its work and ensure its independence. It is funded by the Department of Health and the Welsh Assembly. A number of publications and other products are available including knowledge reviews, which take a systematic approach to the gathering, analysis and appraisal of knowledge on a particular topic. The website is available in English and Welsh.

BioMed Central

www.biomedcentral.com

BioMed Central is an independent publishing house committed to providing immediate free access to peer-reviewed biomedical research. All original research articles in journals published by BioMed Central are immediately and permanently available online, without charge or any other barriers to access. The publisher takes the view that open access to research is central to rapid and efficient progress in science and that subscription-based access to research is hindering rather than helping scientific communication. A number of journals related to health policy are available.

RADICAL REFORM REQUIRED TO SAVE FRENCH HEALTH CARE SYSTEM FROM COLLAPSE

The report of the High Council on the Future of National Health Insurance, (*Rapport du Haut Conseil pour l'avenir de l'assurance maladie*), a governmental advisory body made up of 53 representatives from the health insurance industry, trade unions, health care professions and academics, was published in January. The report claims that the French health system faces collapse in little more than a decade unless radical reforms are undertaken. In particular the inefficiency and waste within the current system are heavily criticised. By 2020, without change the system is predicted to be at least €66 billion in debt. Yet in the same week that the report was published thousands of French health workers held a one day strike

and marched on the Ministry of Health in Paris in January to protest against government plans to cut costs in the country's health system.

While the French may view their health system very favourably it is among the most expensive in Europe. French citizens consume three times as many antibiotics as the Germans and more than twice the amount of anti-cholesterol medication compared with the UK. The council lamented the failure of successive French governments to undertake reform and amongst its recommendations suggested that revenue might be boosted by

increasing the contributions of the unemployed and the retired.

The organisation of the system was heavily criticised, as being badly regulated and governed. The Council also stated that both the behaviour and expectations of patients and physicians had to change, and that there had to be much more emphasis on using proven effective interventions. Furthermore financial incentives might be given to encourage patients to adopt preventative measures. Welcoming the report, the French government hope to present plans for reform by July 2004.

The report is available on-line in French at www.sante.gouv.fr/ass_maladie/haut_conseil/ind_rapport.html

IRELAND IMPLEMENTS BAN ON SMOKING IN THE WORKPLACE

On the 29 March, Ireland became the first EU member state to introduce an almost total ban on smoking in the workplace including bars and restaurants. Fines of up to €3,000 may be levied on those employers who do not enforce the law. Exemptions from the ban include prisons, nursing homes and psychiatric hospitals, as well as hotel bedrooms. The ban follows a report prepared on 'The Health Effects of Environmental Tobacco Smoke (passive Smoking) in the Workplace', commissioned by the Office of Tobacco Control and the Health and Safety Authority, which concluded that exposure to the hazards of tobacco smoke can best be controlled by legislation in places of work.

Minister for Health and Children, Micheál Martin, said "There can be no dispute over the damaging effects of tobacco and second hand-smoke. There can be no dispute about the health benefits of this measure. This

legislation has been introduced in the interest of health and in the interest of the Irish people. It is as a result of unequivocal expert advice, which states that the best way to protect workers from the effects of environmental tobacco smoke is through legislative measures".

The measure has been broadly welcomed by the general public, health interest groups and Irish trade unions. "Taking the health risks into account, all employees still have a right to smoke following the introduction of the ban but they will not have the right to pollute the workspace of their colleagues. Workers welcome the ban because it gives them a basic human right to feel safe in their workplaces from these diseases" said David Begg, General Secretary of Irish Congress of Trade Unions. The Irish Business and Employers Confederation also said the ban had caused "little or no difficulty" to its members.

More information at <http://www.smokefreeatwork.ie/>

LESSONS FROM THE FRENCH HEATWAVE: CIVIL CODE TO BE STRENGTHENED TO PROTECT THE ELDERLY

A report into the 15,000 deaths, mostly of elderly people during the last August's heatwave in France, was published this February by the French Senate.

The report concludes that the grave situation was made much worse by the indifference of children to the fate of their elderly parents. Therefore, the French Civil Code will be amended so that is now requires adult children to be kept up to date regularly on their parents' health status.

This is in addition to the existing requirement to provide for parents who do not have the means to look after themselves financially.

The report is available in French at www.senat.fr/rap/r03-195/r03-195_mono.html

MAJOR AGREEMENT REACHED AT HEART HEALTH CONFERENCE

A two day conference, Promoting Heart Health: A European Consensus, was held in Cork in February under the auspices of the Irish Presidency in conjunction with the European Society of Cardiology and the European Heart Network. Cardiology and policy advisors from all 25 current Member and Accession States reached agreement on the best approaches for promoting heart health and tackling heart disease, across the EU. Implementation of this agreement the Presidency believes will also improve the overall health of the population, reducing death and disability from the other major diseases in Europe such as stroke and cancer.

Key conference recommendations are:

- Individuals must address their lifestyle and health behaviours; this specifically pertains to smoking; diet and being active.
- Countries should actively encourage further advances in tobacco control policies.
- It was agreed that, with the increase in obesity levels, countries need to develop comprehensive and integrated European food, nutrition and physical activity policies. This requires a societal approach involving the agriculture, food, marketing and retail sectors.
- Excessive alcohol consumption was cited as a contributory factor to heart disease and public policies are needed to address high levels of alcohol consumption, at individual country level, as part of the overall strategy to promote heart health.
- The health services can take a leadership role in promoting heart health to those at high risk through systematically encouraging and assisting those at high risk to lead heart healthy lifestyles, combined with appropriate treatments.

More information is available at www.eu2004.ie/templates/news.asp?sNavlocator=66&list_id=336

Commissioner Byrne addressing the conference commented on the economic consequences of poor heart health noting that "A recent [article in] *Eurohealth* estimated the direct and indirect economic cost of cardio-vascular disease to be between €70–135 billion per year in the EU. That is greater than the total annual EU budget. Compare the press coverage!" He went on to call for a greater focus on prevention. "At European level, the Community is committed to identifying and addressing many of the risk factors involved. With this authoritative data, we can empower our citizens to make healthy choices and to reduce their level of personal risk. We can play a significant role in reinforcing national and local prevention efforts. Prevention is not only better than "cure", to cite the old adage. Effective prevention is also the structural cure for our health systems long-term economic problems. In this context, I would urge Member States to continue to invest in prevention efforts. In the short term, prevention measures obviously require investment. But, if well-targeted and effective, the potential dividends are very high indeed."

Speaking at the conclusion of the conference the Irish Minister for Health and Children Micheál Martin stated that "this conference has resulted in much welcome discussion. The sharing of individual country experiences, challenges and successes in tackling heart disease has helped us to reach conclusions which, in the long-term, will benefit all EU citizens. This is a major step for heart health in Europe and the importance of this consensus cannot be underestimated. The recommendations from this consensus will contribute to a better quality of life for EU Citizens and a decline in death rates from heart disease." The recommendations from the conference will be presented at the EU Health Council Meeting in June.

CALL FOR IMPROVED ACTION TO TACKLE AIDS IN EUROPE

At a ministerial conference hosted by the Irish Presidency in Dublin Castle on 23 and 24 February, *Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and Central Asia*, the United Nations, World Bank and the Global Fund to fight AIDS, Tuberculosis and Malaria called on European ministers to take decisive action to prevent the further spread of AIDS across Europe and to treat those in need. They warned that young people and other groups, such as sex workers, men who have sex with men and injecting drug users, are particularly at risk of HIV infection. Dr Peter Piot, UNAIDS Executive Director, said "Europe and Central Asia are at the centre of the fastest-growing HIV epidemic in the world. There is no time to waste – European Ministers must urgently scale up and roll out effective HIV prevention and treatment programmes. Given that the EU will form the biggest trading bloc in the world, covering more than 500 million people, it is in the EU's best interest to prevent the AIDS epidemic from crippling Europe's social and economic development."

Further information is available at www.euro.who.int/eprise/main/WHO/Progs/SED/Home

THE INTERNATIONAL MARKET FOR MEDICAL SERVICES: THE UK-GERMANY EXPERIENCE

This report by Ian Birch and Marion v. Boxberg, published by the Anglo-German Foundation in February, reviews recent experience of contracts between UK health service providers and German clinics and hospitals and assesses the potential for a market for German hospital services to develop in the UK. It also aims to identify barriers to the development of a competitive UK market for German hospital services in the UK, focusing on three categories: technical, administrative/legal and attitudinal.

The full report is available at www.agf.org.uk/pubs/pdfs/1443web.pdf

DRUG-RESISTANT TUBERCULOSIS LEVELS 10 TIMES HIGHER IN EASTERN EUROPE AND CENTRAL ASIA

A new report from the World Health Organisation released in March indicates that tuberculosis (TB) patients in parts of eastern Europe and central Asia are 10 times more likely to have multidrug-resistant TB (MDR-TB) than those in the rest of the world. There are geographical concentrations of TB-drug resistance across many of the countries of the former Soviet Union. Six out of the top ten global hotspots are: Estonia, Kazakhstan, Latvia, Lithuania, parts of the Russian Federation and Uzbekistan, with drug resistance in new patients as high as 14%. "TB drug resistance is an urgent public health issue for countries from the former Soviet Union," said Dr Mario Raviglione, Director of WHO's Stop TB Department. "It is

in the interest of every country to support rapid scale-up of TB control if we are to overcome MDR-TB. Passport control will not halt drug resistance; investment in global TB prevention will."

The report states that the "most effective strategy to prevent the emergence of drug resistance is through implementation of the DOTS". DOTS (directly observed treatment, short-course) is an internationally agreed treatment strategy, designed to ensure patients take their medicines properly. It has proved effective in preventing drug resistance. The report also notes that TB control strategies used in eastern Europe and the Russian Federation have recently begun to improve with the introduction of the DOTS strategy.

More information at http://www.who.dk/mediacentre/PR/2004/20040401_1

EUROPEAN PARLIAMENT COMMITTEE ADOPTS REPORT ON THE ORGANISATION OF WORKING TIME

The European Parliament's Employment and Social Affairs Committee has adopted a Report on the organisation of working time, in response to the Commission's report on the effectiveness of current EU legislation in the area. The Committee has demanded infringement procedures against the UK for abuse of the individual opt-out – 33% of workers have signed individual opt-outs while only 16% work in excess of 48 hours a week, suggesting that opt-out agreements are being signed even when unnecessary. The Committee's Report calls for individual opt-outs to be scrapped by the end of 2006. This would have a huge effect on UK employment practices.

The Committee's Report makes a clear preference for more imagina-

tive on-duty shift patterns over the opt-out, particularly in the health sector. Despite the Report's concern over the 48 hours maximum becoming the average, it dismisses amendments to reduce the maximum to 42 hours a week. The Committee has accepted the Commission's general principles of health and safety, reconciliation of work and family and flexibility as drivers of working time organisation – effectively demoting health and safety as the primary reason for working time rules.

The Committee adopted the Report with a small majority of 19 to 15, with 3 abstentions. It is calling on the Council to request from the Commission an amended directive, which sets out options available to them as soon as possible.

The Report is available on:

www.europarl.eu.int/meetdocs/committees/empl/20040121/517094en.pdf

The Commission Communication and open consultation on working time are available on:

http://europa.eu.int/comm/employment_social/consultation_en.html

EUROPEAN PARLIAMENT BACKS DRAFT DIRECTIVE ON PROFESSIONAL QUALIFICATIONS

The European Parliament has voted in favour of a new draft Directive on the Recognition of Professional Qualifications. The proposal for a Directive aims to replace 15 existing Directives in the field of the recognition of professional qualifications. There are a number of changes proposed compared with the existing rules, including greater liberalisation of the provision of services, more automatic recognition of qualifications and increased flexibility in the procedures for updating the Directive. The Parliament also supported the Commission's proposal to facilitate cross-border service provision by qualified professionals while ensuring adequate protection for service users.

The proposed Directive establishes the principle of the free provision of services under the original professional title, subject to certain conditions with a view to protecting service users. According to the proposal, any nationals of a Member State legally established in a given Member State may, in principle, provide services on a temporary and occasional basis in another Member State under their original professional title without having to apply for recognition of their qualifications. They would, however, have to comply with certain obligations to provide the recipients of the services and the administration concerned with information. For health professions, where public safety concerns are particularly important, those obligations would include advance declarations to host Member State authorities and, in some cases, pro forma registration. The text as amended by the Parliament will now, under the EU's 'co-decision procedure', be debated by the Council of Ministers, which is expected to adopt a Common Position in May 2004.

The text on professional qualification is available at http://europa.eu.int/comm/internal_market/qualifications/index_en.htm

EUROPEANS RECOGNISE THE IMPORTANCE AND GOALS OF THE EUROPEAN YEAR OF PEOPLE WITH DISABILITIES 2003

On 17 February, a new *Eurobarometer* survey was published on the evaluation of the European Year of People with Disabilities in 2003. The survey shows that the European Year was recognised and understood by a good percentage of EU citizens and served as a valuable awareness raising campaign. The survey also highlighted that the public has increased awareness and concern for people with disabilities, when compared to a survey carried out in 2000.

“The European Year of People with Disabilities 2003 was the beginning of a new dynamic process improving opportunities for all people with disabilities”, stated Margot Wallström, acting European Commissioner for Employment and Social Affairs. “The exceptional mobilisation of stakeholders during the Year, including people with disabilities and their families, demonstrated a broad desire to move towards concrete social, economic, political and cultural participation of people with disabilities and

the full achievement of equal opportunities.”

The Commission adopted a framework for the immediate policy follow-up to the EYPD. This includes an Action Plan with a time horizon of 2010, to introduce disability issues into all relevant Community policies and develop concrete actions in crucial areas enhancing the participation of disabled people in society. In addition to noting the increased awareness of Europeans about disability-related issues, the *Eurobarometer* also found that:

- On average, 85% of Europeans believe that disabled people have the same legal rights to work as able-bodied people;
- Concerning the adaptation of work places: 43% of Europeans think that employers conform in this respect;
- A large majority of Europeans think that people with severe mental or physical disabilities should only work in a protected environment.

The full report is available at

http://europa.eu.int/comm/public_opinion/archives/ebs/ebs_198.pdf,

while the Commission's European Action Plan on equal opportunities for people with disabilities is available at

http://europa.eu.int/comm/employment_social/index/7003_en.html.

IMPROVING EMPLOYMENT PROSPECTS FOR THE ILL AND DISABLED

European policymakers took the first steps towards establishing long-term initiatives to improve the workplace for those with a chronic illness (including mental) or disability at a high-level conference that took place on 17-18 November in Reggio di Calabria, Italy. Co-organised by the European Foundation for the Improvement of Work and Living Conditions, the Italian Presidency of the EU and the region of Calabria, the conference presented research highlighting various ways of tackling issues surrounding illness and employment, as well as providing some information on the socio-economic impact of being excluded from the workforce. Attended by policymakers, social partners and NGOs from throughout Europe, it also assessed how best to maintain or adapt employment situations for those who develop health problems at work, and examine the interrelationships between workplace measures and social protection systems. The event took place as part of the European Year of People with Disabilities and in the context of achieving better employment and promoting a more inclusive society under the Lisbon objectives.

More information and access to information from some presentations at www.eurofound.ie/living/reggio_conf/reggio_conf.htm

FREE MOVEMENT OF GOODS:

COMMISSION CLARIFIES EU RULES FOR PARALLEL IMPORTS OF PROPRIETARY MEDICINES

In January the European Commission published a Communication clarifying how the principle of free movement of goods within the EU applies in practice to parallel imports of medicinal products. Parallel imports are products imported into one Member State from another and placed on the market in the destination Member State, outside the manufacturer's or its licensed distributor's formal channels. In the case of medicines, such imports are allowed if the product imported is identical or suf-

ficiently similar to one already authorised for sale in the Member State of destination. Aiming to help businesses and national administrations take full advantage of the Internal Market in medicinal products, the Communication covers the rights and obligations of the parties concerned and the guarantees to which they are entitled according to EU law.

Internal Market Commissioner Frits Bolkestein said: “This Communication makes clear to national administrators the conditions under

which parallel imports of medicinal products must be allowed and to those marketing medicinal products how they must proceed if they wish to undertake such parallel imports. The ultimate aim is to ensure patients and healthcare providers can benefit from parallel imports, without taking any risks with patient safety.”

The full text of the Communication is available at

www.europa.eu.int/comm/internal_market/en/goods/art2830.htm

SECURING GOOD HEALTH FOR THE WHOLE POPULATION

In April 2003, the UK Prime Minister, the Finance Minister and the Health Minister asked Derek Wanless, ex-Group Chief Executive of NatWest Bank, to provide an update to his first report on long-term health trends for health and health care with a particular focus on cross-departmental work on preventative health measures and health inequalities. This second report *Securing Good Health for the Whole Population* was published on 25 February 2004.

The review looked at how public health spending decisions are taken and how to ensure that they could be taken, by whoever takes them, as cost-effectively and consistently as possible, in order to improve health outcomes for any given level of resources. This included an assessment of the evidence about what interventions work and at what stage they work and examined the adequacy of the evidence base on which they are made.

Twenty-one specific recommendations were made including the development of a framework for the use of economic instruments to guide government interventions in relation to public health and to use a consistent approach to the economic evaluation of public health interventions. Furthermore the Minister for Health should have the responsibility of ensuring that all government departments take into account the impact on population health of any major policy development.

Both the English Health Minister, John Reid, and the Finance Minister, Gordon Brown, welcomed the publication of the report. Mr Brown said that "the first report by Derek Wanless set out the argument for a long-term financial framework for reform and modernisation of the NHS and showed the gains to be made both for the health of the nation and for the economy. His latest report suggests that everyone has a role to play in the improvement of

our public health – employers, the public services, communities and individuals as well as the Government – and we must all now consider the recommendations he makes."

The report is available on-line at www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm

THE ECONOMIC IMPACT OF PHARMACEUTICAL PARALLEL TRADE

A study of EU pharmaceutical trade undertaken at the London School of Economics concludes that there are no direct benefits to patients and recommends a re-evaluation of current practice by policymakers.

The study, which analyses the impact of cross-border brand-name prescription medicine trade within the European Union, suggests that although the overall number of parallel imports is continuing to increase, healthcare stakeholders are realising few of the expected savings. Further, the study demonstrates that profits from parallel imports accrue mostly to the benefit of the third-party companies that buy and resell these medicines.

The study's key objective was to provide a basis for assessing the relative future healthcare and industrial policy implications of parallel imports, with particular consideration for the fundamental principle of free movement of goods within the EU. A key driver behind the study was the lack of official data on pharmaceutical parallel imports or exports from the majority of EU countries, making informed debate on the pros and cons of the practice impossible.

The study can be accessed at www.lse.ac.uk/collections/LSEHealthAndSocialCare/pdf/Workingpapers/Paper.pdf

EUROPEAN PARLIAMENT REPORT HIGHLIGHTS NEED FOR STRATEGIES FOR HEALTH AND HEALTH CARE OF OLDER PEOPLE

On 11 March, the European Parliament adopted a report drawn by German MEP, Karin Jöns, in response to the Communication from the Commission The European Parliament, the European Economic and Social committee and the Committee of the Regions on a *Proposal for a Joint Report on Health care and care for the elderly: Supporting national strategies for ensuring a high level of social protection*.

In her report (A5-0098/2004), Ms Jöns underlines the importance of prevention to reduce the risk of serious illnesses (cancer, cardiovascular diseases) or other problems (allergies, respiratory diseases, arthritis, etc.). Member States are amongst other initiatives invited to:

- Ensure provision of home care;
- Guarantee access for the elderly to preventative cures, physiotherapy, rehabilitation and other services to guarantee their independence as long as possible;
- Step up research in the field of gerontology; and promote research in the field of palliative medicine.

The report also stresses the excessively long waiting lists for care in Member States and considers that, Member States should improve their cooperation to ensure better provision of care without bringing into question the financial balance of social security systems. It calls on the Commission to further work on the mobility of patients.

The report is available at www2.europarl.eu.int/omk/sipade2?PUBREF=//EP//TEXT+REPORT+A5-2004-0098+0+DOC+XML+V0//EN&L=EN&LEVEL=3&NAV=S&LSTDOC=Y

News in Brief

Evaluation of Swedish public health research published

This February 2004 report provides the descriptions, observations and recommendations made by an international panel, chaired by Finn Kamper-Jorgensen, and commissioned by the Swedish government to evaluate Swedish public health research.

The panel was generally very impressed by public health research in the country, noting that it benefits from an excellent data infrastructure, an enlightened public sector, a productive public health research workforce, and is seen to contribute to evidence based public health policy making. The report though noted that the priority for public health research compared with basic biomedical and medical research was low.

Recommendations made include increased funding and reduced fragmentation of research, as well as putting a greater emphasis on interventions related to health promotion and health services research, as these the panel stated 'seemed to have been seriously weakened'.

The full report is available at www.fhi.se/shop/material_pdf/evaluationreport0402.pdf

UK: House of Lords report on impact of ageing population

The Lords Economics Affairs Committee report, *Aspects of the Economics of an Ageing Population*, is a comprehensive examination of pensions policy, labour supply, age discrimination and the retirement age in the UK. The report notes that the current pension scheme is failing many older women and minorities who live in poverty, and that ageism and age discrimination remain and need to be addressed. The report does however conclude on a positive note, observing that population ageing does not pose a threat to the continued prosperity and growth of the UK economy.

The report is available at www.parliament.the-stationery-office.co.uk/pa/ld200203/ldselect/ldeconaf/179/17902.htm

The pros and cons of restructuring health care systems to focus more on primary care services

A report prepared by Rifat Atun from Imperial College London for the Health Evidence Network reviews the evidence and outlines considerations for policy-making. The evidence shows some advantages for health systems relying more on primary health care and general practice, in comparison with those based more on specialist care: better population health outcomes; greater equity in, access to and continuity of care; and lower cost.

The full report is available at www.who.dk/document/Hen/primaryspecialist.pdf

European Year of Education through Sport

The European Year of Education through Sport (EYES) has been officially launched in Dublin, Ireland. Information about the focus of this Year, which aims to make sport a more integral part of people's education and life, and associated events, can be found on the EYES website:

www.eyes-2004.info/254.0.html

Enhanced patient mobility

The project Europe for Patients (e4p), recently launched under the 6th Framework Research Programme's component on scientific support to policies will analyse the benefits and challenges arising from enhanced patient mobility in Europe. This will build on the earlier work of the High Level Reflection Process on Patient Mobility, suggesting areas where changes are needed in legislation, regulatory frameworks, and working methods.

Coordinated by IESE Business School, e4p brings together the partners who worked on the December 2001 Ghent Conference (LSHTM, LSE, OSE, AIM and Ghent University) complemented by the European Observatory on Health Care Systems and research institutions from Northern Ireland, Slovenia and Estonia.

*Project coordinator, Magdalene Rosenmüller magda@iese.edu
www.europe4patients.org*

What are the most effective and cost-effective interventions for alcohol control?

A recent report prepared for the Health Evidence Network by Esa Osterberg from the Finnish National Research and Development Centre for Health and Social Welfare, STAKES, indicates that the most effective approach uses a combination of: increases in alcohol prices, reductions in the availability of alcohol, and measures against drink-driving and underage drinking. Furthermore these measures can be undertaken generally at low cost.

The full report is available at www.who.dk/document/ben/alcoholcontrol.pdf

CAM in the UK and Germany – research and evidence on supply and demand

In recent years, the market for complementary and alternative medicine (CAM) has apparently seen tremendous growth in most countries of the EU. Similarly, there have been changes in the supply of services including the numbers of practitioners active in the provision of CAM services. This report written for the Anglo-German Foundation by Dixon, Saka, Le Grand, Riesberg, Weinbrenner, and Busse deals with the current definitions, demand and structures of the supply of complementary and alternative medicine in the UK and Germany. This analysis of the status quo in the field of CAM use and CAM provision aims to provide the empirical knowledge base necessary for future research into regulation and policy-making in both countries. The report concludes by identifying the potential for future research building on findings presented.

The report is freely available at www.agf.org.uk/pubs/pdfs/1413web.pdf

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Programme

7th European Health Forum Gastein

6th to 9th October 2004

Global Health Challenges

European approaches and responsibilities

What determines health?

Values, principles and objectives of health policy

Mental health on the agenda: promoting social inclusion

Towards high-performing health systems

Pharmaceutical policy



www.ehfg.org

Wednesday
6th October 2004

PROGRAMME OVERVIEW

12:30 – 13:00

Plenary

Opening

13:00 – 14:30

Plenary

Global health: the 21st century challenge

15:00 – 18:00

Parallel
Forums

A1

Values, principles and objectives of health policy in Europe

A2

Promoting social inclusion in an enlarged Europe: putting mental health on the agenda

A3

Pharmaceutical policy in the enlarged Europe

18:30 – 20:00

Workshops 1a

Workplace health promotion: healthy employees – successful companies. How to manage an ageing workforce?

1b

The next five years of patient mobility and health systems in Europe

20:15

Reception and Opening Evening hosted by G Burgstaller, Governor, Land Salzburg

Thursday
7th October 2004

09:00 – 12:00

Parallel forums A1, A2, A3 continued

12:30 – 14:00

Lunch

L1

Towards a health-competent consumer: policy action for improved health information

Workshops

L2

Cancer treatment: a priority for patients in Europe

and

L3

Promoting social inclusion, tackling discrimination, improving health: health, social and economic benefits

Sessions

L4

International networking to address inequalities

14:30 – 18:30

Parallel
Forums

B1

What determines health?

B2

Towards high-performing health systems: value for money and sustainable financing

Workshop

2a

Meeting the challenges of a healthy heart for European women

19:00 – 20:30

Workshops

3a

Improving health system performance: new evidence from international research

3b

Challenges for long-term care

21:00

International evening

Friday
8th October 2004

09:00 – 11:00

Parallel forums B1, B2 continued

Workshop

4a

Survey of Health, Ageing and Retirement in Europe (SHARE)

11:15 – 13:30

Plenary

Europe's role: partners in world health

13:30 – 14:30

Reception

15:00 – 18:00

Workshops

5a

Improving health literacy: a challenge in an ageing Europe

5b

Towards a European global health strategy

18:15 – 19:15

Plenary

Conclusions

20:00

Conclusion evening

Saturday
9th October 2004

9:15 – 13:30

Workshops

6a

HIV/AIDS in Europe – economic and demographic challenges for health systems and disenfranchised populations

10:00 – 13:00

6b

Focused workshop for high level policy-makers

09:00 – 18:00

Social programme

19:00

President's evening

Mittwoch
6. Oktober 2004

PROGRAMMÜBERSICHT

12:30 – 13:00

Plenarsitzung **Eröffnung**

13:00 – 14:30

Plenarsitzung **Weltweite Gesundheit: die Herausforderung des 21. Jahrhunderts**

15:00 – 18:00

Parallel Foren
A1 Werte, Prinzipien und Ziele der Gesundheitspolitik in Europa
A2 Förderung der sozialen Integration in einem erweiterten Europa: Die psychische Gesundheit auf die Agenda setzen
A3 Arzneimittel im erweiterten Europa

18:30 – 20:00

Workshops
1a **Betriebliche Gesundheitsförderung: Gesunde Mitarbeiter – Erfolgreiche Betriebe; unterstützende Maßnahmen der betrieblichen Gesundheitsförderung betreffend ‚ältere‘ MitarbeiterInnen**
1b **Patientenmobilität und Gesundheitssysteme in Europa: Die nächsten fünf Jahre**

20:15

Empfang und Eröffnungsabend; Gastgeberin: G Burgstaller, Landeshauptfrau, Land Salzburg

Donnerstag
7. Oktober 2004

09:00 – 12:00

Fortsetzung Parallel Foren A1, A2, A3

12:30 – 14:00

Lunch workshops und sessions
L1 **Auf dem Weg zu einem gesundheitsbewussten Konsumenten: Massnahmen zur Verbesserung der Gesundheitsinformation**
L2 **Krebsbehandlung: eine Priorität für Patienten in Europa**
L3 **Förderung der sozialen Integration, Abbau von Diskriminierung und Verbesserung der Gesundheit: Soziale, wirtschaftliche und Gesundheitsvorteile**
L4 **Internationales Netzwerk zur Bekämpfung von Ungleichheiten**

14:30 – 18:30

Parallel Foren
B1 Was bestimmt Gesundheit?
B2 Auf dem Weg zu Hochleistungsgesundheitssystemen: PreisLeistungsverhältnis und nachhaltige Finanzierung

Workshop 2a **Ein gesundes Herz für europäische Frauen**

19:00 – 20:30

Workshops
3a **Leistungsverbesserung in der Gesundheitsversorgung: Neueste Ergebnisse internationaler Forschung**
3b **Herausforderungen für die Langzeitversorgung**

21:00

Internationaler Abend

Freitag
8. Oktober 2004

09:00 – 11:00

Fortsetzung Parallel Foren B1, B2

Workshop 4a **Untersuchung zu Gesundheit, Altern und Ruhestand in Europa (SHARE)**

11:15 – 13:30

Plenarsitzung **Europas Rolle – Partner in weltweiter Gesundheit**

13:30 – 14:30

Empfang

15:00 – 18:00

Workshops
5a **Verbesserung der Gesundheitsbildung: Eine Herausforderung in einem ‚alternden‘ Europa**
5b **Auf dem Weg zu einer europäischen Strategie zur Förderung der weltweiten Gesundheit**

18:15 – 19:15

Plenarsitzung **Schlussfolgerungen**

20:00

Abschlussabend

Samstag
9. Oktober 2004

9:15 – 13:30

Workshops
6a **HIV/AIDS in Europa – ökonomische und demographische Herausforderungen für Gesundheitssysteme und benachteiligte Bevölkerungsgruppen**

10:00 – 13:00

6b **Workshop für hochrangige Entscheidungsträger**

09:00 – 18:00

Gesellschaftsprogramm

19:00

Präsidentenabend



Wednesday
6th October 2004

PLENARY SESSIONS

12:30 – 13:00

Opening

M Rauch-Kallat

Minister for Health and Women, Austria

A Gustav

President, Commission for Economic and Social Policy, EU Committee of the Regions

Eröffnung

Ministerin für Gesundheit und Frauen, Österreich

Vorsitzender, Fachkommission für Wirtschafts- und Sozialpolitik, EU Ausschuss der Regionen

13:00 – 14:30

Global health: the 21st century challenge

M Danzon

Regional Director, World Health Organization, Europe

Overview of global health status

Justice and inequalities in health, life expectancy, treatment and care. New health threats and global challenges including climate change

Weltweite Gesundheit: die Herausforderung des 21. Jahrhunderts

Überblick über weltweiten Gesundheitsstatus

Sozialer Friede und Gesundheitsungleichheiten, Lebenserwartung, und Gesundheitsversorgung. Neue Gesundheitsgefahren und globale Herausforderungen inklusive Klimawandel.

J Baudoy

Health Network Director, World Bank

UN Millennium Development Goals (MDGs)

The MDGs to reduce poverty, hunger and tackle ill-health, gender inequality, lack of education, access to clean water and environmental degradation put health at the heart of development. The MDGs offer an excellent opportunity for concerted action to improve global health. How are national governments and international institutions addressing and achieving these goals?

UN Millennium Entwicklungsziele

Die Ziele der Armut- und Hungerbekämpfung, Gesundheitsförderung, Geschlechtergleichstellung, Zugang zu Ausbildung, und sauberem Wasser, sowie Umweltschutz platzieren Gesundheitsaspekte im Zentrum der Entwicklungspolitik. Sie bieten eine gute Gelegenheit für konzertierte Massnahmen zur Verbesserung der weltweiten Gesundheit. Wie verwirklichen nationale Regierungen und internationale Organisationen diese Ziele?

D Yach

Professor of Global Public Health, Harvard University (tbc)

Avoidable chronic disease including mental health

Neglected Global Epidemics: the increasing burden of death and disability in developed and developing countries caused by non communicable diseases – including cancer, mental health, obesity, heart disease and stroke.

Vermeidbare chronische Krankheiten und psychische Gesundheit

Vernachlässigte globale Epidemien: steigende Todes- und Invaliditätsraten in entwickelten und Entwicklungsländern ausgelöst durch nicht-übertragbare Krankheiten – Krebs, psychische Gesundheit, Übergewicht, Herzerkrankungen und Schlaganfall.

Interact Worldwide (tbc)

Global NGO Perspective

Citizen focused perspectives on health, poverty, reproductive and women's health in the international development agenda.

Weltweite NRO Perspektive

Bürgerbezogene Perspektive zu Gesundheit, Armut, reproduktiver und Frauengesundheit in der internationalen Entwicklungsagenda

Friday
8th October 2004

11:15 – 13:30

Europe's role: partners in world health

D Byrne EU Commissioner for Health and Consumer Protection

J Frenk Minister of Health, Mexico

H Hoogervorst Minister of Health, Netherlands (EU Presidency) (tbc)

I Kickbusch Head of the Division of Global Health, Epidemiology and Public Health, Yale University
European Commission DG for External Relations (tbc)

Moderator: J Wyn Owen, Secretary, Nuffield Trust, London

Themes

Health, foreign policy and global security: What constitutes a 'foreign policy' and where are the opportunities and options for health. A strategic vision of the potential for European external relations in a health context.

Impact of European trade, health and development policies on global health

Towards a global health strategy for the European Union?

Panel discussion

R Waneck

State Secretary of Health, Austria

18:15 – 19:15

Conclusions

Presentation of results of Parallel Forum Sessions

Simultaneous interpretation in English and German

Europas Rolle: Partner in weltweiter Gesundheit

Themen

Gesundheit, Aussenpolitik und globale Sicherheit: Was ist 'Aussenpolitik' und welche Möglichkeiten für Gesundheitsfragen gibt es. Eine strategische Vision für Europäische Aussenbeziehungen in einem Gesundheitskontext.

Auswirkungen der europäischen Handels- Gesundheits- und Entwicklungspolitik auf die weltweite Gesundheit.

Auf dem Weg zu einer globalen Gesundheitsstrategie für die Europäische Union?

Podiumsdiskussion

Staatssekretär für Gesundheit, Österreich

Schlussfolgerungen

Präsentation der Ergebnisse der Parallel Foren

Simultanübersetzung in Englisch und Deutsch

Wednesday 15:00 – 18:00
 Thursday 09:00 – 12:00

PARALLEL FORUM **A1**

Chair: I Kickbusch, Professor and Head of the Division of Global Health, Epidemiology and Public Health, Yale University

Rapporteur: A Rys, Jagellonian University

Programme organiser: H Stein, European Public Health Centre

Sponsored by an unrestricted educational grant from Merck Sharp & Dohme

Values, principles and objectives of health policy in Europe: The need for a European consensus as the basis for a new concerted health strategy

Europe faces unprecedented challenges brought on by the enlargement process, continuing limitations on healthcare resources and a trend toward citizen-driven health policy. At this critical time there is a definite need to examine the key values and principles that underpin health policy in Europe, and to reaffirm the need for a common European approach.

Werte, Prinzipien und Ziele der Gesundheitspolitik in Europa: Die Notwendigkeit für einen europäischen Konsens als Grundlage für eine neue konzertierte Gesundheitsstrategie

Europa steht heute vor beispiellosen Herausforderungen, hervorgerufen durch EU Erweiterung, begrenzte Finanzmittel für die Gesundheitsversorgung und einer verstärkt bürgerbestimmten Gesundheitspolitik. In dieser kritischen Zeit besteht die Notwendigkeit, die maßgebenden Grundwerte und Prinzipien europäischer Gesundheitspolitik zu untersuchen und einen gemeinsamen europäischen Ansatz erneut zu bestätigen.

I Kickbusch Head of the Division of Global Health, Epidemiology and Public Health, Yale University

The European challenge – balancing solidarities in health

Die europäische Herausforderung – Gleichgewicht zwischen Solidarität und Gesundheit

F Vandenbrouke Minister of Employment and Pensions (tbc)
M Kokeny Minister of Health, Social and Family Affairs
M McKee Professor of European Public Health, London School of Hygiene and Tropical Medicine
K Leppo Director General for Health, Ministry of Social Affairs, Finland

The social Europe of the future – moving from national to European solidarity

Das soziale Europa der Zukunft – Der Weg von nationaler zur europäischen Solidarität

U Becker Direktor, Max Planck Institut für Internationales Privatrecht
Y Jorens Professor of Social Security Law, University of Gent
T Petrangolini Secretary General, Cittadinanzattiva

The rights of the European citizen – balancing equity with choice

Die Rechte der europäischen Bürger – Gleichgewicht zwischen Chancengerechtigkeit und Wahlmöglichkeiten

S Stevens Health Policy Advisor to the British Prime Minister
J Figueras Head of Secretariat, European Observatory on Health Care Systems and Policies
M Messmer-Wullen Austrian Stroke Association

The European potential for value-oriented health policies

Das europäische Potential für wert-orientierte Gesundheitspolitik

M Wismar Policy Analyst, European Centre for Health Policy
L Gunning-Schepers Dean, Academic Medical Centre, University of Amsterdam
B Weihrauch Head of Department, Ministry for Health, Social Affairs, Women and Family, North Rhine-Westphalia

Governance and health targeting – experiences and future potential

Regierungskunst und Gesundheitsziele – Erfahrungen und zukünftige Möglichkeiten

M Marinker Visiting Professor, Kings College London

The “Madrid Framework“ – an instrument for consensus

Der „Madrid Rahmen“ – Ein Instrument zur Konsensfindung

Panel and Open Discussion:
 The potential for international cooperation in establishing common health policy values that can be embraced on all levels

Podiums- und offene Diskussion: Die Möglichkeiten der internationalen Zusammenarbeit zur Erreichung gemeinsamer auf allen Ebenen durchsetzbarer gesundheitspolitischer Werte

PARALLEL FORUM **A2**

Wednesday 15:00 – 18:00

Thursday 09:00 – 12:00

Chair: J Klein, Director,
Mental Disability Advocacy
Program, Open Society
Institute Budapest

Rapporteur: D McDaid,
London School of Economics
& Political Science, London

Promoting social inclusion in an enlarged Europe: putting mental health on the agenda

The forum will address the significant and widespread barriers to the social inclusion of people with mental health problems. The enlargement of the European Union in 2004 presents an opportune time to ensure that mental health is recognised as a crucial aspect of health and social welfare policy.

The forum will concentrate on topics such as mental health as a human rights issue; the importance of engaging governments in the reform process; and mental health, human rights and the law as they relate to achieving real social inclusion for people with mental health problems.

Part I Setting the scene: Barriers to social inclusion

An overview of the present situation

J Klein, Mental Disability Advocacy Program (MDAP), Open Society Institute

Mental health as a human rights issue

I Perez, Senior Advisor to the Commissioner for Human Rights, Council of Europe

Engaging Governments in the dialogue

R Jenkins, Institute of Psychiatry

Part II What do we want to achieve? What are the challenges?

Mental health, human rights and the law

C Parker, Legal and Policy Consultant

Achieving social inclusion

G Quinn, National University of Ireland, Galway

Progress and challenges in mental health reforms: a government view

H Hinkov, Chief Expert, National Centre for Public Health

The situation at the community level

A Porter, Lead Commissioner Mental Health, NHS, Brighton and Hove City

Part III Meeting the challenges

Focusing on the solutions: what should governments consider in developing mental health policies?

J Bowis, Member of the European Parliament

Financing of reforms – how can it work?

M Knapp, Centre for the Economics of Mental Health, Institute of Psychiatry

Developing law, policy and national plans

T Tomov, Bulgarian Institute for Human Relations

Part IV International cooperation: Involving stakeholders

Panel Discussion

Chair: J Bowis, Member of the European Parliament

C Huitink, Service user, Dutch Mental Health Association

A Toker, Family member

Z Bugarsky, Soteria Foundation

S Bandol, Service user, Aripri Association

J Henderson, Senior Policy Advisor, Mental Health Europe

M Funk, Coordinator Mental Health Policy and Service Development, WHO

I Perez, Senior Advisor to the Commissioner for Human Rights, Council of Europe

D Puras, Mental health professional, Vilnius University

A Fidler, The World Bank



OPEN SOCIETY INSTITUTE

Hosted by the Mental
Disability Advocacy Program,
Open Society Institute

Programme organiser:
H Stein, European
Observatory on Health Care
Systems and Policies

Forum A2 will be conducted in English

PARALLEL FORUM **A3**

Wednesday 15:00 – 18:00
Thursday 09:00 – 12:00

Chair: E Mossialos,
 European Observatory on
 Health Systems and Policies

Rapporteur: S Vogler,
 Austrian Health Institute,
 ÖBIG

Pharmaceutical policy in the enlarged Europe

Priorities in European pharmaceutical policies under the Dutch presidency

JF Hoogervorst, Minister of Health, Welfare and Sport or high-level representative (tbc)

European response to encourage competitiveness and innovation

P Weissenberg, Director, European Commission, DG Enterprise

European action for achieving the goals of competitiveness, public health and European global responsibilities

B Kouchner, Chairman of the Board of the ESTHER public-interest grouping

Part I Pricing, reimbursement and innovation

Investing in innovation – should the EU do more to match US investment in innovative medicines?

B Ager, Director General, European Federation of Pharmaceutical Industries and Associations (tbc)

Affordability of pharmaceuticals in the enlarged Europe

KP de Joncheere, Regional Adviser, WHO Europe

Moderated panel discussion amongst stakeholder representatives

Introduction and overview

I Rosian, Austrian Health Institute, ÖBIG

The research-based industry perspective

P Mazan, Executive Director, Association of International Research-based Pharmaceutical Manufacturers, MAFS

The pharmacists' perspective

High-level representative of the Pharmaceutical Group of the European Union, PGEU (tbc)

The public health perspective

High-level representative of Instituto Nacional de Farmácia e do Medicamento, INFARMED (tbc)

The generic industry perspective

G Perry, Director General, European Generic medicines Association, EGA

The insurance perspective

A Kiewel, German Federal Association of Craft Guild Health Insurers on behalf of the Association Internationale de la Mutualité, AIM

Part II Health Technology Assessment (HTA)

Chair: F Kristensen, Chair of International Network of Agencies of Health Technology, INAHTA

Benefits and risks of HTA from the European public health view

B Merkel, Head of Unit Health Strategy, DG Sanco (tbc)

HTA – Cost-containment or quality instrument?

B Jönsson, Centre Director, Stockholm School of Economics

HTA – Does it encourage or hinder innovation?

I Gillespie, Head of Biotechnology Unit, OECD

HTA from political and ethical perspective

(tba)

Perspectives on HTA

Moderated panel discussion amongst stakeholder representatives

Introduction: Overview on HTA under a global dimension – impact on policy and practice and scope for transnational cooperation

F Kristensen, Chair of International Network of Agencies of Health Technology, INAHTA

EU candidate and new member countries

L Gulásci, Head of the Unit of Health Economics and Health Technology Assessment, University of Economics, Budapest

EU member state (Germany)

A Rüter, German Agency for HTA at the German Institute for Medical Documentation and Information

Medical devices

High-level representative of Eucomed (tba)

Pharmaceutical industry

High-level representative of pharmaceutical industry (tba)

Patient

J Rule, Cancer BACUP, London (tbc)

Social insurance

J Probst, General Manager, the Main Association of Austrian Social Security Institutions, MAASSI (tbc)



Programme organisers:
 M Moritz, I Rosian, S Vogler,
 Österreichisches
 Bundesinstitut für
 Gesundheitswesen/Austrian
 Health Institute (ÖBIG)

Thursday
Friday

14:30 – 18:30
09:00 – 11:00

PARALLEL FORUM **B1**

Co-chairs: M Hübel, European Commission, Health and Consumer Protection DG; C Needle, Strategic Director, EuroHealthNet

Rapporteur: A Morgan, Head of Social Determinants Programme, HDA



NHS

Health Development Agency

Hosted by the European Commission, organised in cooperation with the Health Development Agency, England

What determines health?

Many of the European population's greatest health gains have been due to activities in non-health care fields. This session will focus on underlying determinants of health and practical ways of addressing them at different levels of society, including:

- The value of linking health with other policies
- The relationship between health and the environment
- Social determinants and health inequalities
- Underlying determinants and health promotion.

Was bestimmt Gesundheit?

Viele große Fortschritte in der Gesundheit der Bevölkerung in Europa wurden durch Maßnahmen außerhalb des medizinischen Bereiches erzielt. Die Diskussion wird sich mit grundlegenden Gesundheitsdeterminanten und praktischen Lösungsansätzen auf unterschiedlichen Gesellschaftsebenen beschäftigen, unter anderem:

- Der Bedeutung der Verbindung zwischen Gesundheit und anderen Politikbereichen
- Der Beziehung zwischen Gesundheit und Umwelt
- Soziale Determinanten und Gesundheitsungleichheiten
- Determinanten und Gesundheitsförderung

J ten Dam Coordinator, Support Centre for Community Health, Netherlands Institute for Health Promotion

S Wamala Associate Professor and Research Manager, Swedish National Institute of Public Health

The wider determinants of health: from theory to practice

Gesundheitsdeterminanten im weiteren Sinne: von der Theorie zur Praxis

B Menne Medical Officer, Global Change and Health, WHO European Centre for Environment and Health

L Abenheim (former Director General of Public Health, France) Professor of Epidemiology and Public Health, CHU Cochin, Paris

Climate change and extreme weather: new challenges for public health?

Klimawandel und extremes Wetter: neue Herausforderungen für die öffentliche Gesundheit?

X Bonnefoy Regional Adviser, WHO European Centre for Environment and Health, Bonn

E Göpel Professor, University for Applied Sciences, Magdeburg

Health and the impact of the housing and the urban environment

Gesundheit und die Bedeutung von Wohnraum und städtischem Umfeld

K Jons MEP

H Klee Sustainable Health Systems, World Business Council for Sustainable Development

W Cerfeda Confederal Secretary, European Trade Union Confederation

Tackling the social determinants of health: the role of the social partners

Soziale Determinanten der Gesundheit: die Rolle der Sozialpartner

M Kökény Minister of Health, Social and Family Affairs

E Pott Director, Bundeszentrale für gesundheitliche Aufklärung

G Robertson Chief Executive, NHS Health Scotland

G Molleman Director, Centre for Knowledge Management and Quality, Netherlands Institute for Health Promotion

L Bertinato Veneto Region, Department of Health, Office for International Public Health

Katrin Saluvere Deputy Secretary General of Health, Estonia

T Rose General Secretary, EHPA

National health promotion policy to address inequalities

Nationale Gesundheitsförderungsmassnahmen zur Beseitigung von Ungleichheiten

Thursday 14:30 – 18:30
Friday 09:00 – 11:00

PARALLEL FORUM **B2**

Chair: PC Smith, Professor of Economics, University of York
Co-chair: CJ Chen, Minister of Health, Taiwan

Rapporteur: P Scherer, Counsellor to the Director, OECD Directorate for Employment, Labour and Social Affairs



Programme organiser: Elizabeth Docteur, OECD



Sponsored by the Bureau of National Health Insurance, Taiwan

Towards high-performing health systems: value for money and sustainable financing

Health and health care have improved dramatically over the past few decades, but at a cost. European countries now devote an average of 8% of GDP to health. Cost and financing pressures are likely to persist or even increase. Nevertheless, opportunities exist to further improve performance by increasing responsiveness, reducing outstanding disparities in health and access to services, and improving the quality of care and health outcomes.

This session will explore how health systems have responded to increased fiscal pressures and examine what has worked and under what circumstances. It will also look ahead to identify possible new and untested approaches to addressing these challenges.

Auf dem Weg zu Hochleistungsgesundheits-systemen: Preisleistungsverhältnis und nachhaltige Finanzierung

Gesundheit und Gesundheitsversorgung haben sich in den letzten Jahrzehnten dramatisch verbessert. Dies hat seinen Preis. Europäische Staaten wenden derzeit im Schnitt 8% ihres BSP für Gesundheitsausgaben auf. Kosten- und Finanzdruck werden wahrscheinlich weiter anhalten oder sogar steigen. Trotzdem bestehen Möglichkeiten der Leistungsverbesserung durch Verbesserung des Reaktionsvermögens, Reduktion von Gesundheits- und Zugangsungleichheiten, sowie der Verbesserung der Versorgungsqualität und des Behandlungsergebnis.

Die Parallelsitzung wird sich mit der Reaktion der Gesundheitssysteme auf verstärkten Finanzdruck beschäftigen und herausfinden welche Massnahmen unter welchen Umständen greifen. Ausserdem werden vorausschauend neue und ungetestete Ansätze zur Lösung dieser Herausforderungen identifiziert.

The context for reform: what is driving change in today's health systems?

Towards high-performing health systems: challenges and opportunities for reform

The role of European values in defining or constraining reforms

Der Reformkontext: Was trägt den Wandel in heutigen Gesundheitssystemen

Auf dem Weg zu Hochleistungsgesundheitssystemen: Herausforderungen und Reformchancen

Die Rolle europäischer Werte bei der Bestimmung und Beschränkung von Reformen

E Docteur Senior Health Economist, OECD

J Figueras Head of Secretariat, European Observatory on Health Systems & Policies

Sustainable financing for tomorrow's health and long-term care systems

Importance of solidarity and maintained equity in financing

Is there a need for an increased role in private financing in European health systems: the changing role for individuals in health financing

Nachhaltige Finanzierung zukünftiger Gesundheits- und Pflegesysteme

Die Bedeutung von Solidarität und der Sicherung des Gleichheitsgrundsatz in der Finanzierung

Besteht die Notwendigkeit einer verstärkte Rolle für private Finanzmittel in europäischen Gesundheitssystemen: Die veränderte Rolle des Einzelnen in der Finanzierung

(tba)

N van Thiel Consultant, Eureko (tbc)

In search of more value for money: Can we improve quality and system performance without raising cost pressure?

Health care quality improvement: What will it take and what are the cost implications?

Towards more cost-effective care: Is there scope for improving prevention and treatment for chronic conditions?

Is there a trade-off between cost control and equity? Evidence from single-payer approach

Auf der Suche nach einem besseren Preisleistungsverhältnis: Verbesserung der Systeme ohne Kostensteigerung

Qualitätsverbesserung im Gesundheitswesen: Was sind die Erfordernisse und Kosten?

Auf dem Weg zu einer kosteneffektiven Versorgung: Besteht Handlungsspielraum zur Verbesserung der Prävention und Behandlung chronischer Krankheiten?

Gibt es einen Kompromiss zwischen Kostenkontrolle und Gleichheit? Erfahrungen mit einem Einzelzahler Ansatz

S Leatherman Senior Advisor, Nuffield Trust (tbc)

Sir A Macara Chairman, National Heart Forum, UK

JR Lu Chang Gung University

Stakeholder perspectives: implications of change for health-care providers and patients

M Kekomaki Chief Administrative Physician, Helsinki University Central Hospital (tbc)

Perspektiven von Interessengruppen: Auswirkungen des Wandels für Versorgungsanbieter und Patienten

A Coulter Director, Picker Institute Europe

M Kekomaki Chief Administrative Physician, Helsinki University Central Hospital (tbc)

Roundtable discussion: Paying for the health systems of the future

Simultaneous interpretation in English and German

Diskussionsrunde: Finanzierung der Gesundheitssysteme der Zukunft

Simultanübersetzung in Englisch und Deutsch

Moderator: PC Smith Professor of Economics, University of York

SPECIAL INTEREST SESSIONS

Wednesday
6th October 2004

18.30 – 20.00

Chair: M Gleitsmann, Head of the Social Policy and Health Department, Austrian Economic Chamber
Co-chair: A Penk, Country Manager, Pfizer Corporation

Hosted by
Austrian Economic Chamber
Co-hosted by
Pfizer Corporation Austria



Workshop 1a: Workplace health promotion: healthy employees – successful companies How to manage an ageing workforce?

The Austrian Network Workplace Health Promotion – tasks and services

O Meggeneder, Deputy Director, Upper Austrian Health Insurance Agency

Workplace health promotion and age management in small- and medium-sized enterprises – a study on the benefit and successful models

B Kriener, Head of Health Promotion Department of thepartners.at, Social & Health Management Corp.

To be confirmed

Representative of a 'best practice' company

Chair: B Merkel, Head of Unit, European Commission, Health and Consumer Protection DG

Organised by
the European Commission,
Directorate-General for Health
and Consumer Protection



Workshop 1b: The next five years of patient mobility and health systems in Europe

Health systems across Europe are becoming more interconnected than ever before, bringing both opportunities and threats.

After years of hesitation there is now action at European level, with the Commission proposing practical cooperation following the patient mobility reflection process and an overall policy framework for healthcare and long-term care using the open method of coordination.

But what should this action aim to achieve? What are the possible advantages and disadvantages? And how should the new Commission and Parliament address rise to this challenge in the next five years?

In this session, developments around patient mobility will be presented and there will be an opportunity to discuss the key challenges which will arise for the coming years.

Thursday
7th October 2004

12.30 – 14.00

Sponsored by
Johnson & Johnson



Lunch Workshop L1: Towards a health competent consumer: EU policy action for improved health information

Providing health information has recently given rise to great controversy at EU level, in particular in relation to the revision of the EU pharmaceutical legislation and the debates as part of the G10 process and the health claims Directive. Involving all EU institutions the Commission has as a result been instructed by the Parliament in December 2003 to analysis the current situation and to propose concrete EU action.

With a view to input into this process and to develop a concrete and practical policy framework, J&J recently supported a Roundtable of key stakeholders. This proposed policy framework will be at the core of the Gastein workshop.

R Elgie, President, European Patients Forum (tbc)

P Singleton, Senior Associate, Cambridge University Health (tbc)

S Ratzan, Vice President, Johnson & Johnson (tbc)

Lunch Workshop L2: Cancer treatment: a priority for patients in Europe

One in three Europeans will be diagnosed with cancer at some point in their lives. Every year nearly 4 million cancer patients are diagnosed in Europe and with 750,000 deaths it is the second highest cause of mortality in the EU population. But do residents within Europe have the same access to the best available cancer care when they need it? This session will offer medical, scientific and patient perspectives on this important issue.

Availability of treatment – who actually decides?

JF Smyth, Director, Cancer Research Centre, the University of Edinburgh; incoming President of the Federation of European Cancer Societies

The patient perspective

Representatives from cancer patient organisations within Europe

Sponsored by
F Hoffmann-La Roche Ltd



SPECIAL INTEREST SESSIONS

Thursday
7th October 2004

12.30 – 14.00

Lunch Session L3: Promoting social inclusion, tackling discrimination, improving health: health, social and economic benefits

The relationship between the promotion of good health and emotional well-being and the generation of economic benefits has been well discussed. Yet individuals who develop mental and physical health problems can find themselves the subject of discrimination: limiting their ability to maintain or regain employment, pursue education and fully participate in society.

A range of effective interventions and strategies are available to tackle issues such as stress and depression, musculoskeletal problems in the workplace and child health, yet Europe continues to pay the health, social and economic costs by not intervening early to prevent or tackle these issues.

Presentation of evidence on costs of failing to prevent or address these issues

A look at potential solutions across different lifestages, including school and the workplace, and the potential benefits to be gained

The extent to which social inclusion and anti-discrimination measures are also needed for effective implementation of such strategies

Coordination between stakeholders and across sectors

Chair: D McDaid,
LSE Health & Social Care;
European Observatory on
Health Systems and Policies;
Editor Eurohealth

Organised by Eurohealth

eurohealth

Chair: JK Davies,
Vice-President, European
Region, IUHPE

Presented by the
International Union of Health
Promotion and Education
and supported by the Health
Development Agency



Health Development Agency



Lunch Session L4: International networking to address inequalities

This session will focus on the core strategy of effective networking adopted by the International Union for Health Promotion and Education, both in Europe and globally, to tackle inequalities by strengthening people and institutions involved in health promotion.

Examples from its linked key strategies of capacity building, advocacy, knowledge development, partnership building and technical development will be highlighted in order to demonstrate the value of the need for sustained investment in health promotion to promote the health of all populations.

Thursday
7th October 2004

14:30 – 17:30

Workshop 2a: Meeting the challenges of a healthy heart for European women

Exploring the breadth of issues facing the newly enlarged Europe in the promotion and management of cardiovascular health for Europe's 228 million women.

Moderator:
S Logstrup, European
Heart Network



Moderator:
P Berman, EHMA



Sponsored by BMS and
co-organised by BMS, EHMA
and EHN

Bristol-Myers Squibb Company

Setting the scene

Meeting the challenges of promoting and managing cardiovascular health for women in Europe from a political, scientific, economic and clinical perspective.

The challenges

Panel discussion with stakeholders and participation from the audience

Health policy

J O'Toole, Irish Permanent Representation to the EU

Heart health science

S Priori, University of Pavia, Fondazione S. Maugeri

Health promotion

S Volqvartz, Danish Heart Foundation

Health economics

B Jönsson, Stockholm School of Economics

Health management

J Higgins, Manchester University, Centre for Healthcare Management (tbc)

Health promotion perspective

P McGuire, European Institute for Women's Health

Industry perspective

G Sperti, Bristol-Myers Squibb

Patients' perspective

A van Poucke, Patients' Organisation of the Netherlands Heart Foundation

Clinical perspective

M Doeren, Charité Clinical Research Center of Women's Health

SPECIAL INTEREST SESSIONS

Thursday
7th October 2004

19:00 – 20:30

Organised by Organisation
for Economic Co-operation
and Development



Workshop 3a: Improving health system performance: new evidence from international research

Details to be announced

Chair: A Kitson, Executive
Director – Nursing, Royal
College of Nursing

Workshop 3b: Challenges for long-term care

All 25 Member States are reflecting on the dynamics in health, social development and internal market. Many discussions, think-thanks, are taking place to reflect on the possible health care reforms and initiatives of reflection are taken place by the European Commission, the European Parliament, OECD, WHO and the Industry.

The ongoing process of liberalisation in Europe will have an effect on the role of the health care professions and the outcomes for the European citizens. The potential service directive, the working time directive and the directive on mutual recognition of professional qualifications will influence our practice and the care process available to the European Citizens.

It is therefore of importance to determine, even within a global approach, the responsibilities of the Commission, the Council of Ministers and the MEPs. We need to develop a common policy formulation framework enabling health professions to respond to the patients, citizen's needs, to tear down the barriers between intra- and extramural care and to facilitate the crossover from one sector to the other, especially for the care for the elderly.

Our discussion should facilitate a multidimensional model of health reform enabling the health care professions to use the framework within the Social Model of the European Union.

In order to achieve this goal, the Standing Committee of Nurses of the EU (PCN) will facilitate four 'challenged speakers' in discussion with all participants.

No speeches, no agendas, no documents, just dialog! The rapporteur will present the results of the workgroup to the Gastein organisers and the chairs of the plenary meetings.

Organised by
the Standing Committee of
Nurses of the EU



Friday
8th October 2004

9:00 – 11:00

Organised by
R Winter-Ebmer, University of
Linz and Institute for
Advanced Studies, Vienna



Workshop 4a: Survey of Health, Ageing and Retirement in Europe (SHARE)

Combining interdisciplinary information on ageing problems in Europe

O Lipps, Mannheim Research Institute for the Economics of Ageing

Comparable health indicators for an ageing European population

R Winter-Ebmer, University of Linz and Institute for Advanced Studies, Vienna

Friday
8th October 2004

15:00 – 18:00

Sponsored by Pfizer



Workshop 5a: Improving health literacy: a challenge in an ageing Europe

Details to be announced

Chairs:
J Wyn Owen,
The Nuffield Trust (tbc)
J Martin, World Health
Organization (tbc)

Workshop 5b: Towards a European global health strategy

This workshop will draw on discussions in the plenary sessions to consider possible practical elements in a European global health strategy, recognising the increasing interdependence between Europe and the world, the scale of global health challenges, and how Europe can marshal its unique resources to meet them in more focused and concerted ways.

I Kickbusch

G Lister, The Nuffield Trust (tbc)

R Labonte, Director and Professor, Community Health and Epidemiology, University of Saskatchewan (tbc)

J Bell, Member of Cabinet of Commissioner David Byrne (tbc)

J Martin, World Health Organization (tbc)

A Ingram, The Nuffield Trust (tbc)

Hosted by The Nuffield Trust



SPECIAL INTEREST SESSIONS

Saturday
9th October 2004

9.15 – 13:30

Workshop 6a: HIV/AIDS in Europe – economic and demographic challenges for health systems and disenfranchised populations

The HIV/AIDS challenge: impact and consequences for socioeconomic development in Europe

HIV/AIDS in the wider European neighbourhood: trends and findings from recent World Bank studies J Godinho and T Novotny, World Bank

MDGs, AIDS and Youth: what does the future hold for economic and social development? J Baudouy, World Bank

The AIDS epidemic – impact of on policy making: a case study from Russia S Sharp, UNDP

UNAIDS – national and international roles in policy making L Loures, UNAIDS

The Global Fund and its outreach to the disenfranchised U Weber, GTFAM

Addressing the challenge: local and global responses to serve disenfranchised populations and foster exchange and experience

Making services work for poor people: examples of public-private partnerships (tbd)

How countries cope with AIDS: a case study from Moldova V Soltan, OSI, Moldova

The role of NGOs: combating AIDS and reducing drug-related harm in Central and Eastern Europe and Central Asia A Sarang, Central and Eastern European Harm Reduction Network

Addressing the AIDS challenge through networking Françoise Hamers, EuroHIV

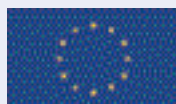
Reaching marginalized groups via national programmes E Klinkert, Ministry of Foreign Affairs, The Netherlands

European HIV/AIDS strategies. The EU Centre for Disease Prevention and Control B Merkel, European Commission

Co-chairs:
A Fidler, World Bank and
a representative from the
European Commission

Rapporteur:
M Rosenmöller,
IESE Business School

Jointly organised by
the World Bank and
the European Commission



Saturday
9th October 2004

10:00 – 13:00

Workshop 6b: Focused workshop for high level policy-makers

Health system reform, values and mental health EHFG is hosting a special workshop by invitation only for some of the most senior decision-makers attending the Forum. The workshop will be led by the European Observatory on Health Systems and Policies and will review with participants some of the key issues covered over previous days in more depth and in terms of their concrete impact on national policy.

How political and practical realities and values affect uptake of evidence and implementation of change The themes to be explored this year are health system reform and the values that underpin it and mental health. The focus will be on how the political and practical realities in countries facilitate or hinder the uptake of evidence and affect the implementation of real change.

The workshop will also be an opportunity for participants to voice their concerns, raise questions and strengthen their international networks.

Organised by
S Lessof, J Figueras and
D McDaid,
European Observatory on
Health Systems & Policies



Sponsoring

The EHFG is offering a wide range of sponsorship and communication opportunities, including supporting membership, social event sponsoring, hosting of special interest sessions, scholarships and comprehensive sponsor partnerships.

For further information please contact Mr Frank Berndt by telephone at the IFG office or by email: frank.berndt@ehfg.org

David Byrne



This year's European Health Forum Gastein addresses European approaches and responsibilities in view of Global Health Challenges.

The issues being debated – values, principles and objectives, health determinants, social inclusion, the future of health systems and pharmaceuticals – are high on the health policy agenda at national and EU level, particularly in view of the enlarged Europe. At the same time, there are important global dimensions in all of these topics.

No doubt, the EHFG will play its role to the full in providing input and impetus to these discussions.

EU Commissioner for Health and Consumer Protection

Das diesjährige European Health Forum Gastein befasst sich mit Lösungsansätzen und Verantwortung angesichts globaler Gesundheits Herausforderungen.

Die Themen der Diskussion – Werte, Prinzipien und Zielsetzungen, Gesundheitsdeterminanten, soziale Integration, die Zukunft des Gesundheitswesens und Pharmazeutika – stehen sowohl auf nationaler wie auch auf EU-Ebene ganz oben auf der Tagesordnung der Gesundheitspolitik, vor allem angesichts eines erweiterten Europas. Diese Themenbereiche haben überdies eine wichtige globale Dimension.

Gewiss wird sich das EHFG in diesen Diskussionen mit Beiträgen und wichtigen Impulsen seiner Rolle entsprechend voll einbringen.

Reinhart Waneck



From its very beginnings, the EHFG has always looked beyond the frontiers of the European Union, also embracing those European states that did not belong to the Union. In the meantime, some of these countries have become members of the European Union and can now actively help shape the future of Europe.

The fact that this year's EHFG is also placing a strong focus on global themes and perspectives constitutes a meaningful development of this conference, which has become the most important health policy conference on a European level.

State Secretary in the Ministry of Health and Women

Das EHFG hat immer über die Ränder der Europäischen Union hinausgeblickt und von Anfang an auch jene europäischen Staaten miteinbezogen, die nicht der Union angehörten. Inzwischen sind einige dieser Länder Mitglieder der Europäischen Union geworden und können somit aktiv an der Gestaltung der Europäischen Zukunft mitwirken.

Dass sich das EHFG in diesem Jahr verstärkt auch globaler Themen und Sichtweisen annimmt, ist eine sinnvolle konzeptionelle Weiterentwicklung dieser inzwischen bedeutendsten gesundheitspolitischen Konferenzveranstaltung auf Europäischer Ebene.

Günther Leiner



On May 1, 10 new countries joined the European Union. The challenges for a European health policy are increasing.

During this year's congress, we shall try to offer our new friends some support and ideas, also giving them a platform that will help them integrate as soon as possible and provide them with a voice.

Health directly concerns us all and reflects the overall situation of a society. We willingly accept the challenges facing us, and are looking forward to discuss aspects that may unite or divide us beyond national borders, in order to achieve a better future for health in a larger Europe.

President, European Health Forum Gastein

Am 1. Mai sind 10 neue Länder der EU beigetreten. Die Herausforderungen an eine europäische Gesundheitspolitik nehmen zu.

Wir wollen versuchen während des diesjährigen Kongresses unseren neuen Freunden Hilfen und Ideen anzubieten und gleichzeitig ihnen eine Plattform verschaffen sich schnell zu integrieren zu können und aber auch sich Gehör zu verschaffen.

Gesundheit betrifft uns ganz direkt und ist ein Spiegel einer gesellschaftlichen Gesamtsituation. Gern nehmen wir die Herausforderungen an, die sich uns stellen um über nationale Interessen und Grenzen hinaus verbindende und auch trennende Aspekte zu Diskutieren um eine bessere Zukunft für Gesundheit in einem größeren Europa zu schaffen.

Maria Rauch-Kallat Minister for Health and Women



The pressure to reform health systems in all European states has continuously mounted in recent years. This is closely related to the efforts to generally slow down the rise in public expenditure.

Despite the different organisation of their health systems, European countries can learn from each other, and a look beyond Europe's borders is also certainly worthwhile. This year's EHFG will particularly address this global perspective.

Der Reformdruck auf die Gesundheitssysteme aller Europäischen Staaten hat sich in den letzten Jahren kontinuierlich erhöht. Dieser steht in engem Zusammenhang mit den Bestrebungen, öffentliche Ausgaben in ihrem Wachstum generell zu begrenzen.

Die Europäischen Staaten können trotz der unterschiedlichen Organisation ihrer Gesundheitssysteme voneinander lernen, auf jeden Fall lohnt sich jedoch auch der Blick über Europa hinaus. Das diesjährige EHFG wird sich verstärkt dieser globalen Perspektive widmen.

Marc Danzon Regional Director, WHO



The theme of this year's Health Forum is both timely and relevant.

We need now to look beyond the geographical boundaries of the newly enlarged European Union and face our global responsibility in tackling the enormous health threats encountered by the less privileged countries. Both within the European Region itself and in other continents.

The core values of solidarity, social justice and equity enshrined in many of our Health Systems can and should take central stage in the international policy debate.

WHO with its broad European and global mandate stands ready for a renewed effort to work with its Member States and other national, international organisations and the Civil Society, to address this global health challenge."

Das Thema des diesjährigen Gesundheitsforums ist ebenso zeitgemäß wie relevant.

Wir sind aufgefordert, uns über die geographischen Grenzen der gerade eben erweiterten Europäischen Union hinweg unserer globalen Verantwortung bei der Bewältigung der enormen Gesundheitsprobleme der weniger privilegierten Länder zu stellen. Sowohl in Europa als auch in anderen Ländern.

Zentrale Werte wie Solidarität, sozialer Frieden und Gerechtigkeit, die in vielen unserer Gesundheitssysteme verankert sind, können und sollen im internationalen politischen Diskurs im Mittelpunkt stehen.

Mit ihrem breiten europäischen und globalen Mandat steht die WHO für einen neuerlichen Einsatz bereit, um diese globale Gesundheitsherausforderung zusammen mit ihren Mitgliedsstaaten, anderen nationalen und internationalen Organisationen und der Zivilgesellschaft anzunehmen.

Gabriele Burgstaller Governor of Salzburg



In order to improve the health of European citizens, it will be necessary to reduce social and economic inequalities.

The central task of EU health policy shall be to secure and maintain the health of all people, paying particular attention to those who are already ill, who are insufficiently covered by the health care system or who are living in poverty.

Regional and national strategies and concepts need to be developed and implemented in the European Union. I therefore wish all success to the European Health Forum Gastein.

Für die Verbesserung der Gesundheit der europäischen Bürgerinnen und Bürger ist der Abbau von sozialen und wirtschaftlichen Chancenungleichheiten erforderlich.

Die zentrale Aufgabe der EU-Gesundheitspolitik ist die Sicherung und der Erhalt der Gesundheit jedes Menschen, wobei auf jene besonders geachtet werden muss, die bereits krank sind, gesundheitlich unzureichend versorgt sind oder die in Armut leben.

Dafür sind regionale und nationale Strategien und Konzepte zu entwickeln und in der Europäischen Union umzusetzen. In diesem Sinne wünsche ich dem European Health Forum gutes Gelingen.

Booking Information

We provide a variety of services to assist you during your stay. Booking the congress and your accommodation through the International Forum Gastein will ensure that you benefit from all these services: direct shuttle service from Salzburg Airport (1 hr) or Schwarzach-St. Veit/Bad Hofgastein railway stations; participation in all EHFG sessions, special interest sessions; and social events for all participants and partners including the weekend, if you choose to stay until Saturday or Sunday.

For further information and a registration form please contact the IFG office or visit our homepage at www.ehfg.org. Hotel rates are available upon request. Accompanying persons (non-participants) staying in the same room pay 60% of the regular hotel rates.

All information in this announcement is subject to change.

Buchungsinformationen

Wir bemühen uns, Ihren Besuch so angenehm wie möglich zu gestalten. Wenn Sie den Kongress und Ihr Hotel über das Internationale Forum Gastein buchen, stellen Sie sicher, dass alle angebotenen Leistungen inbegriffen sind: Direkter Transferdienst vom Flughafen Salzburg (1h) oder den Bahnhöfen Schwarzach-St. Veit/Bad Hofgastein; Teilnahme an allen EHFG Veranstaltungen; Special Interest Sessions; gesellschaftliche Rahmenveranstaltungen für alle Teilnehmer und Begleitpersonen einschliesslich des Wochenendes, wenn Sie sich entscheiden bis Samstag oder Sonntag zu bleiben.

Für Einzelheiten und ein Anmeldeformular kontaktieren Sie bitte das IFG Büro oder besuchen Sie unsere Homepage unter der Internetadresse www.ehfg.org. Hotelpreise sind auf Anfrage erhältlich. Nicht am Kongress teilnehmende Begleitpersonen im gleichen Zimmer zahlen 60% des regulären Hotelpreises.

Änderungen der Informationen dieser Programmankündigung bleiben vorbehalten.

CONGRESS FEES <i>includes 20% VAT</i>		KONGRESSGEBÜHREN <i>inklusive 20% Mwst</i>
Standard fees	EUR 1,550	Standardgebühr
Reduced fee: <i>a contribution towards costs, available only to representatives of consumer/patient organisations and universities</i>	EUR 415	Reduzierte Gebühr: <i>Ein Kostenbeitrag, nur anwendbar auf Vertreter von Konsumenten-/Patientenorganisationen und Universitäten</i>

Cancellation fee is 10% of the total amount due until 10 September 2004, 50% thereafter. Cancellation must be submitted in writing. Die Stornogebühr beträgt bis 10 September 2004, 10% des Gesamtbetrages, danach 50%. Stornierungen gelten nur schriftlich.

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