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eurohealth

The media & health

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COMMENT

Today's news, tomorrow's chip paper?

There is a saying in England that today's news will be end up being used as a wrapping for fish and chips tomorrow, and that a story will burn brightly but then be long forgotten. This era itself is now fading away in an age of 24 media coverage, the incredible expansion of the internet and an insatiable public appetite for stories. This should not be lost on those working in the health field. We need to strive continuously to get our message across, whether as policy makers, researchers, healthcare professionals or consumer groups. Development and implementation of policies, uptake of new treatments and the promotion of healthy lifestyles are heavily dependent on public engagement. Transparency and an opportunity to ask questions, provide feedback, and influence this process are critical.

The media has a powerful role to play in this process, and we ignore it at our peril. Negative public perceptions are formed quickly and then may be reinforced by a constant stream of adverse headlines. Immunisation rates against measles, mumps, and rubella in the UK have continued to remain below target, now many years after concerns were first raised in a single scientific journal paper that subsequently hit the headlines of the mainstream media. One of the lessons arising from this is that stakeholders need to pause for thought before releasing information and should consider carefully how accessible this is, both to journalists and the general public. In particular, the concept of risk needs to be communicated more effectively to avoid unintended adverse consequences on the utilisation of services and perhaps ultimately on the direction of policy.

A welcome step to improve communication and provide opportunities for feedback has been the first EU Open Health Forum, and the ensuing opportunity for all to reflect on a new health strategy for the EU. Key themes on the future European health policy, observations on the health forum process and responses to the reflection process all feature in this issue of *Eurohealth*. The reflection process is designed to be inclusive, noting how "different actors must work together to foster good health across the EU". There is still time to input into this process and it is to be hoped that the responses are as diverse as hoped for by the Commission. However, all these positive developments at the European level are unlikely to receive much attention in the mainstream media. How much better it would be if such positive opportunities for engagement with European structures that often seem remote to the ordinary citizen, might be publicised in the mainstream media? Trying to get across these positive challenges is very much an uphill challenge, as the news media have different priorities and needs, but it is a challenge to which we must rise.

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

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

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

The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

Design and Production: Westminster European, email: westminster.european@btinternet.com

Printing: Seven Corners Press Ltd

ISSN 1356-1030

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The future direction of EU health policy

This article summarises the key points presented by Commissioners David Byrne and Pavel Telička at the first EU Open Health Forum in Brussels on 17 May 2004.

David Byrne and Pavel Telička

"The challenge is to ensure that health interests are properly recognised and articulated"

Our work on health has shifted a great deal over the past years from reaction to action. In the first few years of the Directorate General for Health and Consumer Protection (DG SANCO) its work was mainly defensive, i.e. it sought essentially to protect the European public, for instance, by overhauling the EU's food safety laws; by addressing risks associated with blood and blood products; and by discouraging tobacco use.

However, as soon as this work was under way, attention was turned towards the development of a more proactive approach to public health. A strong emphasis was put on the broad concept of 'good health' which identifies health not only as a key element of individual welfare and happiness, but also as a key element in a broader societal context, that is, for social cohesion, productivity and economic sustainability. The protective and the proactive nature of our work are essential and have become a fundamental expectation of European citizens.

In order to achieve healthy public policy, health needs to be at the heart of the policy agenda. The challenge is therefore to ensure that health interests are properly recognised and articulated, whether we are discussing inner city development, regional transport infrastructure, social policy, atmospheric pollution or international trade, to mention just a few examples.

So, what is the EU's role in this? What can we add at the European level? The EU can function as a catalyst for change and facilitate progress. For example, the EU can support the work of the Member States' health authorities with key policy challenges such as how to 'square the circle' of meeting ever rising patient expectations while keeping control of healthcare spending; how to identify which new treatments and technologies our healthcare systems should invest in; how to rise to the challenge of the obesity epidemic in Europe; and how to make the healthy option the easy option for our citizens, whether this is saying no to tobacco, taking more exercise or making healthier food choices.

There have been some major health policy achievements at European level in recent years. For example, there has been significant progress in the fight against tobacco use, including high visibility health warnings on tobacco products and restrictions on tobacco promotion; the 2003-2008 public health programme is in place and producing results; we have created a framework to promote the safety of blood, tissues and cells; our planned European Centre on Disease Prevention and Control is on course to open its doors in 2005; and the Commission has just recently set up a High Level Group on Health Services and Medical Care.

However, there are still several health issues which need to be addressed: the rise in the incidence of chronic diseases; the threat from newly emerging infectious diseases; the influence of new patterns of behaviour and consumer choices on health; the increasing longevity of the population; the rising expectations of citizens as regards health information and healthcare; and the

health gap between the 10 new Member States and the rest of the Union.

More specifically, HIV/AIDS is an area for urgent action where priority setting and strong leadership are of utmost importance, and crucial at all levels. In Western Europe the number of HIV infections is on the rise and in some Eastern European countries the epidemic is growing faster than anywhere else in the world. A new HIV/AIDS agenda needs to be defined and to be successful this requires concerted actions. Society at large has to be mobilised and appropriate policy responses need to be identified.

Yet another area of great importance concerns the environment and health. There are a number of environmental factors that play a strong role in causing or aggravating disease. For example, the link between smoking, respiratory diseases and cancer is obvious. On the other hand, there is a real need to improve our understanding of the causal links and to improve our efforts to monitor emissions, exposures and health outcomes. We also need to ensure that policy instruments, research programmes and actions are appropriately coordinated to maximise benefits. The EU Action Plan on Environment and Health addresses several of these issues and covers a whole range of EU policies.

The main theme at the Open Health Forum was Health and Enlargement. It has become common to classify the EU Member States into the 'old' and the 'new' Member States. A more realistic statement is that there are real differences between the Member States. We may all live in the same village, but some families are, in fact, better off than others. If we want to build a Europe of equal health, bridging the health gap will be one of the biggest challenges we need to address in the coming years.

Clearly, this cannot be achieved without substantial financial resources. Resources for investing in health will have to come from national budgets as well as from the EU. Several Member States are already channelling some of their EU Structural Funds allocations towards health investment. The Structural Funds provide a good opportunity to finance health related projects, particular for the new Member States.

However, the new Members States and Candidate countries also need know-how and support in developing their health expertise and in building the capacity of their health sectors to compete for the limited funds available.

In more general terms, there are four distinct areas where the EU can make a tangible contribution to improving the health of Europe's citizens:

1. Focusing on citizens and patients: to make reliable information on health available to European citizens, and to promote their active participation in the health decision-making process;
2. Promoting health as a driver of economic growth, sustainable development and quality of life;
3. The High Level Reflection Process on patient mobility and healthcare developments has led to the identification of actions that will help the health sector. We need to find ways of improving co-operation to ensure resources are used well, information is improved, and the exchange of best practice promoted; and
4. The EU needs to develop its role in international forums in response to globalisation.

"HIV/AIDS is an area for urgent action"

The Commission's EU Health Strategy from May 2000, identified integrating health into all EU policies as one of its key objectives. This means ensuring that public health experts and health policy stakeholders have a strong input in EU decision making.

The Health Policy Forum, launched by the Commission in 2001 and bringing together some 60 representatives of European level health networks and stakeholders, was an important step towards this objective. However, the Open Health Forum, bringing together as it does some of the leading health experts and opinion-formers from all across Europe, provides a platform for even wider participation of stakeholders. The Open Health Forum has the potential to be a powerful voice in Brussels which will be heard not just in the Commission, but also in the European Parliament, the Council, the media and, beyond Brussels, the general public.

The first Open Forum took place on 17 May in Brussels with the overall theme 'Health in the Enlarged Europe' and attracted around 300 participants from a wide range of organisations. You can find speeches, presentations and photos of the event at http://europa.eu.int/comm/health/ph_overview/health_forum/open_forum_04/contributions_en.htm. Participants' feedback and evaluation of the conference will also be posted on the site.

Citizens and health

Tamsin Rose

"Empowerment and responsibility must not become a mechanism to penalise individuals for 'wrong' choices"

The Workshop on Citizens and Health at the EU Open Forum on 17 May 2004 was designed to open a debate on some key questions:

- What are citizen and patient rights and how do they alter the roles and responsibilities for health?
- How do socioeconomic factors impact on health and therefore to what extent can individuals be made responsible for their own health?
- In terms of equity in treatment choice and availability how is complementary and alternative medicine (CAM) addressed in Europe?
- What are the barriers to greater patient participation in decision-making in health and how can they be addressed?

These are complex and important questions which however need more consideration than that possible in a short workshop. The discussions at the Forum (See Box) raise some issues for further exploration.

Rights

The patients' rights agenda has emerged from patient advocacy and a growing frustration with poor medical responsiveness to individual needs, concerns and situations. In addition a series of studies looking at civil servants in England (the Whitehall studies) have demonstrated that the more choices and power an individual has, then the better their health status. The World Health Organization has developed extensive material on health rights as part of the fundamental human rights process as well as specific rights for patients when entering the healthcare system. At the European level there is no standardised approach to health rights other than Article 35 of the Charter of European Fundamental Rights, now included in Part II of the new EU Constitutional Treaty. This states that everybody has the right to treatment and preventative health care. Each Member State has pursued a different path on patient rights, some through legislation and others through guidelines, codes or other non-binding mechanisms.

A rights based approach to health provides a road map for empowerment, ensuring that when individuals become ill and enter the healthcare system that they are still treated with respect and dignity. It is a challenge for health professionals and for health service planners to respond adequately to citizen and patient rights. This requires a re-balancing of the power relationship and recognition that improving health is a shared process with both professional and patient playing a part in taking decisions. But do all individuals want to be actively involved in making decisions? Anecdotal evidence shows that there are often wide divergences between those who want to be part of developing a treatment plan and individuals who want the healthcare system to deliver a solution without having to understand and debate the issues with a health professional. This raises the question about who is responsible for the subsequent health outcome? For example, if an individual exercises their right not to reveal information about previous conditions or symptoms or other medication that they take and there is a negative side-effect from treatment, where does responsibility lie? If a patient does not complete a medication regime or ignores professional advice, where does the fault lie? Surveys show that only about 50% of those with chronic conditions follow their treatment regimes. Furthermore 10% have to receive medical treatment because of harm caused by earlier medical care. Perhaps the root of the problem is a search for blame when a negative health outcome occurs. If input into health is a shared responsibility then who is accountable for poor results? It is important to understand the responsibility issues because litigation for health problems is increasingly common.

Information and choice

There is a continuing information need for individuals and family members. Information about diagnosis, prognosis, treatment options but also more informal sharing of experience about how illnesses and conditions affect everyday life, work, relationships etc. Concerns were also raised that there is an information overload which requires time, persistence and luck to navigate successfully to find information that is relevant, useful and appropriate. Information alone is not enough, neither is

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blind provision of more information. Patient organisations, advocacy groups and support networks can help by acting as a filter, collating information and helping to interpret and use this material. This places great responsibility on these structures many of whom have strong personal involvement but are very under-resourced.

As the political emphasis on providing choice in health is expanded, attention needs to be paid to the CAM community, facing similar issues to those currently being addressed by the medical community such as training and qualifications, quality and safety, access and affordability. In some countries, European governments have tended towards prohibitive regulation while others have opted for a more structured approach to address training standards, quality and safety. For recognised CAM disciplines several health insurers will reimburse costs. This situation of patchy regulation and unequal access must be addressed to enable all citizens to have real choice in health treatment and encourage them to be more pro-active on their own health. Political will can ensure the significant economic and institutional resources that are needed to enable patient and public involvement in health services. This pressure can also overcome inertia or tradition in the education of healthcare professionals to incorporate the principles of partnership with patients, the need for clear communication and the provision of timely information.

The limitations of the goal of making individuals responsible for their health become clear when the impact of socioeconomic status is examined. The key determinant in poor health status is poverty which compounds the negative effects of inadequate housing, degraded environment, limited education, a lack of employment opportunities, high-risk behaviours and unhealthy lifestyles. It seems that money can buy good health. The most critical 'choice' in life is in having parents from a privileged background with all the social and economic advantage that this can provide.

Linking citizens with their health status means recognising that there must be opportunities for decisions, input and choice throughout the healthcare system. It also means recognising that individuals are very different and some may want extensive information, to exercise real choice and gain knowledge and skills on their own illness or conditions. Others may expect their healthcare systems to take care of their health problems and not have to engage in choices. The greatest challenge will be meeting the needs of individuals throughout this spectrum particularly as sometimes one person may be passive for some health elements and extremely active on another health question. Acknowledgement of the importance of socioeconomic status on opportunities in life means that empowerment and responsibility must not become a mechanism to penalise individuals for 'wrong' choices.

EU OPEN HEALTH FORUM, PARALLEL SESSION III, CITIZENS AND HEALTH

Rapporteur: Deirdre O'Connell, European Patients Forum.

The four contributors to the session covered various aspects of the topic, Citizens and Health.

Stella Kyriakides, EUROPA DONNA – The European Breast Cancer Coalition, (Patient and citizen rights: a statement of values) discussed values of patient rights from an advocacy perspective, using Europa Donna as an example of how patient rights can be ensured by patient advocates, trained in advocacy methods and aware of their rights.

Darja Havelkova, Czech Shiatsu Federation, (Exercising choice in health treatment) spoke about the extensive use of complementary and alternative medicine in Europe today, the differing national regulations, and current trends in regulation in relation to the active involvement of citizens in their own health care.

Tamsin Rose, General Secretary, of the European Public Health Alliance, (Access to health for all citizens) reviewed determinants of health, including health services, barriers to access and empowerment, concluding that lifting people out of poverty would do most to improve health.

Barrie Taylor, from the Commission for Public and Patient Involvement in Health (Citizens and health: the road to empowerment), described how the Commission is offering opportunities for citizens to have an input into health planning and policy issues, bringing together lay and professional strands to work together. The key themes covered in the discussion were information, access, responsibility, partnership/integration, and training/empowerment.

Information: There can be too much or too little information, or not the right kind. What is needed is accurate and performance tested information, with awareness that people have varying capabilities. Do carers or families have enough good information? How to access information should be part of citizenship programmes and we must have ways of assessing information. The use of the internet should have been covered in the agenda; it has been very valuable to people with rare disorders, while it can also be abused

Access: There are various barriers to access, many socioeconomic. Even informed patients cannot always get access, if, for example, they do not live in a place with good services. As regards access to CAM, the EU should put more resources into studying this area; at present there could be said to be discrimination against CAM and its users.

Responsibility: Who is responsible for the health of citizens? The government has a responsibility to enable individuals to take more responsibility. Some groups, for instance the homeless face huge barriers. There are moral assumptions underlying the lifestyle approach to health and health prevention.

Partnership/Integration: This is required between scientists, doctors, patients, and industry and also between decision makers and the public. There is a need for equal respect and for forming alliances.

Empowerment/Training: Governments and the EU should fund training programmes via patient advocacy groups.

A questionnaire was handed out at the session looked at responsibility for health and key actions for government. When asked, "Who should have the main responsibility for our health?" responses were: individuals, national governments, healthcare professionals, parents/family and local/regional authorities. Key areas identified for government action were: education in schools, banning smoking in public places, use of financial incentives, increased availability of health promotion, more space for exercise, regulation of access to products that may be harmful with provision of health warnings and prioritisation of access to health care services.

A health strategy for the EU:

A response to Commissioner Byrne's call for reflection

Martin McKee and Paul Belcher

Introduction

On the 15th July 2004 David Byrne, the European Commissioner for Health and Consumer Protection, launched a process of reflection that will shape a new health strategy for the EU.[1] He emphasised how important it is that the people of Europe can live longer, healthier lives, and noted the progress that has been made, as Europe's citizens are now living in better health than ever before. Yet he also sounded a note of caution, highlighting the large differences in health that have persisted, with the poor, the socially excluded, and minorities particularly affected by ill health.

The consultation document sets out where we are now and identifies much that needs to be done. However a health strategy involves choices, about priorities, policies, and means. The reflection process is designed to be inclusive, noting how "different actors must work together to foster good health across the EU". To make this a reality, Byrne asks a series of questions about how to proceed. In this paper we have tried to answer some of these questions.

"Individual choice is important but it can only be effective if governments step in to make it a reality."

The role of the individual

Many factors contribute to the unequal burden of disease and premature death in Europe but four, smoking, poor diet, lack of physical activity, and hazardous drinking are especially important. The document makes much of the importance of individual choice: "health is, to a great extent, determined by individual choices" and "Many of the choices for achieving good health lie in the hands of the citizens themselves". Of course, ultimately, people do make choices about how they lead their lives, yet it is also important to understand how those choices are frequently constrained.

This is most obvious in the case of smoking; exposure to the harmful effects of tobacco is not a matter of free choice for most people. First, surveys consistently show that most smokers want to quit.[2] Many fail to because of the highly addictive properties of nicotine, with modern cigarettes containing additives such as ammonia designed to boost the nicotine kick that keeps people addicted.[3] Second, those working in places where they are exposed to other people's smoke have no choice.

However there are many other constraints on an individual's ability to make healthy choices. Many people are unable to gain access to affordable nutritious food, as the retail food industry concentrates its resources on those with the greatest purchasing power and public transport is withdrawn from unprofitable routes.[4] Physical activity becomes a difficult choice for those working long hours, perhaps with multiple jobs and inadequate childcare provision, with no nearby leisure facilities.

So for many of Europe's citizens, and especially the most vulnerable to poor health, choice is often an illusion. The resources required to promote health are especially susceptible to market failure. Many are 'public goods', which are under-produced if left to the market. Individual choice is important but it can only be effective if governments step in to make it a reality.

Putting health at the centre of EU policy making

The document emphasises the role of health as a driver of economic development, an issue that is now on the global agenda as a result of the pioneering work of the Commission on Macro-Economics and Health.

The contributions of health to wealth are several. Most obviously, a healthy workforce is more productive and a healthier

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population places fewer demands on the money required for health care. However wealth also contributes to health, and health is, in itself, a perfectly good indicator of the progress of nations and even, as has been suggested by Amartya Sen,[5] may even be better than conventional measures such as Gross National Product, which are a far from perfect measure of human happiness. If this mutually reinforcing relationship is to be sustained, there is a need for continuing investment in both the prevention of disease and the means of treating it when it occurs.

The document asks whether the EU can do more to disseminate evidence on the relationship between health and wealth and on the efficiency of health systems but also asks whether it should do more. It is only beginning to take on these roles so this question may be premature. However what is clear is that there is a considerable demand for such exchange of information and, if adequately resourced, the EU could make an important contribution to this process, building on the many existing initiatives. Perhaps more importantly, the development of a new strategy offers the opportunity to make a reality of the Treaty requirement that a high level of health protection should be part of all EU policies. Health can also be a casualty of economic growth, especially where that growth is unevenly distributed or is achieved at the cost of environmental degradation. This must not happen.

Specific issues

The document asks what should be done on certain specific issues. One is how the EU's role in communicable diseases should develop. The new European Centre for Disease Prevention and Control will begin work in May 2005. This is a long overdue development. However, compared with the American Centres for Disease Control, it will operate on a very limited scale. Of course the analogy is not perfect; the new European centre will be grafted on to existing national infrastructure. Yet it will be important to monitor the demands placed on the new centre, ensuring that it has the resources to do its job.

A European centre is critically dependent on the information fed to it by national surveillance systems. Yet in many parts of Europe these systems are far from perfect. The centre will build on a series of existing networks, frequently built up in the face of considerable difficulty, by a few dedicated enthusiasts who had the vision to see that a coordinated European response to communicable disease was needed.[6] Yet in many cases the coverage of these networks is patchy. There are large parts of Europe in which reporting and investigation of outbreaks is far from adequate. Putting this right, with sustained investment in laboratories and public health systems, is primarily a responsibility for Member States but the EU can also play a role in developing standards and exchanging information on good practice.

It will be essential that the work of the new centre is not confined to the territory of the Member States. As was all too apparent in the SARS outbreak, communicable diseases do not respect national frontiers. It will be important that the EU's often labyrinthine rules facilitate rather than obstruct the Centre's ability to work in other parts of the world, and in particular in the EU's new neighbours in eastern Europe and North Africa.[7]

"Should all governments follow the Irish and ban smoking in public places? The answer must be an emphatic yes."

The document also identifies tobacco as an issue requiring action by the EU. It asks, should all governments follow the Irish example and ban smoking in public places. The answer must be an emphatic yes. First, improved research methods, with more precise measures of exposure, have revealed that exposure to second hand smoke is considerably more dangerous than was previously believed,[8] a finding consistent with recently discovered tobacco industry research on animal testing. Second, surveys in many European countries are showing majority support for smoking bans; in many cases most smokers are also in favour of action. Third, as the Irish experience shows, as long as there is some attempt at enforcement, that bans work and are widely accepted.

But what can the EU do to facilitate this process? First, it should support work that exposes the depressing number of 'independent' experts who have succumbed to the temptation to take money from the tobacco industry,[9] including several who have influential links with governments in some Member States. Ironically, this year one highly paid tobacco industry consultant was appointed to a EU health committee, although his extensive links were not known to the Commission when the appointment was made. The availability of millions of pages of industry documents on the internet as a result of American court settlements means that these people can no longer hide. The apparent ease with which individuals can enter such committees is extraordinary. Greater scrutiny, by experts

"Greater scrutiny is required of individuals who put themselves forward for EU health related committees"

from the health sector, is required of individuals who put themselves forward for EU health related committees. In addition, the European Commission must publish a declaration of interest for each applicant.

Second, it can disseminate evidence that dispels the many myths pedalled by the industry. This includes exposing the research commissioned by the industry, some of which was fraudulent and some simply designed to mislead, that sought to undermine the evidence that second-hand smoke is harmful.[10] It also involves exposing the fallacy that the problem can be dealt with by improved ventilation. It must be recalled that many of the harmful constituents of second-hand smoke are odourless; to reduce them to safe levels would require a system that could create a rate of airflow similar to sitting outside during a gale.[11]

Finally, it must expose the myths about the economic impact of smoking bans. In New York sales tax receipts on food and drink increased by 12% and employment in the hospitality industry increased in the nine months after the smoking ban was introduced.[12] However, the most important evidence is from a systematic review of research on the impact of bans on bar and restaurant revenue.[13] All of the 37 studies that found an adverse economic impact had been funded by the tobacco industry or were written by consultants known to have industry links. In contrast, all of the 60 independent studies found either no impact or an increase in sales or employment.

However, the EU can also do much to help those who are smokers. For example:

- It can do more to clamp down on smuggling, recognising the key role played by some tobacco companies in facilitating large scale smuggling activity. [14]
- It can step back and ask what cigarettes are actually for? The answer should be clear; they are methods for delivering nicotine, an addictive drug with important effects on the cardiovascular and nervous system. This then raises the question of why this drug remains unregulated. There is a strong case for establishing a nicotine regulatory authority that can consider the various roles of the increasing sources of nicotine (chewing gum, patches) many of which have fewer harmful effects than cigarettes.
- Finally, given the scale of health damage from tobacco in Europe, the EU can shape the policy dialogue by committing to a long term goal of a smoke-free Europe and a medium term goal of reaching levels already achieved in some parts of the world, such as the 11% in California.

A third set of questions ask about the EU's roles on nutrition and obesity. The EU is especially well-placed to do something by virtue of the many areas where it has responsibility that have an impact on these issues. These include transport, agriculture and fisheries, trade, and the internal market. Its scope for action extends from exchanging evidence of best practice to passing legislation. A major challenge, but one that, experience suggests, may be somewhat problematic, involved reform of the Common Agricultural Policy.[15] At last tobacco subsidies are on the way out, but Europe's agricultural policy continues to favour production of fats over fruit and vegetables. The EU destroys 1 million tons of fruit and vegetables each year while over-producing 6 million tons of sugar annually, not to mention subsidising the provision of high fat milk in schools.

The document contains a welcome recognition of the role of health impact assessment, asking how it might operate in practice. The challenge for the Commission is how to learn from the growing body of experience in both health and environmental impact assessment. These experiences are showing that impact assessment can provide the information that is needed to shape policy but is also highlighting the need to build sufficient capacity to undertake such assessments.

Research

The document's recognition of the importance of health research is also welcome, asking whether new infrastructures such as the US National Institutes of Health (NIH) would bring benefits. This is a question that merits further consideration. It seems unlikely that a EU institution would ever have the resources available to the NIH and there is also the risk that the vagaries of EU legislation and budget setting would compromise the continuity that such a major initiative would require. Furthermore, while much has been done to reduce the administrative burden involved in the 6th Framework Programme, there is still much that needs to be done. As an intermediate step, there may be more benefit to be achieved by facilitating closer cooperation between national and non-governmental funding bodies.

Mobilising different actors: partnerships for health

The document notes the importance of openness and civil society participation in the development of health policy. The existing mechanisms, such as the Open Forum and the Health Policy Forum, have not been especially successful and some question whether these and other processes, such as G10 (pharmaceuticals) and the High Level Reflection Process on Patient Mobility and Healthcare, actually fulfil the Commission's own criteria for consultations as set out in the White Paper on Governance. The breadth and diversity of the public health and healthcare community must also be recognised and included in these processes and not left to single sectors, such as patient or healthcare groups. There is a need to rethink these models, developing a shared understanding among those involved about what the realistic expectations should be for these bodies. There is also a need to extend participation to organisations with something to say but which might not be organised at a European level. For example, many national organisations have much to contribute to the development of policies on particular issues.

It also asks about how to foster partnerships. DG Sanco works with very limited resources. It has few, often overstretched, staff and little easy access to technical expertise. One possible solution might be modelled on the WHO system of Collaborating Centres, in which certain academic and technical centres would be designated as providing expertise in specific areas. In most cases, this would only involve some minor adjustment of their existing work to ensure that it met the particular needs of the Commission. However, it would also provide a rich source of advice that could be tapped when rapid answers are needed.

Health on the international agenda

A final set of questions relate to health on the international agenda, in particular in relation to policies such as trade and international development. With an economy that is now larger than that of the United States, the EU has the potential to be an even greater force for good in the world, offering an alternative vision to what has become the dominant neo-liberal economic paradigm. This has become increasingly important as the USA has, in areas ranging from landmines to climate change, retreated from multi-lateral solutions to the world's shared problems. The challenge, once again, is ensuring that health really is an integral element of all the EU's policies.

Moving forward

Commissioner Byrne has embarked on an ambitious programme that, if successful, really will put health at the centre of the EU's activities. Unfortunately despite the Treaty obligations and the strenuous efforts of many people, health can too often seem a peripheral issue at a European level, taking second place to the promotion of the internal market. We are now presented with an opportunity to make a difference. In this article we have set out some responses to this consultation. It is important that others do so too.

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The Dutch presidency: *Some activities in the field of health*

Frits Tjadens and Benno van Beek

"Enlargement is an unprecedented activity that poses enormous challenges"

The Dutch presidency of the EU is the first of the EU25. This will clearly shape this presidency, as well as possibly the aftermath of the Convention. The enlargement is an unprecedented activity that poses enormous challenges. Furthermore, the Dutch Presidency will be faced with a renewed European Parliament and with a new Commission. Thus, the Dutch Presidency is an unprecedented one, facing challenges never seen before. The same goes for the challenges that the Dutch presidency meets in the field of health. In this article we identify some of the relevant issues. Also we discuss some of the activities that the Dutch Presidency is undertaking to address these issues, such as an informal Health Council, preceded by an EU-wide NGO-conference on Health and the Market and a side event linked to mutual cooperation European Economic Area wide between health care registers and supervisory bodies.

Enlargement in a renewed context

The accession is a fact, and 29 countries are now within the European Economic Area. The new member states have gone through a transition that will hardly have finished and that will require a lot of after-care. Most have experienced much turmoil, hopes and despair in the aftermath of the decline of the Soviet empire and have had to reinvent themselves. This they have done over the last 15 years, sometimes stumbling along the way, and now communism is something that the older generation speaks of, but that the younger generation, full of aspirations and dreams, while sometimes disappointed by the treatment given by the EU15, (as new Polish Commissioner, Danuta Hubner, intimated in a March 2004 interview to *Euroactiv*), nevertheless regards as ancient history.

Because of the enormous differences between these countries and the previous EU15,[1] programmes were developed to assist the Accession States to deal with the structures and Acquis to be implemented all over the enlarged EU according to the Copenhagen criteria. Thus the new Member States have received an enormous amount of assistance in the implementation of the *Acquis Communautaire*.

Assistance for new Member States: EU PHARE TWINNING AND HEALTH PROFESSIONALS

With the means of the EU PHARE Twinning funding, the Ministry of Health of the Netherlands is assisting the Ministry of Health of the republic of Poland to fully implement the current acquis concerning the mutual recognition of qualifications of medical professions. This, as may be known, concerns both the so-called General System professions as well as the professions, regulated in the current Sectoral Directives (doctors, dentists, pharmacists, general care nurses and midwives).

On the Polish side it requires the implementation of the Directives in relevant Polish legislation and the build-up of relevant infrastructure. The Dutch have assisted by having a so-called Pre-Accession Advisor (now after May 1 a Resident Technical Advisor) in Poland for the duration of the project and by bringing in experts from the Netherlands, UK , Germany, Belgium and Sweden depending on the Polish request for assistance.

Similar assistance programmes have been or are being implemented in other new Member and Candidate States: the French are assisting the Romanians and the Germans, together with the English, assist the Czech Republic. The Netherlands is also helping Lithuania with this task. The PHARE program runs across all EU-Acquis Chapters.

Health issues in the enlarged EU

The Convention was disappointing in the naming of health(care) in the draft Constitution but the recent Irish Presidency took up the issue to strengthen the health component. Even though there still is uncertainty about the realisation of a real European Constitution (because now it is up to citizens of the EU member states to vote for it), it is fairly safe to state that the issue of health and the internal market is

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growing in importance rather quickly. Several developments in the near future will need to be dealt with on a European level:

The accession of new Member States leads to worries about:

Communicable and/or infectious diseases that may be on the rise in new Member States.

Food safety.

Health care labour markets: even though there are serious discussions going on about quantity (and fears of flooding labour markets led to restrictions on access to many western labour markets), it can be expected that the mobility of health professionals will grow. This will lead to issues of patient safety and thus of a need for further development of the quality control of health care systems and health professionals.

Life style related illnesses

On the other hand the European Commission has recently set out its overall health strategy for the coming years:*

Patient mobility.

Ageing and the sustainability of healthcare systems, especially with regards to the care of the elderly; tackled using the Open Method of Coordination.

The issue of E-health, which is growing in importance from the introduction of a European health insurance card to telemedicine.

Furthermore, the following issues could also be mentioned:

Mobile delivery of health services might develop if health organisations in the EU15 use the lower cost of labour in the new Member States and arrange 'medical tourism' to these states backed by ECJ rulings.

In an enlarged EU diseases that had been rare may seem less so, thus the issue of *orphan drugs* will play an even bigger role than before, even though access to medications in many of the new Member States is still lagging behind that found elsewhere in the EU.

The interrelationship between employment and family caring responsibilities in ageing societies will gain importance. Even though the need to work longer, both in terms of hours per week and also in total years may be an economic necessity, it adds to the burden of an ageing society that needs to take care of chronically or terminally ill relatives. Furthermore, it is not only the health workforce that faces increasing shortages; family networks are also decreasing in size rapidly. This could lead to ever growing burdens for informal carers and to an increasing risk of them becoming patients as well. This leads to the conclusion that European health policy as well as economic and social policy should act on the health of, and support for, family carers as part of the complete health workforce by taking steps to prevent their health deteriorating as a result of caregiving.

"it is not only the health workforce that faces increasing shortages; family networks are also decreasing in size rapidly"

Health and the Community

The Dutch presidency in the autumn of 2004 will be the first to deal with this expanded European Union, with all these issues on the health front in full glare of the community. This perhaps is one of the reasons why several initiatives are taken, another being the increasing 'interference' by the ECJ (and thus: of the Internal Market) on, according to the subsidiarity principle, national health issues.

So, just before the informal Council of Health Ministers (9 September 2004), NGOs from all over Europe will gather to discuss all topics in relation to the four freedoms and health during a two day-conference in the Hague under the title '*Shaping the EU Health Community, Balancing Health, Social Developments and Internal Market*'. European NGOs and their Dutch counterparts are working closely together to develop a programme that tackles the crux of current European discussions.

In the background several Commission papers may play a crucial role. Not only is it about the three 'health-communications' mentioned previously, but also about other Communications such as the Green Paper on Services of General Interest, and the Proposal for a Directive on Services in the Internal Market (COM(2004)2; 2004/0001 (COD). Both papers serve as foundation stones for a Europe-wide discussion that may have a severe impact on healthcare. Thus, the conference basically deals with the essential dualism existing in the European Community on issues such as health, health care delivery and equity of access. At all stages one can see the fundamental dilemma creeping up between the growing influence of the Internal Market over issues that are part of the competence of national governments. It is thought that not only might the outcomes prove productive for the Informal Council of Health

* See COM(2004)301final: Follow-up on the High Level reflection process on patient mobility and health care developments in the European Union of 20 April, to which Commissioner Byrne added his Health Strategy on 15 July.

"migration of health care professionals is and will remain an issue on the EU agenda"

Ministers, but that they might also provide relevant input to the newly developed High Level Group on Health Services and Medical Care.

Mutual recognition EEA-wide

Another issue gaining importance is the mutual recognition of qualifications of medical professions. The shortages in some labour markets in Western-Europe and the abundance (at least, for the near future) in the new Member States, leads to the expectation that mobility will be on the increase. For instance, even though the Netherlands is not opening up its labour market to most of the new Member States during the transitional period, for certain health professions the restrictions are lifted, due to shortages that impair the quality of health care.[2]

As such, migration of health care professionals is and will remain an issue on the EU-agenda, both as issue of *immigration* and as issue of (temporary) *emigration*. And, yes, the combination also may occur. This issue is linked to several other health-topics:

– Regulating migration in relation to health care workforce surpluses and shortages. A Council of Europe working group at this moment is working on this. At EU-level, discussions are also linked to the issue of monitoring both labour-supply in health care systems and migration flows.

– A possible further harmonisation of qualifications without new directives (for instance as triggered by European Centres of Excellence).

– Professional misconduct crossing national borders. Recently the Commission introduced a revised proposal COM(2004)314, which (partly) accepts 55 of 125 amendments made by the European Parliament to the original proposal. It has now been accepted by the Council.

For this purpose it is interesting to note that the Dutch Presidency will also be characterised by a EEA-wide conference for (sectoral) health care registration and clinical governance bodies in Amsterdam on 9–10 December 2004. It will be a follow-up to the last Dutch Presidency in 1997. The current objective is to discuss the options for registration bodies to work more closely together on the issue of cross border movement of health care professionals, especially on the issue of professional misconduct, while at the same time taking into account issues of privacy and the potential for blacklisting. While the basic foundations are already in place in the current Sectoral Directives, there is nevertheless much that still can be gained, through better knowledge of the registration process and it's workings in countries.

On the other side there are the clinical governance bodies, linked to the quality of health care. Increasingly they are faced with cross border care scenarios, either through the mobility of health care workers or through the mobility of patients. Thus, there is an increasing awareness that cross-national cooperation between bodies responsible for quality control across Europe could prove useful, but it still somewhat unclear as to how this cooperation could be achieved and under what conditions.

As a preparatory activity, Polish and Dutch twinners on the 'mutual recognition of the qualifications of health care professionals' decided to redevelop their 1-year celebration of twinning into a 2-day international seminar with the title '*From mutual recognition to mutual communication? Five months of the Internal Market in new Member States*'. Participants from all the new member states and elsewhere were invited to a seminar held in Warsaw in September 2004.

In order to provide relevant input for the conference, an EEA-wide analysis to tackle these questions will be conducted. The results will not only be made public during the Amsterdam-conference, but will also be compiled for a public website, www.nizw.nl/eeahealthpros. Thus information on all aspects of the registration of health care professionals will be made available. Furthermore, the conference will deal with questions such as how cooperation between registration bodies can be enhanced, how regulatory bodies responsible for safeguarding quality perform, what legal restrictions exist, what can be learnt across bodies and what are the possibilities and constraints in respect of cross border care.

Conclusion

The Dutch presidency of the EU in the autumn of 2004 will be special, characterised by full membership of ten new Member States, complemented by a New Commission and new European Parliament. Furthermore, within the health field it will try to tackle in practical ways some of the topics that will quickly gain prominence as a result of the formation of new policy goals, and because of the sheer scale of geographical enlargement.

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Headlines and deadlines: the media and health issues

David McDaid

"the focus tends to be on negative events, such as failing hospitals or the latest health scare"

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We live in the age of the soundbite, where both print and broadcast media outlets are highly fragmented, and the need to hook potential consumers to maintain circulation and/or viewing ratings through eye catching news stories has never been greater. Yet at the same time we also live in a world of rolling 24 hour news coverage where stories that once may have been covered for a few hours are constantly recycled, developed and re-examined to unearth all possible angles. It is a world where some health related issues are widely covered, often featuring as lead stories in both print and broadcast media.

Fostering good links between media outlets, health policy makers and researchers can potentially be very beneficial in getting across public health related messages: providing information and dispelling myths about health care interventions and healthy living.[1] It can therefore be an excellent tool to help individuals make informed choices on health related issues. In reality though the picture seems to be one where good communication between these groups is the exception rather than the rule, and where the focus tends to be on negative events, such as failing hospitals or the latest health scare, rather than on positive health messages.

Conveying the concept of risk in a way that can be easily related to by a general public whose knowledge and understanding of science is limited remains a challenge. The risks associated with stories can be blown out of all proportion. These difficulties have meant that coverage of health stories can have disproportional adverse consequences such as reducing the willingness of individuals to seek medical care or to use specific health promoting interventions. They may also have the potential to influence the eventual development of government policy.

MMR controversy

This can perhaps best be illustrated by the ongoing controversy in the UK over the safety of the measles, mumps and rubella (MMR) vaccination and it's possible links with bowel disease and autism. Sensationalist reporting of the findings of one published scientific paper had a dramatic impact on the level of public confidence in the vaccine. Vaccination rates for infants that had peaked at 92% in 1996, fell back to 84% by 2002, following negative press coverage. The effects of this media coverage may be long lasting, one recent analysis suggests that resistance to vaccination is likely to remain high, despite a major publicity and awareness campaign, as parents balance the risk of infection against the risk of vaccination. This study concludes that it will take a considerable time to restore vaccination rates, in similar fashion to what transpired with the whooping cough vaccine two decades earlier.[2]

A recent study funded by the Economic and Social Research Council in the UK assessed the media's role in the public understanding of science, based on an analysis of both television, radio and press news on science in over a seven month period, coupled with two nationwide surveys which looked at the public's knowledge, opinion and understanding of science related issues reported in the media.[3] The study focused on MMR and two other well reported issues, climate change and cloning/genetic medical research.

In all three cases while knowledge of the issues did not improve over the study period, the authors noted that "*what people knew usually corresponded with those aspects of the science stories that received most persistent coverage. The details or subtleties of media coverage are, in this respect, much less important than the general themes of that coverage, in which certain ideas are repeated and associated with one another. While this does mean some information is communicated effectively to most people, it can also result in widespread misunderstanding – even if the reporting itself is generally accurate*."

Of the three issues that were looked at, MMR had by far the biggest level of public engagement, even though there were fewer articles compared with the other two issues. MMR was more likely to be the focus of editorials and opinion pieces, and

"Journalists will always need to find headline grabbing stories"

covered by news reporters rather than science/health specialists, and furthermore stories were most likely to feature contributions by members of the public. Coverage of the MMR debate appeared to have been skewed so that in spite of the fact the overwhelming body of evidence indicated that the vaccine was safe, the public perceived that the scientific community were evenly split on the issue. Some newspapers even actively campaigned for single vaccinations despite the lack of any evidence that this was a safer alternative. The study concluded that "*research questioning the safety of something that is widely used should be approached with caution, both by scientists publishing that research and journalists covering it. This is especially the case if any decline in public confidence has negative consequences for public health.*" This view was shared by almost half of the respondents in their public survey.

Impact on resource allocation and policy

The impact of the MMR debate in the UK is by no means an isolated case of the adverse impact that media reports can have for health. Another example, which had implications for resource allocation can be seen in Italy, following claims in the media of the success of what in reality was a new unproven treatment (di Bella) for a wide range of cancers. This publicity fuelled public demands for access to the treatment, leading to the health authorities providing funding for a large scale trial, which ultimately was shown to be ineffective and a waste of a valuable resources, not to mention the false hope that it generated.[4]

In Canada, coverage in the press of the risks of the infection of blood products with Creuzfeldt-Jakob disease (CJD), was linked directly to changes in policy, potentially having both health and resource consequences.[5] One newspaper reported statements by an American haemotologist giving evidence to an inquiry on the blood system; these were subsequently picked up the Canadian newswire leading to stories of a "new killer virus". A chain of events led to the Red Cross recalling all their blood products, an event estimated to have cost 11 million Canadian dollars and creating shortages of some blood products. In analysing the views of journalists later it was suggested that some felt that because they had not done enough previously to report the potential risks of hepatitis C and HIV contamination of blood products, they over reacted in the case of CJD.

The nature of news

The media can have an influence on health behaviour and ultimately on policies both for good and for bad. Principal challenges include improving the way in which information is communicated to the public, and in particular the concept of risk, as well as ensuring that stories are based on good quality information. Another challenge is to encourage the publication of less sensational positive health stories and messages. However all this must be grounded with an understanding of the reality in which the media must operate, and in particular what constitutes 'news'.

It is important to distinguish between specialist media outlets such as health magazines and documentary style in depth format features about health issues, and even features buried deep within newspapers, with what will appear in headlines and be the subject of rapid deadlines. For the former, journalists are more likely to have some expertise in the area, or to have dialogue with experts, and there is typically more time to corroborate facts, and obtain a range of perspectives from stakeholders including policy makers, scientists and health care professionals, patient groups and the public. Moreover editorial decision-making may remain in the hands of a specialist 'science' or 'health' editor. There is much also to gain from the journalist's perspective if they can develop a good relationship with a reliable source of information on a variety of health related issues.

The greater challenge is faced at the sharp end of news production, where as studies have shown, although detailed messages may not be assimilated by the public, key perceptions of health issues such as MMR and CJD can be quickly formed, and reinforced through constant repetition of a small number of headlines, and perhaps distorted views on an issue. For instance an analysis of health news in the press, radio and television commissioned by the King's Fund[6] calculated a crude number of deaths required for a story in the UK in order to raise the debate on the balance of health news coverage in the media. Whereas there were more than 8,500 deaths due to smoking and 7,500 due to obesity for each related story covered, it took only 0.25 deaths from measles, 0.33 deaths from variant CJD and 19.56 deaths from AIDs per story covered.

Barriers faced by journalists

There are many difficulties to face. Can we really expect journalists to change their

focus of coverage? How can journalists meet the demands of their audience to provide attractive and entertaining news stories, while at the same time minimising the reduction in the quality of information? How can this take account of the limited general understanding of science?

One recent study convened two focus groups of journalists writing on health related issues in Sweden and the UK, and also conducted surveys worldwide to identify some of the challenges and barriers to the communication of health messages from the perspectives of the journalist.[7] Respondents in the UK identified commercial pressures, and weak editorial control where accuracy was not a major issue as key barriers, whereas in Sweden the lack of time to prepare stories, the sheer volume of information and the difficulty in finding reliable sources were all cited. Other barriers identified included a lack of knowledge, limited space for stories and too much terminology. The study highlighted the difficulties journalists can have in finding truly independent expert sources, as many researchers may have conflicts of interests, which may bias their responses, or at best mean that they will only talk 'off the record'. It did though find that the journalists wanted to explore ways of improving the quality of information in their stories.

Meeting the challenge

Journalists will always be faced by time pressures and the need to find headline grabbing stories, this is simply the nature of the news media. Researchers and policy makers cannot assume that the news should feature positive health stories and have a greater focus on public health messages. The media operate in a different environment where news worthiness does not take account of such public health goals. This is not to say though that there are not times when public health and positive stories will not be prominent in the news. Nor should it imply that is impossible to improve the quality of information used, or the way in which stories are reported so that risks and benefits are communicated in a way that can be more easily understood by the general public. Unfortunately there is as yet little evidence as to which approaches may be effective in achieving this modest goal. However it is reasonable to assume that theories used for the dissemination of knowledge more broadly are applicable here as well.

This inevitably means that a number of different mechanisms will need to be used, perhaps most importantly strengthening the links between researchers and the media. Researchers need to be aware of the constraints faced by journalists including their lack of time and limited knowledge of an area. Research units, many of whom still often pay only lip service to the notion of dissemination outside of academic publications, need not only to set aside resources to prepare concise briefs for policy makers, but similarly should prepare sound, non-jargonistic and informative information for the press.

"Researchers need to be aware of the constraints faced by journalists"

There may also be some merit in running short courses for journalists to help them understand scientific jargon, and get a basic grasp of the evidence based medicine approach, including both it's strengths and limitations. This may also help them in their interpretation of absolute and relative risks and in the challenge of attributing outcomes to specific interventions or potential health risks. Another mechanism may be for media organisations to draw up guidance for their staff when reporting on health issues.

While this will not change the understandable need for headline grabbing stories it may at least help promote balance and better communication of information on risk when a story breaks. It is in this early stage that key public perceptions are formed on health issues, which, as is evident in the case of MMR in the UK, may be difficult to change later on, in spite of an overwhelming body of scientific evidence.

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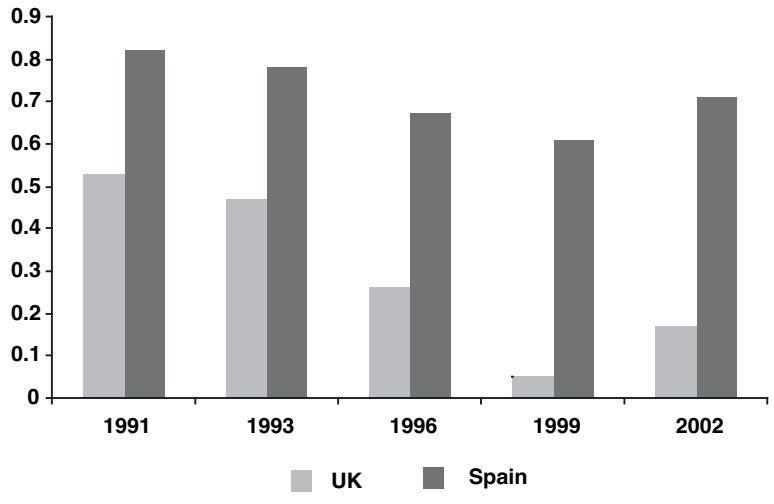
The role of the press media in reporting on genetically modified food in UK and Spain

Marta Vilella-Vila and Joan Costa-Font

The risks, and less frequently the benefits, of new biotechnology (including genetically modified [GM] food) are increasingly communicated to the public through the media. However, the European public still is sceptical. The index of optimism on biotech in the European Union declined steadily over the period 1991–1999 (Figure 1),[1] reaching its lowest level in 1999 in line with media coverage patterns. Biotechnology is an area where due to the lack of knowledge individuals might be prone to be exposed to 'media created knowledge'. Therefore, a relevant policy issue is the role of the media in influencing public perception of new biotechnology applications and in particular GM food.

Eurobarometer survey 52.1 in 1999 revealed that 72% of Europeans agreed with the statement that they "would take time to read articles and watch TV programmes on the advantages and disadvantages of advances in biotechnology". In addition, 81% of Europeans felt they were inadequately informed about biotechnology and 69% perceived that newspapers and magazines reporting on biotechnology do good work for society. When examining country effects, the UK ranks first among EU countries in having the highest share of the population (30%) who answer that newspapers "do not do good work". Spain ranked first in the share of the population not interested in taking the time to acquire more information on biotechnology (27%). This evidence opens the door for a debate on the role of the media as determining public perceptions of risks and attitudes towards new biotechnology application, and specifically GM food.

Figure 1 EUROPEAN OPTIMISM ABOUT BIOTECHNOLOGY 1991–2002



Question: Do you think that biotechnology will improve our quality of life in the next twenty years?

Source: Eurobarometer surveys several years.

Here we report a summary of the results from a study[2] examining press media coverage in the area of biotechnology as well as survey evidence on public perceptions in the UK and Spain. We proceed by examining the key features influencing the public perception of GM food in Europe, followed by an analysis of the press media in Spain and the UK and finally we provide a description of the patterns identified in examining attitudes towards GM food and biotechnology applications.

Key features influencing public perception of GM food in Europe

The first GM product in Europe, Zeneca tomato purée, was first imported to Europe from the United States in the mid-1990s. All cans were both clearly labelled and resembled a similar non-GM product. The problem arose when GM food ingredients entered the market as bulk commodities. The first was GM soya, imported in 1996, followed by sweetcorn, grown in the USA and then traded internationally, to those countries that did not block its entry. Indeed, some concerns began to emerge as a result of the scant knowledge available regarding the long-term impact and the potentially irreversible effects of products that employed biotechnology.

However, it was not until 1998 that media attention towards this issue began to intensify. In 1998, six EU member states

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imposed an unofficial moratorium on the approval of new varieties of GM crops. On 14 February 1999, the bio-safety convention to establish international regulations governing GM organisms began in Cartagena, Colombia. Again, GM foods came dramatically to the public's attention with the publication in 1999 of a statement signed by 126 influential food writers and journalists condemning the use of GM foods. This initiative was promoted by the environmental organisation, Greenpeace.

In October 2001, German Agriculture/ Consumer Affairs Minister Renate Künast and Environment Minister Jürgen Trittin wrote to the European Commission stating that the moratorium should remain in place until the revised GMO deliberate release directive came into force in October 2002 and future traceability/labelling regulations were clarified. In May 2003, President George W Bush launched a legal challenge to the EU at the World Trade Organisation, to force Europe to accept imports of US GM crops. In July 2003 laws intended to end a European Union-wide ban on new genetically modified foods were passed by the European Parliament. Europe's Health and Consumer Protection Commissioner David Byrne, told the European Parliament: "I believe we have got in place legislation … to enable consumers to make the choice for themselves whether to consume GM foods or not". Under the new law, all foods with more than 0.9 per cent genetically modified content will have to be labelled.

In the UK, the government launched a public debate in June 2003. The aim was to listen to the public's views before deciding whether to license GM crops in the country. This is arguably the country's first nationwide public discussion around GM issues. Local authorities and network groups organised meetings to weigh up the pros and cons. The findings, along with the views submitted to an internet site, were then fed back to the government to help inform their policymaking on GM. The situation thus is now rather different to that of the late-1990s, when the story of GM food began to be written. Almost all food in the shops is non-GM and it could be argued that it is those who would wish to buy GM food that are being denied a choice. The new (2003) EU labelling regulations are now even stricter than before and consumers will finally have a choice about whether or not they aim to consume products containing modified crops. As noted, in July 2003, the European Parliament approved a new set of regulations that impose additional labelling requirements on those wishing to sell any foods derived from GM sources.

Content analysis findings in the UK and Spanish press

Public debate on genetically modified foods has become highly polarised. Some groups have set out to establish a less partisan perspective by involving a range of people with different viewpoints and working towards consensus. In the meantime, the amount of media coverage has been extensive, especially in the UK. Our findings indicate a *great increase in coverage in Europe during early 1999*. It is worth noting that after the peak in 1999, there was certainly a reduction in the volume of newspaper coverage. Overall, this qualitative content analysis reveals that coverage in the UK and Spain has been characterised by an *extreme focus on risks and the potential hazards to public health*. Overall, European coverage is biased towards negative effects, framing the reality of GM food as a highly controversial issue. Thus, the British and Spanish media coverage is driven mostly by controversy, as the dominant themes rarely display a positive emphasis on the potential benefits of GM food. The empirical evidence on media content reveals that *GM food is a topical issue within the British press, as a high level of reporting led GM food to become a front-page news story 13 times during 1999*. Within a press that influences opinion leaders and policy makers, the theme emerges as a complex debate that involves many stakeholders, namely scientists, politicians and state headquarters, food companies and other interested parties. All employ the media as a risk communication tool.

"a important policy issue is the role of the media in influencing public perception"

In the UK there is a remarkable variation between broadsheet and tabloid reporting. Whereas *The Guardian* acts as a significant agenda-setter in the GM food debate, *The Sun* tabloid courts extensive popular attention. Contrary to *The Guardian's* broad and somewhat pedagogical coverage, it became noticeable that a detailed debate was rarely found in *The Sun*. In a tabloid, there is no pretension of generating a rich debate among the counterparts involved and the language constantly aims at reinforcing the idea of "Frankenstein food" and "mutant food". Unlike the UK, GM food was not reported as a topical issue by the Spanish press, where there was less coverage, resulting in less controversy, with comparatively poor public debate. In Spain,

"a lack of trust is a key element in the influence of the media on attitudes"

where the tabloid press does not exist in the same way as in the UK, the results of content analysis among the different newspapers' appear fairly diluted. We looked at whether this media reality corresponds to readers' perceptions, in showing them to be closer in knowledge, attitudes and risk awareness.

Attitudes and public perception of GM food

The evidence examined suggests that both people in the UK and in Spain envisage the use of modern technology in the production of foods to be a decidedly risky business. On the other hand, research shows that the lay public perceive some biotech procedures as beneficial, since their use may make it possible to feed more people in a more efficient way ultimately benefiting consumers, but simultaneously potential human risks and ethical concerns are recognised to be causing anxiety.

Trust in stakeholders plays a meaningful role in influencing safety concerns. In both the UK and Spain, the sources of information most trusted by the public are the medical profession, consumer and environmental organisations. On the other hand, the media ranks among the least trusted. Therefore, it is worth pointing out that although the media is often regarded as responsible for socially amplifying risk, if they are among the least trusted stakeholders one might expect to find readers to be more critical with the information reported. Thus, a lack of trust might be a key element in the role of the media in influencing attitudes. Distrustfulness is especially relevant among UK society, where 30% declare that newspapers "do not do good work".

The newspapers examined highlight how different journalistic treatment and coverage has an influence in public perceptions of GM food and biotechnology in general Attitudes and perceptions of risk in the UK appear to be different when considering those people who read *The Sun* or *The Guardian*. *Sun* readers exhibit higher disagreement with GM food and their risk perceptions are also lower. In contrast, *Guardian* readers appear to be more aware of the potential risks of GM food and consequently, their attitudes tend to be more negative. In Spain, general attitudes appear to be similar regardless of the newspaper considered. Here, where tabloid press does not exist, the disparities among consumers of different newspapers appear to be rather weak, as they are found to be closer in knowledge, attitudes and risk perception.

Policy implications

Information sources and organs of mediation, the media among them, will be key actors in influencing public perceptions of GM food. Therefore, substantive efforts need to be made to communicate risks in order to allow individuals to make informed decisions. Content analysis between a sample of the UK and Spanish press exhibits substantial differences in both the amount of news and the public debate generated. The more limited support for GM food in the UK coincides with a major social debate played out in the media, which appears to have negatively influenced public acceptance of GM food. Furthermore, perceptions of risk on GM food have increased in line with news reporting. However there is still little evidence to set up a direct cause-effect relationship between negatively biased news and the lack of public trust in the field. Furthermore, it should be acknowledged that scepticism in Europe might be partly the consequence of the BSE crisis and other food scares.

Several policy implications can be drawn from our study:

First, informing the public about the risks and benefits on issues that constrain current and future innovation should be undertaken in the light of known individual psychological responses.

Second, governments and the European Union should make use of existing policy tools to overcome market failures resulting from a public lack of knowledge and understanding of biotechnology.

Third, if risk communication is to rely on trusted channels, then if as we find the media does not stand among the most trusted information channels, other societal stakeholders, namely the medical profession and consumer and environmental organisations might be employed.

Further, the media, however, should be encouraged to provide information on biotechnology in a way that convinces the public of both the benefits and the risks. Accordingly, it is possible that some incentives should be introduced into the market to reduce the temptation for journalists to provide ambiguous although sometimes sensational information.

Finally, a key information source is education. The technical nature of biotechnology information might generate the need to provide the public with better education on scientific developments.

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Individual incentive schemes in social health insurance systems

Richard B Saltman and Hans FW Dubois

"market-oriented changes are potentially in conflict with traditional commitments to solidarity."

Introduction

Starting in the late 1980s, Social Health Insurance (SHI) systems in Western Europe sought to develop and/or apply new organisational approaches capable of constraining overall expenditures. Under increasing fiscal pressure and anxious to achieve more market-style levels of operating efficiency, these systems experimented with a variety of different demand-side mechanisms. On closer consideration, however, many of the more sweeping proposals were found to be incompatible with core commitments to solidarity in access and treatment, and, over time, were modified or dropped.[1]

This interest in the potential advantages of demand-side reforms continued to evolve during the 1990s. Several market-derived measures were adopted in countries like Germany (choice of sickness fund) and the Netherlands (choice of sickness fund; nominal flat-rate premiums). Switzerland's SHI system, introduced in 1996, contained a variety of choice and competition-oriented measures.[2] Most recently, existing measures have been supplemented by a variety of additional, typically voluntary experiments and/or sick fund-initiated pilot projects. The range and scope of these new approaches suggest the possibility that a new period of reform may be germinating, one in which the market-oriented changes may be less global in character, yet still potentially in conflict with traditional commitments to solidarity.

Recent mechanisms

The range of demand-side mechanisms currently in use or under development in pilot projects includes a number of approaches that appear to reflect a new policy departure for SHI systems. These can be grouped into four distinct categories:

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1. Provider networks and/or selective contracting

Sickness funds shift from broad open-ended contracts with all providers to specified arrangements with selected physicians and/or hospitals. In return for voluntary adherence to this sub-set of providers, patients receive better continuity of care (clinical benefit) but normally no financial benefit (Switzerland is an exception). Sickness funds hope these networks will reduce unnecessary care and thus reduce overall expenditures.

2. Large up-front deductibles

A form of cost-sharing, deductibles require subscribers to pay 100% of initial medical costs up to a pre-set ceiling. As with motor or property insurance, subscribers who elect higher deductibles have increased self-risk, and, therefore, receive a reduction in their premium.

3. No-claim bonuses

A no-claim bonus rewards the subscriber for not using services. Rewards can take a wide variety of forms (partial reimbursement of a paid premium, lower future premiums or bonus credits exchangeable for goods). No-claim bonuses give the subscriber a financial incentive not to use services, or, if feasible, to pay out-of-pocket for occasional use. The mandatory sliding no-claim bonus currently proposed in the Netherlands would institute a special type of no-claim bonus, resembling a deductible.

4. Flat-rate premiums

Flat-rate premiums require the insured to pay the same amount regardless of income. These differ dramatically from the normal arrangement in SHI systems, collected as a percentage of wages up to an income ceiling. The traditional approach, while not progressive in its impact on equity, is only mildly regressive.[3] Flat-rate premiums are highly regressive.

Country experience

Experiments and/or pilot projects with these four types of individual incentive schemes are currently ongoing in Germany, the Netherlands, and

"In France, Germany and the Netherlands patients can visit a doctor outside the network without penalty…Swiss sickness funds can offer discounts to those who are willing to restrict provider choice".

Switzerland as well as (to a lesser degree) France. Since the application in each country differs, this section looks more closely at specific country approaches.

Provider networks and selective contracting

German law hardly allowed sickness funds to negotiate individual physician contracts prior to the implementation of *GKV-Modernisierungsgesetz* on 1 January 2004. However, this new law now expands provider-contracting possibilities, allowing for individual contracts with medical centres with salaried doctors, and individual contracts with organisations that offer integrated clinical services. The new law also stipulates that 1% of total payments to providers should be directed to these integrated care initiatives.

Germany has had physician networks in the narrow sense since the late 1980s. There are also physician networks with emergency services and coordinated timetables, and practice networks with integrated care associated with hospitals. Examples of the latter are the *Diagnostischen Zentrums* in Papenburg and the AOK network *Praxisnetz Nürnberg Nord*. A special case was the *Praxisnetz Berlin* where the industry sickness fund association (BKK) was actively involved (although since 2003 several German sickness funds also participate in Regional Disease Management Programmes). This project began in 1996, however it was unable to attract large numbers of patients, and in 2002 was discontinued. Patients were asked to join voluntarily and, while better continuity of care was provided, there were no financial incentives.

A successor project was set up in *Nordrhein-Westfalen* in January 2004. It differs from the Berlin project in that it intends to concentrate only on patients with three severe conditions (breast cancer, coronary disease, and a need for orthopaedics), and it will work with high quality clinics and use treatment patterns based on best practice. It is presumed that patients will have less incentive to shop around, and that the financial benefit of having longer-term contracts with clinics will outweigh extra treatment costs. The project started only with 5 of the 220 BKK sickness funds, but if deemed successful, the model will be applied to all BKK funds.*

In France, since the beginning of 1998, an optional gate-keeping system in ambulatory services exists. If patients choose a GP acting as a gatekeeper, those patients without complementary health insurance (that covers GP fees) no longer have to pay the entire visit fee up front, but only the *ticket modérateur* (about 1/3). The *médecins référents*, as participating GPs are called, receive the balance directly from the social security system. Patients benefit clinically from better continuity of care.[4,5] The *médecin référent* benefits financially, receiving a fixed amount per year per patient enrolled (for 2004 this amount is €45.74).* In September 2003, 6,363 physicians participated (about 12% of all French GPs), and the number of patients participating has nearly doubled since 2000, reaching 1,032,760, or 1.7% of the French population.[6] The impact of these arrangements on health care costs and quality seems to be marginal so far,[5] and consultations seem to be slightly higher for participating physicians, but there are signs that *médecins référents* prescribe less while their patients are typically older and high-cost-diseases are more frequent among them than is the case for other GPs.[7]

In the Netherlands, both the sickness fund AGIS and the private company, *Alant Medical,* are experimenting with integrated care concepts. Since 2000, AGIS (1.5 million sickness fund insured, about 15% of all Dutch sickness fund insured) has been developing a preferred provider project for diabetes patients. The first phase involved some 6,000 patients in Amsterdam as of April 2003. The next phase will be larger and AGIS will reward providers with bonuses tied to outcomes (physiological indicators, quality of life, consumer surveys). All AGIS insured with diabetes can choose to participate if they are willing to limit their diabetes-related visits to the contracted group of 'best practice' providers. As Dutch law does not allow premium differentiation within one sickness fund, patients receive no financial benefit. Nevertheless, the long-term purpose of the project is to offer such a premium discount as soon as the law allows it.* *Alant Medica*l also is experimenting with integrated care arrangements, which it offers to sickness funds. They consist of specialised clinics for prevention of coronary diseases and for women's health.*

In all three countries, France, Germany, and the Netherlands, patients can still opt to go to a doctor outside the network without penalty. The Swiss case is different. Swiss sickness funds are allowed to offer certain legally determined premium discounts to those insured who choose to

restrict provider choice by participating in a provider network. The first such network (*HMO-Gruppenpraxen*) was established in 1990.[8] One year earlier, the *Bundesrat* created the legal framework that allowed for experimental implementation of alternative forms of health insurance. The 1994 Health Insurance Law (KVG) legalised network constructions from 1 January 1996 for all sickness funds. Currently, different configurations of provider networks exist over the whole spectrum: from loose networks to full staff model HMOs.[9] More than 2,000 doctors and, on 12 December 2002, 7.6% of the insured participate in one of these networks.[10] Patients are restricted in their choice of provider to, typically, 5–7 doctors, but sometimes more than 30 as in Geneva, working in the group (GPs and some specialists), and are referred to other specialists if needed. In return, patients receive a premium discount of between 8 and 25%.* There are signs that solidarity has been affected as these networks appear to encourage risk selection.[9,11]

Upfront deductibles

In Switzerland, all sickness fund subscribers have an initial deductible each year. The amount was set at 230 SFr since 1 January 1998, but has been increased to 300SFr as of 1 January 2004. While optional deductibles have existed since 1987, the 1996 compulsory sickness insurance act gave all Swiss the possibility to opt for a higher deductible of (for adults): SFR 400, 600, 1200 or 1500. In return, a discounted premium is offered. These discounts were reduced on 1 January 2004 when the new minimum deductible was introduced. Now, they amount respectively to 3, 9, 24 and 30%.* Between 1994 and 2002 the percentage of insured choosing to participate in one of the four higher deductible schemes increased steadily from 9.0% to 40.5%.[10]

Since 1 January 2004, some BKK sickness funds in Germany also offer deductibles. The highest income insured can elect either a deductible or a no-claim bonus scheme (see below). Beyond the mandatory enrolment period of one year, sickness funds have considerable freedom in designing the system. An example is the Bayer BKK which offers a maximum deductible of €750 for 2004 in return for a €600 premium discount if no care is used during a year (preventive care is excluded). This arrangement is intended to restrain voluntarily insured members from switching to commercial health insurers.*

No-claim bonuses

In Switzerland no-claim bonuses have been allowed since 1990.* Subscribers have the option to enroll in a five-year scheme which charges a 10% higher initial premium, but each subsequent year offers an increasing premium discount if no services are used. The largest insurer (*CSS Versicherung*, covering 1.2 million people, about 15% of the Swiss population) implemented this tiered bonus system on 1 January 1993, however, the number of persons enrolled never exceeded 300 and decreased steadily to 227 in 2003.* In 1995, only 0.46% of the overall Swiss population subscribed to this voluntary scheme, a percentage that fell to 0.12% of the Swiss population in 2002.[10]

While in 1989 and 1990 there were some experiments with paying back contributions by private insurance companies in Germany, sickness funds were only allowed to experiment with no-claim bonuses from the late 1990s. The AOK sickness funds started a pilot project in 1996 in Hamburg with a no-claim bonus (some other pilot projects followed). In 1998 the project was cancelled, when it became clear that only a few healthy AOK insured would benefit from the scheme.

Since 1 January 2004, German law has allowed sickness funds to offer a voluntary no-claim scheme. So far, several AOK and BKK funds introduced some variation of the system. The government determined that it should only apply to the highest-income participants: those who earn incomes above the mandatory ceiling and then voluntarily choose to remain in the statutory system. The thinking is that this limitation protects lower income subscribers from abstaining from necessary care for financial reasons. A spokesperson of the AOK expects the concept to be expanded in the future to a broader range of sickness fund insured, as in Switzerland.* Sickness funds are free to design key aspects of the scheme. Several AOK funds introduced systems that reward patients with financial bonuses for preventive measures (for example, immunisation, healthy life style, etc.), while other funds reward their insured with bonus credits (exchangeable for goods).

"So far, no-claim bonuses have been voluntary, the Dutch proposal will change this".

Thus far, no-claim bonuses have been voluntary. The Dutch proposal for a mandatory, sliding, no-claim bonus, if approved by Parliament, will change this (see Table 1). Subscribers will be reimbursed by their sickness fund for a certain part of the pre-

Table 1 NO-CLAIM BONUS SCHEMES

	Germany	Switzerland	Netherlands (proposed)
Introduced	1 January 2004 (also: several pilot projects in the late 1990s)	1990 (experimental regulation; adapted and consolidated by 1996 law)	1 January 2005
Discount when no care is used in a year	Different schemes (one month of premium refund / bonus credits exchangeable for goods / etc.)	Year without care: 1st 10% higher premium 2nd 15% discount 3rd 25% discount 4th 35% discount 5th 45% discount	About EUR 250 refund
What happens when care is used during a year?	Different schemes (no refund / no bonus if not preventive care / etc.)	Move back one year on discount scale	Discounted from deductible
Scope	Voluntary sickness fund insured (earning more than EUR 46,350 in 2004), subscribed to a sickness fund that chose to implement such a scheme	Sickness fund insured if the fund chose to offer the scheme	All sickness fund insured
Voluntary/Mandatory	Voluntary	Voluntary	Mandatory
Minimum period of enrolment	1 year	5 years (abolished in 2004)	Permanent

mium paid (threshold) minus declared health costs if the declared expenses lie below the threshold. Maternity care and part of the cost of a GP consultation would be excluded. The new plan replaces the earlier proposal of a deductible of a similar amount. Sickness funds preferred deductibles to be paid in advance to prevent difficulties in collecting after-service payments. Sliding no-claim bonuses solve this problem while having basically the same effect as an up-front deductible, making patients pay for the first health care costs incurred.

"new demand-side mechanisms raise important strategic questions for SHI systems"

Flat-rate premiums

In the Netherlands, sickness funds have charged a small additional flat-rate premium since 1989. For 1989 and 1990 this was set nationally at €70.79 per year. Since 1991, each sickness fund has its own rate. Until 1996, these remained just below €90 per year with little variation among funds. Since 1996, these flat-rate premiums have increased substantially, and the difference between the amounts charged by different sickness funds has increased as well. In 2003, these premiums were between €239.40 and €390 annually. In 2004, there was a slight decrease to between €215.40 and €358.20.[12]

In the 1990s, Belgium introduced annual income-independent contributions for sickness fund insured which increased steadily in small amounts to €12 in 2003, but are now back to €6. These small fees serve to create a reserve and are usually agreed upon between the sickness funds at a national level. Other income-independent contributions made directly to the sickness fund have existed for decades: the insured pay a monthly membership fee of about €4–8 varying among sickness funds. They are used to provide extra services under strict government control. The self-employed opting to have equal SHI coverage as wage-earners (the self-employed only have compulsory SHI for large risks, while wage-earners are compulsorily covered for smaller-risks as well) have to pay an age-dependent flat-rate premium of between about €20-55 per month.*

Conclusion

The growing number of experiments with demand-side mechanisms represents a new departure for SHI systems in Western Europe. In the past, these systems have been characterised by solidarity among their membership as well as stability in their operations.[1] These new approaches, however, appear to break with key elements of that tradition. Regarding solidarity, up-front deductibles and flat-rate pre-

miums are highly regressive in that lower-income members have proportionally higher costs. No-claim bonuses encourage patients to not seek care (or potentially to pay out-of-pocket) in order to obtain a financial benefit, an incentive that, again, typically has a stronger attraction for lower-income subscribers. Selective contracting creates the potential for a multi-tiered system, differentiated initially by quality of care, but potentially, if tied to any of the other three mechanisms, by financial status. Regarding stability, introducing price differentials for individual subscribers can trigger self-selection and adverse selection in patterns that undermine collective insurance. Thus, it would appear that these new demand-side mechanisms raise important strategic questions about the likely long-term consequences for SHI systems.

Several mitigating circumstances should be noted, however. First, these measures so far have not been generalised to the entire population (the additional flat-rate premium in the Netherlands is an exception). Second, they thus far involve only voluntary participation by patients (again, the Netherlands may soon be an exception). Third, the sums involved are relatively small, with most health system funding still tied to the traditional percentage-of-income arrangement. Moreover, in Germany, the sickness funds are already compensated by the national risk adjustment scheme for those enrolled in a disease management programme.

Finally, these new measures are not being utilised within all SHI systems. Thus far, there has been no movement toward such experiments in Austria and Luxembourg (where subscribers have no choice of sickness fund) or in Belgium (where the ideological roots of sickness fund membership remain undiluted).

Despite these caveats, however, there may be legitimate concern that these demand-side mechanisms represent a break with the previous SHI understanding of solidarity. Some observers worry, for example, that the Dutch (AGIS) and German (BKK) experiments may be laying the groundwork for more fundamental health system restructuring.

"Observers worry, that Dutch and German experiments may be laying the groundwork for more fundamental health system restructuring."

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* *Acknowledgement: We would like to thank the following for information and comments: Aldien Poll (AGIS), Jaap Maljers (Alant Medical), Anne-Kathrin Haas (AOK-Bundesverband), Beatrix Grohn and Beate Männel (BKK-Bundesverband), Dirk Van Herzele (Christelijke Mutualiteit Midden-Vlaanderen), Beat Haeflinger (CSS), Marie-Odile Safon (l'IRDES), Frans van Zon (Ministerie van Volksgezondheid, Welzijn en Sport), Herman Devis (Socialistische Mutualiteit Antwerpen) and Patricia Leiber and Ursula Scherrer (Swiss Federal Office for Public Health).*

Private health insurance, commercialisation and EU legislation

The next stage in Dutch health care reform

Tom ED van der Grinten and Marina W de Lint

Introduction

Developments such as the ageing and indeed double ageing of the population and the increased individualisation of society are leading to an explosive rise in the cost of healthcare in almost every country in Western Europe. In order to continue to guarantee healthcare access for all in future, national governments are finding themselves forced to re-examine the organisation and structure of their national healthcare systems. In some cases, this process of re-examination is leading to drastic changes in the national system. This is certainly true of the Netherlands.

"the government is leaning quite radically towards private, commercial implementation"

The government of the Netherlands recently opted for a new basic insurance for curative care, which has its basis in private law and which can be implemented by both non-profit and for-profit health insurers and healthcare providers.[1] This approach does not represent a departure from the course followed in the Netherlands for some 15 years in terms of system reform, on the way to regulated competition, but the government can now be said to be leaning quite radically towards a private, commercial implementation. This new Dutch experiment is likely to be of interest to other European countries, not least due to the discussion it has generated regarding the issue of how this intended approach relates to European law.

In this article we discuss the new plans for the Dutch system of health insurance, the choice for a basis in private law and the argumentation the government employs in this respect against the background of the European regulations. We conclude by expressing a number of reservations with regard to this policy.

Plans to reform the Netherlands' system of health insurance

The present Dutch system of health insurance is divided into three compartments (see Figure 1). The first concerns insurance to cover the cost of long-term care. Under the Exceptional Medical Expenses Act, all citizens of the Netherlands are insured for the cost of such care by law. The insurance in the second compartment, which encompasses curative care, has a dual character: approximately two-thirds of the population, that is to say every citizen whose income is below a certain threshold, are insured by law in accordance with the Compulsory Health Insurance Act, while the remaining section of the population is required to take out insurance on the private insurance market (including the public-law insurance schemes for civil servants). All other care is seen as belonging to the third compartment, for which everyone can take out supplementary insurance on the private market.

According to the government, the current system of health insurance is unable to counter the challenges facing the countries of Western Europe in particular. The cost of care is increasing dramatically, while the care system has also been found wanting in its ability to respond to patient and customer demand. In order to tackle these problems, the government sees reform of the care system as essential. The point of departure for this approach is competition between care providers and between health insurers, in combination with a stronger position for customers/patients. The government will set the framework and remain responsible for the accessibility, affordability and quality of care. In order to bring this about, the division of responsibilities

Figure 1 CURRENT HEALTH INSURANCE SCHEMES IN THE NETHERLANDS

1st compartment	Long-term care	Exceptional Medical Expenses Act	
2nd compartment	Curative care	Compulsory Health Insurance Act	Private insurance
3rd compartment	Supplementary care	Private insurance	

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needs to be modified and the associated instruments must be reviewed.

In terms of the health insurance system, the government believes it is essential to abandon the dual insurance structure in the second compartment and replace it with a single general insurance provision for curative care (and that this new insurance should be integrated with the existing Exceptional Medical Expenses Act provision in the long term). This is because there are major differences between the compulsory forms of health insurance set out in the Compulsory Health Insurance Act on the one hand and the private health insurance schemes on the other hand.

First of all, there is the legal basis for the insurance: the former are public-law insurance provisions, which means that everyone who meets certain criteria laid down by law is insured. This also means that the law imposes obligations on the organisations that implement these compulsory forms of insurance, such as the duty of acceptance, the obligation to offer a clearly defined basic package and obligatory participation in an equalisation fund. Private health insurance schemes, on the other hand, have their legal basis in private law: insured status is not determined directly by law but by an insurance agreement between the insurer and the policy holder. In principle, the insurer is free to determine the conditions under which he is prepared to enter into such an agreement (with the exception of policies under the Health Insurance Access Act).

A second important difference between these two types of insurance is that the organisations that implement the Compulsory Health Insurance Act are subject to a not-for-profit regulation not applicable to the private insurers. Doing away with these differences creates a level playing field for health insurers in the second compartment, thereby strengthening the desired competition.

The government's aim of removing the duality in the second insurance compartment enjoys wide-ranging support and is not subject to discussion. However, there is controversy surrounding the type of action to be taken in this regard. In order to do away with this duality, there are in fact two options available: a public-law approach (along the lines of the current compulsory health insurance funds) and a private-law approach (along the lines of the current private health insurance). The government has opted for the second approach, a controversial choice because it represents a radical shift in the way typical government tasks are carried out. Since the advent of the welfare state, the Dutch government has managed the structure, organisation and implementation of social health insurance as part of the social security system, sharing responsibility with the social partners and organisations in the field (an approach known as neo-corporatism). Now, however, the government has put considerable faith in private initiative and commerce, without being able to fully foresee what consequences this move will have for how the system functions.

One possible consequence of the government's choice deserves to be examined particularly closely, since it forms the focus for the discussion in the Netherlands. Various observers have pointed out that the choice for the private-law approach brings with it the risk that the European Union's internal market regulations will apply in full to the new health insurance, thereby undermining the foundation of income solidarity and risk solidarity upon which the system is based. A particular concern in this regard is that the new health insurance will fall within the scope of Europe's regulations governing private insurance, the non-life directives.

"will the non-life directives apply to the new standard insurance for curative care?"

EU legislation and health insurance

The Member States of the European Union have the power to structure their own social security systems as they see fit. However, recent legal precedents set by the European Court of Justice have made it clear that even health insurance systems, which are clearly identified as part of a system of social security, are not exempt from European influence.[2] It therefore seems likely that this influence will extend further as more market-related elements are incorporated into a social security system.[3]

The government plans in question have been designed with the express intention of increasing the influence of the market on the health insurance sector, as attested by such measures as the prospective private-law basis, commercial implementation and full nominal premium. At the same time the government also wants to anchor the system firmly in social parameters (risk and income solidarity) by regulating the conduct of those implementing the new insurance. It is at this point that the above-mentioned non-life directives appear on the horizon. These directives are based on the treaty provisions for the free movement of services and freedom of establishment and

are intended to encourage these freedoms in the non-life insurance sector. The non-life directives forbid Member States from intervening in the general and specific conditions of a non-life insurance policy. This means that in principle a national government cannot impose obligations on private insurers.

The question that has come to concern the Netherlands is whether the non-life directives will in fact apply to the new standard insurance for curative care. The third non-life directive does not apply to forms of insurance which are part of a statutory social security system (Article 2, paragraph 2). It is up to the European Court to decide on the applicability of this social security stipulation, as set out in the non-life directive, based on substantive criteria and not on the qualification given by a Member State itself. In the case of the Commission against Belgium (C-206/98), the Court ruled that this article must be interpreted in such a way that this directive applies to insurance provisions implemented by insurance companies at their own cost and at their own risk within the framework of a statutory social security system.

"The non-life directives mean that a national government cannot impose obligations on private insurers."

None of the parties to the discussion in the Netherlands dispute the fact that, in principle, this ruling must mean that the new standard insurance falls within the scope of application of the non-life directives. After all, the express aim of the Dutch reforms is that the organisations implementing this insurance will compete with one another and that taking financial risks is essential to this process.

What is subject to discussion, however, is whether the Netherlands can appeal to the exemption clause in the third non-life directive, thereby ensuring that the non-life directives cannot be applied after all. Some people are of the opinion that Article 54 of the third directive should be interpreted strictly and that the exemption only applies when there is a statutory social security system in force alongside the private health insurance (the new standard insurance). Given that the new Dutch standard insurance is intended to replace the statutory social security system as a whole, any appeal for an exemption on such grounds would have no chance of success. Others maintain that the exemption need not be interpreted so strictly and that it can also be invoked in cases where the new private-law system is set to replace the social security system in the course of time. The European Court of Justice has yet to rule on the exact scope of Article 54 of the third non-life directive, so it remains unclear which interpretation is the correct one.

All things considered, there is at least a risk that the non-life directives will apply and that an appeal to the exemption clause will not succeed. This brings with it the risk that it will be impossible for the Dutch government to impose the statutory restrictions needed to safeguard the income and risk solidarity of the new system.

Dealing with uncertainty

With the aim of obtaining greater certainty about the feasibility of the government's plans, the Ministry of Health, Welfare and Sport consulted European Commissioner for the Internal Market Frits Bolkestein on 1 October 2003. His answer came back within a matter of weeks.[4]

According to Mr Bolkestein, Article 54 of the third non-life directive does not have to be interpreted strictly and can be invoked to ensure that private insurers are subject to obligations in the interest of the common good, such as a duty to accept and a ban on premium differentiation. However, insofar as these obligations restrict the free movement of services and freedom of establishment, they must be objectively necessary and must not extend further than needed to accomplish the goal for which they were intended. While Mr Bolkestein does not expect any problems in this regard, he does point out that, due to the lack of a detailed legal text, it is not possible to say whether the intended Dutch system meets these requirements.

The European Internal Market Commissioner also expresses a number of reservations. In his view, the setting up of a risk equalisation fund should be examined with reference to the European regulations on state support. He is also of the opinion that, although there are no objections to including a choice between monetary and non-monetary options from the perspective of EC legislation, the exclusive prescription of a non-monetary approach could well meet with objections. According to Mr Bolkestein, it cannot be ruled out that legally obliging insurers to offer services in kind (as opposed to restitution) contravenes decrees regarding the free movement of services. Such an obligation could form a major barrier to foreign insurers seeking to offer their services in the Dutch market, since they would be obliged to engage in contracts with local healthcare providers for this purpose and this would be much more difficult for them than for their Dutch counterparts. Mr Bolkestein there-

fore argues that such an obligation should be seen as going against the principles of proportionality and necessity.

Lastly, Mr Bolkestein makes another relevant comment on the option (apparently suggested by the health ministry) of keeping the new health insurance system entirely beyond the reach of the non-life directives. The Commissioner feels that this is not a realistic option. After all, according to the Court of Justice, all insurance activities that form part of a compulsory social security system are within the scope of the non-life directives if they are carried out by insurance companies operating at their own risk and using insurance techniques based on private-law contractual relations. If the Netherlands were to decide to set up a system outside of the scope of the non-life directives, it would have to ensure that its activities could not be regarded as insurance activities. In this regard it would probably not be enough to have these activities carried out by organisations with a legal form different to those explicitly mentioned in the non-life directives. What is more, a Member State is not allowed to permit an organisation with another legal form to carry out insurance activities.

Based on its consultation with the European Internal Market Commissioner, the Dutch government concludes that the private insurance approach does not form an impediment to imposing a duty of acceptance, an obligation to provide a package compiled by the government or a ban on premium differentiation. While acknowledging that the demands of necessity and proportionality must still be taken into account, the government does not regard this as an insurmountable problem. Besides, it is not necessarily so that a public-law approach would exempt the insurance from the applicability of the non-life directives.

The government therefore concludes that both approaches are within the realm of possibility and that they do not differ significantly in terms of both their substantive functioning and the extent to which they serve the objectives of efficiency and quality. However, the government has a clear preference for a private-law design with strong public safeguards. It believes that this approach best realises the desired clarity in terms of the division of responsibility between government, citizens and insurers. In December 2003, the Minister of Health, Welfare and Sport informed parliament of the government's decision to go ahead with its plans in their present form.

Commentary

From a European perspective, a number of noteworthy points emerge from the way in which the Dutch government has dealt with the uncertainty surrounding the feasibility of its plans for reforming the system of health insurance.

First of all, the decision to consult a member of the European Commission regarding questions about the feasibility of the Dutch plans is an unusual one. After all, the only EU body in a position to examine national regulations with reference to the EC Treaty and secondary community law is the European Court of Justice. An explanation supplied by the European Commission or a member thereof can never be binding in such a case, neither for the Member States nor for the Court. It is obvious that such assurances do not provide the desired certainty on this issue. Nor do they dispel the danger that the approach selected may yet encounter problems in relation to European legislation.

"the decision to consult a member of the European Commission is unusual"

Another singular aspect of this process is the government's assertion that both approaches, the public-law approach and the private-law approach, are more or less equally matched in terms of their substantive functioning, while it nevertheless expresses a clear preference for the latter, without offering further clarification.

Considering these two points, one is compelled to ask why the Dutch government is prepared to take a legislative risk with regard to the approach it has chosen while an alternative exists, in their own words an equally good alternative, which does not have this risk attached or at least to a far lesser extent. In our opinion this legislative discussion masks the real issue at stake, that is to say the issue of the added value offered by a private-law insurance approach as opposed to a public-law approach. What 'profit' is there to be gained and by whom? This discussion is neglected when it should in fact take precedence over deliberations with regard to possible legal risks. After all, a legal risk is there to be taken when it is evident that the matter at hand is worth or more than worth the risk. In our view, this is symptomatic of a fundamental turnaround in political and social relations in the Netherlands: from a Christian and social-democratic inspired design of the welfare state to a neo-liberal order with a strong emphasis on individual freedom and responsibility, and considerable faith in the influence of the market. In such a climate,

privatisation and commercialisation are taken for granted, which means that their application to healthcare (and other sectors within the welfare state) requires no justification in its own right. It is an ideology which steers decisions in a given direction and yet which is not really open to political discussion at present. In the current political climate it is enough for the health minister to announce that the government is embarking on a particular course and will consider the need to shift direction as and when the time comes.

Apart from all this, it is also worth reminding ourselves of the possibility that these reforms may not end up being implemented in the form envisaged by the present government. Although the conditions for reform of the healthcare system appear to be more favourable than ever before (the sense of urgency is great) previous attempts at reforming the Dutch healthcare sector have demonstrated just how powerful a veto the stakeholders are able to mobilise at crucial moments, to block developments they regard as disagreeable. In other words, the ball is still very much in play…

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Musculoskeletal health

Preventing a dependent population

Anthony D Woolf, Kristina Åkesson, Juliet Compston, Karl-Göran Thorngren, Piet van Riel and Alex Watt

Musculoskeletal conditions are common and their impact is pervasive. They are the most common cause of severe long-term pain and physical disability across Europe. They are a major burden on health and social care. In Europe 20% to 30% of adults are affected at any one time by musculoskeletal pain and the WHO Global Burden of Disease Project[1] has identified osteoarthritis as one of the top ten causes of disability for countries within the EU and back pain is a major cause of work incapacity.

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Two in five women over 50 years will sustain an osteoporotic fracture. Two in five people with a musculoskeletal problem are limited in their every day activities. Musculoskeletal conditions (excluding trauma) account for almost 25% of the total cost of illness in European countries.[2] They are the second most common reason for consulting a doctor and in most countries constitute between 10% to 20% of the primary care practice burden.[3] One in five of all Europeans are under long term treatment for rheumatism and arthritis.[4] They are the commonest cause of health problems limiting work and up to 60% of people on early retirement or long-term sick leave claim musculoskeletal problems as the primary reason.[5]

Throughout Europe, the burden on the individual and society of musculoskeletal conditions will increase dramatically. The presence of many of these conditions increases markedly with age and many are affected by lifestyle practice, such as obesity, smoking and lack of physical activity. This potential dramatic increase in the burden of musculoskeletal conditions has been recognised by the UN and WHO with the endorsement of the Bone and Joint Decade,

an initiative that is globally supported by professional, scientific and patient organisations. Recognition of this problem has also lead to the European Union supporting two major projects. The first to identify indicators of musculoskeletal health that should be used across the community to monitor the burden of disease[6] and the second to develop a public health strategy to reduce the burden of musculoskeletal conditions across Europe – *The European Action Towards Better Musculoskeletal Health Report*.[7]

Musculoskeletal conditions and their impact

Musculoskeletal conditions are a diverse group of complaints brought together by their association with pain and impaired physical function. The most important conditions in terms of frequency and impact are osteoarthritis, rheumatoid arthritis, osteoporosis (including fragility fractures) low back pain and musculoskeletal injuries including sprains and strains. The *Eurobarometer* survey[8] found that nearly a quarter of all Europeans have long-standing problems with their muscles, bones and joints of which back pain is the most common.

Musculoskeletal pain is often recurrent or persistent and this in combination with lack of function of the musculoskeletal system results in disability. The prevalence of musculoskeletal conditions increases with age and although most common at older ages, there is a major impact on the working population leading to work loss and early retirement which has an associated economic burden on society. Musculoskeletal conditions cause more functional limitations in the adult population in most welfare states than any other group of disorders. In the Ontario Health Survey[9] musculoskeletal conditions caused 40% of all chronic conditions, 54% of all long-term disability, 24% of all restricted activity days and there are similar statistics in Western Europe.

As a consequence musculoskeletal complaints are a major cause of sickness absence, and come second only to respiratory disorders in short-term sickness absence and are the major cause of long-term absence. They are also the most common reasons for disability pensions and back pain is the most common of the musculoskeletal conditions causing this. In the Netherlands musculoskeletal diseases have been found to be the most expensive disease category regarding work absenteeism and disablement.

Musculoskeletal conditions were also found to be the most expensive disease category in the Swedish Cost of Illness Study representing 22.6% of the total cost of all illness, 90% of these were indirect costs.[2,10] 47% were attributable to back pain, 14% to osteoarthritis and 5.5% to rheumatoid arthritis. In the Netherlands musculoskeletal costs ranked fifth at age 15 to 44 years, second at age 45 to 64 years and third at age 65 to 84 years after dementia and stroke.[11]

Disability generates a lot of hidden costs associated with support by family and carers and lost opportunities such as a history of back pain preventing somebody pursuing a physically active career. There is also the issue of stigma and social exclusion associated with physical disability. There are therefore clearly strong arguments for implementing a public health policy to improve musculoskeletal health by prevention and control of musculoskeletal problems.

Strategies for the prevention and control of musculoskeletal conditions

Common themes for the prevention and control of musculoskeletal problems have been identified in the *European Action towards Better Musculoskeletal Health Report*.[7] There is a large body of evidence about specific interventions for the prevention and treatment of the different musculoskeletal conditions. The European Bone and Joint Health Strategies Project developed these strategies by bringing together this evidence with experts and relevant health professionals along with the experience of those who have or are at risk of musculoskeletal problems. This collaboration provided a unique opportunity to develop a methodology that would allow the integration of the evidence for all the different major musculoskeletal conditions. This has resulted in strong clear messages.

As musculoskeletal problems are so common and pervasive, there is a strong argument for a European health promotion campaign aimed at their prevention and thus minimising their impact. There is evidence that musculoskeletal health can be improved by a number of health promotion strategies. These include: physical activity to maintain physical fitness, maintaining an ideal body weight, having a balanced diet, avoiding smoking and the balanced use of alcohol, promoting accident prevention programmes, programmes to avoid abnormal or overuse of the muscu-

"Musculoskeletal problems are the ommonest cause of health problems limiting work"

loskeletal system at the workplace and during leisure activities.

Overall it is important to raise the awareness of problems that relate to the musculoskeletal system to create a more positive attitude to the importance of its prevention and the need for early effective management.

It is also clear that some groups of the population are at greater risk than others and it is more cost effective to target these. Case finding strategies have been developed for osteoarthritis, rheumatoid arthritis, back pain, osteoporosis and musculoskeletal injuries that need to be disseminated, implemented and evaluated. Once those at greatest risk are identified there are now effective interventions for prevention. For example the progressive destructive course of rheumatoid arthritis can be reduced and osteoporosis can be effectively prevented and treated to reduce the risk of fracture.

Musculoskeletal problems like many other health conditions, do not often become apparent until their first manifestation and the prevention of long-term disability requires early case identification, assessment and appropriate care. There is strong evidence that this will not only reduce the symptoms but also maintain function and reduce dependency and costs. This needs to be achieved on a background of enabling those with musculoskeletal conditions to know what to do and to have the skills to manage and take responsibility for their own condition in the long-term.

Effective treatments have been recommended in the *European Action towards Better Musculoskeletal Health Report* for the major musculoskeletal conditions but the greatest barrier is ensuring access to these. This not only requires the provision of services but also awareness among the public, patients and health professionals of what can and should be achieved. Many of the musculoskeletal problems are considered to be an inevitable part of ageing and their impact at younger ages on quality of life and the economic burden on the individual and society have not been fully appreciated. Traditionally the education of health care professionals has been inadequate in this area. In parallel to the initiatives to recommend public health policies for the prevention and control of musculoskeletal conditions, there have also been recommendations developed for education of health care professionals by the Bone and Joint Decade Education Task Force.

What are the implications for different stake holders?

The identification of the enormous burden of musculoskeletal conditions and of strategies for their prevention requires European and national policies that recognise the importance of musculoskeletal health and encourage and facilitate implementation of the *European Action towards Better Musculoskeletal Health Report*. The burden along with the evidence of what can be achieved to reduce it justifies musculoskeletal conditions standing alongside other healthcare priorities across Europe. These preventative strategies will also have benefits for other areas such as cardiovascular disease. There is a need for further research that will facilitate the implementation of the strategies as well as the collection of data, for example as part of health interview surveys, to monitor their effectiveness. The investment is not only needed in the provision of appropriate care but in raising awareness and knowledge amongst the public, patients and healthcare providers on how musculoskeletal health can be improved.

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Advancing integrated care for older people through EU Policy:

CARMEN thematic network expertise informs the European agenda

Nicoline Tamsma, Philip Berman and Henk Nies

"a range of EU policy areas do have some impact on the further advancement of integrated care"

Europe's population is getting older. The challenges that this poses to EU member states are reflected in many Community policies and programmes. The Lisbon agenda, the EU's roadmap to a knowledge-based economy and to modernising the European social model is one example, as is the Community's programme for research and development. Funded though the Fifth Framework Programme, the CARMEN (Care and Management of Services for Older People in Europe Network) project sought to improve the management of integrated care services for older people. The project explored a range of avenues towards good quality, accessible and sustainable client-centred services. While facilitating the exchange of expertise and good practice, the project also specifically focused on policy issues both at national and European levels.

Managed and coordinated by the European Health Management Association (EHMA), 40 European organisations from 11 European countries participated in CARMEN between March 2001 and June 2004. The Network brought researchers together with a broad range of stakeholders, including professionals, providers, purchasers, informal carers, and representatives of older people themselves. The dialogue between this diverse group of experts formed the heart of the project. This enabled problems and good practices to be explored from many different angles. Although finding common ground was not necessarily the main objective, there was striking agreement over the key challenges as well as over the key components of solutions leading to better and more efficient integration of services.[1,2]

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Policy focus

Grounded in practice as well as theory, the insights acquired through the CARMEN project provided solid building blocks for policy. As pointed out earlier, strategic management of services at policy level was an explicit focus of the project. The results of these efforts with regard to national policy are reflected in the CARMEN Policy Framework,[3] which offers a checklist for policy makers at national and regional level.

In addition to its policy recommendations, the CARMEN network has also published recommendations for a European research agenda[4] with strong connections to the EU policy issues described in this article. There is a real need for the Commission to support research on integrated care for older people if its policy objectives are to be met.

When the CARMEN project was still on the drawing board, it was anticipated that any analysis of relevant implications for policy development and implementation at EU level would have to target various policy processes that the Council, Parliament and Commission are involved in. Under the principle of subsidiarity, the organisation and delivery of health and social care services are the responsibility of Member States and the EU has no specific competency in this field. Consequently, there is no such thing as an EU policy on health care, let alone a policy on long-term or integrated care.

There are, however, a range of EU policy areas that do impact more or less indirectly on the further advancement of integrated care, such as internal market and social policy (including employment, social exclusion, pensions and social protection). Over the period of the CARMEN project, new developments emerged from these frameworks that would have implications for the whole system of services involved in integrated care, for carers, and for older people themselves.

"the Lisbon European Council stressed that social protection systems needed to be reformed to continue to provide quality health services in an ageing society"

The European policy context

Health care and long-term care for older people: tackling common challenges within the social protection agenda

The most immediate link to CARMEN's key concerns emerged from the Lisbon European Council in 2000 and its follow-up with regard to the social policy agenda. In response to a Commission communication,[5] the Council stressed that social protection systems needed to be reformed in order to continue to provide quality health services in light of an ageing society. Subsequently, the Gothenburg Council (2001) asked for an orientation on the field of health care and care for older people, against the backdrop of the 'open method of coordination'. Building on the principle of subsidiarity, this method of working allows Member States to tackle common challenges and problems, while at the same time continuing to define their own national strategy, and benefiting from experiences and good practices of other Member States.

Since then, the issue of health care and long-term care for older people has been at the centre of a string of publications:

1. A report based on another Commission Communication[6] (December 2001), suggesting EU member states should ensure three broad objectives:

Access for all regardless of income or wealth.

A high level of quality of care.

Financial sustainability of care systems.

2. A joint report from the Commission and the Council on supporting national strategies for the future of health care and care for the elderly (March 2003), based on information provided by Member States on how they deliver the objectives above .[7]

3. A European Parliament report confirming the validity of the three key objectives for the modernisation of health care and long-term care as well as the importance of further structured cooperation between Member States.[8]

4. A Commission Communication defining a common framework to support Member States in the reform and development of health care and long-term care using the open method of coordination[9] and proposing common objectives for health care provision. The timeframe proposed for this open coordination process would see the Commission starting work on identifying possible indicators for joint objectives before the end of 2004 and Member States presenting medium-term policy objectives by Spring 2005. This would then lead to an initial series of development and reform strategies in health care and long-term care for the period 2006–2009.

Internal market policy and its consequences for services and patient mobility

Incorporating the freedom of individuals, goods, services, and capital, the EU internal market rules do impinge on health care and integrated care provision as was clarified by numerous rulings of the European Court of Justice (ECJ).[10] This led to the publication of two different proposals from the Commission:

1. Parallel to the Communication on health care and long-term care, the Commission published another Communication which evolved out of the High Level Process of Reflection on Patient Mobility. It presents a set of concrete proposals to address patient mobility as a consequence of the EU internal market.[11] The two Communications complement each other. Together, they present an overall strategy for developing a shared vision for European health care and social protection systems.

2. A proposed Directive on services in the internal market[12] to provide a legal framework to eliminate obstacles to the freedom of establishment for service providers and the free movement of services. Covering a wide variety of services that the Commission considers as 'economic service activities', it includes an article on the assumption of health care costs. The proposal would also reinforce the distinction between hospital and non-hospital care made by the ECJ* in recognising patients' rights to benefit from reimbursement in the case of medical treatment dispensed in another Member State, and would provide a universal definition of hospital care across the EU.

CARMEN's recommendations for EU policy[13]

Overall comments

The Commission has initiated a process towards the development of a shared vision for European health care and social protection service, which has great potential to enhance integrated care for older people. This potential should be maximised by a broad focus which includes perspectives on empowerment, prevention, social values such as equity and solidarity, and the role of informal carers. The shared vision should appreciate the contribution of all

* See case law European Court of Justice on the free movement of patients: Kohll (C-158/96), Decker (C-120/95), Smits and Peerbooms (C-157/99), Vanbraekel (C-368/98) and Müller-Fauré (C-385/99).

elements of the health and social care system to improving services for older people, embracing whole systems service provision. A narrow focus on acute care only would be a missed opportunity.

Given CARMEN's commitment to put older people in the centre of service development and delivery, its strong plea for the promotion of older people's positive contribution to society may come as no surprise. Older people should be seen as individuals, not a uniform group; as assets to society, not a social burden. The Lisbon agenda is the EU's most prominent stage to take on both economic and social challenges. Recognising this, a good balance between economic and social objectives is essential in order to protect vulnerable citizens, support independence and achieve a positive outcome for older EU citizens in all Member States.

Tackling challenges with regard to health care and long term care

The suggested open method of coordination is to support Member States' national strategies in tackling common challenges. Maybe one of the most prominent hurdles to sustainable solutions for delivering care for older people is the administrative, financial and organisational compartmentalisation of health and social care systems. Country-specific problems tend to follow the dividing lines of these system compartments, with the division between social and health care being particularly prominent and the problems in the acute health care sector often taking centre-stage. Member States should be encouraged to establish mechanisms and incentives to work across these two main pillars and their sub-sections, and to stimulate policy developments that encourage joint working and innovation at sector interfaces. Similarly, Member States should stimulate clear and coordinated policy responsibilities across local, regional and national level.

National Action Plans (NAPs) set up by Member States to deliver common social policy objectives should allow for the implementation of activities that enable the positive contribution of health and long-term care to other social policy areas, and vice versa. EU economic and social policy instruments, such as the Structural Funds, should support further development of the whole system of integrated care provision, including the development of services outside hospital and residential settings.

Nationally, solutions should focus on establishing a coherent system of services with a range of attractive and suitable options for all older people, including vulnerable people with multiple needs, regardless of socioeconomic status, ethnicity, gender or lifestyle. Accessible, good quality domestic services and other forms of care provided in the home setting should be available to ensure older people can continue to live independently. Structural support for informal carers is an essential element in achieving overall objectives with regard to accessible, good quality and financial sustainable long-term care. 'It should include practical, emotional and financial measures.

Other social policy themes

Next to the proposals on health care and long-tem care, the broader European social policy agenda includes issues such as employment, pensions and social inclusion. All three of these are already subject to the open method of coordination. The four processes could well be streamlined through delivery of the Lisbon agenda. This offers many opportunities for mutually reinforcing policy measures to advance health care and care for older people.

With regard to employment, active measures need to be taken to improve the image, status, remuneration and work pressures in the care sector, to stimulate employment and career opportunities in these sectors and to encourage a sustainable workforce. Measures designed to support longer working lives should take the position of older family carers into account. Their socioeconomic position should be protected against repercussions in terms of pension rights, income and/or social isolation.

In terms of social protection and inclusion, measures should be taken to prevent poorer health among older people leading to impoverishment and low income, which in turn may restrict access to care. If Member States introduce or increase co-payments and/or means testing as a cost-containment measure in health system reform, this should not lead to poverty, social exclusion, unequal access, or increase of health inequalities.

Pensions are a very important financial resource for older people. If older people are to pay more towards the costs of their care, Member States should be encouraged to cordinate pensions and other forms of financial social security on the one hand, and co-payment arrangements on the other. EU programmes aimed at tackling social exclusion should facilitate projects that encourage social participation and

"active measures need to be taken to encourage a sustainable workforce in the care sector"

CARMEN has been supported by the European Commission's 'Quality of Life and Management of Human Resources' Programme, which is part of DG Research's 5th Framework Programme. The authors are solely responsible for the views expressed in this article, which does not represent the opinion of the Community.

independence of older people and their informal carers.

Gender equality being a fifth key social policy objective, older women's health, financial and social resources may need specific consideration. Compared to men, life-expectancy of women is higher and they can expect to live more years in ill-health. Consequently, their need for health care and long-term care services will be higher. As women's pensions and other financial resources are often less than those of men, women may be particularly vulnerable to adverse effects of cost-shifting from public to individual budgets and the reduction of publicly funded standard care packages.

Internal Market

In following up the recommendations emerging from the High Level Process of Reflection on patient mobility and healthcare, the focus should be on the whole system of health and social care, not on acute and hospital care only. A limited focus will lose sight of many challenges posed by internal market opportunities, including the increasing flow of older people seeking semi-residential services abroad, and the increasingly diverse group of people moving across borders to offer their services in privately purchased home care arrangements. The suggested High Level Group on Health Services and Medical Care should include experts and stakeholders from the social care sector as well as the health care sector in order to oversee the whole range of services that citizens can now access abroad as a consequence of European Court of Justice rulings. It might also include representatives of older people, patients and carers.

For patients who have received part of their treatment abroad, measures have to be taken to ensure sufficient quality, access, and continuity of care. Case-management and communication issues deserve particular attention. Patients should not be denied access to post-hospital care in their home country as a result of having received treatment in another country. The Commission's proposal for a directive on services in the internal market would reinforce the distinction between hospital and non-hospital care. Measures should be taken to guard against negative effects of Community legislation on health system compartmentalisation, and on opportunities for integration and innovation across sectors.

Future involvement from the CARMEN network and EHMA

CARMEN has been pro-active in linking with the Commission ever since the publication of the Commission's December 2001 Communication[6] and continued that dialogue as the project progressed. While the CARMEN project as such is finished, through EHMA the thematic network aspires to function as an instrument for the involvement of key stakeholders in further progress made within the EU social protection agenda both at national and EU level, and as a testing ground for common objectives and indicators should these be developed through future collaboration processes between Member States. The formula of a thematic network has also proven to be a productive tool for the exchange of good practices, which could again contribute to the open method of coordination.

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Evaluating complex social interventions

John Øvretveit

"Organisational changes and reforms are being carried out with very little reliable understanding of their progress and consequence"

Introduction

The 'evidence based medicine' movement has changed attitudes, if not always the practice, of clinicians. Many agree that their practice should be informed by research about treatment effectiveness, but most also recognise that they will need to compare the research conditions with those of their own setting to assess whether they could expect similar results with their patients. Can they carry out the treatment reported in the research in the same way and are their patients sufficiently similar to those selected for the research? Research does not always transfer to all settings, but needs to be translated.

The same judgements need to be made by policy-makers and managers when seeking to use research to inform their decisions about whether to introduce a policy or organisational change. They need to assess whether a change reported in the research can be applied in the same way in their local situation, and if it were, would the results be the same?

However, the little evaluation research into organisational and health systems changes often fails to describe either the change made or the local situational factors which helped or hindered implementation. Often very few outcomes are reported, yet decision-makers are interested in a number of the consequences of such changes.

Although policy-makers and managers' decisions will never be made only on the basis of research evidence, research could improve their decision-making. Organisational changes and reforms are being carried out in healthcare with very little reliable understanding of their progress and consequences. It is possible that large amounts of time and money are being wasted, and that these changes could be better informed by research. Evaluation can strengthen democracy by holding politicians and managers to account for decisions and by enabling implementation of decisions.

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There are challenges in evaluating complex changes in healthcare and this in part accounts for the lack of research in this area. This paper considers methods for carrying out such research that could provide situationally-rich information allowing better informed decisions to be made. It describes how medical research designs have been adapted, but also looks at research methods new to health care which aim to understand how the context of the change influences the change, rather than 'controlling-out' the context. These designs help policy-makers to translate changes more effectively to their local setting and speed the spread of changes likely to be effective.

The need to evaluate complex social interventions

'Complex social interventions' (CSIs) include hospital mergers or quality programmes, external inspection processes, or introducing diagnostic related group (DRG) funding for hospitals. These and others are costly changes, but are increasingly used, often with little evidence of effectiveness. Evaluations of CSIs could help policy makers to decide if such a change would improve healthcare and how best to implement the change in their local setting.[1]

Sophisticated evaluation designs have been developed to evaluate treatments. Research using these designs is increasingly used by clinicians in their practice to decide the best treatment for patients. These designs have also been used to evaluate simple interventions to health care organisations, such as a training programme.[2] However, it is difficult to apply these designs to evaluate complex social interventions: what are the challenges, and are there methods which can give the evidence which policy-makers need?

The randomised controlled trial design

How do we know that lower costs per patient, or improved quality are in fact produced by a change carried out to get these results and not caused by something else, such as a new manager? Why not use methods for treatment evaluations that control for these other factors?

"It is not easy to use randomisation or control for many of the more complex social interventions"

When applied to treatments, the randomised controlled trial (RCT) design excludes influences other than the treatment-intervention. This increases certainty that any change to patients is due to the intervention rather that to something else, such as some patients taking other treatments at the same time. A RCT gives measures of patient status before and after the experimental intervention as well as measures of another group of patients' status before and after they received the comparison intervention. It is the researcher's task to prove that the difference is due to the intervention and not to something else, such as different types of patients in the two groups, or changes in the way the interventions were applied. Randomisation, control and prospective design rule out other things which could explain any measured before-after differences between the experimental and control groups: this makes it possible to control for factors other than the treatment-intervention.

This design has been used successfully not only to evaluate treatments to patients and services, but also to evaluate some interventions to services. An example of an intervention to a service is a training programme, where service personnel rather than patients are the 'target'. A RCT can be used to compare this training intervention to an alternative, such as no training. We can randomise service personnel to the experimental intervention (training) and to the control intervention (no training). We can select valid measures of the results of training so as to get data sensitive to the training and which does not register other factors. We can choose services that are similar so as to rule out differences in data between the two groups that could be caused by other factors such as resources or types of service.

RCT for evaluating complex social interventions

RCTs can control for most other influences or explanations with a careful study design and the cooperation of participating services. However it is not easy to use randomisation or control for many of the more complex social interventions for services which we need to evaluate.

DRG payment systems for hospitals, a hospital merger, or a hospital quality programme are complex because they are multiple interventions: there is training but there is also an intervention to inform or consult personnel, an intervention to change the work which people do, interventions to procedures and systems and more. They are also social interventions in two senses:

- They are interventions that change to adjust to changing conditions, they 'evolve' rather than being 'implemented' in a linear fashion.
- The organisations they are aimed at are social entities, constantly changing and involving sub-groups who interpret and respond to changes in different ways.

In the language of sociology and political science complex social interventions are carried out by individuals and social groups who interpret and adapt to their situation, they are not standardisable treatments. These 'interventions' also act on organisations which do not respond like human physiology but which involve multiple groups who interpret and respond to the change differently. In addition the organisation is part of the surrounding social, economic, political and cultural environment. The organisation's interaction with this environment affects the results of the intervention in a way which is different to the way a patient's environment affects their response to a drug or surgery.

These complex changes are interventions to services that are widely used. Current management wisdom is that the effects of these interventions are worth the costs of the intervention: but is this like thinking that patients with epilepsy are cured by bloodletting? Current medical wisdom is that only an RCT can discover if these interventions are effective, but it is not practical to allocate these interventions randomly to an experimental group of hospitals and to a comparison group. The intervention itself changes over time and is not a standard dose, and the hospitals also change as a result of other factors. Even if it is possible to trial the intervention in some hospitals and not in other similar hospitals, there are many things we cannot control for, and which could explain any before-after differences between the two groups.

Control, or understand?

Do these challenges mean that research cannot assess whether social interventions like DRG payment, mergers or hospital quality programmes are effective? There are two schools of thought. First the 'quasi-experimentalists', who take the RCT as the ideal. Randomisation might not be possible, but we can try to get comparable groups of personnel or organisations, those 'exposed' to an intervention like a merger,

and those not exposed. We can try to standardise the intervention by choosing or planning mergers which are similar and compare these with comparable paired non-merger hospitals. We might also be able to design and carry out the study prospectively rather than retrospectively. The second school of thought, the 'social evaluators', argue that an RCT is not only impractical, but undesirable. The following gives an example of a social evaluation and then explains the arguments against using RCT design.

An example of a social evaluation

In 1994 six Norwegian hospitals introduced quality programmes as an experiment sponsored by the Norwegian Medical Association to find out if 'total quality management' (TQM) was effective. I was asked to evaluate this experiment. The hospitals ranged from a small 55 bed to a large 800 bed teaching hospital. We could not randomly allocate TQM to different hospitals, so I selected another six comparable hospitals and set about collecting data to find out if the quality programmes produced outcomes which were different in the two sets of hospitals.

I soon abandoned this approach because it became clear that each of the six TQM hospitals was carrying out very different activities in the name of TQM. Each had interpreted this concept of TQM differently, and each were changing their programmes regularly, so that what was carried out was nothing like what was planned.[3]

The approach I took was, first of all, to describe the actual activities each carried out which they called 'TQM', using theories about how to implement TQM and their plans to guide data gathering for the description. With this description it was then possible to see more clearly what outcomes might be expected and to gather data about the changes which did happen. Over a four year period I gathered the views of a cross-section of personnel about what outcomes they expected and what had happened, and also their views about what caused these outcomes, and compared this across the six hospitals. I also gathered data about hospital costs and patient outcomes and found differences, but could not be sure these were due to the TQM programmes and not to something else.

This study could not show conclusively that TQM was effective. What it did give was the first description of how hospitals interpreted and carried through a quality programme and the assessments of personnel about the results. It discovered important differences between the programmes. The comparisons found that personnel assessed as more successful those programmes that had taken steps to involve middle managers and doctors. It found in all of the hospitals that better results were achieved in those departments where measurement and project teams were used in a particular way.

The limitations of RCTs for CSIs

Even if a controlled trial design would have been possible, why would it have been less desirable than the 'social evaluation' design? There are a number of arguments of the 'social evaluation' school.[4] RCTs only measure a few limited outcomes which are suited to statistical calculations for assessing the probability of before and after outcome differences being greater than chance. In evaluating social interventions we need to assess a broader range of outcomes, not just patient outcomes but those for many different stakeholder groups.

RCTs only assess outcomes. They do not help us understand the mechanisms or processes which produce the outcomes. When assessing social interventions we are interested in which aspect of the intervention was the most 'potent', and in how and why it had any effect we may detect. We can make use of informed people who are involved in the change to theorise about how the intervention produces effects, or fails to do so. Because the intervention is a social one, to a social organisation, and if many people hold the same views, then their views have an impact regardless of whether their views are 'true' or not.

RCTs standardise the intervention, each patient is exposed to the same intervention so that before and after differences could not later be attributed to individual treatments that were slightly different. However, it is not practical to standardise most social interventions such as a merger, but, more importantly, not desirable to do so. Research suggests that some social interventions such as a merger or quality programme are most effective when the concept is adapted to the local situation, which includes adjusting the intervention as it progresses. Drug doses are adjusted to patients, but the adjustments of social interventions as they are applied to social organisations are of a different order. With social interventions the planned 'merger' is not the same as what actually happens. The point is not to standardise the intervention,

"some social interventions such as a merger or quality programme are most effective when adapted to the local situation, and adjusted as they progress"

"'real time' action evaluation research can help make better informed policy and management decisions about whether and how to carry out a change"

but to describe it as it unfolds and evolves. Standardising it makes it likely to fail.

RCTs try to control-out situational factors. The more that they do, then the more the findings are thought to be generalisable to other settings. But with complex social interventions, the situational factors cannot be separated and in one sense are an important part of the intervention. But this does not mean that the findings cannot be generalised to other settings because they are so situationally-dependent? The point is not to control-out situational factors but to understand them. Social interventions like mergers are changed as they are carried out, not only to adjust to the 'internal' reactions of personnel, but also to external changes like changes in government or funding or new laws. We can control-out these factors by comparing similar organisations exposed to the same changes in context, but we are then less able to understand how and why those carrying out the intervention adapted it to the change in context.

The attribution problem for social evaluators

'Social evaluators' concentrate on describing the complex intervention as it 'unfolds' over time, rather than controlling the intervention by standardising it. They aim to understand which factors of the 'situation' are important for the effectiveness of the intervention. Rather than controlling-out these factors, they use informed participants' ideas about what these factors are, as well as other more objective data to assess the possible influence of these factors. This can help others to decide if the intervention would be effective in their local situation and which factors to pay attention to for carrying-out the intervention successfully.

However, if 'social evaluators' do not use control or randomisation, how can they establish if any of the apparent outcomes of an intervention like a merger are, in fact, produced by the merger and not by something else? These are some of the techniques used:

- A comparison group can be used to help rule-out context factors, like a change in funding explaining any discovered outcomes.
- A cross-section of informants can be used to collect data about what they think are outcomes, and to collect their ideas about how to assess whether these are the outcomes of the intervention and not something else.
- Data can be collected on intermediate or short-term outcomes, such as personnel reactions, which can more easily be linked to the intervention than patient or cost outcomes often distant from the intervention.

Conclusions

Expensive changes and interventions are being made to health care systems but with little knowledge about whether they are effective. Policy makers need to know if these changes are effective elsewhere, and how to carry through these changes if they decide to do so. RCTs can be used to evaluate some interventions, but many complex social interventions like mergers or structural reforms cannot be evaluated using this research design.

This does not mean that these changes cannot be evaluated at all. There are evaluation methods which can provide decision-makers with knowledge about how a complex change was carried out and the results. 'Quasi experimental' designs can tell us about the effectiveness of some social interventions. There are also 'social evaluations' which give less certain findings about effectiveness, but a greater understanding about a range of effects and about how these effects came about. They also give a description of what is actually done to carry out the intervention so that decision-makers do not confuse the concept or plan with what actually happened in a real situation. Such studies also examine which situational factors helped or hindered the change and how the change was adjusted to these factors as it was carried through over time. This type of 'real time' action evaluation research can help make better informed policy and management decisions about whether and how to carry out a change.

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E-Health and the informed patient

Anders Olauson

Development of the internet and its application to health care has opened up new possibilities for patients to become informed about their health and well being. Developments in digital and information technologies in health care have also allowed doctors and researchers to generate more information than ever before. The importance of e-health for the informed patient is enormous and important from several different perspectives because:

- Patients throughout Europe meet new challenges in new therapies as well as new knowledge regarding their diagnosis.
- New knowledge is not always easy to understand or to apply.
- The existing health care system is not designed to meet this new situation.

"there is a need to exchange information for patients around the world"

The imperative to provide information for the patient and what it means in practice is especially acute in an organisation such as Agrenska that focuses on the needs of children and their families faced with rare disorders.

Each one of us has been, or is going to be, a patient at some point either because one will have to look for help from a health care professional or a hospital due to illness or because of a wish to improve health in search of a better quality of life. All of us have an interest in our own health, and we are always passively or actively looking for something that could improve it.

During the last decades, scientific opportunities and medical breakthroughs have had an enormous impact on the quality and length of life. More is to come and even faster than before. With the incredible biomedical developments today, it is possible to get a cure or a treatment somewhere on this Earth for nearly any health condition. This does not mean that we can cure every illness and restore health, but it means that we can improve health conditions to a much greater extent than before.

Obstacles to overcome

There are of course many obstacles that have to be overcome and there is a lot of new knowledge to be developed in order to really cure illnesses. Among some of the most pressing is the need to:

- Get drugs faster to the patient.
- Provide safer and more targeted products.
- Develop new ways of cooperation between the patient and many different partners, such as pharmaceutical companies, government, academic, scientific or health professional organisations.

The possibilities are great but truly impossible to achieve without providing greater information for patients in future. This is not limited to greater individual responsibility and compliance alone. Future patients have to be much more closely involved in stimulating research and facilitating clinical trials through better and smarter information technology directed to predicting risks and benefits. Finally, there is a need to exchange information for patients around the world in a trustworthy and secure way.

Although good in principle, we are still not in general in this situation today. Our task is to develop many more situations and places where this interaction between the patient and different partners can effectively take place. The interaction will not occur if we simply create a meeting or, send out a survey, or talk with professionals. Information for the patient requires cooperation in situations meeting certain standards.

The Agrenska Foundation

One example of such a meeting place is the Agrenska Foundation in Sweden. Agrenska is dedicated to the provision of information not only for patients but also for their entire families, and serves as an information exchange for patients with specific diagnoses. Agrenska is focusing in particular on rare diseases in children and their families. Since the beginning of 1989 more than 3000 families have participated in different diagnosis-related family programmes. As these diseases are rare, the need for information is particularly intense. Moreover as these conditions affect children, their impact on families and society is that much more profound.

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"costs to society are less than for uninformed patient"

It is within the Family programme at Agrenska that these interactions take place. Children already identified by the medical system come to Agrenska with their parents and siblings because they all need information. Here meetings take place between many different partners, such as researchers from pharmaceutical companies, government representatives, academic, scientific or health professionals, and the patients.

Together with Microsoft, Agrenska has developed a virtual platform on the Internet (www.agrenska.se/familyprogram) for use by the children and their families. They can use this either to exchange experiences and thoughts after their visit in a chat forum where they also can exchange information with the experts that they met during the visit. Children can also use a 'picture diary' to exchange information with friends and/or professionals.

This two-way interaction is very important because information with respect to the conditions seen at Agrenska has to come directly from different actors. It is equally valuable that this information then goes back from the patient to the researchers, or to health care system professionals. The benefits of this programme are undoubtedly recognised not only in Sweden but also internationally. This can be seen by the interest from different institutions and companies worldwide. Among those who have publicly acknowledged Agrenska's approach and confirmed the importance of the programme are the US National Institutes of Health, The European Organisation for Rare Diseases (Eurordis), a range of universities and hospitals in Europe, and patient organisations in Japan, the Middle East, and South Africa.

The lesson from these visits is two-fold: firstly the need is the same regardless of where people live, and secondly this type of a meeting place can be used in a variety of different cultural and governmental environments. Of course, without the involvement of Microsoft as an information technology provider major obstacles would have remained.

Lower costs

A report prepared in 1997 by the School of Economics and Commercial Law in Göteborg has shown that the health care costs with respect of children who had not gone through a tailored information family programme were notably higher than those of treated children, SEK 35,200 per annum in comparison with SEK 13,300 per annum respectively. This difference could be attributed to the fact that when compared to the other families, informed families crucially knew several important facts:

- When they should seek medical care for their child.
- Where to go, and whom to ask for care.
- How they should proceed.
- When they did *not* have to go to the hospital because they could manage by themselves.

This is the way an informed patient/person acts and behaves, and that is why costs to society are less than for uninformed patients.

Fundamental questions

In the final analysis, there are still many fundamental questions to be asked before declaring a universal preference for informed patients. Who wants an informed patient? Today we live in an individualistic society and there is a tendency for each one of us to have to make decisions about everything from pensions to what we want from our schools. So the answer may be that we have already left an 'uninformed' place for one where you have to be informed in order to cope. However, there are still some senior doctors in Europe who think that it is totally wrong that the pharmaceutical industry has their own direct contacts with patient organisations.

How can a patient be informed? The patient can receive information from the state, from patients' organisations, from different companies who deliver services, and from other bodies based on science and good standards. Must every patient be a well-informed patient? In my view, the answer is no, and this is important from a democratic point of view. Knowledge should never be that type of important power. What differentiates an informed patient from an uninformed patient? An informed patient has a feeling of empowerment as he or she is receiving more appropriate treatment, has a better sense of well-being and ultimately a better quality of life.

Who will take the responsibility to change the way healthcare services are organised today, in order to meet the needs of informed patients? The only individuals with this kind of authority are politicians. If they do not take up the challenge, their voters will force them to, either directly through elections, or by the growing use of services run by private individuals or independent companies.

WEBwatch

E-mail d.mcdaid@lse.ac.uk to suggest websites for inclusion in future issues.

Dutch Presidency

www.eu2004.nl

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

The Nuffield Institute for Health, University of Leeds

www.nuffield.leeds.ac.uk

The Nuffield Institute for Health, conducts research in the areas of management, medicine, health and social sciences, and also has a strong focus on linking evidence, policy and practice. As well as providing information on research activities, and teaching programmes, a wide range of working papers, reports and other publications can be downloaded.

The Healthcare Commission

www.healthcarecommission.org.uk

The Healthcare Commission is a new organisation that was launched on the 1st April 2004. It exists to promote improvement in the quality of healthcare in England and Wales. In England only this also includes regulation of the independent healthcare sector; separate bodies are responsible for these functions in Wales. Every NHS organisation in England is given a star rating from zero to three, showing how it has performed against a range of indicators and targets. In addition to publishing clinical governance reviews (routine inspections of NHS organisations), and conducting investigations when serious problems arise within the NHS, independent reviews of private sector services are also produced, together with national NHS staff and patient surveys. The Commission also produces an annual report for the UK Parliament on the state of healthcare in England and Wales. Themed reports including a recent review of national cancer care services is now available online.

Centre de Recerca en Economia i Salut (CRES), Pompeu Fabra University, Barcelona

www.upf.es/cres

The Economics and Health Research Centre (CRES) is a special research centre of Universitat Pompeu Fabra founded in 1996. It undertakes a range of health policy, management and economics research, with a strong multi disciplinary focus. The website provides access to working papers and other publications, in addition to providing information on events, activities and detailed staff profiles. The website is available in Catalan, Spanish, and English.

The Association of Public Health Observatories

www.apho.org.uk/apho

The Association of Public Health Observatories (APHO) has been established since June 2000. It was set up with the multiple aims of being a learning network for the 10 public health observatories in England and Wales and other users; to be a single point of contact for external partners; to be an advocate for users of public health information; and to coordinate work across the public health observatories. Publications available on the website include reports on regional health indicators in the English regions. Information on contacts and expertise, work in progress and forthcoming events are also available.

The Maltese Ministry of Health, The Elderly and Community Care

www.health.gov.mt

The website provides a wide range of information on public health and health care services in Malta. Links are provided to other health related bodies on the island. Press releases, reports and information on healthy living are also provided. Most information is available in English although some reports are only available in Maltese.

The European Year of Education Through Sport

www.eyes-2004.info

The Council of the European Union and the European Parliament made 2004 the European Year of Education through Sport 2004 (EYES 2004). The main objective of the campaign has been to sensitise the European public to the importance of sport in an educational context as well as to increase the significance of physical activities in school curricula. A wide range of information is provided on activities and events in all official Community languages.

NEW PUBLICATIONS

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

Towards the Global Elimination of Brain Damage due to Iodine Deficiency

Edited by B Hetzel, F Delange, J Dunn, J Ling, V Mannar, C Pandav

New Delhi, Oxford: Oxford University Press, 2004

ISBN 0-195-67095-7

578 pages. Paperback

Review by
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Iodine deficiency is the most common preventable cause of brain damage in the world today, with at least 2 billion at risk in 130 countries. This book chronicles the work of a dedicated group of scientists who have been involved in research on this and also the essential dissemination, persuasion and evaluation of appropriate policies for eliminating this scourge.

Iodine deficiency has been considered as a scourge of mankind since ancient times causing both goitre and brain damage at all ages, including for the foetus during pregnancy. People live in an environment where the soil has been leached of iodine due to flooding of river valleys or in hilly and mountainous areas by high rainfall and glaciation. This leads to iodine deficiency in all forms of plant life. Thus large numbers of people, particularly in Asia, live in areas where their diet is deficient in a vital element required for the development of the thyroid hormones. In iodine deficiency the thyroid gland enlarges to form goitre, something recorded since 3,000BC. The recognition of the relationship with brain damage is of more recent origin, and the introductory chapter chronicles the clinical, animal and biochemical and epidemiological studies that have been done to demonstrate this and other forms of iodine deficiency disorder (IDD). Various estimates are given about the magnitude of the problem, ranging from 1.6 to 2.2 billion people at risk. The effects, in economic terms are also described. There are also examples of anecdotal reports of the elimination of IDD in the 1970s at village level in Indonesia, China and India.

IDD has been considered as a problem for developing countries, particularly in Asia, and obviously the major international agencies targeted action in developing countries. However the problem in Europe was not neglected by the International Council of the Control of IDD.

Endemic goitre, often complicated by endemic cretinism, has been reported for centuries, especially in mountainous areas in Switzerland, Austria, Italy and France. IDD has been entirely eradicated in Switzerland, since 1990, due to the implementation of a salt iodisation programme, which has been continually sustained. The impact of this programme has been noted by medicine, so that IDD has not been considered an important problem for some years and become neglected. Yet in 1999 it was considered by the WHO that 34 European countries were affected by IDD, with a total population of 670 million of which 275 million were at risk. In 2002, the following countries were still considered deficient: Belgium, Denmark, France, Germany, France, Hungary, Italy, Ireland, Serbia and Montenegro, Romania, Slovenia, Spain and Turkey as well as many of the countries previously comprising the Russian Federation.

It is shaming that iodine deficiency; the most common preventable cause of mental deficiency in the world, is still so common in Europe. This is due to the lack of awareness and concern by health authorities, doctors and the public at large. This book demonstrates the great diversity of legal, political, and logistic measures required in order to have an effective iodised salt programme in place to eliminate IDD and its health consequences.

The participants in IDD research and implementation adopted a 'wheel model' for their work, an excellent model of what needs to be done if a disease is to be controlled. The outer ring is concerned with the population at risk, the prevalence of IDD, the salt economy, the health profession and public community groundswell education and training, resource allocation and assessment of prevalence of IDD, urinary iodine and salt iodine levels as outcomes. The spokes comprise correspondingly situation assessment, communication, developing action plans, achieving political will, implementation of the programme and finally its evaluation.

The development of the steps that were taken to mobilise global concern with IDD and its control by the involvement of the UN and its agencies, WHO and UNICEF, are fascinating. It is not often that one reads a coherent narrative of the necessary steps required to mobilise the international community to take effective action to control a preventable condition. Perhaps the only other example is the eradication of smallpox. The difference with IDD is however, that industry had to be involved, consumers persuaded and systems developed in order that people in very remote, inaccessible regions could be reached.

This volume describes the measures taken in the various countries and regions and illustrates the complexity and different political, legislative, logistic as well as communication methods required. Although it is reckoned that almost 70% of households now have access to iodised salt and that about 80 million newborns are protected, with a saving of over one billion IQ points, there are still

41 million unprotected newborns. This shows the continuing need to sustain progress made, tackle the problem of countries backsliding in their iodised salt coverage and help and encourage salt producers.

The story of IDD, so far, is a remarkable example of how epidemiological scientists can do both good science, and also develop and influence methods of prevention and control. It is a good example for teachers demonstrating the methods of disease control for a non-infectious condition. It illustrates the complexity and challenge of effective interventions based on good evidence and the need for adaptability in different locations.

The book has many photographs and sketches by Anne Hetzel of the affected, as well as the areas in which work was done. For epidemiology it is both an example of how a dedicated group of scientists can work well together for a common goal and how one can introduce non-epidemiological medical scientists into our field. This work is a fitting description of how an 'ancient scourge' can be controlled.

Public Policy and Social Welfare Series, Volume 28:

Providing Integrated Health and Social Care for Older Persons

A European Overview of Issues at Stake

Edited by Kai Leichsenring and Andy M. Alaszewski

Aldershot: Ashgate,2004

ISBN 0-7546-4196-1

510 pages. Paperback

£27.50

This book brings together information from the *Providing Integrated Health and Social Care for Older Persons – Issues, Problems and Solutions* (PROCARE) project in the EU Fifth Framework Programme (Quality of Life and Management of Living Resources, Area "The Ageing Population and Disabilities") that aims to help in defining the new concept of integrated health and social care for older people in need of care by comparing and evaluating different modes of care delivery. The project will identify structural, organisational, economic and social-cultural factors and actors that constitute an integrated and sustainable care system with enhanced outcomes for all actors involved.

This book gathers the achievements of the first project phase (2002) that consisted in a literature overview focusing on the question which of the variety of innovations in modes of organisation, finance and professional collaboration observed in Europe over the last decade have been the most successful and long-lasting ones. Thus, national reports from nine EU Member States (Austria, Denmark, Finland, France, Germany, Greece, Italy, the Netherlands and the UK) will be presented by scholars from leading research and consulting agencies in these countries. The national reports follow a mutually agreed structure.

The publication is introduced by a general overview and a more theoretic article defining the issues at stake. It provides a general overview on European approaches towards integrated social and health care services and policies that are to be developed to face the growing need of care in ageing societies; furthermore, it provides indicators for successful approaches and models of good practice to overcome the 'social-health-divide' and a better understanding of the meaning of integrated services and coordination of social and health systems in the different countries. Finally, facts and figures about coordination at the interface between health and social care for older people as well as problems and solutions ('lessons to learn') concerning regulation and coordination are exhibited by well-known scholars in social and health policy research.

Professor Adalbert Evers, from Justus-Leibig-University in Germany in reviewing the book has said that it's strength "lies in the fact that it brings together what is usually separated: theoretical reasoning and down-to-earth organisational model building, the presentation of illustrative national peculiarities and of well-structured cross-national analysis, a reflection of the values that are so important for the actors of change and sober empirical reports - for the use of a broad range of professionals, scientists and policy makers."

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COMPILED BY EUROHEALTH WITH ADDITIONAL INPUT FROM EUROHEALTHNET

HEALTH UNDER THE DUTCH PRESIDENCY

The focus of health under the Dutch Presidency is on cooperation between Member States. The mantra of this work is the relationship between healthcare and adjacent areas of policy, such as agriculture and the environment. A wide range of issues are being covered including: ageing populations, health and the internal market, infectious diseases, healthy foods, cross border mobility of patients and professionals, information for patients, and issues around the environment and health. The Presidency will also play an active role in the European Year of Education through Sport.

More information on the Dutch Presidency is available at: www.minvws.nl/en/themes/european_union_dutch_presidency/default.asp

Conference: Shaping the EU Health Community

As part of the Presidency, a conference, *Shaping the EU Health Community,* was held in The Hague from 7–9 September attended by 440 stakeholders in health care, including representatives of consumer groups, from all 25 EU Member States. The following themes were discussed.

Public health and internal market
As the European Union regulates alcohol, tobacco and food, and associated services, such as advertising and sales promotion, there is huge potential for influencing health outcome through effective market legislation.

Cross border care
Standardised information about provision, quality, price and availability of care is needed.

eHealth
ICT is a tool to ensure the required level of information, choice and empowerment. A full vision of the integration of eHealth into health and social care is needed from the Health Ministers of the European Union.

Drugs and medical devices
More transparency is needed in prescription, use and pricing of drugs and medical devices. Therapeutic added value should be foremost for all parties concerned, i.e. industry, prescribers and consumers.

Health care in the local community
Primary health care should be incorporated in policy and decision making at the EU level. Therefore, indicators should be developed.

Long term care
Public campaigns for health promotion and healthy ageing are needed to postpone the dependency of the elderly.

Among the principle outcomes of the conference were a recommendation that decisions taken by European institutions should contain a health impact assessment, and that European standards and codes are required to promote the quality of health care. The conference also stated that public campaigns are necessary to inform European citizens about health promotion and healthy ageing. The chair of the conference, Ms Iris van Bennekom, hailed the conference a success and was delighted about the willingness of the representatives of the European health care sector to work together towards better health care in the European Union.

Informal Health Council

The conference was followed by an informal Health Council held in Noordwijk from 9–10 September. Ministers of Health of the Member States of the European Union, exchanged ideas on the theme of *Health Care in an Ageing Society, a Challenge for all European Countries*. The subject was introduced by Professor NS Klazinga (Professor of Social Medicine at the AMC/University of Amsterdam). The ministers also took note of the conclusions of the conference *Shaping the EU Health Community*. The meeting gave rise to a number of observations by the Dutch Presidency. These included acknowledgment that ministers across Europe are concerned about the financial and social sustainability and efficiency of their health care systems. Demographic ageing, the introduction of new medical technology and growing expectations concerning health care and health care services all play a role in this development. While greater ageing is a sign of progress and success it was noted that this also presents challenges. First, how can Member States ensure that ageing citizens remain healthy for as long as possible? Second, how can health care be organised in such a way as to guarantee that all will have access to necessary health care without overloading the labour market? Third, how can health care systems be reformed in order to provide the next generation with a financially feasible model?

The meeting demonstrated that while each country is pursuing its own policy regarding these challenges, there are similarities. In many cases, reforms of the health care system include combinations of: introducing more financial incentives to improve efficiency and productivity while respecting solidarity; introduc-

Further information and presentations from the 'Shaping the EU Health Community' conference are available at www.euhealthcommunity.org

ing a more patient centred care system; and stimulating more personal responsibility.

In order to keep society, healthy, active and productive the participation of older people in society needs to be enhanced, evidence based policies for chronic diseases need to be stimulated, and a new balance is required between personal and public responsibility in order to safeguard affordable, accessible and sustainable health systems. The Dutch also observed a common need to improve cost awareness upstream prevention strategies, and to invest in primary and community based care while also stimulating integrated care, medical innovation, health education and the empowerment of patients. The Ministers agreed to the Dutch Presidency initiating a meeting with members of the High Level Group on Health Services and Medical Care in an informal setting in addition to the regular meeting to discuss the introduction of a permanent mechanism on health care issues in order to submit a proposal to the December 2004 Council.

The Informal Council was also one of the final opportunities for Commissioner Byrne to set out his perspectives on the way ahead. In his speech the Commissioner stressed the need to balance quality improvements with the need to maintain core values and ensure sustainability. He commented that "our response should focus on improving the quality of healthcare and health promotion, not by reducing solidarity and access to healthcare, nor by creating financially unsustainable systems." He also recognised the crucial role to be played by older citizens to continued economic growth stating that "active, healthy older people are a valuable resource for society. We can project the possible costs of increased healthcare, but we do not project the additional contribution that these people will make to their families, to society and to the economy at large." The Health Council will meet formally on 4 October and 6-7 December

Further information on the Informal Health Council is available at www.minvws.nl/images/future_challenges_tcm11-54749.pdf

APPOINTMENT OF NEW COMMISSIONERS

The incoming President of the European Commission, Jose Manuel Durao Barroso, has announced the portfolios for the 25 new Commissioners due to take office from 1 November for the next five years. These include:

Research and Science: Janez Potocnik (Slovenia)
Mr Potocnik is 46 and was educated in Ljubljana. He was an economic analyst by profession before becoming director of the government office for European affairs in 2000 and subsequently at the Prime Minister's Cabinet. He was Minister for European Affairs from 2002 until his nomination as Commissioner.

Employment, Social Affairs & Equal Opportuinities: Vladimir Spidia (Czech Republic)
Mr Spidia is 53 and was educated in Prague, with a varied career including public administration. He was elected to the Parliament in 1996, and became Minister of Labour and Social Affairs in 1998 then Prime Minister in 2002. He resigned in spring 2004 and was recently nominated as European Commissioner to replace Pavel Telicka, who will complete his period of office in October.

Health & Consumer Protection: Markos Kyprianou (Cyprus)
Mr Kyprianou is 44 and was educated at Athens, Cambridge and Harvard. He practised law in Cyprus 1985–2003, specialising in company law and taxation. Mr Kyprianou was elected to the House of Representatives three times from 1991 before becoming Finance Minister 2003-2004, when he was nominated to the European Commission.

In October the European Parliament will question the proposed Commissioners in a series of public hearings prior to voting on whether to approve the new college of Commissioners as a whole. Provided the new Commissioners are endorsed they will then take up their positions on 1 November.

Profiles of all new Commissioners are available from: http://europa.eu.int/comm/commissioners/newcomm_en.htm

AWARD ANNOUNCED FOR BEST COMMENTARY ON EUROPEAN HEALTH CARE REFORM

Tech Central Station Europe is offering a prize of €2500 for the best commentary piece by a European on the theme, *Putting patients first: Visions for European Health Care*. According to TCS Europe Editor, Craig Winneker, "Europeans endure long waits for medicines, treatment and surgeries – and pay high taxes for this substandard level of care. Patients lack choice and access to the best medicines. European patients deserve 21st century care and this contest seeks to engage Europe's best minds on how to improve their country's health care system."

The contest is open to all Europeans and while submissions must be in English, special consideration will be given to original thinking. The contest will also consider previously published pieces on this exact theme. Such submissions must have been published within the previous 3 months and a translation should accompany the piece it was not originally in English. Please submit to pieces by November 15 to Henrik Rasmussen at hrasmussen@techcentralstation.com and include a short personal biography as well as all relevant contact information.

Results of the contest will be announced in December. The top five commentaries will be published by www.techcentralstation.com. Authors will be compensated if their piece is selected for publication. Pieces must not exceed 1,000 words and will be judged by a panel consisting of TCS editors, Nick Schulz and Craig Winneker, and TCS host, James K Glassman. Tech Central Station is a news site, focusing on free markets and technology.

Europeans less inclined to exercise to protect their health says Commission

2004 has been designated the European Year of Education through Sport. As part of the initiative the European Commission has chosen to re-issue a 2003 survey which shows that only one in three EU-15 citizens engage in sport on a weekly basis and only 15% exercise three times a week. The Eurobarometer Survey interviewed 16,000 people over the age of 15 from the 15 Member States. During the year the Commission aims, through a series of initiatives across Europe, to raise awareness about the beneficial links between education and sport. This will focus on the key role that a healthy lifestyle plays in reducing cardiovascular disease and other life-threatening problems. To emphasise the importance of sport in everyday life, EU ministers have agreed to include sport in the EU Constitution. It was the first time ever that there has been an explicit reference to sport in an EU treaty.

French public health law to shift from cure to prevention

A proposal to amend France's public health laws has gone through a second reading in the Senate. One of the key innovations proposed in the text is to shift the focus of the healthcare system from treatment to prevention. Officials note that France ranks low in Europe in prevention efforts and has a high rate of premature death, (i.e. death before the age of 65). Only 2% of the annual national health budget of €150 billion is devoted to prevention. The new law will be a significant step in increasing the nation's investment in health education and prevention efforts. In addition, measures targeting dangerous products have been adopted, such as an amendment that will set a minimum threshold for cigarette prices making it impossible to have special offers targeting new consumers.

More information at : www.senat.fr/dossierleg/pjl03-019.html

HEALTH MINISTERS TO MAP OUT A PAN-EUROPEAN STRATEGY ON NON-COMMUNICABLE DISEASES BY 2006

On 6 September it was announced by the WHO Regional Committee for Europe that the WHO European Region is to have a sustainable strategy to face the large and growing problem of non-communicable diseases.

Over 300 delegates representing the 52 Member States of the Region have decided to give high priority to non-communicable diseases and to develop a comprehensive European strategy by the end of 2006. The strategy is to target the main killer diseases in the Region, such as cancers, cardiovascular diseases, diabetes and respiratory diseases. It will also explore ways to counter the risk factors responsible for their heavy and growing burden: tobacco use, alcohol abuse, raised blood pressure, raised cholesterol, overweight or obesity, low fruit and vegetable intake, and physical inactivity.

"The Member States' very explicit support for this strategy shows that they are determined to take action to limit the harm done by non-communicable diseases", said Dr Marc Danzon, WHO Regional Director for Europe. "Progress in this area, and on tackling risk factors as a whole, can only come from the combined efforts of individuals and society as a whole", he added. Of WHO's six regions, the European Region is the worst afflicted by non-communicable diseases, and their growth is startling. In 2002, they caused 86% of deaths and 77% of disease burden. According to WHO statistics, the leading non-communicable diseases in the Region in 2002, in terms of mortality, were cardiovascular diseases, cancers, respiratory disorders, digestive disorders and neuropsychiatric disorders. In terms of burden of disease, the chief contributors were estimated to be cardiovascular diseases (23%), neuropsychiatric disorders (20%) and cancers (11%).

Across the Region, non-communicable diseases not only target individuals, but also attack societies and countries, placing extra strain on health-care systems and threatening economic and social development. They overwhelmingly affect the poor. Mortality from cardiovascular diseases, for instance, has increased at all ages in the newly independent states (NIS) over the past decades. In 2000, the average figures for cardiovascular disease mortality were three times higher than those for the then European Union. The Region's poorer countries face the double burden of rising non-communicable disease rates, as well as persistent communicable diseases and inadequate health systems. People in low socioeconomic groups have twice the risk of serious illness and premature death of those in high socioeconomic groups, partly owing to poorer access to healthy food and greater tobacco and harmful alcohol consumption. Most health-system resources go to non-communicable diseases and this trend will continue. A significant proportion of the total cost of care falls on patients and their families.

Non-communicable diseases are largely preventable. Dr Gudjón Magnússon, Director, Division of Technical Support, Reducing Disease Burden, at the WHO Regional Office for Europe said "There is a lot of action in different countries, by governments, donors, the private sector, nongovernmental organizations and other groups, but we need these different players to pool their knowledge and work together. That is the only way we are going to reduce the death and suffering inflicted by non-communicable diseases. A European strategy on non-communicable diseases could be the beginning of a new united fight to save the lives not just of the citizens of today's Europe, but of generations to come."

More information on non-communicable diseases is available at www.euro.who.int/mediacentre/20020617_1

News in Brief

What are the palliative care needs of older people and how might they be met?

Many countries have ageing populations. With coordinated care, more people could die at home if they wished, and with specialist palliative care more patients and their families would benefit from a range of better outcomes. A new report from the Health Evidence Network written by Elizabeth Davies from the Department of Palliative Care and Policy at Guy's, King's and St Thomas' School of Medicine, London concludes that, although further research is needed, the more pressing issue is to put existing knowledge about palliative care into practice and sustain the good practices that already exist, throughout the health care system.

The report is available at www.who.dk/eprise/main/WHO/Progs/HEN/Syntheses/palliative/20040722_3

World Mental Health Day 2004

World Mental Health Day 2004 will be observed on 10 October. This year's theme is entitled "The relationship between physical and mental health: co-occurring disorders."

More information together with access to the the World Federation on Mental Health's Annual Report 2003 can be found at www.wfmh.org

International conference – PROCARE: Providing Integrated Health and Social Care for Older Persons – Facing the Challenges in Europe

PROCARE is a two year international research project co-financed by the European Union's Fifth Framework Programme with the aim to promote the new concept of integrated health and social care for older persons in need of care by comparing and evaluating different modes of care delivery. PROCARE has been carried out by a consortium of ten organisations from nine European countries. The results of this two year project will be presented at the conference taking place from 21–23 October in Venice.

More information at: www.euro.centre.org/procare

What are the equity, efficiency, cost containment and choice implications of private health-care funding in western Europe?

Over the last 20 years the level of private spending on health care has risen in many western European countries, leading to concern about its impact. The main channels of private spending are private health insurance policies and cost-sharing schemes in public health systems. A new report from the Health Evidence Network written by Sarah Thomson and Elias Mossialos from the European Observatory on Health Systems and Policies at the London School of Economics concludes that private sources of health care funding are often regressive and present financial barriers to access. They contribute little to efforts to contain costs and may actually encourage cost inflation.

The report is available at http://www.who.dk/HEN/Syntheses/hcfunding/20040629_3

Sixth Annual Conference on Integrated Care

This conference taking place at Dublin Castle on 14–15 February 2005 aims to bring together researchers, policy makers and practitioners working with providers of health and social care to exchange knowledge and experiences on integrated care. The deadline for submission of abstracts is 1 November 2004.

Further information available at www.integratedcarenetwork.org/conference2005/

Health in the EU from a Dutch Perspective

The Dutch Presidency have published a document entitled '*How do we do, Health in the EU from a Dutch Perspective*'. This looks at a range of health issues: health status, health determinants, and health care systems and compares the Dutch situation with other Member States health situations.

This is available at www.minvws.nl/images/how%20do%20we%20do_tcm11-51837.pdf

Marc Danzon nominated to second term as WHO Regional Director for Europe

Dr Marc Danzon has been nominated to a second five-year term as the WHO Regional Director for Europe. Dr Danzon, a French national and the first representative of France to lead a WHO region, announced in February this year that he would run again. No candidate opposed him. Dr Danzon will formally begin his second term on 1 February 2005. He called the vote on his re-election an endorsement of the WHO Regional Office for Europe's continuing work "to support Member States in better responding to the health needs of their citizens".

For his second mandate, Dr Danzon will give priority to "helping Member States to strengthen their capacity to respond to health threats; continuing the fight against obesity and noncommunicable diseases; providing health decision-makers with validated and accessible health information; and, of course, contributing to the global fight against HIV/AIDS."

More information at www.who.dk/eprise/main/who/mediacentre/pr/2004/20040907_1

Europeans demand changes to their healthcare systems

A study, entitled "*Impatient for Change - European attitudes to healthcare reform*" published by The Stockholm Network reveal that 84% of respondents think that changes to national health systems are urgent or necessary. The desire for change is the strongest among the working-age, taxpaying population of the EU. 77 % of those surveyed believe that patients should be given more information about their illness and about the quality of care provided by doctors and hospitals, including in other countries.

It is available at www.stockholm-network.org/pubs/imp.pdf

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